Section 1: Introduction & General Information

Welcome

We would like to extend to you a personal welcome to Land of Lincoln Mutual Health Insurance Company (LLH). Enclosed is your Provider Manual, written specifically to address the requirements of delivering quality healthcare services to our LLH plan members (“members”).

This manual serves as a resource and reference guide supplement to your provider agreement. The information contained in this manual is proprietary to LLH and is not to be copied in whole or in part, nor distributed without LLH’s express written consent.

This guide contains information about reimbursement, eligibility, benefits, contact information and LLH policies and procedures. It is designed to provide assistance in all areas of your practice, from making referrals to receiving payment for your services.

From time to time, LLH will revise relevant policies and procedures and communicate regulatory requirements. Changes and updates will be posted to LLHealth.org/providers/provider-library or communicated via electronic provider newsletters.

Thank you for providing quality healthcare services to LLH plan members. We hope you find this tool useful and welcome your feedback. Comments can be emailed to physicianinfo@landoflincolnhealth.org.

Sincerely,

Frank Mancuso, Vice President, Network Contracting

Monica Katz, Vice President, Operations & Partnerships
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About Land of Lincoln Health

Land of Lincoln Mutual Health Insurance Company (LLH) is a nonprofit, consumer-governed cooperative and a new kind of health insurance company. Founded in 2013, Land of Lincoln Health's mission is to pioneer change in the industry and create more health insurance options for the people of Illinois. We work hand-in-hand with top local hospitals, building plans with the doctors and health systems members know and trust.

We comply with all regulations and requirements put forth by the Illinois Department of Insurance (DOI) and the Centers for Medicare and Medicaid Services (CMS).

Mission, Vision & Core Values

Mission: Land of Lincoln Health creates value by simplifying consumers’ access to high-quality, affordable care and services collaborating with healthcare providers to provide innovative insurance and wellness solutions.

Vision: We will be the health insurance partner of choice as a result of our relentless commitment to innovation and to empowering all of our stakeholders to experience maximum value in the rapidly evolving healthcare delivery system.

Core values:
- We believe in innovation, diversity and teamwork, bringing together communities to create solutions that positively impact the health and wellbeing of our members.
- We are committed to transparency in our operations as a consumer oriented and operated plan.
- We expect excellence and integrity in all aspects of our operations and relationships.

Quality

We are committed to quality and have made accreditation a strategic goal for our organization. The Department of Health and Human Services selected the National Committee for Quality Assurance (NCQA) as an accrediting entity for Qualified Health Plan (QHP) issuers who participate in the Marketplace. NCQA accreditation is the most comprehensive evaluation in the industry, and the only assessment that bases results of clinical performance (i.e. HEDIS measures) and consumer experience (i.e. CAHPS measures). As a new health plan, LLH received NCQA interim accreditation in 2014—our first full year in operation—and received full accreditation in 2015.

This manual will be revised as policies or regulatory requirements change. Revisions shall become binding 30 days after the date indicated on any notice that is provided by mail or electronic means, or such other period of time necessary for LLH to comply with any contractual, legal and/or accreditation requirements.
### Section 2: Overview of Contacts & Products

**Contact Information for Providers**

<table>
<thead>
<tr>
<th>Land of Lincoln Mutual Health Insurance Company</th>
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</thead>
<tbody>
<tr>
<td>222 S. Riverside Plaza, Suite 1600</td>
</tr>
<tr>
<td>Chicago, IL 60606</td>
</tr>
<tr>
<td>844-674-3844</td>
</tr>
</tbody>
</table>

**24 Hour Nurse Advice Line for LLH Members**

| 844-448-4436 |

**Provider Updates**

| Providercontracts@landoflincolnhealth.org |

**Claims**

| 844-674-3838 |

**Claims mailing address:**

<table>
<thead>
<tr>
<th>Land of Lincoln Health</th>
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</thead>
<tbody>
<tr>
<td>Attn: Claims</td>
</tr>
<tr>
<td>PO Box 618357</td>
</tr>
<tr>
<td>Chicago, IL 60661-8357</td>
</tr>
</tbody>
</table>

**Electronic claims submission:**

| EDI Vendor #: 90096 |
| EDI Clearinghouse: Emdeon |

**Compliance/Fraud and Abuse Hotline**

| 855-809-3043 |

**Confidential mailing address:**

| Land of Lincoln Health |
| Attn: Compliance Officer |
| 222 S. Riverside Plaza, Suite 1600 |
| Chicago, IL 60606 |

**Confidential website:**

| landoflincolnhealth.ethicspoint.com |
| Confidential email: |
| compliance@landoflincolnhealth.org |

**Credentialing**

| 844-674-3838 |

**CVO mailing address:**

| Land of Lincoln Health |
| Attn: Credentialing Department |
| 222 S. Riverside Plaza Suite 1600 |
| Chicago, IL 60606 |

**Fax:** 312-506-4981

**Quality Improvement**

| 312-948-5652 |

**Mailing address:**

| Land of Lincoln Health |
| Attn: Quality Improvement Department |
| 222 S. Riverside Plaza Suite 1600 |
| Chicago, IL 60606 |

**Fax:** 312-506-4981
Our Health Plans & Networks

At Land of Lincoln Health, we offer a variety of PPO health insurance plans to individuals and families, small groups and large groups.

To learn your network status, use our Find a Doctor tool at LLHealth.org/providers/find-doctor-tool. For a step-by-step guide to using our Find a Doctor tool, visit LLHealth.org/courses/use-find-doctor-tool-provider.

Traditional 2-Tier PPO Plans

Our Traditional 2-Tier PPO Plans have a standard In-Network and Out-of-Network structure.

Below you can see the 2016 plan and network names for all Traditional 2-Tier PPO Plans:

<table>
<thead>
<tr>
<th>Traditional 2-Tier Plans and Networks</th>
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</thead>
<tbody>
<tr>
<td><strong>2016 Individual &amp; Family</strong></td>
</tr>
<tr>
<td>Plan Names</td>
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<tr>
<td>Land of Lincoln Health Traditional PPO</td>
</tr>
<tr>
<td>Network Names</td>
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<tr>
<td>LLH 2 Tier PPO</td>
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<tr>
<td><strong>2016 Large Group</strong></td>
</tr>
<tr>
<td>Plan Names</td>
</tr>
<tr>
<td>Land of Lincoln Engagement PPO</td>
</tr>
<tr>
<td>Land of Lincoln Preferred PPO</td>
</tr>
<tr>
<td>Land of Lincoln Health HSA-Compatible PPO</td>
</tr>
<tr>
<td>Land of Lincoln Health Elite PPO</td>
</tr>
<tr>
<td>Network Names</td>
</tr>
<tr>
<td>LLH PPO</td>
</tr>
<tr>
<td><strong>2016 Small Group</strong></td>
</tr>
<tr>
<td>Plan Names</td>
</tr>
<tr>
<td>CO-Options LLH National Elite PPO, a Multi-State Plan</td>
</tr>
<tr>
<td>Land of Lincoln Health Copay PPO</td>
</tr>
<tr>
<td>Land of Lincoln Health HSA-Compatible 80 PPO</td>
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<tr>
<td>Land of Lincoln Health HSA-Compatible 100 PPO</td>
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<tr>
<td>SBAC Land of Lincoln Health HSA-Compatible PPO</td>
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<tr>
<td>Network Names</td>
</tr>
<tr>
<td>LLH PPO</td>
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</tbody>
</table>

| 2015 Small Group                    |

| **2016 Individual & Family**         |
| Plan Names                           |
| Land of Lincoln Health Traditional PPO |
| Network Names                        |
| LLH 2 Tier PPO                       |
| **2016 Large Group**                 |
| Plan Names                           |
| Land of Lincoln Engagement PPO       |
| Land of Lincoln Preferred PPO        |
| Land of Lincoln Health HSA-Compatible PPO |
| Land of Lincoln Health Elite PPO     |
| Network Names                        |
| LLH PPO                              |
| **2016 Small Group**                 |
| Plan Names                           |
| CO-Options LLH National Elite PPO, a Multi-State Plan |
| Land of Lincoln Health Copay PPO     |
| Land of Lincoln Health HSA-Compatible 80 PPO |
| Land of Lincoln Health HSA-Compatible 100 PPO |
| SBAC Land of Lincoln Health HSA-Compatible PPO |
| Network Names                        |
| LLH PPO                              |
Preferred Partner 3-Tier PPO Plans

Our Preferred Partner 3-Tier PPO Plans give members an added level of benefits when they seek care from In-Network Tier 1 Preferred Partner doctors and hospitals. These doctors and health systems are contracted with LLH to provide a more cost-effective option for members who choose a Preferred Partner PPO plan. Members with these plans also have access to LLH's In-Network Tier 2 doctors and hospitals.

PHCS PPO One Network: LLH may access the PHCS Primary PPO network and contract with providers throughout the state. PHCS is LLH's nationwide wrap network. Note: A direct contract with LLH (or FHN for FHN plans only) supersedes a PHCS contract for providers that are contracted with both or all three networks.

