



INTRODUCTION

For over 25 years, Alliant Health Plans has been a leading health care insurance provider in Georgia. Health care providers founded our not-for-profit company with a distinct goal: to focus on our members' overall health and well-being and service them proudly, with honor and integrity. In looking to better our practices and improve our work, Alliant Health Plans has created an entirely new approach to health care. By putting doctors in charge of treatment decisions and patients ahead of profits, we return medicine to its original purpose of healing.

Alliant Health Plans is a Provider Sponsored Health Care Corporation (PSHCC) under the Office of Commissioner of Insurance's regulatory oversight in Georgia. Alliant Health Plans strives to offer optimal health care to our members. That goal is accomplished by including physicians and community leaders on our board of directors to determine how best to deliver care in the communities we serve. Alliant Health Plans offers health insurance plans for businesses and individuals.

Provider Manual

This manual assists in-network and out-of-network providers with daily operations and administrative guidelines required for rendering services to Alliant members. Alliant Health Plans will comply with the laws of the state in which it operates. This provider manual can also be found by accessing our website, AlliantPlans.com.

Disclaimer

This manual covers many topics; however, it is not all-encompassing. Also, the information provided is subject to change as updates, revisions, and additions occur. Users are encouraged to visit AlliantPlans.com for the most up-to-date information.

All parties will comply with applicable federal and state laws, rules and regulations; and to maintain licenses, certificates and accreditations required in accordance with such applicable laws, rules and regulations.

Payable benefits, if any, are subject to the terms of the policy in effect on the date the service is rendered. In the event of any inconsistency between this manual and Georgia State law, state law supersedes. In addition, if a conflict between this manual and a Member's Contract exists, the Contract supersedes. Member Contracts can be referenced at AlliantPlans.com.

Key Term

For the purpose of this manual, any reference to the term "Member" means employee, subscriber, enrollee, beneficiary, insured, or any other person, including spouse or dependents, who is eligible to receive benefits under an Approved Plan.



Contents

INTRODUCTION	1
IMPORTANT INFORMATION	3
PROVIDER RESOURCES	5
PROVIDER CREDENTIALING & RECORDS.....	10
ADMINISTRATIVE GUIDELINES.....	12
COVERAGE GUIDELINES	20
UTILIZATION MANAGEMENT	28
QUALITY MANAGEMENT	36
HIPAA	43
APPENDIX A: CREDENTIALING CRITERIA.....	44
APPENDIX B: NETWORK PROVIDER QUALITY MANAGEMENT MANUAL – HEDIS®	66

IMPORTANT INFORMATION

ELIGIBILITY, MEDICAL BENEFITS, CLAIMS STATUS & QUESTIONS

Alliant Health Plans Client Services	(800) 811-4793
	ClientServices@AlliantPlans.com
Alliant Health Plans Client Services Business Hours	M – F, 9:00 a.m. – 5:00 p.m. ET The automated features for eligibility are available 24 hours a day, 7 days a week.
Please have your Tax ID and the Member ID available when you call. The Member ID can be found on the Member's Identification Card or an Explanation of Payment.	
<i>Online Eligibility, Benefits, and Claim Status are available by registering for our online portal. Please see Provider Web Resources below.</i>	
Mental Health Referrals	(800) 811-4793
24-Hour Nurse Advice Line	(855) 299-3087
Alliant Health Plans Website	AlliantPlans.com
Provider Directory	Visit AlliantPlans.com, select Find A Provider.
Provider Relations & Credentialing	(706) 629-8848 or ProviderRelations@AlliantPlans.com

CLAIMS SUBMISSION

Claims Submission	Alliant Health Plans, Inc. P.O. Box 2667 Dalton, GA 30722
Electronic Claims Submission	Payor ID: #58234 Clearinghouses: Change Healthcare or SDS (Smart Data Solutions)

PROVIDER WEB RESOURCES

Eligibility, Benefits & Claims Status	Visit AlliantPlans.com, select Providers, and choose Provider Portal. To register, please contact Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com.
Fee Schedules	Contact Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com.
Prime Therapeutics	Prime Therapeutics is the pharmacy benefit manager. To access, visit AlliantPlans.com, select RX Formulary Lists from the bottom right of the home page under Pharmacy Resources.

PHARMACY BENEFITS, CLAIMS & QUESTIONS

Prime Therapeutics Customer Service	(844) 451-8288
Prime Therapeutics Formulary Information	Visit AlliantPlans.com, select RX Formulary Lists from the right-hand menu.

MEDICAL PHARMACY

Prime Therapeutics Medical Pharmacy Customer Service	(800) 424-1799 Option 3, Option 2, Option 1
Prime Therapeutics Medical Pharmacy Fax	(888) 656-6671
Prime Therapeutics Medical Pharmacy Web Portal	https://GatewayPA.com/ Click <i>New Provider Access Request</i> to request login info

MEDICAL MANAGEMENT & PRIOR AUTHORIZATION

Alliant Health Plans Medical Management	(800) 865-5922
Alliant Health Plans Medical Management Fax	(866) 370-5667
Alliant Health Plans Medical Management Address	Alliant Health Plans P.O. Box 2667 Dalton, GA 30722
Alliant Health Plans Medical Management Business Hours	9:00 a.m. – 5:00 p.m. ET

MOBILE MEMBER APP

Coverage at your fingertips! Alliant Health Plans has a mobile app – available on the App Store or Google Play. Share with your patients so they may gain quick access to their plan information, claim information, EOBs, and ID cards. Members can search Alliant Health Plans to download the Mobile Member App today!



PROVIDER RESOURCES

Member ID Cards

Providers should confirm Member eligibility and benefit coverage before rendering services since individual Member benefits vary. Please refer to the Member's ID card for the resources available to assist in obtaining this information.

SimpleCare – Group with PHCS Wrap Network

SUBSCRIBER:		ID #:	
GROUP NAME:		GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
PPO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/\$	SPEC VISIT:	\$
DED (I/F) OON:	\$/\$	ER VISIT:	\$
MAX OOP (I/F) INN:	\$/\$	URG CARE:	\$
MAX OOP OON:	N/A	Ded, Coins, Limits may apply	\$
COINSURANCE:	%	Rx BRAND:	%
		Rx SPEC:	%

PHCS

AlliantPlans.com	
Member Client Services:	(866) 403-2785
Provider Client Services:	(800) 811-4793
Prior Auth, Referral:	(800) 865-5922
Pharmacy Help Line (Prime):	(844) 451-8288
24-Hour Nurse Advice Line:	(855) 299-3087
Medical Network:	AlliantPlans.com
Submit Claims:	NEIC—#58234
Mail Claims:	Alliant Health Plans, Inc.
	P.O. Box 2667
	Dalton, GA 30722
Benefits may be limited or reduced outside of our service area or with a non-network provider. Refer to your plan documents.	Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.
Possession or use of this card does not guarantee coverage or payment.	This policy is fully insured and regulated by the State Insurance Commissioner.
Card Issue Date: XX/XX/XXXX	

Please note network exclusions detailed [here](#).

4Corners – Level-funded Group with PHCS Wrap Network

SUBSCRIBER:		ID #:	
GROUP NAME:		GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
PPO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/\$	SPEC VISIT:	\$
DED (I/F) OON:	\$/\$	ER VISIT:	\$
MAX OOP (I/F) INN:	\$/\$	URG CARE:	\$
MAX OOP OON:	N/A	Ded, Coins, Limits may apply	\$
COINSURANCE:	%	Rx BRAND:	%
		Rx SPEC:	%

PHCS

AlliantPlans.com	
Member Client Services:	(866) 403-2785
Provider Client Services:	(800) 811-4793
Prior Auth, Referral:	(800) 865-5922
Pharmacy Help Line (Prime):	(844) 451-8288
24-Hour Nurse Advice Line:	(855) 299-3087
Medical Network:	AlliantPlans.com
Submit Claims:	NEIC—#58234
Mail Claims:	Alliant Health Plans, Inc.
	P.O. Box 2667
	Dalton, GA 30722
Benefits may be limited or reduced outside of our service area or with a non-network provider. Refer to your plan documents.	Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.
Possession or use of this card does not guarantee coverage or payment.	
Card Issue Date: XX/XX/XXXX	

Please note network exclusions detailed [here](#).

4Corners – Level-Funded Group without PHCS Wrap Network

SUBSCRIBER:		ID #:	
GROUP NAME:		GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
PPO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/\$	SPEC VISIT:	\$
DED (I/F) OON:	\$/\$	ER VISIT:	\$
MAX OOP (I/F) INN:	\$/\$	URG CARE:	\$
MAX OOP OON:	N/A	Ded, Coins, Limits may apply	\$
COINSURANCE:	%	Rx BRAND:	%
		Rx SPEC:	%

PHCS

AlliantPlans.com	
Member Client Services:	(866) 403-2785
Provider Client Services:	(800) 811-4793
Prior Auth, Referral:	(800) 865-5922
Pharmacy Help Line (Prime):	(844) 451-8288
24-Hour Nurse Advice Line:	(855) 299-3087
Medical Network:	AlliantPlans.com
Submit Claims:	NEIC—#58234
Mail Claims:	Alliant Health Plans, Inc.
	P.O. Box 2667
	Dalton, GA 30722
Benefits may be limited or reduced outside of our service area or with a non-network provider. Refer to your plan documents.	Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.
Possession or use of this card does not guarantee coverage or payment.	
Card Issue Date: XX/XX/XXXX	

4Corners – Level-funded Group with PHCS Primary Network

		AlliantPlans.com	
SUBSCRIBER: GROUP NAME:		ID #: GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
PPO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/S SPEC VISIT:	\$	Rx PCN:
DED (I/F) OON:	\$/S ER VISIT:	\$	Rx GENERIC:
MAX OOP (I/F) INN:	\$/S URG CARE:	\$	Rx PREF:
MAX OOP OON:	N/A Ded, Coins, Limits may apply	\$	Rx BRAND:
COINSURANCE:	%	\$	Rx SPEC:
Member Client Services: (866) 403-2785 Provider Client Services: (800) 811-4793 Prior Auth, Referral: (800) 865-5922 Pharmacy Help Line (Prime): (844) 451-8288 24-Hour Nurse Advice Line: (855) 299-3087 Medical Network: AlliantPlans.com		Submit Claims: NEIC—#58234 Mail Claims: Alliant Health Plans, Inc. P.O. Box 2667 Dalton, GA 30722	
Benefits may be limited or reduced outside of our service area or with a non-network provider. Refer to your plan documents.		Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.	
Possession or use of this card does not guarantee coverage or payment.			
Card Issue Date: XX/XX/XXXX			

Please note network exclusions detailed [here](#).

SoloCare – Individual/Family Plan PPO

		AlliantPlans.com	
SUBSCRIBER: GROUP NAME:		ID #: GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
PPO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/S SPEC VISIT:	\$	Rx PCN:
DED (I/F) OON:	\$/S ER VISIT:	\$	Rx GENERIC:
MAX OOP (I/F) INN:	\$/S URG CARE:	\$	Rx PREF:
MAX OOP OON:	N/A Ded, Coins, Limits may apply	\$	Rx BRAND:
COINSURANCE:	%	\$	Rx SPEC:
Member Client Services: (866) 403-2785 Provider Client Services: (800) 811-4793 Prior Auth, Referral: (800) 865-5922 Pharmacy Help Line (Prime): (844) 451-8288 24-Hour Nurse Advice Line: (855) 299-3087 Medical Network: AlliantPlans.com		Submit Claims: NEIC—#58234 Mail Claims: Alliant Health Plans, Inc. P.O. Box 2667 Dalton, GA 30722	
Benefits may be limited or reduced outside of our service area or with a non-network provider. Refer to your plan documents.		Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.	
Possession or use of this card does not guarantee coverage or payment.			
Card Issue Date: XX/XX/XXXX			

SoloCare – Individual/Family Plan HMO

		AlliantPlans.com	
SUBSCRIBER: GROUP NAME:		ID #: GROUP #:	
001	005		
002	006		
003	007		
004	008		
SUBSCRIBER EFFECTIVE DATE:			
HMO:	OFFICE VISIT:	\$	Rx BIN:
DED (I/F) INN:	\$/S SPEC VISIT:	\$	Rx PCN:
DED (I/F) OON:	\$/S ER VISIT:	\$	Rx GENERIC:
MAX OOP (I/F) INN:	\$/S URG CARE:	\$	Rx PREF:
MAX OOP OON:	N/A Ded, Coins, Limits may apply	\$	Rx BRAND:
COINSURANCE:	%	\$	Rx SPEC:
Member Client Services: (866) 403-2785 Provider Client Services: (800) 811-4793 Prior Auth, Referral: (800) 865-5922 Pharmacy Help Line (Prime): (844) 451-8288 24-Hour Nurse Advice Line: (855) 299-3087 Medical Network: AlliantPlans.com		Submit Claims: NEIC—#58234 Mail Claims: Alliant Health Plans, Inc. P.O. Box 2667 Dalton, GA 30722	
This plan does not have out-of-network benefits. Referrals not required. Refer to your plan documents.		Visit AlliantPlans.com or call Client Services for detailed Prior Authorization requirements.	
Possession or use of this card does not guarantee coverage or payment.			
Card Issue Date: XX/XX/XXXX			

Front of Card

Subscriber	Name of Member
ID #	Unique identifying number for the policy
Group	Name of the employer group that holds the policy or plan OR Name of Plan Group type
Group #	Unique identifying number for the employer or group
Member Information	The unique identifiers for each Member on the policy. Please note, each Member on the policy has the same ID# with a unique 3-digit person code at the end.
Subscriber Effective Date	The date a subscriber's current policy became effective
PPO/HMO	Plan type and specific plan design
Deductible (I/F) INN	In-network Deductible for individual and family
Deductible (I/F) OON	Out-of-network Deductible for individual and family
Max OOP (I/F) INN	In-network Maximum out of pocket for individual and family
Max OOP (I/F) OON	Out-of-network Maximum out of pocket for individual and family
Coinsurance	The percentage for which the Member is responsible
Copay Amounts	Copay amounts may vary by provider type: PCP, Specialist, ER, Urgent Care
Rx BIN & Rx PCN	Used by pharmacies to submit claims through an electronic clearinghouse (No Group Number is required when processing through Prime Therapeutics)
Rx Copay	Pharmacy benefit copay amounts that vary by prescription type

Please use the Member ID, located on the ID card's front, in all communications (telephone or written) with Alliant Health Plans. Be sure to verify the use of the correct 3-digit person code at the end of the ID# to ensure accurate information is provided and claims submissions are processed correctly. We are committed to protecting the privacy of the personal information of our Members.

Back of Card

Member Client Services	Phone number for members to call for assistance
Provider Client Services	Phone number to reach eligibility, claims, and benefits
Prior Authorization, Referral	Phone number to reach prior authorizations and referral assistance
Pharmacy Help Line	Phone number to reach Prime Therapeutics Member Services
24-Hour Nurse Line	Members may seek medical advice from trained nurses
Medical Network	Web address to search for in-network provider
Payor ID	Unique # for filing electronic claims
Claims Address	Address for submitting claims
Alliant Health Plans Website	Web address to access Alliant Health Plans
Card Issue Date	The date the current card was issued to the subscriber

Logos on Card

Alliant Health Plans	Company Name
PHCS	Designates if the PHCS network is available on this plan. PHCS is a nationwide network of health care professionals and hospitals.
SoloCare	Designates individual product

SimpleCare	Designates group product
4Corners	Designates level-funded group product

Provider Relations

The Provider Relations team is available to assist providers. You may reach your representative at (706) 629-8848 or ProviderRelations@AlliantPlans.com to inquire about:

- Contracting
- Fee Schedules
 - In-network providers may have access to their current fee schedules by corresponding with their Provider Engagement Liaison
 - Out-of-Network providers may request service-specific reimbursements by completing the Provider Request for Out-of-Network MAC Payment form, which can be found by visiting AlliantPlans.com/Providers/Forms and Documents. Note: All Out-of-Network pricing is determined based on the MAC Rate as defined in the Certificate of Coverage.
- Provider Application/Enrollment and Credentialing
- Provider Portal Registration
- Medical Record Requests
- HEDIS®
- Risk Adjustment Data Validation Audits (RAD-V)
- Provider Updates
- Directory Updates

For claims questions, please call Client Services at (800) 811-4793. Client Services may escalate claims to the Provider Relations team for further review.

Electronic Provider Directory

An electronic provider directory is maintained to allow clients, Members, and providers convenient access to information. Providers can use the directory to:

- Identify in-network providers for Member referral purposes
- Assist Members with finding the nearest in-network care

The electronic provider directory can be accessed by visiting AlliantPlans.com and completing the following steps:

- Click on Find a Provider
- Search by Provider Name, Specialty or Location as well as other demographic factors

Please note that certain providers or counties may be excluded from the networks offered to members. Exclusions may vary by network. Please visit the *Find A Provider* feature on AlliantPlans.com and select the appropriate network to view excluded providers or counties.

- For PHCS Wrap Network exclusions, click [here](#).
- For PHCS Primary Network exclusions, click [here](#).

Provider data is audited regularly through provider outreach and surveys as required by NCQA, CMS, and state regulations. If you are aware of an inaccuracy in our data, please contact Provider Relations via email at ProviderRelations@AlliantPlans.com or report inaccuracies using the “click here to report updated information” option within the search results of the directory.

Provider Referrals

Providers are encouraged to refer Members to in-network providers. Assistance in finding an in-network provider can be obtained by calling Alliant Health Plans Client Services line at (800) 811-4793 or refer to the Provider Directory at AlliantPlans.com.

Out-of-network providers are encouraged to contact Alliant Health Plans at (706) 629-8848 or ProviderRelations@AlliantPlans.com to inquire about becoming an in-network provider.

Alliant Health Plans provides and maintains appropriate access to primary care services, behavioral health care services, and specialty care services. In the event of an emergency, please direct Members to go to the nearest Emergency Room. For non-life-threatening behavioral health emergencies, please direct members to the Emergency Room at their local hospital.

Use of Marketing Material

Providers wishing to use Alliant Health Plan's name or logo on correspondence or marketing material must obtain permission in advance. Contact Provider Relations via email at ProviderRelations@AlliantPlans.com.

PROVIDER CREDENTIALING & RECORDS

Credentialing

The Credentialing Department manages the verification process of provider credentialing applications. Credentialing Representatives collect and verify each applicant's information, including but not limited to education, licenses, practice history, historical sanctions, call coverage, board certification, hospital admitting privileges, and malpractice coverage.

The Credentials Committee and Health One Board of Directors reserve the discretionary authority to approve, voluntarily withdraw, or deny applicants' participation, except as otherwise required by law. Applicants applying for participation in Alliant Health Plans' network shall be responsible for and shall have the burden of demonstrating that all the requirements are met.

The Credentials Committee meets monthly, and the Board of Directors meets quarterly. Once a provider's application has been processed and reviewed, providers are sent written notification of their effective date. Effective dates are not assigned retroactively and are not determined by the application's submission date, the signature date on the contract, or a provider's initial start date at their practice.

A copy of the full credentialing criteria may be found in Appendix A or obtained by contacting Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com.

Credentialing Data Source

For all non-facility-based providers, the Credentialing Department utilizes the Council for Affordable Quality Health Care (CAQH), Universal Credential Data Source. HealthOne Alliance performs credentialing on behalf of Alliant Health Plans. Providers need to ensure HealthOne Alliance is an authorized payer within CAQH to review all credentialing information.

Right to Review

To the extent permitted by law, we recognize a provider's right to review submitted information supporting the credentialing application. Providers may obtain information regarding their initial or re-credentialing application status by contacting Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com. This number can also be used to request information regarding general requirements for participation and correct any erroneous information.

Recredentialing

Recredentialing is conducted at least once every thirty-six (36) months in accordance with credentialing policies and procedures. When required, before terminating a provider, a written notice of termination is issued.

Provider Record Loading and Changes

Provider records must be kept current and accurate. This important and ongoing administrative process impacts key business operations, which include:

- Compliance with state and federal guidelines
- Accurate and timely payments to providers
- Online Provider Directory
- Reporting payments to the IRS
- Notification of policies and procedures

Providers should submit loading information for all service locations except those billed with Place of Service (POS) 12, 21, 22, 31, 51, and 61. Network participation is determined at the service location level. This service location mapping applies to all claims, including those billed with POS 24.

Any change to the information supplied on the original application/contract must be reported in writing. To ensure accuracy and allow for updates to be made promptly, this written notification should be clear, concise, contain both the old and new information, and include the effective date of the change. The following are the types of changes which should be reported as soon as possible:

- New Address
- New Telephone Number
- New Fax Number
- Additional office location
- Provider termination
- New ownership
- Change in provider name
- Change in Tax ID
- New Tax ID
- Change in hospital affiliation
- Change in board certification status
- Change in liability coverage
- Change in practice limitations
- Change in call coverage
- Change in licensure, state sanctions, and any restriction, or malpractice awards
- New provider joining a group

Please address all written change notices to Alliant Health Plans at the address below or via email at ProviderRelations@AlliantPlans.com:

Alliant Health Plans
Attn: Provider Relations
P.O. Box 1128
Dalton, GA 30722

The Provider Update Form is conveniently located on AlliantPlans.com and is easily submitted via email. To submit updated information, click on Providers, and choose Forms & Documents. You will find the [Provider Update Form](#) under the General Resources section. From there, type your changes on the fillable form, save and email to Alliant Health Plans at ProviderRelations@AlliantPlans.com, or fax to (706) 529-4275.

ADMINISTRATIVE GUIDELINES

Claims Processing

This section of the manual explains how to file electronic and paper claims. Included are guidelines on filing specific claims (for example, claims that require coordination of benefits) and identifying tools available to inquire about claim status.

Electronic claims filing is Alliant Health Plans' preferred claim submission process. Providers are encouraged to submit claims electronically by utilizing a third-party clearinghouse.

Alliant Health Plans accepts computer-generated paper claim submissions. Claims must be on the standard red and white forms with no handwriting. Mail paper claims to:

Alliant Health Plans, Inc.
P.O. Box 2667
Dalton, GA 30722

The following summary of timeframes applies to all providers, both in-network and out-of-network, unless otherwise stated in your provider contract. For additional information, please refer to the specific section regarding each guideline.

Original Claim Submission	180 days from the beginning date of service
Adjusted/Corrected Claim Submission	180 days from the beginning date of service
Claim Dispute	180 days from the beginning date of service
First Level Appeal	180 days from the claim decision date
Second Level Appeal	60 days from receipt of the First Level Appeal decision
Claim Overpayment Requests	365 days from the claim decision

Electronic Claim Submission

Electronic transmission or EDI (Electronic Data Interchange) is the most efficient, cost-effective way to file claims. It can reduce administrative time, improve claim accuracy, and expedite claim payment turnaround time.

Providers interested in filing claims electronically should contact the clearinghouse listed below to set up this option or verify their vendor of choice can interface with Change Healthcare.

Change Healthcare
Provider questions/problems: (800) 845-6592 (option 2)
Connection inquiries: (800) 444-4336
Payor ID: 58234

Electronic Claim Attachment

Alliant Health Plans cannot receive electronic claim attachments at this time. If claim submissions include an attachment (i.e., explanation of benefits, office notes, etc.), please mail a paper copy of the claim and attachment to:

Alliant Health Plans, Inc.
P.O. Box 2667
Dalton, GA 30722

Claims Submission

When submitting an electronic or paper claim to Alliant Health Plans, be sure to complete all data elements on the appropriate red and white form, with only computer-generated lettering, as necessary for the claim to be processed. In some situations, Alliant Health Plans must obtain additional information, which is not provided on the claim form (i.e., operative report).

A claim is not considered "clean" until Alliant Health Plans has all the information needed to determine a payment decision.

Original Claim

An original claim must be submitted within 180 days from the beginning date the service was rendered, or as specified in your provider contract. Claims received more than 180 days after the beginning date of service (or the time frame specified in your provider contract) may be denied for payment. The provider shall not bill the Member or Alliant Health Plans for any such denied claims.

Denied Claim

A remark code will identify a claim denied due to insufficient information on the Explanation of Payment (EOP), which will indicate the additional information required to process the claim. All claims, including resubmissions, must be submitted within 180 days of the initial date of service or the time frame specified in your provider contract.

Adjusted Claim

If a previously processed claim needs to be resubmitted due to a billing error or to provide additional information not included initially, please submit either a corrected claim electronically using the correct Resubmission Code or Type of Bill code or a paper claim (with the appropriate Resubmission or Type of Bill codes) to the address listed below. Please designate the corrected claim by stamping "Correction" or "Reconsideration" on the front of the claim form. Adjusted or corrected claims must be submitted within 180 days from the beginning date the service was rendered. Once Alliant Health Plans has re-evaluated the claim, a letter or new EOP will be issued.

Submit correction or reconsideration request to:

Alliant Health Plans, Inc.
P.O. Box 2667
Dalton, GA 30722

Coordination of Benefits

When Alliant Health Plans is the secondary insurance carrier, please provide the primary carrier's information and a copy of the EOP for the claim to be considered for secondary payment. As the secondary payer, Alliant will pay the Member's cost-share amount assigned by the primary payor (up to and not to exceed Alliant's contracted allowed amount with the provider). Member cost share applies.

Claim Status Verification Options

Participating providers may obtain claim activity information via (a) online provider portal or (b) Client Services representative.

Notification of Claim Determination

Alliant Health Plans provides notification when a claim is processed. An electronic notification is referred to as an Electronic Remittance Advice (ERA), and a paper notification is referred to as an Explanation of Payment (EOP).

When a claim determination is completed, an ERA or EOP is generated. Provider payments are issued via electronic funds transfer (EFT), virtual card, or mailed to the billing address recorded in Alliant Health Plans' provider system. It is crucial to report address updates promptly to ensure claim payments and correspondence are not delayed.

Each ERA or EOP will provide the following details:

- Provider name
- TIN
- Member name and ID number
- Dates of service
- Applicable dollar amounts (billed, non-covered, allowed)
- Member responsibility amounts (deductible, coinsurance, copayment)
- Remark codes

A Member's financial responsibility information is detailed on the ERA or EOP. Dollar amounts are reflected in the non-covered, deductible, and coinsurance fields, with a summary of these amounts reflected in the "Remark Codes" section of the EOP. Remark codes indicate if a claim was processed as in-network or out-of-network, if benefit maximums have been met, and if additional information is required by Alliant Health Plans to continue processing a claim.

Electronic Payment

Alliant Health Plans encourages electronic payment. To enroll, view instructions provided in Appendix C.