To assist in the identification of Preferred Partner plans, the partner logo will be displayed on the member's ID card, along with the plan and network names. Below you can see the 2016 plan and network names for all Preferred Partner 3-Tier Plans:

<table>
<thead>
<tr>
<th>Preferred Partner 3-Tier Plans and Networks</th>
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<tbody>
<tr>
<td><strong>2016 Individual &amp; Family</strong></td>
</tr>
<tr>
<td>Names</td>
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<tr>
<td>Adventist LLH 3-Tier PPO</td>
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<tr>
<td>Centega LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Champion LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Chicago Health System LLH 3-Tier PPO</td>
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<tr>
<td>Family Health Network LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Illinois Health Partners LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Presence Health LLH 3-Tier PPO</td>
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<tr>
<td>Swedish Covenant LLH 3-Tier PPO</td>
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<tr>
<td>Riverside LLH 3-Tier PPO</td>
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<tr>
<td><strong>2016 Large Group</strong></td>
</tr>
<tr>
<td>Plan Names</td>
</tr>
<tr>
<td>Adventist LLH PPO</td>
</tr>
<tr>
<td>Centega LLH PPO</td>
</tr>
<tr>
<td>Champion LLH PPO</td>
</tr>
<tr>
<td>Chicago Health System LLH PPO</td>
</tr>
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<tr>
<td>Swedish Covenant LLH PPO</td>
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<tr>
<td>Plan Names</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Adventist LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Centegra LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Centegra LLH 3-Tier HSA-Compatible PPO</td>
</tr>
<tr>
<td>Chicago Health System LLH 3-Tier PPO</td>
</tr>
<tr>
<td>Family Health Network LLH 3-Tier PPO</td>
</tr>
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<td>Illinois Health Partners LLH 3-Tier PPO</td>
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<td>Presence Health LLH 3-Tier PPO</td>
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<tr>
<td>Swedish Covenant LLH 3-Tier PPO</td>
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<tr>
<td>Riverside LLH 3-Tier PPO</td>
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<tr>
<td>Land of Lincoln Health 3-Tier PPO</td>
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### 2016 Small Group

<table>
<thead>
<tr>
<th>Plan Names</th>
<th>Network Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adventist LLH 3-Tier PPO</td>
<td>Adventist PPO</td>
</tr>
<tr>
<td>Centegra LLH 3-Tier PPO</td>
<td>Centegra PPO</td>
</tr>
<tr>
<td>Land of Lincoln Freedom PPO</td>
<td>LLH PPO III</td>
</tr>
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### Section 3: Provider Responsibilities

**Overview**

Under the terms of the Participating Provider (or Hospital) Agreement, providers are independent contractors and are solely responsible to members for the provision of health services and the quality of those services. This means providers and LLH do not have an employer-employee, principal-agent, joint venture or similar arrangement. It also means providers have a duty to exercise independent medical judgment to make healthcare decisions regardless of whether a health service is determined to be a covered service. Nothing in the Provider Agreement or this manual is intended to create any right for LLH to intervene in medical decision-making regarding a member. Additionally, providers are responsible for the costs, damages, claims and liabilities that arise from their own actions. LLH does not endorse or control the clinical judgment or treatment recommendations made by providers.
Providers participating in LLH's network are expected to verify member eligibility, adhere to our administrative and clinical guidelines, follow access to care and office waiting time standards, comply with provider contract terms (including all clinical coverage guidelines, reimbursement policies and access to medical records), follow cultural and linguistic requirements and adhere to our quality and utilization management programs. Provider responsibilities defined within this manual apply to all contracted providers.

We require precertification for certain services and procedures; failure to obtain precertification for those required services shall result in the denial of a claim. LLH's precertification determination relates solely to administering plans and is not, nor should it be construed to be, a medical decision. Providers and their patients make the decision as to whether the services or procedures are provided. A list of medical services that require precertification can be found at LLHealth.org/providers/provider-library. To learn more, consult the Medical Management section of this manual.

**Provider Portals**

Our Provider Portals give you the resources you need to manage your patients’ health. You can request Provider Portal access at LLHealth.org/superuser-reg/. We have two Provider Portals:

**Claims & EOPs Portal**
- Check claim status
- Review EOB/EOP
- Case management
- View primary care physician assignment (if applicable)

**Verification & Benefits Portal**
- Verify member eligibility
- View a member’s Schedule of Benefits and Coverage

**Electronic Fund Transfer Payment**

Providers are required to sign up for electronic fund transfer (EFT) payment to expedite the reimbursements process. Once you sign up, payments will be electronically transferred to your designated account, and you will receive an Explanation of Provider Benefits (EOP). To access the Electronic Funds Transfer Authorization Agreement, visit LLHealth.org/providers/provider-library.
Provider Notification Requirements

Demographic changes
Individual providers directly contracted with LLH are required to immediately notify us of any changed demographic information and any other provider information that impacts our directory, patient access and/or claim processing. All changes are to be sent in writing to:

Land of Lincoln Health
Attn: Network Management
222 S. Riverside Plaza, Suite 1600
Chicago, IL 60606

Requested demographic changes can also be emailed to providercontracts@landoflincolnhealth.org.

If a provider is contracted with PHCS, all changes must be submitted to PHCS.

A contracted entity must notify LLH of any changes for all participating providers covered under the Provider Agreement via the Approved Provider Roster (provider roster) available at LLHealth.org/providers/request-to-join-network. Only the contracted entity may submit add/termination changes to its participating provider roster. Participating providers may submit individual demographic changes; however, those submitted demographic changes must be approved by the contracted entity. Failure to notify LLH of changes to the provider roster may result in denial of claims.

Changes that require notice to LLH include, but are not limited to:
- Additions—provider joining the hospital/ancillary/practice group
- Name and/or address change
- Tax identification number (TIN) or national provider identification (NPI) change
- Change in legal entity
- New facility site
- Change in services provided
- Change in acceptance of new patients
- Terminations—provider no longer participates in the hospital/ancillary/practice group
  - Notice required 60 days prior to effective date
- Closed facility sites

Certain changes may require an amendment, assignment or new agreement, depending on the reason for the change. For specific information, check with your LLH Network Management contact or email providercontracts@landoflincolnhealth.org.

Most new participating providers (including new ancillary and facility locations) must be credentialed before rendering treatment to any LLH member (see Credentialing).
Effective dates
Notice of new providers should be given to LLH at least 30 days prior to the effective date. Failure to notify LLH within 30 days may result in a denial of claims for services rendered by that provider.

Delegated groups
Effective dates provided by the delegated groups will be honored when possible. Please note that LLH cannot give an effective date more than 30 days retroactive from the date of receipt of the new provider.

Non-delegated groups
The effective date will be 30 days from the credentialing approved date.

Termination dates
Notice of terminated providers should be provided to LLH no fewer than 90 days prior to terminating his or her status as a participating provider. The terminated provider shall notify all affected members that he or she will no longer provide services except for continuity of care as applicable. The provider agrees that he or she shall continue to provide covered services to members, pursuant to the terms of the Provider Agreement, no more than 90 days from the effective date of terminations. LLH shall pay the provider for such services in accordance with the terms of the Provider Agreement. In the event of termination of the Provider Agreement, the provider agrees to assist in the transfer of members to other participating providers.

Both providers and LLH will endeavor to assign any termination dates to a future date (generally 60 days from the date LLH receives claim utilization data) unless the termination is due to a quality or member safety issue. Providers may submit claims with service dates through the assigned future date for payment consideration. Claims submitted 180 days after the termination date or beyond will be denied.

Provider Rights & Responsibilities

Participating providers are responsible for understanding and complying with the terms of the Provider Agreement and this section. Please call the LLH Provider Relations team with any questions regarding your rights and responsibilities under the Provider Agreement, and as described in this section. All participating providers are responsible for:

- Complying with the terms of the Provider Agreement.
- Informing members prior to providing non-covered services, and except in the case of emergency services, the member (not LLH) shall be financially liable for such services.
- When refusing to provide services for which the member believes he or she is entitled, notifying that member of his or her right to appeal a decision.
- Providing, arranging or coordinating 24-hour healthcare services for members in accordance with accepted and recognized professional standards. A recorded message or answering service that refers members to emergency rooms is not acceptable.
- Informing LLH in writing of any revocation or suspension of a provider’s license or certification.
• Informing LLH of changes in licensure status, tax identification number, phone number, address, status at In-Network hospitals, loss of liability insurance and any other change that would affect a provider's status with LLH.
• Providing access to LLH, or its designee, to examine the provider's facilities, books and medical records to assure compliance with any and all obligations required under the Provider Agreement or this manual.
• Providing up-to-date contact information for a provider's medical practice.
• Providing healthcare services without discriminating on the basis of health status or any other unlawful category.
• Upholding all applicable responsibilities outlined in the Member Rights and Responsibilities section of the Provider Manual.
• Maintaining open communication with a member to discuss treatment needs and recommended alternatives without regard to benefit limitations or LLH administrative policies and procedures. LLH encourages open provider-patient communication regarding treatment alternatives and does not restrict providers from discussing all available care options with members.
• Providing all services in a culturally competent manner.
• Providing timely transfer of member medical records when care is to be transitioned to a new provider, or if the Provider Agreement terminates.
• Participating in LLH Quality Improvement and Utilization Management programs. These programs are designed to identify opportunities for improving members' healthcare. These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health or clinical studies. LLH will communicate information about these programs and extent of provider participation through special mailings and updates to this Provider Manual.
• Securing precertification or referral from LLH prior to providing any of the non-emergency services that require precertification as listed on the provider precertification list.
• Verifying eligibility of members prior to providing services.
• Collecting applicable copayments, deductibles and coinsurance from the member as required by the Provider Agreement and this Provider Manual at the time of service, when possible. Copayment amounts for office visits are listed on member ID cards. It is considered unacceptable billing practice and contractually prohibited for providers to waive a copayment/coinsurance obligation.
• Complying with all requests for information (e.g., medical records) to the health plan in a timely manner. Note: As part of the LLH enrollment process, all members authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic or other medical or medically-related facility or institution to disclose health information to a covered entity to the extent permitted by law to insurers for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, to validate the member’s risk adjustment score or to allow the insurer to conduct utilization review and quality improvement activities.
• Submitting accurate claim data to prevent the following:
  o Fraud: The knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.
Abuse: A practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss. Abuse usually does not involve a willful intent to deceive.

Billing error: The incorrect submission of services rendered (see Reconsideration).