Member Liability

- Members are responsible only for payment of non-covered services (some non-covered services apply to provider responsibility but are indicated on the Explanation of Payment), copayments, deductibles, and coinsurance.
- Members are not financially responsible for the following:
 - Difference between the billed charge and the contracted amount
 - Charges denied due to re-coding of procedure or re-bundling of procedures
 - Any amounts denied due to the in-network provider's failure to comply with the Prior Authorization requirements of the Utilization Management program
 - Members are responsible for obtaining necessary Prior Authorizations when receiving services from PHCS or out-of-network providers
 - Claims denied due to timely filing requirements
 - Medical and service errors
 - Non-medically necessary services
 - Other exclusions

Non-medically Necessary Services

Neither Alliant Health Plans nor the Member is financially liable for non-medically necessary services.

To seek reimbursement from the Member for non-medically necessary services, the provider must obtain a signed waiver with the following information before rendering services:

- Date of service
- Facility/provider name and place of service
- Service to be rendered
- Statement verifying the Member understands and agrees to the terms of the waiver

- Dated form with Member signature

The provider is responsible for maintaining a copy of the Member's waiver and providing it to Alliant Health Plans upon request.

Observation Stays

An observation stay that exceeds 23 hours will be paid as an inpatient stay.

Claims Dispute Process

A claim reduction or denial is communicated through a statement printed on the Electronic Remittance Advice (ERA), Explanation of Payments (EOP), and letter.

Claim Pricing & Fee Schedule Disputes

Alliant Health Plans strives to make accurate and timely claim reimbursements. If there is a disagreement with claim pricing, please contact Client Services to discuss any concerns.

Mail: Alliant Health Plans, Inc.
P.O. Box 1247
Dalton, GA 30722
Phone: (800) 811-4793

Alliant Health Plans must receive notification of a reimbursement variance within 180 days from the claim decision or the period specified in your Provider Contract. The following key pieces of information are required for Alliant to address concerns:

- Provider name and TIN
- Provider location/address of service
- Member name and ID number
- Date of service
- Detailed description of the issue

Internal Dispute Resolution

Contractual disputes can be resolved through the internal dispute resolution process. Please contact your Provider Relations Representative or Alliant Health Plans at:

Mail: Alliant Health Plans
Attn: Provider Relations
PO Box 1247
Dalton, GA 30722
Phone: (706) 629-8848
Fax: (706) 529-4275
Email: ProviderRelations@AlliantPlans.com

Alliant Health Plans will use all reasonable efforts to resolve your dispute within 60 days of receipt.

Policy Procedural Denials & Appeals

Claim denials based on the terms of the medical plan or policy may include, but are not limited to:

- Non-covered services
- Benefit discrepancies
- Eligibility

- Untimely filing
- Out-of-Network benefits

To file claim appeals, please submit a written request to:

Mail: Alliant Health Plans, Inc.
 Appeals Department
 P.O. Box 1247
 Dalton, GA 30722
 Fax: (706) 637-3221

Providers are to submit claim appeals in writing. The [Provider Appeal Form](#) can be found by visiting AlliantPlans.com, selecting the Provider section and choosing Forms and Documents from the left-hand menu. The written explanation should include the provider's position and supporting documentation to help expedite the review process. Appeals may be submitted without the Provider Appeal Form but must consist of all elements outlined on the form.

A party independent from the original claim decision will be appointed to review and determine the appeal's outcome.

Medical Appeals

Claim denials based on the terms of the medical plan or utilization management may include, but are not limited to:

- Failure to comply with utilization management requirements, including Prior Authorization
- Prior Authorization denied as not medically necessary
- Experimental or investigational services
- Exhaustion of benefit

To file a claim or clinical appeal, please submit a written request to:

Mail: Alliant Health Plans
 Medical Appeals Department
 P.O. Box 1247
 Dalton, GA 30722
 Fax: (866) 370-5667

Providers are to submit claim appeals in writing. The written explanation should include the provider's position and supporting documentation to help expedite the review process. Please note, providers may not charge for medical records provided in support of an appeal.

A party independent from the original claim decision will be appointed to review and determine the appeal's outcome. Appeals related to clinical matters will be reviewed by Alliant Health Plans and/or an independent, external, board-certified health care professional with relevant expertise. Alliant Health Plans may consult with or request medical experts' involvement as part of the appeal process.

First Level Appeal – Clinical & Non-Clinical

A provider or Member may initiate a first-level appeal on a claim. The appeal must be submitted within 180 days of the claim decision. First-level appeals submitted more than 180 days after the claim decision date will not be considered.

Pre-service Appeal

Decision made within 15 calendar days from receipt of a request for appeal. Notification will be in written or electronic form.

Post-service Appeal

Decision made within 30 calendar days from receipt of a request for appeal. Notification will be in written or electronic form.

Concurrent/Expedited Review (Clinical Only)

Decision made within 72 hours or 3 calendar days from receipt of a request for appeal. Notification will be in written or electronic form.

Second Level Appeal (Optional)

A provider or Member may initiate an optional second level appeal on a claim. This is not required and instead a provider or Member may move directly to an External Review within 123 days of the first-level denial. If opting to submit a second-level appeal, it must be submitted within sixty (60) days from receipt of the first-level appeal decision.

Pre-service Claims

Decision made within 15 calendar days from receipt of a request for review of the first level appeal decision.

Post-service Claims

Decision made within 30 calendar days from receipt of a request for review of the first level appeal decision. Notification will be in written or electronic form.

Concurrent/Expedited Review (Clinical Only)

Decision made within 72 hours or 3 calendar days from receipt of a request for review of the first level appeal decisions. Notification will be in written or electronic form.

Urgent Clinical Appeals

Clinical appeals may require immediate action if a delay in treatment could pose a health risk to the Member. In urgent situations, the appeal does not need to be submitted in writing. Please contact the Utilization Management Department at (800) 865-5922.

Pharmacy Appeals

For appeals on pharmacy prior authorizations that fall under the pharmacy benefits contact:

Prime Therapeutics LLC
Attn: Appeals Department
2900 Ames Crossing Rd,
Egan, MN 55121
Fax: (855) 212-8110

For appeals on medical pharmacy prior authorizations for provider administered specialty drugs, contact:

Prime Therapeutics LLC
Attn: MP-3002
PO Box 64811
St. Paul, MN 55164
Fax: (888) 656-6671

Claim Underpayments

If there is concern that an underpayment may have occurred, please submit a written request for an adjustment within 180 days of the claim decision, or as specified in your provider contract. Requests for

adjustment submitted after such a time frame may be denied for payment. Additionally, the provider is not permitted to bill the Member, or Alliant Health Plans, for such underpayment amounts. Please submit a written request for an adjustment to:

Mail: Alliant Health Plans, Inc.
Appeals Department
P.O. Box 1247
Dalton, GA 30722
Fax: (866) 634-8917

Claim Overpayments

Alliant Health Plans will request an overpayment refund from the provider within 365 days from the date of the claim decision, as mandated by Georgia state law or as outlined in the provider's contract. Alliant Health Plans will send the provider one formal refund request indicating the refund must be issued within 30 days from the letter's date. If the provider does not issue the refund within 30 days, Alliant Health Plans may begin recouping the funds 60 days from the refund request date. An updated Explanation of Payment will be generated upon receipt of the requested refund. Providers who wish to implement a Recoupment Processing Exception Request, visit the Provider section of AlliantPlans.com, view Forms and Documents, and complete the [Recoupment Processing Exception Request Form](#). To dispute refund requests, providers must contact Alliant Health Plans Client Services at (800) 811-4793 before the 60th day after the date of the refund request.

Medical Bill Review (MBR) and Claim Audit Provision

Alliant Health Plans reserves the right to request and review medical records to determine benefits according to the Member contract. Per Alliant Health Plans' policies and procedures, no benefits will be payable if the health care provider does not submit a Clean Claim, obtain required Prior Authorization approvals, and submit upon request complete/legible itemization and complete/legible medical records. Providers may not charge for medical records requested to process claims.

At Alliant Health Plans' discretion, claims are subject to audit by Alliant Health Plans or by an independent bill review firm or claim auditor. Alliant Health Plans' medical bill audit may be performed with or without records, and the review is not subject to waiver by any third-party agreement including, but not limited to, any Provider Network Contract(s), unless specifically prohibited, or other re-pricing arrangements, or the guidelines of any health care provider (e.g., physician, hospital or another facility).

Alliant Health Plans will review claims to ensure that the charges are correct and proper, billed using the most accurate and appropriate Current Procedural Terminology (CPT), International Classification of Diagnosis (ICD), Healthcare Common Procedure Coding System (HCPCS) and Revenue codes, and documented in the medical records.

All Contract/claim adjudication determinations will be made using Alliant Health Plans' Policies and Procedures that are based on the coding and billing guidelines of the American Medical Association, CMS / Federal Government guidelines for proper coding and billing including, but not limited to, CMS Provider Billing and Reimbursement Guidelines, the National Correct Coding Initiative (NCCI) guidelines, CMS Physician Fee Schedule (PFS) Relative Value File, and other Federal/clinical acceptance or coverage guidelines published by the Food and Drug Administration (FDA), National Comprehensive Cancer Network (NCCN), and the Federal National Library of Medicine-National Institute of Health.

As a result of any claim audit/review, Alliant Health Plans will not provide benefits for services and supplies that:

1. Are not ordered by a physician;
2. Are not documented in the patient's medical record(s);

3. Do not require a physician order;
4. Are routinely ordered/provided as a general clinical requirement of the physician or facility, rather than for the documented specific medical need of the patient;
5. Are routine and unbundled from the global room charge/service, unbundled from any global charge/service or a professional charge(s) that is already considered separately reimbursable;
6. Are billed as technical or professional charges using CPT/HCPCS coding that has no technical or professional component;
7. Are up-coded using either historical medical events/diagnoses that are not in active treatment or facility or procedure acquired diagnosis(es) that are not typical to the treatment of the diagnosis(es).
8. Are rendered as the result of a hospital-acquired condition ("HAC"), which is not Alliant Health Plans' or the Member's liability.
9. Are not covered by any other provision of the Member's Certificate of Coverage.

Alliant Health Plans will implement and utilize all applicable rules and guidelines regardless of whether the Federal Government/CMS waives their own guideline(s) as a requirement of their own adjudication process(es).

Alliant Health Plans retains maximum legal authority and discretion to determine what is covered or not covered under the Member's Certificate of Coverage, based on the results of any claim audit and medical bill review.

Additional Documentation

Alliant Health Plans reserves the right to request and review invoices, itemized bills or medical records, at no additional charge, to determine benefits. Itemized statements may be required, but are not limited to, the following examples:

- Billed charges reach the lesser of the contracted stop-loss or \$100,000
- Member eligibility changes during the dates of service
- Prior Authorization covers only a portion of the date span

Medical Records may be required, but are not limited to, the following examples:

- Billed charges reach or exceed \$450,000
- Services are unlisted or unspecified
- Change in admission status on a corrected claim

A claim is not considered a Clean Claim until all requested additional documentation is received. Providers may not charge for medical records requested to process claims.

COVERAGE GUIDELINES

This section outlines the general guidelines Alliant Health Plans uses to consider reimbursement of procedures and services. Please note this is not an exhaustive list. If the reimbursement guideline is not identified in your provider contract or this section, please contact Client Services for additional information at (800) 811-4793.

Reimbursement for Covered Services

Payment for Covered Services is solely the responsibility of the payer. It shall be the lesser of the participating provider's billed charges or the reimbursement amount provided in the participation contract, minus applicable copayments, deductibles, and coinsurance. The rates in the participation contract are payment in full for all services furnished to Members. Undisputed amounts due and owing for Clean Claims for Covered Services are payable within the timeframe required by Georgia state law. If the payer fails to pay a Clean Claim within the timeframe required by Georgia state law, prompt pay penalties shall be due and payable by such payer with respect to such claim to the extent required under applicable law.

Air Ambulance

Fixed wing or rotary wing air ambulance may be Medically Necessary in exceptional circumstances. All of the criteria pertaining to emergency ambulance services must be met, as well as one of the following conditions:

- The Member's medical condition must require immediate and rapid ambulance transport to the nearest appropriate medical facility that could not have been provided by land ambulance.
- The point of pick-up is inaccessible by land vehicle.
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment.
- The patient's condition is such that the time needed to transport a patient by land to the nearest appropriate medical facility poses a threat to the patient's health.
- Ambulance or medical transport services are considered eligible for coverage if the patient is pronounced dead after the ambulance is called, but before pick-up, or en route to the hospital.

Ambulance service providers may bill for any coinsurance, copayment, or deductible owed according to the terms of the member's policy. The member is only required to pay the In-Network cost-sharing amount for Out-of-Network emergent air ambulance services, and that cost-sharing amount is applied to the In-Network deductible.

The MAC for Out-of-Network emergent air ambulance services is calculated using the lesser of the provider's billed charges or the QPA (Quality Payment Amount). The QPA is defined as Alliant's median contracted rate for similar services in a specific geographic region.

Add-On Procedures

Add-on procedures performed in addition to the primary procedure by the same physician cannot be billed separately as a stand-alone procedure. Add-on procedures must be billed on the same date of service as the primary procedure. Prior Authorization guidelines may apply.

After Hours Coverage for 24-hour Facilities

After Hours coding for services rendered outside standard business hours in a 24-hour facility is not considered for reimbursement.

Allied Professional Services

Covered Services rendered by Allied Professionals are reimbursed at 85% of the physician's contracted rate unless specifically outlined in the provider's contract, or required by state, federal or CMS regulations. Services provided by out-of-network Allied Professionals are reimbursed at 85% of the maximum allowable cost. Such services must be provided within the Allied Professional's respective scope of practice and licensure in the State in which services are performed. Services performed by an Allied Professional must be submitted with their own NPI in accordance with CMS guidelines. All Allied Professionals practicing at an In-Network provider's office require credentialing. Please contact ProviderRelations@AlliantPlans.com to begin the credentialing process.

ASC Groupers

Alliant Health Plans uses ASC (Ambulatory Surgery Center) Groupers to define outpatient reimbursement. ASC Groupers are periodically updated. For a complete current list of ASC Groupers, please contact Provider Relations at (706) 629-8848 or email ProviderRelations@AlliantPlans.com.

Assistant Surgeon Services

Alliant Health Plans uses CMS guidelines to determine if an assistant surgeon's charges are allowed for the billed procedure.

Claim Edits

Provider claims are processed through editing software to ensure consistency in claims processing and payment standards. Edit logic is based on generally recognized and authoritative coding resources, including but not limited to CMS guidelines, Medicare guidelines, NCCI edits, and AMA/CPT coding.

Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to pay health expenses if a person is covered by more than one insurance plan. Alliant Health Plans follows the regulations established by Georgia state law to determine which insurance plan is the primary payer and the secondary payer's amount. Concerning covered services rendered to a Member, the provider agrees to cooperate to secure the exchange of information between payers to coordinate benefits and third-party liabilities.

Facility Reimbursement Rates

If a Member is confined to an inpatient facility at the time a rate adjustment becomes effective, or at the time of a policy/plan change on the part of the Member, the facility reimbursement for covered services during the inpatient stay will be based on the rates in effect at the time the Member was admitted to the facility or as specified in your provider contract. If an individual ceases to be a Member while being confined to an inpatient facility, Alliant Health Plans will reimburse the facility for covered services in a prorated manner. The prorated reimbursement will be based on the total number of days that the individual was a Member during the duration of the stay.

Modifier Guidelines

When appropriate, providers should use modifiers to define further or explain a service. Alliant Health Plans considers reimbursement for the following modifiers as outlined below:

Modifier	Description	Definition	Payment
50	Bilateral Procedure	<p>Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code. Note: This modifier should not be appended to designated "add-on" codes</p> <p>*Professional charges for Bilateral procedures must be billed on one line with the 50 modifier in order to be reimbursed correctly.</p> <p>**Facility charges for Bilateral procedures must be billed on two lines with the 50 modifier on the second procedure in order to be reimbursed correctly.</p> <p>(Claims may be altered to reflect billing guidelines.)</p>	150% of allowable (100% of the first procedure and 50% of second.)
51	Multiple Procedures	<p>When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.</p>	150% of allowable (100% of the primary procedure and 50% of secondary and subsequent procedures.) Reimbursement is based on highest RVU weight.
52	Reduced Services	<p>Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.</p>	50% of allowable

53	Discontinued Procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.	25% of allowable
54	Surgical Care Only	When 1 physician or other qualified health care professional performs a surgical procedure, and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.	70% of allowable
55	Postoperative Management Only	When 1 physician or other qualified health care professional performed the postoperative management, and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.	20% of allowable
56	Preoperative Management Only	When 1 physician or other qualified health care professional performed the preoperative care and evaluation, and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.	10% of allowable

62	Two Surgeons	When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.	62.5% of allowable
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.	50% of allowable

74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.	70% of allowable
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.	70% of allowable
80	Assistant Surgeon	Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).	16% of allowable
81	Minimum Assistant Surgeon	Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.	10% of allowable
82	Assistant Surgeon (when qualified resident surgeon not available)	A qualified resident surgeon's unavailability is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).	20% of allowable
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery services may be identified by adding modifier AS to the usual procedure number(s).	16% of allowable
P3	A patient with severe systemic disease	Physical status modifiers are utilized to rank the patient's physical status and the various levels of complexity of the anesthesia service provided. P3 outlines a patient with a severe systemic disease.	Increase of 1 base unit.

P4	A patient with severe systemic disease that is a constant threat to life	Physical status modifiers are utilized to rank the patient's physical status and the various levels of complexity of the anesthesia service provided. P4 outlines a patient with a severe systemic disease that is a constant life threat.	Increase of 2 base units.
P5	A moribund patient who is not expected to survive without the operation	Physical status modifiers are utilized to rank the patient's physical status and the various levels of complexity of the anesthesia service provided. P5 outlines a moribund patient who is not expected to survive without the operation.	Increase of 3 base units.
QE	Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)		50% of allowable
QF	Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed		150% of allowable
QG	Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)		150% of allowable
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	Utilized on physician claims to indicate that the physician provided medical direction of 2 to 4 concurrent anesthesia services.	50% of allowable
QX	Qualified nonphysician anesthetist with medical direction by a physician	Appended to CRNA or AA claims to indicate that the CRNA or AA provided the service with direction by an anesthesiologist.	50% of allowable
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.	Utilized by an anesthesiologist when directing a CRNA in a single case.	50% of allowable
FX	X-ray taken using film	When billing for an X-ray service that was done using film, append the FX modifier to the appropriate code.	80% of allowable
FY	X-ray taken using computed radiography technology/cassette-based imaging	Computed radiography technology (including the x-ray component of a packaged service) is defined as cassette-based imaging which utilizes an imaging plate to create the image involved.	90% of TC allowable

CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant		85% of allowable
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant		85% of allowable
Alliant Health Plans relies on information publicized by the American Medical Association in the presentation of usage of CPT modifiers. The information contained therein should not be used in lieu of the Member's specific plan language but used as a tool to understand the acceptance and reimbursement of CPT modifiers for an Alliant Health Plans Member.			
Modifiers will price at the noted percentage of allowable unless the provider and Alliant Health Plans have made a reimbursement agreement outlined in the provider's contract. If a pre-set reimbursement agreement has been made, the modifier will be priced according to the terms outlined in the provider contract.			
Clinical information documented in the patient's records must support the use of submitted modifier(s). Medical records are not required with the claim but must be made available at no charge upon request.			

Certain modifiers deem services as non-covered. When the following modifiers are used, services are considered non-covered: 32, EY, FB, FC, GF, GL, H9, HJ, HU, HV, HW, HX, HY, HZ, PM, Q0, SE SL, and TR.

Multiple Procedures

Unless otherwise stated in the provider contract, Alliant Health Plans utilizes CMS guidelines related to multiple surgeries.

UTILIZATION MANAGEMENT

Where appropriate, Alliant Health Plans benefits plans and policies are subject to Utilization Management requirements. This section will provide a general overview of the utilization management requirements and the provider's responsibilities.

Alliant Health Plans Utilization Management (UM) Program is committed to providing quality and cost-effective health care services to its Members. The UM program is designed to manage, evaluate, and improve the quality, appropriateness, and accessibility of health care services while achieving Member and Provider satisfaction. The UM Program monitors compliance with the National Committee for Quality Assurance (NCQA) standards to maintain accreditation. Alliant Health Plan's UM decision-making is based only on appropriateness of care and service and existence of coverage. Alliant Health Plans does not reward providers or other individuals for issuing denials of coverage or care. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided, and monitored by our Medical Director, who actively seeks input from in-network Providers and other regulatory agencies. The Medical Director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Concurrent Review
- Disease Management
- Provider Appeals
- Medical Policy
- Technology Assessment
- Medical Quality Management
- Retrospective Review
- Transition of Care/Discharge Planning

Providers must cooperate with Alliant Health Plans' quality improvement activities to improve the quality of care, services, and overall Member experience. Providers must also allow Alliant Health Plans to utilize their performance data for quality improvement activities.

Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. Designated staff evaluates the consistency with which health care professionals involved in the UM process apply criteria in decision making through Physician and non-Physician inter-rater reliability (IRR). The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to Alliant Health Plans Members.
- Marketing, Client Services, and UM departments provide Member satisfaction data, which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to Alliant Health Plans Members.

Note: The term "Provider" may include "Practitioner," "Facility," or "Other Licensed Professional."

Prior Authorization of Services

Providers must comply with Prior Authorization requirements. Services that require Prior Authorization can be found at AlliantPlans.com, select Providers, choose Forms & Documents, and choose Procedures Requiring Prior

Authorization. Providers may also use the Prior Authorization Verification Tool in the Provider Portal's Tools section to verify whether a procedure requires Prior Authorization. The tool can also be found in the Provider section of AlliantPlans.com.

The requesting provider is responsible for verifying the Member's eligibility and benefits on the date of service. Prior Authorization requirements apply to all in-network and out-of-network providers. Alliant Health Plans may need to assist in returning the Member to an in-network provider when it is medically safe. Please note: All attempts are made to provide the most current information on the Prior Authorization Verification Tool. However, this does NOT guarantee payment. The Prior Authorization Verification Tool is limited to only the provider's codes and information on the request's date, and a determination of Prior Authorization applicability may change. Codes utilized for Prior Authorization purposes may be amended, from time to time, based upon Center for Medicare and Medicaid Services' (CMS) approval, removal, or rejection of applicable codes. Payment of claims depends on eligibility, covered benefits, provider contracts, correct coding and billing practices, and the medical record documentation to support a Covered Service's Medical Necessity.

Facilities and ordering providers are responsible for obtaining all necessary prior authorizations. The Member may initiate Prior Authorization by calling Medical Management. However, clinical information must be provided by facilities and providers.

Prior Authorization Request Options

Hours of Operation

9:00 am to 5:00 pm (ET)

Phone

(800) 865-5922

Fax using Prior Authorization Request Form

(866) 370-5667

which can be found at AlliantPlans.com, Click Providers, Choose Forms & Documents, and Choose Prior Authorization Request Form under Medical Resources

Prior authorization must be obtained for all elective services in advance of the services being rendered. ***Requests received on the date of admission or date of service are not accepted.*** If you have an urgent case in need of an urgent response, you must submit the request via telephone to the Utilization Management Department (800) 865-5922. A voicemail line is available after business hours and on weekends/holidays for Providers to contact Alliant Health Plans regarding concurrent or urgent information. These calls are returned the next business day. Providers submitting requests via fax should utilize the authorization request form, which can be found by visiting the provider section of AlliantPlans.com and clicking on the Forms and Documents section. The form must be completed in its entirety; any authorization requests received that are not on this form will be returned.

Prior Authorization Review Process

Prior authorization reviews can be initiated by the Member, designated Member advocate, Provider, or facility. However, it is ultimately the facility and Provider's responsibility to contact Alliant Health Plans to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.

Urgent or emergent inpatient admissions must be authorized **within two (2) business days of admission.**

Scheduled admissions/services must be authorized **at least 24 hours prior to admission.**

For all concurrent reviews, requests to extend a current treatment course must be submitted **before the current period's expiration or within one business day**.

Prior Authorization requests must be submitted before scheduled services. Requests for retrospective authorizations are not considered. When a request for an authorization of a procedure, an admission/service, or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Provider rendering care for the day(s) or service(s) that have been denied. Alliant Health Plans' non-payment applies to both facility and Provider rendering care. The Member is held harmless if the Member is eligible when services are rendered, and the Covered Services are received from an In-Network Provider.

Nurse reviewers receive requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying benefits, medical policies, Alliant Health Plans Utilization Management Guidelines, and MCG criteria to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay, and number of services.

Nurse reviewers refer potential denials or questionable cases to a Clinical Reviewer for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued by Alliant Health Plans. This information may be submitted to Alliant Health Plans from the Provider or Provider representative. If an Alliant Health Plans Medical Director denies a request for prior authorization, the Provider or Member may appeal the decision. (See Medical Appeals section.)

Prior Authorization Time Frames

Alliant Health Plans recognizes the importance of established timeframes for utilization management decisions. Prior Authorization turnaround times are as follows:

- Urgent: review and determination are completed within 72 hours or 3 calendar days of receipt of the request for a utilization management determination
- Non-Urgent: Review and determination are completed within 7 calendar days of receipt of the request. Non-Urgent cases may be extended one time for up to 7 calendar days if the following criteria are met:
 - It is determined that an extension is necessary because of matters beyond Alliant Health Plans' control; and
 - Notification is provided to the member before the expiration of the initial 7 calendar day period and includes the circumstances requiring the extension and the date when the plan expects to make a decision; and
 - If a member fails to submit the necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least 45 calendar days from receipt of the notice to respond to the plan request for more information.
- Concurrent Turnaround Times:
 - For reductions or terminations in a previously approved treatment course, the determination is issued early enough to allow the member to request a review and receive a decision before the reduction or termination occurs.
 - For requests to extend a current course of treatment received at least 24 hours or 1 calendar day before the current period's expiration, review and determination are completed within 24 hours or 1 calendar day.
 - For requests to extend a current course of treatment received less than 24 hours or 1 calendar day before the expiration of the current period, review and determination are completed within 72 hours or 3 calendar days.
 - Requests to extend a current course of treatment received more than 24 hours or 1 calendar day after the current period's expiration, or the next business day, are considered administrative requests for retrospective review.

- Concurrent/extended stay reviews are performed for inpatient admissions, and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility, and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and demonstrates Medical Necessity, must be submitted by the facility/Provider contacting the Utilization Management Department either by telephone, fax, or electronically with the additional information to support the request.
- Retrospective Turnaround Times. The review, decision, and notification occur within thirty (30) calendar days of receipt of the request. Cases may be extended for up to 15 calendar days if the following criteria are met:
 - It is determined that an extension is necessary because of matters beyond Alliant Health Plan's control; and
 - Notification is provided to the member, before the expiration of the initial 30 calendar day period, of the circumstances requiring the extension and the date when the plan expects to make a decision; and
 - If a member fails to submit the necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least 45 calendar days from receipt of the notice to respond to the plan request for more information.