- Cooperating with and participating in the member complaint and grievance process, as necessary.
- Keeping LLH members’ information confidential and stored securely. Providers must also ensure their staff members receive periodic training on member information confidentiality and keep and produce records of such training upon request. Only authorized personnel should have access to medical records.

Primary care providers and OB/GYNs
Primary care providers and OB/GYNs have a responsibility to provide access to covered services 24 hours a day, 7 days a week. In practice, this means:

- Member telephone calls should be answered by a live person that is able to connect the member with his or her primary care provider or with a covering provider within 30 minutes.
- In the event that the member cannot receive a return phone call, the answering person must keep the member “on hold” until he or she can be connected directly with a physician.
- On-call providers must return calls within 30 minutes.
- Providers should inform members on how to maintain a healthy lifestyle and prevent illness.
- Obtaining necessary authorizations as listed on the current prior authorization list, except for emergency services up to the point of stabilization.
- Maintaining confidentiality of medical information.
- Providers agree to LLH’s Waste, Fraud and Abuse Policy and Procedures.

Providers will adhere to the Plan Member Hold Harmless Clause (outlined in the Provider Agreement) in accordance with state and federal law. Providers are prohibited from seeking payment from LLH members for any covered service with the exception of copayments, coinsurance, deductibles and charges for non-covered services delivered on a fee-for-service basis.

Transition of Services/Continuity of Care

Transition of Service
In the event a member enrolled in an LLH plan sees a provider who does not participate in the LLH network or does not renew his or her Provider Agreement with LLH, that member can seek Transition of Service. Transition of Service coverage allows new or renewing LLH members to continue to receive covered services for specific medical and behavioral conditions from a provider who does not participate in the LLH network. Transition of Service coverage only applies to select services and must be approved before services will be covered. The Transition of Service period is up to 90 days from the effective date of enrollment if the member is in an ongoing course of treatment; or if the member has entered the second or third trimester of pregnancy by the effective date of enrollment, which includes the provision of postpartum care directly related to the delivery. Transition of Service must be applied for at the time of the member’s enrollment in a new LLH medical plan but no later than 30 days after the effective date of the member’s coverage.
Continuity of Care

Continuity of Care coverage allows existing LLH members to temporarily receive services at In-Network coverage levels for specific medical and behavioral conditions or late-stage pregnancy if their healthcare provider is removed from their LLH network. Continuity of Care is subject to approval and must be supported by clinical information suggesting the ongoing treatment is necessary. Members must apply for Continuity of Care coverage within 30 days of receiving notice of their provider no longer being covered in the network. If LLH determines that transitioning to a participating healthcare provider is not recommended or safe for conditions that qualify, services by the approved non-participating provider will be authorized for a specified period of time of up to 90 days or until care has been completed or transitioned to a participating healthcare provider—whichever comes first.

LLH ensures transitional services for plan members receiving ongoing treatment for chronic or acute medical conditions in the event that a provider leaves the LLH network, meaning care is not disrupted at a critical point in treatment as a result of discontinuing a contract between a provider and LLH or removal from a product network.

If a provider leaves the LLH network for reasons other than the termination of a contract due to situations involving imminent harm to a patient or a final disciplinary action by a state licensing board, but remains within the LLH service area, impacted plan members are notified of the transitional services available and are assisted in selecting a new provider using the Options of Specialty Care Form.

LLH authorizes care during the transitional period only if:

- The provider will continue to accept reimbursement from the health plan at the rates in place prior to the start of the transitional period; and agrees not to seek any reimbursement from the plan member except applicable copayments, as outlined in the Provider Agreement and in this Provider Manual.
- The provider will adhere to the health plan’s policies including, but not limited to, those regarding quality improvement, utilization management and availability of member records.

Within 10 days after the receipt of a member’s completed request for transitional services, LLH notifies the member of the determination in writing. If denied, LLH will cite a specific reason for denial, which may include a refusal to accept LLH’s reimbursement rates, failure to adhere to LLH’s Quality Improvement requirements, failure to provide necessary medical information related to the member’s care or failure to comply with any policies and procedures.

If the physician is not a part of the LLH network and the member chooses to continue care with that physician beyond the time frame approved by LLH, the member’s treatment will be covered at the Out-of-Network rate of the member’s current plan.

The availability of Transition of Service/Continuity of Care coverage does not guarantee that a treatment is medically necessary, nor does it constitute authorization of or precertification for medical services to be provided. Depending on the request, medical necessity determination and formal precertification may still be required for a service to be covered. In no event shall approval of Transition of Service/Continuity of
Care be construed to require LLH to provide coverage for benefits not otherwise covered under the member's Policy.

To learn more about Transition of Service/Continuity of Care, visit LLHealth.org/transition-of-service-continuity-of-care-request.

New Provider Request to Participate in LLH Network

A provider not affiliated with a plan-contracted entity may request participation in a LLH provider network by submitting a letter of interest to our Provider Relations team. Your letter of interest must include the following information:
- Why you are interested in participating in our network
- Your specialty
- Your practice location(s)
- Your hospital affiliation(s)
- Number and percentage of LLH recipients (if applicable) treated in your practice per year
- Language(s) you speak and other cultural competencies
- W-9 form

Letters should be mailed to:

Land of Lincoln Health  
Attn: Network Management  
222 S. Riverside Plaza, Suite 1600  
Chicago, IL 60606

Or emailed to providercontracts@landoflincolnhealth.org

New provider joins a plan-contracted entity: In the event a new provider joins an entity (practice, facility or ancillary site) already contracted by LLH, certain providers must be credentialed by LLH before treating LLH members (see Credentialing). If the entity is a delegated entity, LLH will use the requested effective date indicated on the Approved Provider Roster Form. If the entity is a non-delegated entity, the provider would be required to go through the credentialing process.

Complete the Approved Provider Roster, available at LLHealth.org/providers/request-to-join-network, and email the roster to providercontracts@landoflincolnhealth.org.

After receiving the appropriate forms, LLH will notify the new provider of his or her credentialing status and assist with the credentialing process as needed.
Credentialing

Credentialing refers to a process performed by LLH to verify that an applicant (physician and/or other provider) meets the established policy standards and qualifications for consideration in an LLH provider network. The request form, located at LLHealth.org/providers/request-to-join-network, will ask for the information necessary to start the credentialing process.

A provider in the process of credentialing with LLH must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in an LLH network. All providers within the scope of LLH's credentialing program, applying for initial participation in the organization's programs or networks, must meet the following criteria to be considered for participation:

- Execute a Participating Provider or Participating Hospital Agreement.
- Possess a current, valid, unencumbered, unrestricted and non-probationary license in the state(s) where he/she provides services to the organization's members.
- Clinical privileges in good standing at the facility designated by the provider as the primary admitting facility (for physicians and other providers eligible for hospital privileges).
  - If a provider does not have admitting privileges, his or her application will be reviewed by the Chief Medical Officer (CMO) to determine whether he or she must submit a written description of a formal arrangement for inpatient coverage for his or her patients, should any of them require hospitalization.
- Possess a current, valid and unrestricted Drug Enforcement Administration (DEA) or controlled dangerous substance (CDS) registration for prescribing controlled substances, if applicable to his or her specialty in which he or she will treat the organization's members. The DEA/CDS must be valid in the state(s) in which the practitioner will be seeing the organization's members. Practitioners who see members in more than one state must have a DEA/CDS for each state.
- The provider must have successfully completed appropriate education and training for practice in the specialty for which he or she is expressly seeking LLH participation and for which LLH has a need. Proof of completion must be available upon request by LLH.
  - For non-physicians: Completion of residency or post-graduate training, if appropriate.
  - At a minimum, provider must graduate from an accredited medical school and completion of a residency deemed acceptable for specialty board certification.
- Provider must have no history of state, Medicare or Medicaid sanctions.
- Provider must maintain professional liability coverage with minimum levels of $1 million per occurrence and $3 million per year or state minimum, if applicable.

The Chief Medical Officer reviews each provider file for approval or escalation to the Physician Advisory Committee (PAC). The PAC is comprised of a multi-disciplinary group of physicians and meets monthly for review and recommendation. Initial credentialing is performed when an application is received. Recredentialing is conducted at least every three years thereafter or as otherwise required by state regulations and at the discretion of LLH. Credentialing and recredentialing is performed for all providers requesting participation in an LLH network. LLH credentialing policies and procedures are based on credentialing NCQA requirements.
Supporting documentation must be submitted with each credentialing application. This may include, but is not limited to, licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency and any physical or mental impairments. Documentation submitted by an applicant and/or provider's office is verified for accuracy and completeness. At the discretion of LLH, an applicant may be required to submit additional information.

LLH recognizes a provider’s right to review information submitted in support of his or her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process, a provider may request the status of his or her application by contacting the LLH Credentialing Department at 844-674-3838, option 5.

**Council for Affordable Quality Healthcare (CAQH)**

LLH is a member of the CAQH, an online single-entry national database that eliminates the need for providers to complete and submit multiple credentialing applications. We require providers that are not credentialed through an approved delegated entity to submit their application to CAQH. Physicians and other healthcare providers who are members of CAQH are able to submit an initial credentialing application to LLH or provide the required information at recredentialing rather than completing credentialing applications. **Note:** The aforementioned information is only relative to participating providers.

**Physician Advisory Committee (PAC)**

LLH's PAC is composed of a chairperson, the LLH Chief Medical Officer and participating providers. The committee responsibilities include credentialing, ongoing and periodic assessment of current policies/procedures, recredentialing and the establishment of policies and procedures based on current guidelines and regulations.

Providers seeking network participation or recredentialing are presented to the CMO or the PAC for review and recommendation. The committee will render a recommendation to approve or deny network participation. The provider will be notified of the committee's decision. If approved, a Provider Agreement is executed by the provider and LLH.

**Recredentialing**

LLH conducts a recredentialing process at least every three years in accordance with the LLH Recredentialing Policy, or as otherwise required by NCQA credentialing standards and at the discretion of LLH.