The Provider and the facility are notified via telephone and electronically of the determination. In adverse determination, written confirmation to the Provider, facility, and Member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and confirmation of the decision.

Medical Review

Medical reviews are prospective, concurrent, or retrospective of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered health care services and helps to ensure Members receive the appropriate level of care in the appropriate setting.

Prior authorization requirements may differ based upon a Member's Plan. Benefits are always subject to verification of eligibility and coverage at the time services are rendered. If the In-Network Provider chooses to render services that have not received prior authorization or that do not meet Medical Necessity criteria, according to Alliant Health Plans' Clinical Decision Process, the Member is not financially liable for the charges. However, if the Provider obtains acknowledgment of financial responsibility as described in the Non-medically Necessary Services section (page 14), for the specific procedure and any related services prior to the services being rendered, the Member may be held liable. This acknowledgment cannot be utilized to waive the Provider's prior authorization requirements. Members who obtain services out of network may be responsible for all or a substantial share of the charges.

To review services requiring Prior Authorization, refer to the Procedures Requiring Prior Authorization document on AlliantPlans.com or visit the Prior Authorization Verification Tool to search for specific codes/services. Prior Authorization requirements are subject to change. Providers will be notified of any changes in review requirements through updates via provider newsletter and other Alliant Health Plans communications, including but not limited to the Alliant Health Plans company website, AlliantPlans.com. All information is subject to verification by review of the medical record and other sources.

To promote consistent utilization management across all product lines, Alliant Health Plans uses the following Clinical Decision Process:

- 1) Member's Certificate of Coverage,
- 2) Alliant Health Plans Medical Policy,

3) Utilization Management Guidelines and MCG Care Guidelines to make utilization management decisions.

MCG Care Guidelines are nationally recognized guidelines updated annually by a panel of consultants, including, but not limited to, Providers and registered nurses. Alliant Health Plans uses MCG Care Guidelines to assist in its clinical decision-making processes. There are times when Alliant Health Plans may modify or supplement certain MCG criteria to meet practice patterns among our provider population (e.g., a guideline does not exist, the length of stay needs to be changed, or the decision criteria need to be modified). Providers may request a copy of specific criteria by contacting the Utilization Management Department at (800) 865-5922.

Discharge Dates

Discharge information should be sent daily to Alliant Health Plans to ensure appropriate Member follow-up and care coordination. Discharge dates may be reported in any of the following ways:

- noted via the Alliant Health Plans' Provider Portal for In-Network Providers;
- reported via telephone to (800) 865-5922; or
- faxed to (866) 370-5667.

If faxing or e-mailing, Providers may submit one list with all Member names. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

Medical Review Requirements

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day will be denied. Covered Services that have not been authorized may not be billed to the Member. The Provider may appeal a denial due to lack of information to Alliant Health Plans within 180 days of notification of denial. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.

Denial of authorization may be appealed in writing or discussed with a reviewer through the appeals process described in the Administrative Guidelines section of this Provider Manual.

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Demonstrating measurable, practical improvement in function with an evaluation of the current level of functioning
- Discharge plans & target date

Emergency Admission

In-network Providers are responsible for contacting Alliant Health Plans within two (2) business days of the inpatient admission. A retrospective review will be completed if the Member has been admitted and discharged.

Observation Stays

Prior authorization for observation stays through the emergency room is not required. Observation for elective services, direct admissions from the provider's office, or a transfer from another facility require prior authorization. Members in this status may advance to inpatient admission status if the clinical situation warrants it. An observation stay that transitions to an inpatient admission requires Prior Authorization for both the observation and the inpatient stay. All inpatient admissions need to be reported to the Utilization Management Department before a scheduled admission or within the

next business day for conversion to inpatient admission to determine Medical Necessity and Medical Appropriateness.

When an observation stay results from an outpatient procedure with a Prior Authorization, observation must be specified in the Prior Authorization to be considered for reimbursement.

The medical record must support the need for observation, and a specific Provider's order for observation must be documented.

Non-Compliance

Services requiring prior authorization rendered without obtaining approval are considered "non-compliant." Emergency inpatient admissions require authorization within two (2) business days after services have started or within one (1) business day after conversion from observation to inpatient status. Concurrent reviews should be requested within one (1) business day of the last day approved.

When prior authorization is required for elective procedures, Providers must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. Alliant Health Plans Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has Alliant Health Plans coverage and the Provider discovers that the Member does have Alliant Health Plans coverage, the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, including the reason the authorization was not obtained. The medical records will be reviewed for medical necessity only when a valid reason for not receiving a prior authorization is provided with the request.

Providers should follow the standard appeal process. An appeal will only be overturned if Medical Necessity is determined and there is clear evidence that the provider was not aware that the Member had Alliant Health Plans coverage at the time services were rendered.

Transitional Care/Discharge Planning

Alliant Health Plans acknowledges a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist Providers with discharge planning for its patients who are Alliant Health Plans Members. Discharge planning should begin upon inpatient admission. Alliant Health Plans transition of care/discharge planning nurses will assist Providers and Members upon an inpatient admission, during the prior authorization process, or before an admission if a scheduled inpatient admission. Authorization may be required for the following services and should be completed prior to the anticipated discharge and service date:

- Hospital inpatient admissions;
- Skilled nursing facility/restorative care unit admissions;
- Inpatient rehabilitation admission;
- Certain durable medical equipment;
- Speech therapy.

Out-of-Network Services

Benefits may be limited, reduced, or not available in accordance with the terms of the Member's health care benefits plan even if a required prior authorization is obtained. Emergency out-of-network services (based on admitting and discharge diagnosis filed on the claim) are covered, but must be reported to Alliant Health Plans within two (2) business days.

Hospice Services

Hospice services may require prior authorization. Hospice services normally covered include, but are not limited to:

- Part-time, intermittent nursing care
- Medical social services
- Bereavement counseling
- Medications for control or palliation of the illness
- Home health aide services
- Physical or respiratory therapy for symptom control

Hospice services not normally covered include, but are not limited to:

- Homemaker or housekeeping services
- Inpatient and outpatient care
- Meals
- Supportive environmental equipment
- Ambulance
- Chemotherapy
- Private Duty Nursing
- Radiation therapy
- Routine transportation
- Enteral and parenteral feeding
- Funeral or financial counseling
- Home hemodialysis
- Provider visits
- Convenience or comfort items not related to the illness

Refer to your provider contract for specific inclusions or exclusions.

Ambulatory Surgeries, Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in providers' offices. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed and transferred to observation or an inpatient stay, prior authorization is required. Non-emergency elective procedures should be submitted up to thirty (30) days before the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than an inpatient hospital stay require prior authorization. This authorization requirement applies to all Provider types, including but not limited to home infusion therapy Providers, specialty pharmacies, hospitals providing outpatient infusions and injections. A complete listing of Provider-Administered Specialty Pharmacy drugs can be found by visiting AlliantPlans.com and selecting [RX Formulary List](#) from the right-hand menu. Medications requiring prior authorization under the Member's medical benefits plan are identified by blue "MED PA." If the Provider is supplying a Provider-Administered drug that requires a prior authorization, they may do so via the Prime Therapeutics provider portal at <https://GatewayPA.com/>, or they may call Prime Therapeutics Medical Pharmacy at (844) 451-8288 option 3, option 2, option 1. For Specialty drugs dispensed by a retail or specialty pharmacy under the pharmacy benefit, Providers should contact Prime Therapeutics, Alliant Health Plan's Pharmacy Benefit Manager, at (844) 451-8288 option 3, option 1. Prime Therapeutics Management, our

Specialty Pharmacy Network vendor, or Alliant may request additional information, if required, to complete the review process.

Self-Administered Specialty Pharmacy drugs are found on the [RX Formulary List](#) and are marked with a “PA” indicator to reflect which drugs require prior authorization. For Self-Administered drugs requiring prior authorization, the Provider may call (800) 424-1799 Option 3, Option 1 to obtain prior authorization.

Durable Medical Equipment

Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for most lines of business. DME may be subject to retrospective review for Medical Necessity. DME may be covered if it is determined to be Medically Necessary for the Member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the Member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of twelve (12) months.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment. Specific CPT and HCPCS codes and equipment details may be required for Prior Authorization.
- Provider's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable).

Investigational Services

Alliant Health Plans does not cover Experimental/Investigational services. Please refer to the Certificate of Coverage for details.

Clinical Trials

Refer to the Certificate of Coverage for details regarding coverage of Clinical Trials.

Prospective and Retrospective Review

These reviews are conducted based on MCG criteria (if applicable), Alliant Health Plans adopted utilization management guidelines, Alliant Health Plans Medical Policy, and the Member's health care benefits plan. The following listed services are not all-inclusive and may be subject to prospective or retrospective review:

- Possible cosmetic services;
- Potential Investigational services;
- Skilled nursing facility confinements;
- Speech therapy;
- Durable Medical Equipment (when prior authorization is not required);
- Prosthetics, orthotics, and supplies;
- Provider office services;
- Dental, accident-related, and temporomandibular joint dysfunction;
- Pain management;
- Unbundled codes and code combinations; and
- Non-participating provider or no prior authorization was obtained.

QUALITY MANAGEMENT

The Quality Management Program's primary objective is to establish structure and processes that are necessary to define, evaluate, monitor, and ensure that medically appropriate and cost-effective care is provided to Alliant Health Plan members while ensuring patient safety. Alliant Health Plans is also committed to driving continuous improvement in the quality of care delivered to plan members.

Primary goals of the Alliant Health Plans Quality Management Program:

- Review and revise all applicable documents and processes no less than annually to meet current NCQA accreditation standards.
- Review, monitor, and track case management satisfaction survey results.
- Through Member population analysis, identify and conduct wellness outreaches, encourage preventive health screenings, and drive population health strategy.
- Collect and analyze Member-level clinical measures to enhance wellness and case management programs.
- Offer Member satisfaction data to providers to drive continuous improvement in the quality of care.
- Promote the continuity and coordination of care between medical and behavioral health care providers.
- Explore opportunities to increase behavioral health provider participation within the network and behavioral health program development.
- Improve Member communication through Alliant Health Plans' website and marketing materials.
- Continually improve health plan performance on HEDIS measures for both Commercial and Exchange product lines.
- Assess Member satisfaction through survey processes and address identified barriers.
- Support healthy communities through encouragement of Member participation in community wellness events.
- Promote culturally competent care delivery to Members by offering information, training, and tools to staff and providers.
- Provide an adequate and accessible network of qualified providers and providers for Members.
- Continuously assess and leverage available technology to improve quality outcomes using:
 - Self-Management Tools
 - Health Risk Assessments
 - Member Portal
 - Smartphone App

Annual Evaluation

Alliant Health Plans conducts an annual evaluation of the Quality Management Program to ensure quality improvement and future programming. Alliant Health Plans has developed programs, policies, and procedures, identified clinical and service indicators, and designed the committee structure to serve Members and providers best. Alliant Health Plans maintains the National Committee for Quality Assurance (NCQA) accreditation for our Commercial and Exchange products.

Population Health Management

Alliant Health Plans offers various services to our members through our Population Health Management program, which includes Case Management. Case management services are available to all Members. The Population Health Management program's goal is to promote the Member's well-being through health education, resources to assist with health care decisions and build and encourage adherence to quality and cost-effective care plans. Case Managers help members with needs spanning behavioral services and the medical community.

Case Management Services

General Case Management and disease-specific case management programs are available. These services' goals are to increase Member care through coordination of services between the primary care provider, specialist, and other health team members, provide ongoing education and prevention resources, and improve Member care experience.

Wellness program

The wellness program is aimed at identifying members who may have health risks. Resources are provided to empower members to enhance their ability to make informed decisions to promote healthy living. Examples of this program are giving educational material targeted to members who have recently delivered and may benefit from breast cancer screening and those diagnosed with ADHD.

Care Coordination

The Care Coordination program provides member-centric care through interactive involvement with a case manager. Members with potential health needs are identified for this program, which is often short-term. Some areas of focus are management of diabetes, emergency services management, adherence to a treatment plan for depression, appropriate follow up for substance misuse, and behavioral health needs following an inpatient stay.

Complex Case Management

Complex Case Management is an interactive case management program to assist those who have complex health needs to manage their care plan effectively. Some examples of when a Member may need to enroll in complex case management are below, but keep in mind these are not all the reasons:

- Multiple hospitalizations
- High-risk pregnancy
- Severe and persistent mental illness
- Acute catastrophic illness

Transplant Case Management

Transplant Case Management aims to assist a Member in managing their care plan from evaluation for transplant until case management is no longer necessary. Members seeking stem cell or solid organ transplant are eligible for this program. Case managers will promote quality care through Members' direction to facilities in the Alliant Health Plans' transplant network, which is established through careful review of clinical outcomes and accessibility.

Contacting Case Management

- Alliant Health Plans' case management program is designed to assist Members in transitions of care, coordination of care, acute/episodic needs, and complex care management. This program includes telephonic case management, comprehensive assessment tools, and the development of individualized, prioritized care plans. Members are identified for this program via data analysis, predictive modeling, and referrals from utilization management, other disease/wellness programs, providers, and self-referrals.
- If you have any questions or would like to make a case management referral for your patient, please call Alliant Health Plans' Medical Management Department at: (800) 865-5922, Monday-Friday, 8:00 a.m. to 5:00 p.m. ET.
- All Population Health Management programs through Alliant Health Plans, including Case Management, are free, confidential, and available to all members.

Requests for care management should include the following:

- Requesting provider's name and contact information
- Member name, ID, contact information

- Diagnosis and relevant clinical information
- Current treatment setting such as home, acute rehab, inpatient hospital, etc.
- Level of urgency for case management

Following a request for case management, a case manager will reach out to the referral source within two business days. If a more urgent response is needed, please indicate this urgency when phoning in the request.

Preventive Health

Alliant Health Plans has also established preventive health guidelines to improve health care quality, reduce unnecessary variation in care, assist providers in guiding and educating patients, providing a basis for wellness programs, and to improve members' health. These guidelines will help guide wellness interventions, educate providers, and encourage self-management lifestyle changes for Members. The Preventive Guidelines Tool is available at AlliantPlans.com.

For the management of health needs, Alliant Health Plans adopted the United States Preventive Services Task Force (USPSTF) A and B recommendations, healthcare.gov, and the Centers for Disease Control (CDC) recommendations for the following categories:

- Pregnant Women
- Children 0-24 months
- Children 2-19 years
- Adults 20-64 years
- Adults 65 years and older

PHARMACY BENEFIT MANAGER

PRIME THERAPEUTICS

This Plan uses a Pharmacy Benefits Manager (PBM) for the administration of outpatient prescription drug benefits. Prime Therapeutics is the PBM for Alliant Health Plans. For the most up-to-date information about the Prescription Benefit Program, call Prime Therapeutics Customer Service at 1-844-451-8288.

Formulary/Prescribing Guidelines

Alliant Health Plans pharmacy benefits currently covers most legend drugs (or a therapeutic equivalent) approved by the U.S. Food and Drug Administration (FDA). Non-FDA approved drugs are considered experimental and are not covered.

Off-Label Drugs

When prescribed for an individual with a life-threatening or chronic and disabling condition or disease, benefits are provided for the following:

- Off-label drugs; and
- Medically Necessary services associated with the administration of such a drug. An off-label drug is prescribed for a different use from which that drug has been approved for marketing by the U.S. Food and Drug Administration (FDA). All off-label drugs must be pre-approved by Alliant Health Plans.

Controlled Substances

Providers prescribing controlled substances to Alliant Health Plans Members are expected to comply with all existing federal and state laws governing this activity, including but not limited to checking a patient's drug utilization in the applicable State's Prescription Drug Monitoring Program Database (PDMP) or Controlled Substance Monitoring Database (CSMD). An Alliant Health Plans Clinical Pharmacist may conduct personal visits with prescribing Providers to supply information designed to assist the Provider in providing quality, cost-effective health care to Alliant Health Plans members. Timely clinical information is presented around specific high incidence medical conditions. This clinical information is intended to inform the Provider of potential gaps in care, compliance, adherence issues, and opportunities for more cost-effective therapeutic options. Data might be presented to aid in the overall management of Alliant Members.

Plan Exclusions

Alliant Health Plans excludes certain drug classes or individual drugs (e.g., hair loss prevention drugs, drugs indicated for cosmetic purposes, drugs for erectile dysfunction, drugs for weight loss). A Provider or Member may call 1-844-451-8288 to speak with a pharmacy benefit customer service representative for assistance in determining which medications are excluded as covered benefits. Additionally, for more information on drugs excluded from the health plan, a link to the PBM Formulary Look-Up Tool can be located by visiting AlliantPlans.com and selecting [RX Formulary List](#) from the right-hand menu.

Member Drug Copay/Coinsurance

There are many variations of copay/coinsurance structures available to Alliant Health Plan Members. These different structures can carry a percentage of coinsurance for a drug and/or a copay for a drug based on a multi-tier formulary.

Pharmacy Network

Alliant Health Plans accesses Prime Therapeutics national pharmacy network.. In-network pharmacies can be found using the In-Network Pharmacy Locator Tool accessible to members through their Alliant Member Portal. Members and Providers can also access the tool at AlliantPlans.com>Find a Provider>In-network Pharmacy.

Claims Submission

Claims for Provider-administered drugs administered anywhere other than an inpatient setting (ex. Outpatient infusion centers, provider offices, and in-home settings) should be submitted on the appropriate

claim form using the most appropriate CPT® or HCPCS code and the drug's National Drug Code (NDC) number, a 11-digit unique number assigned to a specific drug. The strength of the drug and the number of units administered must also be submitted. Claims for self-administered drugs (ex. Oral drugs, topicals, self-administered injectables, etc.) will be electronically submitted through an in-network pharmacy to the Member's pharmacy benefits manager (PBM). Claims for self-administered drugs will not process through the Alliant Health Plans medical claims system.

Formulary

The Alliant Health Plans national drug formulary is located by visiting AlliantPlans.com and selecting [Formulary List](#) link at the bottom on the member resource page.

Prior Authorization

Certain drugs require a prior authorization to be covered under the benefit. These drugs are noted on the formulary. The prescribing Provider and Member (or Member's representative) are responsible for requesting and obtaining the necessary approval from Alliant Health Plans for drugs that require a prior authorization. Prior authorization must be received before the drug is dispensed or administered.

For pharmacy prior authorizations that fall under the pharmacy benefits (PBM) (ex. Drugs dispensed from an in-network pharmacy):

Phone: 1-844-451-8288

For medical prior authorizations for provider administered specialty drugs that fall under the medical benefits:

Phone: (800) 424-1799, Option 3, Option 2, Option 1. Available Monday through Friday from 9:00 am to 6:00 pm Eastern Time.

Website: GatewayPA.com

Fax: (888) 656-6671

Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. These drugs and their respective quantity limits are noted on the formulary look up tool. More significant quantities require Provider supporting statement for Medical Necessity to exceed the designated quantity limit. You may request prior authorization for quantity limit formulary exception by contacting the following:

Phone: 1-844-451- 8288

Exception Process for a Drug Not Covered on Alliant Health Plan's Formulary

1. The Member or the Prescriber may request a drug coverage exception based on medical necessity reasons when the requested pharmaceutical is not covered on the plan's formulary of covered pharmaceuticals.

Process for Requesting a Formulary Drug Exception:

- The form can be obtained by calling Prime Therapeutics at 1-844-451-8288 . Submit the completed Formulary Drug Exception Request form to Prime Therapeutics . An online version of the Formulary Drug Exception Request form is available by going to the [Formulary List](#) link and accessing Alliant myPrime Documents and Forms.
- A Prime Therapeutics clinical pharmacist will review the form.
- Upon determination, you will receive a notification indicating if the exception has been approved or denied, along with available appeal options for Level 1 or Level 2 Appeals. Appeals can also include an external review by an Independent Review Organization (IRO).

○ For External Appeals in Georgia:

- The Member or prescribing physician can submit a request for external review online at <https://externalappeal.cms.gov>, by calling (888) 866-6205 to ask for an external review

request form, or by sending the request via email to ferp@maximus.com . To request an external review by fax or mail:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: (888) 866-6190

For External Appeals in Tennessee:

○ **You may request an external review by:**

- 1. Calling Alliant toll-free at (800) 865-5922; or**
- 2. Submitting the request via fax at (866) 634-8917; or**
- 3. You may send a written request by mail to the following:**

Alliant Health Plans
Appeals Department
PO Box 1247
Dalton, GA 30722
Phone: (800) 865-5922
Fax: (866) 634-8917

For help with the external review process or to file a complaint please contact the Tennessee Department of Commerce and Insurance (TDCI), Insurance Division by:

- 1. Calling TDCI toll-free at (800) 342-4029 or at (615) 741-2218; or**
- 2. Submitting the request online through the Consumer Complaint Portal; or**
- 3. Mailing or emailing your complaint to the following:**

Tennessee Department of Commerce and Insurance
Insurance Division
500 James Robertson Parkway
Nashville, TN 37243
Email: Ins.Policy.Analysis@TN.gov

Alliant will also provide you with any required forms upon request. Once an eligible request regarding a complaint is complete, the matter will be investigated by the TDCI. There will be no charge to You for the investigation. The TDCI will notify You and Your authorized representative of its decision.

Timeframes for Decisions:

- Standard preservice requests will be decided within 7 calendar days.
- Expedited preservice requests will be decided within 72 calendar hours.
- Expedited concurrent requests will be decided within 24 calendar hours.
- If all required information is not received, the prescriber will be notified of the additional information needed.

MEMBER RIGHTS & RESPONSIBILITIES

Alliant Health Plans recognizes the specific needs of and maintains a mutually respectful relationship with our Member population. Please find a reference list of Member rights and responsibilities below.

Members' Rights

1. Recommend changes regarding the Member's Rights and Responsibilities policy.
2. Receive information about the plan, its services, its Providers, and about your Rights and Responsibilities as a Member.
3. Be treated with respect and recognition of your dignity and right to privacy by the plan, its Providers, and other health care professionals.
4. Privacy and confidentiality for treatments, tests, or procedures you receive.
5. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
6. Voice complaints or appeals about the plan or the care it provides.
7. Participate with Providers in making decisions about your health care.
8. Refuse treatment and be informed by your provider of the medical consequences.
9. Understand where your consent is required, and if you are unable to give consent, the plan will seek your designated guardian and/or representative to provide this consent.

Members' Responsibilities

1. Provide, to the extent possible, information that the plan and its Providers need in order to care for you.
2. Provide the correct and current address and billing information.
3. Follow the plans and instructions for care that you have agreed to with your Provider(s).
4. Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
5. Identify yourself as a Member when seeking care to make sure you receive full benefits under the plan.
6. Allow Alliant Health Plans to review your medical records as part of quality initiatives or compliance with regulatory or governing bodies.
7. Be enrolled and pay any required premium.
8. Pay any annual deductible, copayments, and coinsurance.
9. Pay the cost of Non-Covered Services or excluded services.
10. Choose In-Network Providers and In-Network pharmacies.

HIPAA

Alliant Health Plans, Inc. is committed to the protection of personally identifiable health information of our Members by complying with the HIPAA Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the HIPAA Standard Transactions and Code Sets Regulations, and the HIPAA Security Standards Regulations (the "Security Rule") [See 45 C.F.R Parts 160, 162 and 164, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), at Section 13400, et. seq. of the American Recovery and Reinvestment Act of 2009 ("ARRA"), 42 U.S.C. § 17921, et. seq., and guidance and regulations promulgated thereunder], and requires that network providers comply with these standards and regulations. All network providers are expected to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the protected health information (PHI), either electronic or otherwise, that they create, receive, maintain or transmit, on behalf of the plan(s) in which they participate as required by the Security Rule.

Secure Emails

To comply with HIPAA regulations, Alliant Health Plans sends ALL emails containing protected health information (PHI) in a secure format via Microsoft's Office 365 Secure Email System. PHI includes identifiable information such as Member name, birth date, social security number, subscriber number, diagnosis, or other Member specific information. To access the Office 365 Secure Email, you will need to set up a username and password with Microsoft or generate a four-digit pin after opening the encrypted message. If you have any trouble creating a login/password or have forgotten your password, please contact Alliant Health Plans Provider Relations at (800) 664-8480 ProviderRelations@AlliantPlans.com. Please ensure that any email you send, which includes PHI, is sent via a secure email system. If you do not have access to a secure email system, HIPAA regulations allow for information to be sent via secure fax. This fax can be sent directly to Alliant Health Plans for review. For further direction on what components are considered protected information under the Health Insurance Portability and Accountability Act, please visit www.hhs.gov/hipaa.

Revised 1/2024

APPENDIX A: CREDENTIALING CRITERIA

Allied Professionals

Advanced Practicing Registered Nurse (**APRN**) which includes:

Certified Nurse Midwives (CNM)	Clinic Nurse Specialists Psychiatric/Mental Health (CNS/PMH)
Clinical Nurse Specialists (CNS)	Certified Registered Nurse Anesthesiologist (CRNA)
Nurse Practitioners (NP)	

Additional Allied Health Professionals include:

Audiologist (AUD)	Physical Therapists (PT, MPT, and DPT)
Chiropractors (DC)	Physician Assistants (PA)
Licensed Athletic Trainers (LAT)	Psychologists (Ph.D. and PsyD)
Licensed Clinical Social Workers (LCSW)	Occupational Therapists (OT, MOT, ODT)
Licensed Marriage and Family Therapists (LMFT)	Optometrists (OD)
Licensed Professional Counselors (LPC)	Speech Pathologists (SP and SLP)
Master of Social Work (MSW)	Registered Dietitian (RD)

For purposes of the qualification criteria the above referenced practitioners shall be referred to herein as “Participating Provider” or “Practitioner”.

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One’s Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner’s voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

For purposes of Medicare and Medicaid plans that Health One serves as a delegated credentialing entity, Health One shall directly credential the midlevel provider as a provider that directly bills for his or her services, as applicable and required by the delegated credentialing obligations of Health One. Otherwise, all other Allied Health Providers that satisfy the Health One criteria shall be processed in accordance with the policy below.