**Termination without cause**

As required by law, LLH shall notify a provider in advance of terminating his or her Provider Agreement. Notification will be no fewer than 90 days prior to the effective date of termination. LLH has the right to terminate any individual provider, provider location or line of business within the time frames specified in this manual.

Should a provider, IPA or PHO elect to terminate network participation, a notice of the pending termination must be forwarded to LLH no fewer than 60 days prior to the effective date of termination.
LLH has established a policy and procedure to notify members in advance of an impending termination of a provider. Advance notice is required by LLH to comply with all federal and state laws, rules and regulations, as well as accreditation agencies, regarding the notification of members affected by the termination of a provider.

**Termination for cause**

LLH reviews the Department of Health and Human Services (HHS) and Office of the Inspector General's (OIG) exclusion lists as required by federal regulations. Should a provider’s name appear on a current OIG-excluded provider listing, LLH will take immediate action to terminate the provider’s network participation and, if applicable, take appropriate corrective actions. No hearing will be allowed. Other sanctions (e.g., loss of professional license) are also grounds for immediate termination.

**Delegation**

Delegation is a formal process by which LLH gives a provider group or vendor the authority to perform certain functions on its behalf, such as credentialing, utilization management and claims payment. A function may be fully or partially delegated.

LLH may, at its discretion, delegate specific functions or activities to entities that can demonstrate compliance with LLH’s requirements, standards, policies and procedures. The decision of what function may be considered for delegation is determined by the type of agreement a provider group or vendor has with LLH, as well as the ability of the provider group or vendor to perform functions. Although LLH can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

Prior to the delegation of any activities, LLH evaluates the delegate’s capacity to perform the proposed delegated activities in accordance with NCQA standards.

Delegated providers must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures, available at LLHealth.org/providers/provider-library.

**Section 4: Member Eligibility and Claims**

**Verifying Member Eligibility**

Valence Health administers LLH’s enrollment, claims and provider services. For all claim inquiries, call 844-674-3838 or log into our Provider Portal at LLHealth.org/providers.
**Member ID card**
All Land of Lincoln Health members receive ID cards (see samples below) shortly after enrollment. Be sure to ask LLH members for their ID card at the point of service to verify eligibility, help you process claims, call in precertifications and access other services. Our ID cards also contain information about member pharmacy benefits.

**Note:** Member ID cards are for verification purposes and do not guarantee eligibility. Patient eligibility and benefits should be verified prior to an appointment by using our Verification & Benefits Portal at LLHealth.org or by calling Provider Services at 844-674-3838, option 1. If you are not familiar with the person seeking care, please ask to see photo identification.

To distinguish between the different lines of business on a Land of Lincoln Health member ID card, look for the group number.

Individual health plans do not have a group number. The area outlined on the member ID card below will be blank for these types of plans.

Small (2-50 employees) and large group (51+ employees) plans have group numbers. The group ID will be located in the outlined area on the ID card below.

**Small groups:** Group ID does not start with “L”
**Large groups:** Group ID starts with “L”
1. **Member information**
   Includes the policyholder’s name, dependent information and member ID number.

2. **Pharmacy information**
   Here you can find the Rx Bin number, PCN and Rx group name.

3. **Plan name**
   This is the name of the plan the patient is enrolled in.

4. **Network name**
   This identifies which network your patient is in.

5. **Group ID**
   Group ID numbers help identify which line of business the member belongs to.
   - Individual and family: ID card does not contain a group number
   - Small group: Group number does NOT start with the letter “L”
   - Large group: Group number will start with the letter “L”

6. **Cost of primary care & specialist visits**
   In this section, you will find the copay or coinsurance amounts for primary care and specialist appointments.

7. **Nationwide coverage**
   Logo that indicates the member’s nationwide coverage.
1. Precertification
Some medical services or treatments require precertification. For standard pre-service referrals, LLH makes the decision within 15 calendar days upon receiving the request. You must provide medical justification including, but not limited to, medical history, laboratory results and previous studies as a means to facilitate and ensure accuracy in rendering determination. Requests for precertification must be made via phone or fax at least five business days prior to the medical services or two business days following an emergency admission. Failure to precertify will result in a denial of medical services. A full list of services requiring precertification can be found at LLHealth.org/providers/provider-library under the Policies & Processes tab.

2. Important member phone numbers
These are the phone numbers members can call when they have questions about their health insurance benefits. The numbers listed include:
   - Member Services
   - Pharmacy Services
   - Behavioral Health

3. Dental information
The DentalGuard logo serves to identify members with dental coverage. As a reminder, LLH dental benefits are only available to dependents 18 years old and under.

4. Provider phone numbers
You can call Provider Services at 844-674-3838 to verify eligibility, benefits or claim status.

5. Medical claims address & EDI
Here you will find the mailing address for all Land of Lincoln Health medical claims, as well as the vendor number and clearinghouse for electronic claims.
Preferred Partner 3-Tier PPO Plans
To distinguish between our Traditional 2-Tier PPO Plans and our Preferred Partner 3-Tier PPO Plans, we include the Preferred Partner logo in the top right corner of the Member ID card. Below is a list of our Preferred Partners:

Providers can check member eligibility 24 hours a day, 7 days a week. Except in the provision of emergency services, member eligibility should be verified on the date of service, prior to an appointment. If delivering emergency services, providers should verify member eligibility after delivering the services within 48 hours. If a member is or was not eligible with LLH on the date of service, LLH will not be responsible for charges associated with services provided on that date.

Summary of plan eligibility verification process
Contact our Provider Services team at 844-674-3838 to verify plan member benefits and eligibility, determine which benefits apply to a member, confirm a member’s PCP assignment (if applicable) and determine provider participation status before services are rendered. We will also provide this information when you complete LLH’s precertification process. Providers will receive an authorization number at the time of precertification.

Visit LLHealth.org/providers/plans-benefits-information for specific benefit information. The out-of-pocket maximum is the greatest expense a member will incur before his or her benefits are covered at 100% of eligible expense. Non-covered services are excluded from the annual out-of-pocket maximum.

Summary of electronic eligibility verification process
Verifying member eligibility for LLH plan members (except newborns):
1. Verify the member’s identity by requesting his or her LLH member ID card and a form of photo identification. Request a second form of photo ID whenever possible. If the member is a minor, a parent or legal guardian identification is acceptable if the relationship to the minor is verified with LLH in Step 2.
2. Verify that the individual is enrolled in an LLH health insurance plan and is eligible for coverage by visiting LLHealth.org/provider-portal-splash or calling Provider Services at 844-674-3838, option 4.

Verifying newborn eligibility:
1. Verify the mother’s eligibility in an LLH plan on the newborn’s date of birth (following the steps above).
2. If the mother is deemed eligible, the hospital or treating provider must bill “well-newborn charges” under the mother’s member ID number. Sick-newborn charges should be billed once the newborn has been enrolled in a health plan and has a permanent member ID number.

3. If the newborn’s parent or legal guardian enrolled with LLH through the Marketplace at [healthcare.gov](http://healthcare.gov), he or she must return to the Marketplace and enroll the newborn within 60 days of the date of birth. If the mother remains an LLH member, the newborn may be retroactively enrolled into the LLH plan, as of the newborn’s date of birth, by enrolling the newborn via the Marketplace.

4. If the newborn’s parent or legal guardian did **not** enroll with LLH through the Marketplace, he or she must enroll the newborn within 30 days of the newborn’s date of birth. To enroll, he or she must contact LLH Member Services at 844-674-3844. If the mother remains an LLH member, the newborn may be retroactively enrolled into the LLH plan, as of the newborn’s date of birth, by calling Member Services.

**Note:** Verifying eligibility does not authorize services requiring precertification.

**How to Read Your Explanation of Provider Benefits (EOP)/Remittance Advice**

Contact Provider Services at 844-674-3838 if you determine an error has been made in claims processing or payment. You can also review claim status in the Claims & EOP’s Portal.

**Explanation of Payment**
All contracted providers are reimbursed as stated in their Provider Agreement. Providers receive an Explanation of Payment (EOP) for all claims that LLH receives and processes.

Providers may also obtain copies of EOPs at [https://llh.valencehealth.com](https://llh.valencehealth.com).

**Collection EOP**
When claims are adjusted and there is not a positive balance to offset the negative, your account balance has a negative status. When this happens, you will receive a collection EOP. Every claim paid will apply towards the negative balance until it becomes a positive balance. You may clear a negative balance by sending a refund check payable to Land of Lincoln Mutual Health Insurance Company and mail to:

Land of Lincoln Health  
Attn: Finance Department  
222 S. Riverside Plaza, Suite 1600  
Chicago, IL 60606

Include claim number, date of service and member ID number with the remittance.
Recovery of overpayments
LLH contracts with various companies to take care of claims issues including overpayments, third party liability issues and Medicare secondary payor issues. If you receive a refund request on behalf of LLH, please send the refund as soon as possible.

Providers have 180 days from date on the remittance advice showing claim adjudication to request claim reconsideration.

LLH has the right to recover payment, or retain portions of future payments, if LLH determines an individual was not an eligible plan member at the time of service(s), or due to duplicate payment, overpayment and/or payment for non-covered services or fraud.

Claims Procedures

Providers are required to submit claims and encounter data for all services provided to plan members directly to the health plan according to the terms of your Provider Agreement.

You must submit claim or encounter data using one of the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 electronic format
- A CMS-1500 and/or UB-04, or their successors

Claims must include the provider’s NPI, TIN and the valid taxonomy code that most accurately describes the services reported on the claim. No reimbursement is due for a covered service and/or no claim is complete for a covered service unless the provider’s performance of that covered service is fully and accurately documented in the member’s medical record prior to the initial submission of the claim. Furthermore, members will not be held responsible for any payments to the provider except for applicable copayments, coinsurance, deductibles, and non-covered services provided to such members.