Health One shall directly credential Allied Health Professionals as a provider that directly bills for his or her services. Requirements for Practitioners shall comply with the following eligibility requirements and must satisfy the Health One criteria shall be processed in accordance with the policy below.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:
 - 1.1. Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school, as required by the applicable state licensing or registration agency of the Practitioner’s profession.
 - Undergraduate Education
 - Medical and/or Professional Education
 - Licensed Professional References
 - Work History
 - 1.2 Advanced Nurse Practitioners (**APRN**) shall present official documentation indicating he/she has graduated with a master’s degree or doctorate from an accredited professional school or who shall meet those educational, practice, certification requirements, or any combination of such requirements, as specified by the Board and provide complete information with respect to professional training/activities which shall

include, without limitation, the following:

- Undergraduate Education
- Medical and/or Professional Education
- Licensed Professional References
- Work History

LICENSE

2. Practitioner is a person with a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked or involuntarily or voluntarily surrendered in any state where practitioner practices . If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law. In the event Practitioner was licensed in any state where he or she is no longer practicing, Practitioner shall provide written notification to Health One regarding the disposition of such license and such information may be considered by Health One when evaluating the Practitioner's qualifications.

DEA

3. Eligible practitioners, Advanced Nurse Practitioners (APRN) and Physician Assistants (PA), may hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in any state in which they actively practice. If an APRN or PA does not write prescriptions, their credentialing file will be notated with this information.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.
 - 4.1. Advanced Nurse Practitioners (APRN), Audiologists (AUD), Physician Assistants (PA), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Masters of Social Work (MSW), Occupational Therapists (OT), Optometrists (OD), Physical Therapists (PT), Physician Assistants (PA) and/or Registered Dietitians (RD) are permitted to:
 - 4.1.1. Share insurance limits with their Supervising/Delegating physician at ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate.
OR
 - 4.1.2. Share insurance limits with their employer/physician entity of the provider practice, provided the physician(s) within the provider practice have their own coverage as required under the Health One Physician Credentialing Criteria.

MALPRACTICE

- 4.2. Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.
 - 4.2.1. Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

SUPERVISING/DELEGATING PHYSICIAN

Advanced Nurse Practitioner (APRN), and Physician Assistant (PA) Requirement

5. In accordance with the applicable laws for the Practitioner's scope of practice, the Supervising/Delegating Physician must be in a comparable specialty area or field as that of the APRN or PA. The APRN or PA and Physician shall provide certification to Health One that both parties practice in comparable specialties. The Supervising/Delegating Physician shall be licensed in the State of Georgia or any other State in which both the Practitioner and Supervising/Delegating Physician actively practice and shall have an office in the corresponding state. The Supervising/Delegating Physician must be a participating member of the Health One Network and must confirm to Health One that he or she shall be immediately available for consultation with the APRN and/or the PA.
6. The APRN shall have a valid Nurse Protocol Agreement and shall provide a written attestation of compliance with the Nurse Protocol Agreement. For APRNs that write prescriptions, the Nurse Protocol Agreement shall conform with the limitations set forth by the applicable laws. The Nurse Protocol Agreement will be readily available for review and onsite at Practitioner's office at all times. Upon network's request, Practitioner shall submit a copy of the Nurse Protocol Agreement within the time frame required by HealthOne. In the event the Nurse Protocol Agreement is modified, amended or terminated, Practitioner shall notify HealthOne promptly and no later than three (3) days following such modification, amendment or termination.
7. Physician Assistants (PA) shall have a valid Job Description on file in the State of Georgia or any other State in which they actively practice. The Job Description shall be provided to Health One and it must be signed by the Physician Assistant's current Supervising/Delegating Physician within the past 3 years.

DISCLOSURE

8. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Practitioner's qualifications to participate in the HealthOne Network. Based on its assessment of the Practitioner's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to practitioners credentialing application to approve or disapprove network participation.
 - 8.1. Practitioner shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Practitioner shall submit any applicable information regarding the same for review and consideration.
 - 8.2. Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.
 - 8.3. Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.
 - 8.4. Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.
 - 8.5. Practitioner shall confirm whether he or she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.
 - 8.6. Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal

charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

8.7. Practitioner shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

9.1. Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may participate in the Health One Network, provided his treating practitioner certified that the provider has the physical and mental capacity and capabilities to perform the services required for treatment of patients with reasonable accommodations.. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes. Practitioner shall have an affirmative obligation to provide Health One notification of any physical or mental health ailments that adversely impact his or her capacity to perform the services. Such notification shall be provided no later than three (3) days following the onset of such illness or ailment.

NONDISCRIMINATION

10. Practitioner shall treat all patients regardless of their ability to pay, race, ethnic/national identity, gender, sexual orientation or insurance coverage. Practitioner shall maintain a nondiscrimination policy .

11. Health One maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation, or insurance coverage.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

15. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

16. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status (including any inactive, prior or current licenses in any state), insurance coverage, , sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

1/2025

Behavioral Analyst (BA) (Allied)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

For purposes of Medicare and Medicaid plans that Health One serves as a delegated credentialing entity, Health One shall directly credential the midlevel provider as a provider that directly bills for his or her services, as applicable and required by the delegated credentialing obligations of Health One. Otherwise, all other Allied Health Providers that satisfy the Health One criteria shall be processed in accordance with the policy below.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:
 - 1.1. Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school, as required by the applicable state licensing or registration agency of the Practitioner's profession.
 - Undergraduate Education
 - Medical and/or Professional Education
 - Licensed Professional References
 - Work History

LICENSE

2. Practitioner must maintain a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked or involuntarily or voluntarily surrendered in any state where practitioner practices. If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law. In the event Practitioner was licensed in any state where he or she is no longer practicing, Practitioner shall provide written notification to Health One regarding the disposition of such license and such information may be considered by Health One when evaluating the Practitioner's qualifications.
 - 2.1. If the state in which the practitioner is applying for network participation does not offer a medical license (e.g., State of Georgia), practitioner must hold a current, valid certification with the Behavioral Analyst Certification Board.

DEA

3. Eligible practitioners may hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

- 4.1. Details of any professional liability actions that have resulted in adverse judgments or any financial

settlements.

4.2. Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

DISCLOSURE

5. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the Health One Network. Based on its assessment of the Provider's credentialing information and other facts and circumstances provided through the credentialing process, Health one will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.
 - 6.1 Practitioner shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.
 - 6.2 Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.
 - 6.3 Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.
 - 6.4 Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.
 - 6.5 Practitioner shall confirm whether he or she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.
 - 6.6 Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.
 - 6.7 Practitioner shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.
7. Practitioner is in good general health.
 - 7.1. Practitioner shall certify on the Application that Practitioner is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may participate in the Health One Network, provided his treating practitioner certified that the provider has the physical and mental capacity and capabilities to perform the services required for treatment of patients with reasonable

accommodations. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes. Practitioner shall have an affirmative obligation to provide Health One notification of any physical or mental health ailments that adversely impact his or her capacity to perform the services. Such notification shall be provided no later than three (3) days following the onset of such illness or ailment.

NONDISCRIMINATION

8. Practitioner shall treat all patient, regardless of their ability to pay, race, ethnic/national identity, gender, sexual orientation or insurance coverage. Practitioner shall maintain a policy of nondiscrimination.
9. Health One maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation, or insurance coverage.

AUDITS

10. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

11. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

12. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.
 - 12.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.
 - 12.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

13. Health One, and its agents, reserves the right to require independent verification of any and all of the

Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

14. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status (including any inactive, prior or current licenses in any state), insurance coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

15. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

3/2025

FQHC (Federally Qualified Health Centers)

In order to be considered a Participating Federally Qualified Health Center Provider (FQHC), as an essential community provider, Provider must notify Health One of their FQHC status and verify compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentialing Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal, or termination from participation in the Health One Network.

REGULATORY REQUIREMENTS

1. Provider must maintain a written agreement with the Centers for Medicare and Medicaid Services (CMS) to serve as an FQHC.
2. Provider must receive a grant under §330 of the Public Health Service (PHS) Act, or receives funding under a contract with the recipient of a §330 grant, and meets the requirements to receive a grant under §330 of the PHS Act; or (a) has been notified in writing that the facility meets the requirements for receiving a §330 grant, even though it is not actually receiving such a grant; or (b) was a comprehensive federally funded health center as of January 1, 1990; or (c) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
3. FQHC shall provide written evidence that it satisfied the two qualification criteria described above.

3/2025

Hospital Based Rural Health Clinics (RHC)

In order to be considered a Participating Hospital Based Rural Health Clinic (RHC), as an essential community provider, Provider must notify Health One of their RHC status and verify compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentialing Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

REGULATORY REQUIREMENTS

1. Provider must maintain a written agreement with the Centers for Medicare and Medicaid Services (CMS) to serve as a hospital based RHC (provider based/hospital based RHCs are owned and operated as an essential part of a hospital participating in the Medicare program. RHCs operate under the licensure, governance and professional supervision of that organization).
2. Provider must meet the statute requirements for RHCs in section 1861 (aa) of the Social Security Act and the clinic must be located in a non-urbanized area as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHC), in any one of the 4 types of shortage area designations that are accepted for RHC certification.
 - a. Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act
 - b. Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act
 - c. Medically Underserved Area under Section 330(b)(3) of the PHS Act
 - d. Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1989
3. RHCs may provide both primary and preventive services with the goal of improving health access in rural areas.
4. RHCs must be staffed by at least 50% of the time by midlevel practitioners (such as nurse practitioners (NPs) and physician assistants (PAs)).
5. RHC shall provide written evidence that it satisfied the four qualification criteria described above. Hospital based RHCs must comply with the Organizational Provider Credentialing Criteria.

Oral and Maxillofacial Surgeons

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentialing Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

1.1. Practitioner must be a graduate of an accredited school of medicine and/or dentistry, completed a Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

- Undergraduate Education
- Medical and/or Professional Education
- Internships and Residencies
- Fellowships
- Licensed Professional References
- Work History

Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

1.2 Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Oral and Maxillofacial Surgery (ABOMS); unless Practitioner meets one of the following:

- 1.2.1 Practitioner who has not previously been Board Certified, but has been practicing for at least twenty-(20) consecutive years of medical service in the same or similar specialty since the completion of their Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or
- 1.2.2 Practitioner who was previously Board Certified through a Health One approved board: American Board of Oral and Maxillofacial Surgery (ABOMS), but the board has since expired and has a minimum of ten (10) consecutive years of clinical practice in the same or similar specialty of their Board Certification and has exhibited through their experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis for participation; or
- 1.2.3 Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.

1.3 Practitioner who has a lapse in Board Certification is subject to automatic review.

LICENSE

2. Practitioner must maintain a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked or involuntarily or voluntarily surrendered in any state where practitioner practices. If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner

must maintain a current, valid facility license or permit as required by state law. In the event Practitioner was licensed in any state where he or she is no longer practicing, Practitioner shall provide written notification to Health One regarding the disposition of such license and such information may be considered by Health One when evaluating the Practitioner's qualifications.

DEA

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in any state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

- 4.1. The Practitioner shall disclose the details of any professional liability actions that have resulted in adverse judgments or any financial settlements.
- 4.2. Details of any pending professional liability actions.
This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

Hospital Affiliation

5. For the purpose of Network provider directory, Practitioner shall confirm any hospital affiliation(s). Practitioner shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Practitioner shall submit any applicable information regarding the same for review and consideration.

Disclosure

6. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentialing Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network. Practitioner's qualifications to participate in the HealthOne Network. Based on its assessment of the Practitioner's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.
 - 6.1. Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including

any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

- 6.2. Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.
- 6.3. Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.
- 6.4. Practitioner has not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.
- 6.5. Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.
- 6.6. Practitioner shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.
7. Practitioner is in good general health.
 - 7.1. Practitioner shall certify on the Application that Practitioner is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may participate in the Health One Network, provided his treating practitioner certifies that the provider has the physical and mental capacity and capabilities to perform the services required for treatment of patients with reasonable accommodations. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes. Practitioner shall have an affirmative obligation to provide Health One notification of any physical or mental health ailments that adversely impact his or her capacity to perform the services. Such notification shall be provided no later than **three (3) days** following the onset of such illness or ailment.

NONDISCRIMINATION

8. Practitioner shall treat all patients regardless of their ability to pay, race, ethnic/national identity, gender, sexual orientation or insurance coverage. Practitioner shall maintain a nondiscrimination policy.
9. Health One maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age, sexual orientation or insurance coverage.

AUDITS

10. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

11. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

12. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

- 12.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all the information submitted is accurate. Practitioner is further required to authorize Health One to obtain the necessary information from third parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.
- 12.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal. Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

13. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

14. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status (including any inactive, prior or current licenses in any state), insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

15. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

5/2025

Organizational Providers

In order to be considered a Participating Organizational Provider, Provider must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentialing Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

ACCREDITATION

1. Provider must attain Accreditation in accordance with one of the Health One approved Accrediting Bodies as appropriate for their provider type.

LICENSE

2. Provider must hold a current, valid and unrestricted facility license or facility permit as appropriate for any state where licensed. Providers must hold a current, valid and unrestricted facility license in the State of Georgia in order to dispense or provide any clinical services to Georgia residents, unless the State of Georgia does not maintain a license or certification requirement for the provider type.

DEA

3. Provider must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in any other state in which they actively render services, or provide evidence satisfactory to Health One that the Provider does not require such registration in order to deliver appropriate care.