Please adhere to the following claims procedures:

- Do not submit a duplicate claim for payment within 30 days of the original submission.
- **EDI:** Submit claims electronically within 30 days of service to **EDI Vendor #90096**.
- **EFT and ERA:** Electronic fund transfers (EFT) and electronic remittance advice (ERA) are available. Register with Emdeon or your own clearinghouse to utilize EFT and ERA. You may also complete an Electronic Funds Transfer Agreement form available at **LLHealth.org/providers/provider-library**
- Mail claims to:

  Land of Lincoln Mutual Health
  Attn: Claims
  PO Box 618357
  Chicago, IL 60661-8357
LLH encourages providers to send claims electronically to assure quicker and more accurate processing and payment. If you have questions, please call 844-674-3838, option 1.

Coding edits
LLH will process provider claims that are accurate and complete in accordance with its normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to processing timeliness. Such claims processing procedures and edits may include, without limitation, automated systems applications that identify, analyze and compare the amounts claimed for payment with the diagnosis codes, as well as applications that analyze the relationships among the billing codes used to represent the services provided to members. These automated systems may result in an adjustment of the payment to the provider for the services, or in a request, prior to payment, for the submission of a medical record review that relates to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to LLH (please see the Provider Claims Reconsideration section of this manual for more information). A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

LLH provides a summary of the code edits, policy change notification dates and implementation dates. The list is not intended to be exhaustive but is made available at LLHealth.org/providers/provider-library.

Revenue codes 510-529
Services rendered at hospital clinics and submitted with clinic revenue codes 510-529 are automatically non-covered by LLH. This policy has been in effect since January 2016. These codes are most commonly used to bill for physician hospital visits, making this charge part of the physician's professional claim. It is not separately billable by the hospital. The patient is not responsible for these charges.

Procedure code with Modifier 26
When a claim is submitted with a procedure code that has a Modifier 26 attached, the claim will be denied if that specific procedure code is not billed appropriately. LLH follows CMS guidelines and will uphold all claim denials and not overturn requests for appeals.

Appropriate usage:
- To bill for only the professional component portion of a test
- To report the physician's interpretation of a test
- Procedures that have a “1” in the PC/TC field on the MPFSDB
- Procedures falling into the following types of service; 1-Medical Care/Injections, 2-Surgery, 4-Radiology, 5-Lab, 6-Radiation Therapy and 8-Assistant Surgeon

Prompt payment of claims
A claim is processed promptly if it is approved or denied within the time required by the agreement or the applicable regulation of the state in which LLH is operating. For claims to be paid promptly:
- The completed claim must be submitted electronically or by paper and must not involve an investigation for coordination of benefits, preexisting condition, member eligibility or subrogation (i.e., a “clean claim”).
• A member’s original signature, or “Signature on File” or “Assignment on File” stamp is required for payments made directly to the provider.
  o **Note:** The provider must maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to all payments for service. LLH reserves the right to review the original signed assignment document at any time.
• Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed. LLH reserves the right to request and receive medical records if required for validation requirements.
• The time frame for submitting claims is listed below, if not otherwise specified by the Provider Agreement or applicable state or federal law:
  o Commercial lines of business: 180 days from date of service for physicians; 90 days from date of service for facilities and ancillary providers.

**Reimbursement**

Payment terms are defined in the Provider Agreement. Payments are affected by a number of factors including, but not limited to, the following:

• Member’s eligibility at the time of service
• Whether services provided are covered services under the member’s plan
• Whether services provided are medically necessary as required by the member’s plan
• Whether services were provided without precertification, if precertification is required by the member’s plan
• Amount of the provider’s billed charges
• Member copayments, coinsurance, deductible and other cost-share amounts due from the member and coordination of benefits with third-party payors as applicable
• Adjustments of payments based on coding edits described above

A provider who receives reimbursement for services rendered to LLH members must comply with all federal laws, rules and regulations applicable to individuals and entities receiving federal funds, including, without limitation, Title VI of the Civil Rights act of 1964, Age Discrimination Act of 1975, Americans with Disability Act and Rehabilitation Act of 1973.

Nothing contained in the Provider Agreement or this manual is intended by LLH to be a financial incentive or payment that directly or indirectly acts as an inducement for providers to limit medically necessary services.

LLH applies the CMS site-of-service payment differentials in its fee schedules for Current Procedural Terminology (CPT)® codes based on the place of treatment (physician office services versus other places of treatment).

**Surgical payments**

Surgery reimbursement includes charges for preoperative evaluation and care, surgical procedures and postoperative care. The following claim payment policies apply to surgical services:

• Incidental surgeries/complications: A procedure that was performed incidental to the primary surgery will be considered part of the primary surgery charges and will not be eligible for extra
payment (e.g., appendectomy during a cholecystectomy). Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier (e.g., excessive hemorrhaging). A determination will be made by a physician reviewer on whether the proposed complication merits additional compensation above the usual allowable amount.

- Admission examination: One charge for an admission history and physical, from either the surgeon or the physician, will be eligible for payment, which should be coded and billed separately.
- Follow-up surgery charges: Charges for follow-up surgery visits are considered included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- Multiple procedures: Unless the Provider's Agreement indicates otherwise, for commercial products, LLH will pay the primary surgeon 100% of the allowable fee for the primary procedure, 50% for the second procedure and 25% for each additional procedure. These percentages apply when multiple eligible surgical procedures are performed under one continuous surgical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

Second opinion

- Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the LLH network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an Out-of-Network provider at no cost to the member. Out-of-Network providers will require prior authorization by LLH.

Assistant surgeon

- **Note:** It is the participating surgeon's responsibility to select a participating assistant. LLH only pays for surgical assistants for certain procedures. LLH uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes,” CMS is used as the secondary source.
- Co-surgeon: Each co-surgeon receives 62.5% of the allowable fee. Co-surgeons are defined as two surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure. In these cases, 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 only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with Modifier 62 added. With some claims, additional information may justify additional payment. For example, a provider's clinical notes may establish that a procedure code initially judged incidental to another in LLH's automated process actually involved distinct and significant provider efforts during the provider's encounter with his or her patient. If a provider believes that LLH has adjudicated a claim incorrectly, the provider should follow the procedures set forth in the Coding Edits section above, regarding provider claims reconsideration, or, if applicable, any state specific laws. Please include a copy of the applicable clinical notes with the provider reconsideration request. Providers must accept payment from LLH for covered services provided to LLH members in accordance with the
reimbursement terms outlined in the agreement. Payments made to providers constitute payment in full by LLH for covered benefits, except with respect to copayments, coinsurance and deductible amounts, which are the member's responsibility. These payments made by LLH are net of member copayments, coinsurance and deductibles. For covered services, providers may not balance bill members for a monetary amount over or above the fee schedule provided in their Provider Agreement. The provider is not prohibited by the Provider Agreement from collecting fees for any services not covered under the terms of the applicable member plan. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

**Services that are not medically necessary**
The provider agrees that he or she will not bill, charge, seek payment or have any recourse against a member in the event of a payment denial for services rendered not medically necessary by LLH. In the event of a denial of payment denial for services rendered to members determined not to be medically necessary by LLH, that the provider shall not bill, charge, seek payment or have any recourse against member for such services.

**Provider claims request for reconsideration policy**
LLH requires providers to request a reconsideration for a re-billed or corrected claim, or a claim denied for failure to precertify a procedure that is resubmitted by the provider for the same patient, date of service and/or procedures. A request for reconsideration requires providers to request a reconsideration of:

- A code edit denial on a specific claim.
- A code editing policy where the provider and LLH are using different nationally recognized sources, or the provider and LLH have a different interpretation of a nationally recognized source.
- A claim denied for failure to precertify.

A request for reconsideration is required prior to initiation of the appeals process. The reconsideration filing deadline is 180 days from the date of service.

The full policy and procedure is available at [LLHealth.org/providers/provider-library](http://LLHealth.org/providers/provider-library).

**Pass-through billing**
LLH prohibits pass-through billing. This occurs when the provider requests and bills for a service, that is not performed by the ordering provider or those under his or her direct employ. The provider shall not bill, charge, seek payment or have any recourse against LLH or members for any amounts related to the provision of pass-through billing.

**Fraud, waste and abuse**
Providers are responsible for complying with all applicable laws and regulations. Any instance of suspected fraud, waste or abuse should be reported to LLH immediately. Suspicions, allegations, concerns, questions and complaints can be made anonymously to the LLH compliance hotline at 855-809-3043, or can be submitted online anonymously at [landoflincolnhealth.ethicspoint.com](http://landoflincolnhealth.ethicspoint.com).
Section 5: Medical Management

LLH Medical Director

Medical Management is overseen by LLH's medical director, who serves as the major interface between healthcare organizations, participating providers and other healthcare providers in the community. The medical director is not engaged in the practice of medicine while acting in the medical director role. The medical director is necessary in the establishment of a provider network as well as facilitating provider participation and cooperation. The medical director’s responsibilities include, but are not limited to, the oversight of:

- Quality improvement programs required by federal or state law or accrediting agencies
- Credentialing

Clinical Programs

Contracted providers will comply with LLH utilization and medical policies and procedures.

Utilization Management

The LLH Utilization Management (UM) Program aims to ensure members have timely access to appropriate, medically necessary and cost-effective healthcare services. The program supports an evidence-based medical method to manage the use of services provided to members, and applies nationally-recognized policies, standards of care from InterQual Guidelines Utilization Management, national professional organizations (i.e., American Diabetes Associate, American Heart Association) and other federal government organizations such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Research and Quality (AHRQ), as well as internally-developed clinical criteria for determining level of care and length of stay. Healthcare services are evaluated for medical necessity and appropriateness of services before, during and after the care is performed.

The UM program supports the Quality Improvement program goals of fulfilling the LLH mission to improve health and wellness of our members. The UM process is continuously evaluated for improvement to promote optimal health outcomes. Responsibility for ensuring the implementation of all aspects of the program has been delegated to the medical director by the LLH Board of Directors.

The UM Program aims to provide a consistent and structured process to continually monitor and evaluate the delivery of healthcare and services to our members by:

- Establishing system-wide health management processes across the continuum of care.
- Establishing a process for provider feedback regarding UM process.
- Monitoring indicators to detect possible under- and over-utilization.
- Auditing UM decision timeliness on a monthly basis.
- Determining member and provider UM satisfaction.
• Assessing the utilization of member benefits on an annual basis to identify any changes and needs for member benefits.
• Conducting continuous educational programs for both non-clinical and clinical staff on UM policies, procedures and requirements, including accrediting bodies and governmental regulators.
• Assure appropriate member access to services through analysis of Out-of-Network utilization and overall utilization patterns.
• Tracking dates and times that inquiries are received and times of issue resolution.
• Ensuring that UM decisions are made independent of financial incentives.
• Collecting and reporting appeals by reason relating to the following categories:
  o Quality of care
  o Access
  o Billing and financial issues

**Quality Improvement Committee**

Clinical program outcomes including utilization metrics are presented to the committee for oversight. The CMO or medical director chairs the committee on a monthly basis.

**Precertification of Services**

The precertification process provides a way to ensure all LLH plan members receive medically necessary services in a timely, cost-effective manner by appropriately trained and skilled providers and provider organizations. This process also ensures appropriate care management by consistently applying criteria based on nationally established guidelines to eliminate variability among reviewers. Through precertification, LLH can obtain the appropriate information to manage issues related to benefit determination, site of care and medical necessity. Providers and members are given adequate and timely notification of authorization decisions and alternatives through the precertification process.

LLH requires providers request precertification for certain services for payment to be received. For standard pre-service referrals, LLH makes the decision within 15 calendar days upon receiving the request. You must provide medical justification including, but not limited to, medical history, laboratory results and previous studies as a means to facilitate and ensure accuracy in rendering determination. Requests for precertification must be made via phone or fax at least five business days prior to the medical services or two business days following an emergency admission. Failure to precertify will result in a denial of medical services. A full list of services requiring precertification can be found at [LLHealth.org/providers/provider-library](http://LLHealth.org/providers/provider-library) under the Policies & Processes tab.

LLH evaluates the medical necessity request (as appropriate) and determines if the service is a covered benefit. Failure to obtain precertification may result in a denial or reduction in benefits paid to the provider, as outlined in this manual and in the Provider Agreement. LLH's UM department authorizes payment for medically necessary covered services. In general, a service is considered to be medically
necessary if it is consistent with generally accepted principles of medical practice based on its appropriateness and effectiveness on medical review, evidence-based medicine and effectiveness. Precertification also determines the medical necessity relative to level of care for inpatient and outpatient services. Claims are paid according to how LLH authorizes payment for the service.

LLH’s precertification determination relates solely to administering its plans and is not, nor should it be construed to be, a medical decision. The provider, along with the member, makes the decision as to whether the services or procedures are provided.

Important precertification information:
- **Expedited (urgent) pre-service referral:** LLH makes decisions within 72 hours upon receiving the request.
- **Standard (routine) pre-service referral:** LLH makes the decision within 15 calendar days upon receiving the request. The physician must provide medical justification including, but not limited to, medical history, laboratory results and previous studies as a means to facilitate and ensure accuracy in rendering determination.
- **Emergency inpatient admission:** Contact LLH within two business days following admission.

LLH’s UM team reviews medical necessity and appropriateness of setting and treatment. The team will actively track and manage inpatient stays to ensure coordination of care with the member’s physicians. The LLH case management staff will provide follow-up communications to patients who have an extended length of stay (more than 10 days).

**Discharge planning review**
Discharge planning begins as early as possible during an inpatient admission in collaboration with the hospital’s case management department and the attending physician. Such planning is designed to identify and facilitate any post-hospital care needs for the member.

**Prospective Reviews**
Prospective reviews are based solely on the medical information obtained LLH’s Medical Management team at the time of the review determination. The plan may reverse an adverse determination when the information provided is different from what was reasonably available at the time of the original determination.

Emergencies should be treated without precertification. LLH should be contacted within two business days of the emergency inpatient admission by calling Health Integrated at 844-674-3845. Failure to do so could result in a denial or reduction in payment. Please note that non-urgent, after-hours requests will be reviewed the next business day.

When calling for precertification, please have the following information available:
- Member’s name
- Member's ID number
- Requested service
- Requesting provider's name, telephone number and name of caller
- Member’s primary care provider or attending provider's name
- Diagnosis and ICD-10, CPT and HCPCS codes
- Supporting history and physical findings if criteria is applicable
- Appropriate test results in support of the service(s) being requested
- Primary care provider/specialist evaluation and treatment with dates
- Place of service
- Recent (current) medical clinical notes
- Evaluation and anticipated treatment plan for therapies

Visit LLHealth.org/providers/provider-library to view specific services requiring precertification. Failure to precertify a service or procedure could result in a delay and/or denial of claim payment.

**Concurrent Reviews**

A concurrent review is a method for reviewing inpatient medical care at the time care is being rendered. It applies to all levels of inpatient care, partial hospitalization and intensive outpatient care. It is conducted through medical record review or via telephone with facility case managers. Hospitals and providers are responsible for notifying LLH's Medical Management team of all admissions within two business days by calling 844-674-3845, or faxing at 844-782-2256 (medical precertifications) and 844-782-2257 (behavioral health precertifications).

The main objectives of a concurrent review are:
- Continuously monitoring the medical necessity, level of care and quality of care
- Ensure the efficient management of inpatient days
- Develop discharge plans in conjunction with the provider, member, member's family and/or hospital discharge planner

LLH utilizes nationally-recognized criteria in the review process. These criteria serve as an objective basis for review decisions and case management. In addition, the Medical Management team, along with the medical director, applies clinical judgment and draws on evidence-based medicine and managed care experience, as consideration is given to co-morbidities/complications and the limitations of the healthcare delivery system for facilitating the management of care with the optimal use of resources. The focus is providing the appropriate amount of care at the most efficient level of service for each individual member.

Types of concurrent reviews:
- **Urgent concurrent review:** LLH makes the decision within 24 hours upon receiving the request.
If the request to extend urgent concurrent care was not made 24 hours before the expired, prescribed period of time or (number of treatments), LLH may treat the request as urgent pre-service and make a decision within 72 hours.

- **Inpatient concurrent/extended length of stay review:** If an admission or an extended stay does not meet the required criteria, a request for further review will be sent to the medical director.
  - If the request to approve additional days for urgent concurrent care is related to care not previously approved by LLH, the organization then documents the fact that at least one attempt to obtain the necessary information within 24 hours of the request, but was unable to do so. LLH has up to 72 hours to make a decision.

When a concurrent review identifies an inpatient stay, that does not meet criteria for the level of care being provided, the case is referred to the LLH medical director for determination. In some cases, the medical director may consult with a physician advisor, within the appropriate specialty. If requested, the medical director is available to the attending provider for a peer-to-peer discussion.

Determinations are usually made within one business day of review. Notifications of approvals and/or adverse determinations are provided verbally and in writing.

**Retrospective Reviews**

Retrospective review is a review of medical information and services previously rendered. The provider is responsible for notifying LLH of cases that haven’t been reviewed by the LLH UM team and providing the appropriate information for case evaluation in a timely manner, based on applicable regulations and contractual agreements. The attending physician and/or hospital facility are notified in writing of LLH’s determination. The determination of a service’s medical necessity is based on the analysis of the information given by the provider and the application of nationally-recognized clinical criteria. Benefits will be paid; adjustments can be made according to the review.

**Transplants**

LLH requires the use of the LLH Transplant Network through the Cigna LifeSource Center. Services and supplies rendered or provided for human organ or tissue transplants, other than those specifically named in the Policy, are excluded. Precertification is required. To initiate an organ transplant request, physicians must contact LLH Medical Management at 844-674-3845. Actual benefit coverage is subject to all healthcare coverage provisions, including eligibility status and contractual limitations in effect when services are provided.
**Case Management**

LLH partners with Health Integrated to provide case management (CM) services—a collaborative process between LLH, the member and the healthcare provider. Case management consists of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs. This is achieved through communication and available resources to promote quality, cost-effective outcomes.

The CM Program is staffed by registered nurses and is telephonically-managed care model, supported by written communication for education or reference. The program is designed to assist members with complex, chronic or catastrophic illnesses to enhance the coordination, continuity and quality of care.

Case management goals include:

- Improving the health outcomes and satisfaction of LLH members through collaborative relationships with the member's providers.
- Ensuring members receive appropriate quality and cost-effective healthcare services.
- Providing service that is culturally competent and sensitive to the diverse population of members enrolled in behavioral and medical CM programs.
- Serving as member advocates by enabling members to make informed healthcare decisions and assisting them in navigating through the healthcare system.
- Educating members, families and healthcare providers about benefits, availability of services, resources and other healthcare alternatives.
- Promoting a comprehensive approach to the identification, assessment and management of members with complex needs.
- Providing support and education for members in their efforts to regain optimal health.
- Emphasizing the importance of maximizing member self-management skills in conjunction with caregiver resources to promote positive health outcomes.
- Ensuring compliance with contracts, state and federal regulations and accreditation standards.

Various screening processes are in place to identify members with a high likelihood of benefitting from CM involvement. Initial CM referrals are made when a member is diagnosed with a targeted condition, is experiencing increased utilization, has a catastrophic illness or when unmet healthcare needs are impacting care management.