INSURANCE

4. Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional and/or general liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate. Provider shall authorize the carrier to issue to Health One certificate of insurance policies of Provider upon request of Health One. Notwithstanding the foregoing, Provider shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Provider shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

- 4.1 Details of any professional and/or general liability actions that have resulted in adverse judgments or any financial settlements.
- 4.2 Details of any pending professional and/or general liability actions.
This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Providers shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

DISCLOSURE

5. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:
 - 5.1 Provider shall confirm if anyone in the Provider's staff has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

- 5.2 Provider shall confirm whether Provider or its authorized representatives has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.
- 5.3 Provider or its authorized representatives have not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.
- 5.4 Provider shall confirm whether criminal proceedings have ever been initiated against the Providers or its authorized representatives.
- 5.5 Provider or its authorized representatives shall confirm whether any adverse quality determination concerning Provider treatment of a patient by a state or federal professional review organization.
6. Practitioner is in good general health.
 - 6.1 Practitioner shall certify on the Application that Practitioner is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may for participate in the Health One Network, provided his treating practitioner certifies that the provider has the physical and mental capacity and capabilities to perform the services required for treatment of patients with reasonable accommodations. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes. Practitioner
 - 6.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

7. Provider shall treat all patients regardless of their ability to pay, race, ethnic/national identity, gender, sexual orientation or insurance coverage. Practitioner maintain a policy of nondiscrimination.
8. Health One maintains a policy of nondiscrimination with all providers and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age, sexual orientation, or insurance coverage.

AUDITS

9. Provider shall permit Health One to conduct regular and random on-site audits, including a review of medical records pertaining to Health One related beneficiaries. Provider shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

10. Provider shall execute the Health One Provider Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

11. Provider shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.
 - 11.1 Provider is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.
 - 11.2 Health One Representatives are authorized by the Credentials Committee to request additional

information from the Provider and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Provider has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request.

Health One will respond to a Provider's request via phone, fax, letter or email.

VERIFICATION

12. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

13. Provider shall be solely responsible for notifying Health One in writing of any changes in the Provider's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in facility license/permit status (including any inactive, prior or current licenses in any state), , insurance coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

14. Provider shall comply with any and all Health One policies and procedures related to the operations and Provider participation.

5/2025

Physicians (MD, DO, DPM)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentialing Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

1.1. Practitioner must be a graduate of an accredited school of medicine or osteopathy, completed a Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

- Undergraduate Education
- Medical and/or Professional Education
- Internships and Residencies
- Fellowships
- Licensed Professional References
- Work History

Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

1.2. Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM) or American Board of Oral and Maxillofacial Surgery (ABOMS); unless Practitioner meets one of the following:

- 1.2.1. Practitioner who has not previously been Board Certified, but has been practicing for at least twenty- (20) consecutive years of medical service in the same or similar specialty since the completion of their Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or
- 1.2.2. Practitioner who was previously Board Certified through a Health One approved board: American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM) or American Board of Oral and Maxillofacial Surgery (ABOMS), but the board has since expired and has a minimum of ten (10) consecutive years of clinical practice in the same or similar specialty of their Board Certification and has exhibited through their experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis for participation; or
- 1.2.3. Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.
- 1.2.4. Practitioner who has a lapse in Board Certification is subject to automatic review.

LICENSE

2. Practitioner must maintain a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked or involuntarily or voluntarily surrendered in any state where practitioner practices . If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law. In the event Practitioner was licensed in any state where he or she is no longer practicing, Practitioner shall provide written notification to Health One regarding the disposition of such license and such information may be considered by Health One when evaluating the Practitioner's qualifications.

DEA

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in any state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS (\$1,000,000) per occurrence/THREE MILLION DOLLARS (\$3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

- 4.1. The Practitioner shall disclose the details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

- 4.2. Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

HOSPITAL AFFILIATION

5. For the purpose of Network provider directory, Practitioner shall confirm any hospital affiliation(s).

- 5.1 Practitioner shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Practitioner shall submit any applicable information regarding the same for review and consideration.

DISCLOSURE

6. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Practitioner's qualifications to participate in the HealthOne Network. Based on its assessment of the Practitioner's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.

- 6.1. Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and

provide any applicable documentation regarding same. “Adverse Action” means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

- 6.2. Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.
- 6.3. Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.
- 6.4. Practitioner shall confirm whether he or she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.
- 6.5. Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.
- 6.6. Practitioner shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.
7. Practitioner is in good general health.

Practitioner shall certify on the Application that Practitioner is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse participate in the Health One Network, provided his treating practitioner certified that the provider has the physical and mental capacity and capabilities to perform the services required for treatment of patients with reasonable accommodations. In Health One’s sole and absolute discretion, Health One may request a Practitioner’s personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes. Practitioner shall have an affirmative obligation to provide Health One notification of any physical or mental health ailments that adversely impact his or her capacity to perform the services. Such notification shall be provided no later than **three (3) days** following the onset of such illness or ailment.

NONDISCRIMINATION

8. Practitioner shall treat all patients regardless of their ability to pay, race, ethnic/national identity, gender, sexual orientation or insurance coverage. Practitioner shall maintain a nondiscrimination policy..
9. Health One maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant’s race, ethnic/national identity, gender, age, sexual orientation or insurance coverage.

AUDITS

10. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

11. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

12. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that

may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

- 12.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all the information submitted is accurate. Practitioner is further required to authorize Health One to obtain the necessary information from third parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.
- 12.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

13. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

14. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status (including any inactive, prior or current licenses in any state), insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

15. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

5/2025

APPENDIX B: NETWORK PROVIDER QUALITY MANAGEMENT MANUAL – HEDIS®

Welcome, and thank you for participating with Alliant Health Plans. We appreciate your continued partnership in delivering high-quality care for our members. The key to success is communication, so we hope that you find this manual helpful. Please let us know if we can do anything to make working with us easier.

Founded by health care providers, Alliant Health Plans is a licensed Provider Sponsored Health Care Corporation (PSHCC). As a not-for-profit company, our purpose is to improve health care for our policyholders. We accomplish this by including physicians and community leaders on our board of directors, where they determine how best to deliver care to the communities we serve.

Alliant Health Plans has a radically new approach to health care. By putting doctors in charge of treatment decisions and patients ahead of profits, we're returning medicine to its original purpose: HEALING.

Alliant Health Plans provides our members with exceptional coverage, professional service, and access to high quality, cost-effective care.

We have developed this manual to guide you through the HEDIS® policies/measures. A great effort has been made to ensure that the information on these pages is accurate. Should any conflict exist between this manual's contents and your provider agreement, your provider agreement prevails. Please contact the Quality Assurance Department with any questions.

Provider Communications

Alliant Health Plans wants to be a great partner and develop mutually beneficial partnerships with our providers. Communication is essential to successful relationships, and sharing information responsibly is especially important to us. As questions may arise, please contact Obie Hooper (Quality Assurance Clinical Administrator) during regular business hours.

Address	PO BOX 1128 Dalton, Ga 30722
Website	AlliantPlans.com
Obie Hooper Quality Assurance Clinical Administrator	(706) 891-3399
Molly Owensby Quality Assurance Specialist	(706) 263-3237

Quality Management

Regulatory Requirements

An effective Quality Management (QM) program must comply with the applicable federal and state standards. Compliance requires the collaborative efforts of Alliant Health Plans and all network providers. Alliant Health Plans must meet all regulatory requirements to maintain its National Committee of Quality Assurance (NCQA) Accreditation. This manual describes how Alliant Health Plans must operate and perform the quality measurement and improvement related to health care delivery. This manual's purpose is to assist medical organizations in developing quality assurance and performance improvement programs and provide a road map for monitoring Alliant Health Plans' Quality Management program.

Annually reported standard quality-related measures, including Healthcare Effectiveness Data & Information Set (HEDIS®) and Consumer Assessments of Health Plans Survey (CAHPS), are viewed to ensure that Alliant Health Plans is appropriately providing health care.

HEDIS® (Healthcare Effectiveness Data and Information Set)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized measures specifying how health care plans collect, audit, and report performance information in specific clinical areas, customer satisfaction, and patient experience. HEDIS® data is collected through chart reviews, medical claims, and Member surveys. NCQA maintains HEDIS® and currently, there are 96 measures across six (6) domains of care. These domains are:

1	Effectiveness of care.
2	Accessibility/availability of care.
3	Experience of care.
4	Utilization and Risk-Adjustment Utilization.
5	Health Plan Descriptive Information.
6	Measures Collected Using Electronic Clinical data systems.

It is of value to note that 50% of Alliant Health Plans' accreditation is based on its HEDIS® results. It is paramount that Alliant Health Plans performs well in HEDIS® scoring year after year.

HEDIS® is one of the most widely used sets of health care performance measures in the United States. Alliant Health Plans' performance on the required HEDIS® measures is evaluated against applicable benchmarks and thresholds by product line. For the Commercial Plan, the annual NCQA Benchmarks and Threshold spreadsheet for accreditation scoring is used to make regional and national comparisons. NCQA assigns points for certain HEDIS® clinical measures based on whether the regional and national results fall in the following ranges:

- 0-24th percentile
- 25th-49th percentile
- 50th-74th percentile
- 75th-89th percentile
- 90th percentile and above

With new standards added every year, Alliant Health Plans will keep all avenues of communication open with its providers. The Quality Assurance Department is available to assist providers and their staff with any questions during the HEDIS® chart retrieval process.

As health care costs continue to rise, purchasers of health benefits – large corporations that purchase care on behalf of their population – have become increasingly concerned that health care value has not increased proportionately. As health benefits consume an ever-increasing percentage of expenses, purchasers seek ways to assess care's relative value. HEDIS® offers a way to evaluate an apples-to-apples comparison of health plans.

HEDIS® provides value on three fronts—all of which are equally important. First, HEDIS® measures give the public an unprecedented ability to understand how well organizations achieve results by answering questions such as:

1. How effective and satisfying is the care and service that is delivered?
2. How accessible is care?
3. Does care lead to better outcomes for members?
4. How well does the organization help its members make informed choices about their health?

Second, HEDIS® measures ensure that results are comparable across all organizations. Much of HEDIS® development consists of turning a straightforward concept into a set of rules that can be unambiguously interpreted and consistently applied across organizations, accounting for differences in data systems (and population risk) that might

affect results independent of performance. NCQA learned that this translation is not nearly as simple as it seems and that without awareness of operational details, conceptually attractive measures offer no useful information. An important—and unique—component of HEDIS is its attention to statistical details.

Third, HEDIS® is a component of a more extensive system that encourages accountability and quality improvement in health care. Quality professionals in health care strongly believe that managed care can provide better care, and HEDIS® can help prove them right.

New Measures

The new technical specifications for the 2023 edition of HEDIS® includes six new measures. Two measures were retired for the HEDIS® 2023 season. New measures and changes follow a rigorous development process that ensures they are relevant, scientifically sound, and feasible for implementation.

Changes to Existing Measures

The former Comprehensive Diabetes Care (CDC) measure has been separated into three standalone measures:

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Eye Exam for Patients with Diabetes (EED)

Race and Ethnicity Stratification (RES)

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

RES Stratification will be required on the following measures:

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patient with Diabetes (HBD)
- Prenatal and Postpartum Care (PPC)
- Child and Adolescent Well Care Visits (WCV)

Quality Management

A variety of activities are involved in implementing the QM Program, including, but not limited to:

- Risk Management/Quality Concern Reporting
- Monitoring of Member services activities, including complaints, appeals, and grievances
- HEDIS Data collection/ monitoring
- Member satisfaction surveys
- Member-based performance improvement projects
- Provider-based performance improvement
- Physician Access and availability surveys

RAD-V Audits

In accordance with risk adjustment requirements, Alliant Health Plans performs risk adjustment data validation (RAD-V) audits to validate its members' diagnosis data submitted by the provider through claims. These audits are typically done annually. As a participating provider with Alliant Health Plans, you must provide the necessary medical records to substantiate the diagnosis data submitted by the due date provided with the request.

Quality Ratings

CMS uses a 5-Star quality rating system to measure how well a health plan delivers care to its members. Successful collaboration with our providers and quality patient care for our members is especially important to Alliant Health Plans. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest.

The Star measures are made up of performance measures from HEDIS®, CAHPS, HOS (measures comparison of members health plan assessment over two years), prescription drug program, and administrative data.

Star ratings include measures applied to the following categories:

1. Outcomes: measures that reflect improvements in a Member's health
2. Intermediate Outcomes: actions taken with patients that assist in improving a Member's health status, i.e., controlling blood pressure
3. Patient Experience: the Member's perspectives of the care they receive
4. Access Measures: processes and issues that could create barriers to receiving needed care, i.e., Plan makes timely decisions about appeals
5. Process Measures: those that capture the health care services provided to members who can assist in maintaining, monitoring, or improving their health status

Quality Assurance is a comprehensive department designed to comply with regulatory requirements to monitor the health plan's quality of care and services. This includes administrative activities of the Plan and its contracted providers.

The QA department's purpose is to pursue opportunities for improvements in our members' medical care, service, and wellness. Our focus is on continuous improvement with a constant eye on how care and services can be provided at a higher quality level. Alliant Health Plans has dedicated resources to conduct an ongoing quality assessment of performance toward goals with problem resolution, as necessary.

The Quality Department focuses on three dimensions of health care delivery:

1. Delivery system structure itself
2. Processes involved in delivering health care
3. Results of care delivery

By evaluating and continuously monitoring the three mentioned dimensions, Alliant Health Plans strives to provide the highest quality health care in the most appropriate setting and in the most efficient manner that will better serve our members.

Alliant Health Plans would like to thank you for your continued support in providing our members with the best health care available. If, at any time during the 2022 HEDIS® season, you need assistance or have additional questions, please contact Obie Hooper, QA Clinical Administrator at (706) 891-3399.