Any medical professional involved in a member's care can make a referral. In addition, members are referred for CM evaluations from other LLH departments, such as disease management and member experience. Members may also be referred for an evaluation by their employer group, LLH providers or by self-referral. Referrals can be submitted through the toll-free phone number on the member's identification card.
Disease Management

LLH’s Disease Management (DM) Program is designed to help members work with their doctors to effectively manage ongoing health conditions and improve outcomes. DM programs are available for the following conditions:

- Asthma
- Diabetes

The goal of the DM Program is to decrease condition-related morbidity and associated medical costs for members. This is done by increasing the member's ability to comply with self-monitoring activities and lifestyle changes, and by helping medical providers adhere to clinical guidelines and assist members in achieving their self-management goals.

Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physicians' care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral, or self-referral. To refer a member to a disease management program, call 844-674-3845.

Evidence-based clinical practice guidelines have been developed from published academic literature, national treatment guidelines issued by professional organizations, government institutions, academic research institutions, or other nationally recognized sources. Where evidence based guidelines do not exist from recognized sources, Health Integrated may develop its own guidelines with the participation and input from clinically appropriate practitioners. Evidence based guidelines provide the foundation for the DM program and serve to assist staff in delivering care for participants. The clinical practice guidelines and applicable sources are utilized to develop and maintain all DM staff training materials.

The goal of the Disease Management Program is to decrease condition-related morbidity and associated medical costs for members with diabetes by increasing the member's ability to comply with self-monitoring activities and lifestyle changes, and by helping medical providers to adhere to clinical guidelines and to assist members to achieve their self-management goals.

Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral or self-referral. To refer a member to a disease management program, call 844-674-3845. The clinical practice guidelines that support each of our DM programs can be found at LLHealth.org/providers/provider-library/medical-management/#disease.
Medical Continuity & Coordination of Care

To facilitate continuous and appropriate care for members and strengthen practices among healthcare providers, LLH monitors the coordination and continuity of care across healthcare network settings. The information includes:

- Medical and/or HEDIS medical record reviews
- Member complaints
- Notification and movement of members from a terminated practitioner
- Presence of medical consultant reports
- Home health continuing care plans
- Behavioral health reports following a primary care referral
- Post-hospitalization discharge summaries for behavioral health admission

Section 6: Pharmacy

Pharmacy Program

Land of Lincoln Health is committed to providing appropriate, high-quality and cost effective drug therapy to all members. LLH works with providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are covered by LLH plans, including prescription drugs and certain over-the-counter drugs ordered by an LLH physician or clinician. The pharmacy program does not cover all medications. Some medications require prior authorization and/or step therapy, or have limitations on age, dosage and/or maximum quantities.

Pharmacy Benefit Manager

LLH works with OptumRx to administer pharmacy benefits. Our prescription drug list (formulary) uses medical and utilization management functions to determine whether a prescription is medically necessary. These industry-recognized and –accepted management functions include, but are not limited to, quantity limits, step therapy and prior authorization. These functions help determine whether the prescribed medication is in accordance with generally accepted medical practice standards, is clinically appropriate and confirms that the prescribed medication is not more costly than an alternative product likely to produce therapeutically equivalent results.

All prior authorization requests should be submitted to OptumRx:
1. Complete the LLH/OptumRx Prior Authorization Request Form on the OptumRx website
2. Fax the form to OptumRx (number listed below)
3. Once approved, OptumRx notifies the prescriber by fax
4. If the clinical information provided does not explain the reason for the requested medication prior authorization, OptumRx responds to the prescriber by fax, offering prescription drug list alternatives.

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the OptumRx Pharmacy Help Desk at 800-788-4863.

A phone or fax-in process is available for prior authorization requests:
OptumRx
Prior authorization fax: 866-511-2202
Prior authorization phone: 855-577-6551
PO Box 5252
Lisle, IL 60532

When calling OptumRx, please have patient information readily available, including the member ID number, complete diagnosis, medication history and current medications. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive the designated drug. If the request is denied, information about the denial and appeal rights will be provided to the clinician.

Providers must utilize the prescription drug list when prescribing medication for patients covered by the LLH pharmacy program. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to request a product change in the prescription drug list.

As recommended by the United States Department of Labor, OptumRx’s reasonable medical and utilization management functions apply to ACA preventive drugs. Be sure to refer to the prescription drug list to determine if a drug has a required utilization management edit. If a prescription medication is not listed in the prescription drug list, it is considered a non-covered drug and is therefore not eligible for benefits. If your patient needs a prescribed medication that is a non-covered drug, you may submit a request for a prescription drug list override exception, using the Formulary Exception Approval Form available at LLHealth.org/providers/provider-library. To be eligible for an override, certain criteria must be met, as outlined on the Formulary Exception Approval Form.

**Specialty Pharmacy Provider**

Certain medications are only covered when supplied by LLH’s preferred specialty pharmacy provider, BriovaRx Specialty Pharmacy. These products are listed on the BriovaRx Supplied Biopharmaceutical document available on the OptumRx website. The LLH pharmacy program director and medical director oversee the clinical review of these medications. Providers can request a specialty drug delivery to an office or member by calling BriovaRx at 855-427-4682.

**Prescription Drug List**

The prescription drug list describes the circumstances in which contracted pharmacy providers will be reimbursed for medications dispensed to covered members.
The prescription drug list does not:
- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician or pharmacist
- Relieve the physician or pharmacist of any obligation to the patient or others

LLH has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. The prescription drug list attempts to provide appropriate and cost-effective drug therapy to all participants covered under the LLH pharmacy program. If a patient requires medication that does not appear on the prescription drug list, the provider can submit a prior authorization request for a non-preferred medication. A copy of the prescription drug list can be found at LLHealth.org/learn-more/prescription-drug-benefit-formulary.

Specific Exclusions
The following drug categories are not part of the prescription drug list:
- Fertility enhancing drugs
- Anorexia, weight loss or weight gain drugs
- Experimental or investigational drugs
- Drug efficacy study implementation (DESI) and identical, related and similar (IRS) drugs classified as ineffective
- Infusion therapy and supplies
- Oral vitamins and minerals (except those listed in the prescription drug list)
- Drugs and other agents used for cosmetic purposes or hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Over-the-counter medications (except those listed in the prescription drug list)

LLH covers a variety of over-the-counter medications. All covered over-the-counter medications appear in the prescription drug list and must be written on a valid prescription by a licensed provider.

Maintenance Medications
LLH covers a 90-day supply of maintenance medications that can be found at many retail pharmacies or through OptumRx. Visit LLHealth.org/learn-more/prescription-drug-benefit-formulary for a list of maintenance medications. If you have additional questions, call LLH Provider Relations at 844-674-3838. To transfer a current prescription to mail-order delivery, call OptumRx at 800-788-4863.

Quantity Limitations
Quantity limitations have been implemented on certain medications to ensure safe and appropriate use. These limitations are noted on the prescription drug list.

Step Therapy
Medications requiring step therapy are listed with an “ST” notation throughout the prescription drug list. The OptumRx claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization is required.
Newly approved products
Newly approved drug products will not normally be placed on the prescription drug list during their first six months on the market. During this period, access to these medications will be considered through the prior authorization review process.

Unapproved Use of Preferred Medication
Medication coverage is limited to non-experimental indications as approved by the U.S. Food and Drug Administration. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. LLH will make reimbursement decisions for specific non-approved indications. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

Generic Substitution
LLH requires that generic substitution be made when a generic equivalent is available.

Exception Requests
In the event that a provider or member disagrees with the decision regarding medication coverage, the provider may request an appeal by submitting additional information to LLH. The additional information may be provided verbally or in writing. The information may be faxed to 866-511-2022. A decision will be rendered and the provider will be notified with a faxed response. If the request is denied, the provider will be notified of the appeals process at that time. An expedited appeal may be requested at any time if the provider believes the adverse determination might seriously jeopardize the life or health of a patient.

Section 7: Reconsideration

Provider claims request for reconsideration policy
LLH requires providers request a reconsideration for a re-billed or corrected claim, or a claim denied for failure to precertify a procedure that is resubmitted by the provider for the same patient, date of service and/or procedures. A request for reconsideration requires providers to request a reconsideration of:

- A code edit denial on a specific claim.
- A code editing policy where the provider and LLH are using different nationally-recognized sources, or the provider and LLH have a different interpretation of a nationally-recognized source.
- A claim denied for failure to precertify.

A request for reconsideration is required prior to initiation of the appeals process. The reconsideration filing deadline is 180 days from the date of service. The full policy and procedure is available at LLHealth.org/providers/provider-library.

Providers have a right to file an appeal to a claim decision after following the LLH Reconsideration Policy, which requires LLH Providers to first file Request for Reconsideration with LLH for a re-billed or corrected claim, or a claim denied for failure to precertify a procedure that is resubmitted by the Provider for the same patient, date of service and/or procedures.
The full reconsideration policy and procedure is available at LLHealth.org/providers/provider-library.

If a provider is not satisfied with the resolution of the request for reconsideration, he or she has a right to appeal the decision and have it reviewed by an independent third party. LLH is committed to helping our providers serve our members. Please call the Provider Relations team at 844-674-3838 with questions or concerns.

**Section 8: Appeals & Grievances**

**Adverse determination appeal**
A request for a review of a claim decision, filed by a provider, when a claim is denied for reasons as stated on the Explanation of Payment (EOP). This can be regarding healthcare services, including but not limited to procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a healthcare provider, the denial of which could significantly increase the risk to an enrollee's health; a treatment referral, service, procedure, or other healthcare service, the denial of which could significantly increase the risk to an enrollee's health; or a complaint regarding benefits was filed before services have been rendered and member or provider did not agree with the result.

**Administrative appeal**
A request to review a claim decision, filed by a provider, after a request for reconsideration. This occurs when the provider disagrees with LLH's decision. The decision can include, but is not limited to, timely filing denials, clinical edit denials or partial payment denials.

**Benefits determination appeal**
A request for review of a claim decision filed by a provider when benefits are denied due to the service or treatment being deemed by LLH to be experimental, not a covered service, applicable benefit limits have been reached under the health plan in question, the member's ineligibility for the benefit in question or a lack of precertification.

**Grievances**
A verbal or written complaint about LLH or one of its network providers or pharmacies.

**Internal appeal**
If a member is not satisfied with a claim determination, he or she may appeal the denial by contacting:

Land of Lincoln Mutual Health Insurance Company  
Attn: Appeals  
PO Box 8701  
Portland, ME 04104-8701  
844-674-3844 (toll-free)  
312-506-4927 (secure and confidential fax)
Members have 180 days from the date they receive an adverse determination (i.e., denial of a claim) in which they, or their authorized representative, may file an appeal. We will send members an acknowledgement letter within three business days of receiving their appeal and will inform them whether more information is needed to evaluate their request at that time. We will review the appeal according to the following schedule for administrative and healthcare services:

- Retrospective review is for claims denied after the service has been performed. A decision will be made on the appeal within 60 days.
- Prospective review is for claims submitted prior to service that do not involve the provision of healthcare services. A decision will be made on the appeal within 30 days.
- There are separate time frames for appeals involving the furnishing of healthcare services. "Healthcare services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury including home health and pharmaceutical services and products. A decision will be made on the appeal within 15 business days.
  - Appeals involve healthcare services including but not limited to, procedures or treatments ordered by a healthcare provider. Denials that significantly increase the risk to the claimant’s health may be entitled to an expedited internal appeal (see below).

**Expedited internal appeal**

In addition, you may be eligible for an expedited internal appeal for urgent care requests if:

- The time frame for making a standard determination could seriously jeopardize the life or health of the member, or his or her ability to regain maximum function.
- The request involves an admission, availability of care, continued stay or healthcare service for which the member received emergency services and has not been discharged from a facility.
- The request involves an experimental or investigation determination and the provider certifies, in writing, that the recommended or requested healthcare service or treatment would be significantly less effective if not promptly initiated.

**External independent review**

If there is an adverse decision to the internal review and LLH has not responded to the initial internal appeal within 15 business days after the required information has been received, you have a right to request an external claim review by an independent review organization (IRO). The IRO will be at no cost to you, including any filing fees. To request an external independent review, please call Provider Services at 844-674-3838 for an External Review Request Form. You must file this external review within four months of receiving notice from LLH stating the treatment recommended (or provided by the treating physician), along with the internal review has been denied. External review requests must be submitted to the Illinois Department of Insurance at:

Illinois Department of Insurance Office of Consumer Health Insurance  
External Review Request  
320 W. Washington Street  
Springfield, IL 62767  
877-850-4740 (toll-free)  
217-557-8495 (fax)
**Expedited external appeal**

You may request an expedited external review and expedited internal appeal at the same time. An IRO will determine if the expedited internal appeal needs to be completed before proceeding with the expedited external appeal.

LLH will provide copies of any requested information to you and the IRO within 24 hours of the request. Upon completion of the review, the IRO must provide a decision to you, your authorized representative and LLH within 72 hours of receiving the request.

**Section 9: Quality Improvement Strategy**

**Quality/Accreditation**

The goal of the Quality Improvement Strategy (QIS) is to have a process to objectively measure, monitor, evaluate and continuously improve the highest quality of clinical care and services delivered to LLH members.

An important component of the QIS is LLH's Quality Committee, responsible for the development, implementation and oversight of the quality program for LLH. The committee evaluates the results of quality improvement activities and utilization outcomes and recommends actions to improve and maintain the health status of LLH members.

Additionally, LLH relies on the Provider Advisory Council (PAC) to ensure providers provide high-quality, appropriate, efficient and cost-effective healthcare to members. LLH utilizes member and provider feedback to improve its quality programs. To further promote the adherence to standards of quality, LLH is accredited by the National Committee for Quality Assurance (NCQA) and follows its regulatory requirements.

The NCQA Accreditation Survey review process examines the organization's quality improvement program structure, tests improvement processes and looks for evidence that activities have resulted in measurable improvement in the organization's clinical and service areas.

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

HEDIS® data, taken from the State of Healthcare Quality Report, is a comprehensive look at the performance of the nation's healthcare system. HEDIS® data is the centerpiece of health plan ratings on the federal Marketplace.
HEDIS® is designed to measure, plan and evaluate provider performance to produce a consumer report card. LLH partners with providers to obtain and provide HEDIS results. HEDIS® consists of 81 quality measures across five domains of care:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan description information

The information collected from health plans is published to assist consumers in choosing a healthcare plan, physicians and other healthcare providers. Specific HEDIS® measures may change annually to reflect medical advances and identify new areas to focus improvement efforts.

HEDIS® measures are related to significant public health issues such as cancer, heart disease, asthma and diabetes, as well as the utilization of preventive health guidelines. HEDIS® also includes a standardized survey of consumer experiences that evaluate health plan performance in areas of customer service, access to care, rating of personal doctor and/or specialist and claim processing.

LLH collects HEDIS® data each year. During this time, select provider offices are asked to review a list of plan members through a chart review, which will be scheduled by an LLH representative. Electronic file transfer, fax and onsite chart review options are available. The most efficient and cost-effective method is to provide remote access to the provider’s electronic medical records (EMR). This includes setting up electronic data exchange from the provider’s EMR to LLH. If EMR is not an option, LLH will work with the provider to identify a mutually-agreeable date and time for record review. Providers are asked to send the requested records to LLH or pull the charts for onsite review. The provider will be expected to designate a place to conduct the review if an onsite review is required.

**HEDIS data collection frequently asked questions**

*How are HEDIS® measures generated?*

HEDIS® measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- QHP survey

*Why does LLH need to review medical records when it has claims data for each encounter?*

Medical record review is an important part of the HEDIS® data collection process. Medical records contain information such as lab values, blood pressure readings and test results that may not be available in claims/encounter data.

*Is patient consent required to share HEDIS® related data with the plan?*

The HIPAA Privacy Rule permits a provider to disclose protected health information to LLH for its quality-related healthcare operations, including HEDIS®, provided that LLH has or had a relationship with the individual who is the subject of the information, and the protected health
information requested pertains to the relationship. See 45 CFR 164.506(c)(4). Thus, a provider may disclose protected health information to LLH for the HEDIS® purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in an LLH plan.

*May the provider bill the plan for providing copies of records for HEDIS®?*

According to the terms of the Provider Agreement, providers may not bill LLH or the member for copies of medical records related to HEDIS®.

*How can providers reduce the burden of the HEDIS® data collection process?*

It is in the best interest of both the provider and LLH to collect HEDIS® data in the most efficient way possible. Options for reducing this burden include providing LLH remote access to provider EMR and setting up electronic data exchange from the provider EMR to LLH.

*How can providers obtain the results of medical record reviews?*

LLH’s quality improvement department can share the results of the medical record reviews and show how an individual provider’s results compare to that of LLH overall.

**Quality Reporting System (QRS)**

Per federal requirements, as a Marketplace issuer, LLH is also required to report a subset of HEDIS®, Consumer Assessment of Health Plans and other measures as part of the Quality Rating System (QRS) reporting process. QRS reporting follows the same data collection time frame processes as HEDIS® reporting. However, the QRS measures are based on relative quality and price of QHPs offered in the Marketplace. LLH is required to display the quality rating information on its website to help consumers compare QHPs. This is essential to CMS certifying LLH QHP plans.
## Section 10: Appendix

### Traditional 2-Tier PPO Plans and Networks

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## Preferred Partner 3-Tier PPO Plans and Networks

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Member ID Cards

![Member ID Cards Image]

**Individual & Family Group ID Card**

**Small & Large Group ID Card**

Front of ID card

![Front of ID Card Image]

1. **Member information**
   
   Includes the policyholder’s name, dependent information and member ID number.

2. **Pharmacy information**
   
   Here you can find the Rx Bin number, PCN and Rx group name.
3. **Plan name**  
This is the name of the plan the patient is enrolled in.

4. **Network name**  
This identifies which network your patient is in.

5. **Group ID**  
Group ID numbers help identify which line of business the member belongs to.  
- Individual and family: ID card does not contain a group number  
- Small group: Group number does NOT start with the letter “L”  
- Large group: Group number will start with the letter “L”

6. **Cost of primary care & specialist visits**  
In this section, you will find the copay or coinsurance amounts for primary care and specialist appointments.

7. **Nationwide coverage**  
Logo that indicates the member's nationwide coverage.

**Back of ID card**

1. **Precertification**  
Some medical services or treatments require precertification. For standard pre-service referrals, LLH makes the decision within 15 calendar days upon receiving the request. You must provide medical justification including, but not limited to, medical history, laboratory results, and previous studies as a means to facilitate and ensure accuracy in rendering determination. Requests for precertification must be made via phone or fax at least five business days prior to the medical services or two business days following an emergency admission. Failure to precertify will result in a denial of medical services. A full list of services requiring precertification can be found at
LLHealth.org/providers/provider-library under the Policies & Processes tab.

2. **Important member phone numbers**
   These are the phone numbers members can call when they have questions about their health insurance benefits. The numbers listed include:
   - Member Services
   - Pharmacy Services
   - Behavioral Health

3. **Dental information**
   The DentalGuard logo serves to identify members with dental coverage. As a reminder, LLH dental benefits are only available to dependents 18 years old and under.

4. **Provider phone numbers**
   You can call Provider Services at 844-674-3838 to verify eligibility, benefits or claim status.

5. **Medical claims address & EDI**
   Here you will find the mailing address for all Land of Lincoln Health medical claims, as well as the vendor number and clearinghouse for electronic claims.