Provider Manual

Truli for Health

truli for health

June 2020

Contents

Welcome to the Truli for Health Provider Manual!

This manual is an important resource designed to help you work with us. We will share information about programs, tools and resources available to our providers. We will make updates to this manual on the second Sunday of the month.

If there is any inconsistency between information in this manual and the agreement(s) between you and Truli for Health (your “agreement”), the terms of your agreement(s) shall govern.

Who We Are

BeHealthy Florida, Inc., doing business as Truli for Health, is a new consumer-centric open-access commercial HMO health plan. Our care model is a purposeful collaborative model where like-minded health professionals work together to achieve the best outcomes for our members. Our network is a high-performing collaborative network that features health system and physician group partners in specific regions throughout the state. These partners will work collaboratively to deliver better member experiences and health outcomes. Our members must select a primary care physician (PCP) who will coordinate their care and wellness needs.

Product Launch Schedule by Market

Following is the Truli for Health (Truli) market launch schedule:

July 1, 2020

- Central Florida – Orange, Osceola and Seminole counties
- South Florida – Broward, Palm Beach, Martin, St. Lucie and Indian River counties

January 1, 2021

- Tampa Bay Area – Hillsborough, Pinellas and Pasco counties

Our Health Care Partners

Truli is developed around a group of select integrated health systems and physician groups.

Central Florida

Primary Care	GUIDEWELL Primary Care	https://www.guidewellprimarycare.com/gwpc
	Sanitas A Keralty Company	https://www.mysanitas.com/
Urgent Care Center	GUIDEWELL EMERGENCY DOCTORS Operated by CRUCIAL CARE	http://www.guidewellemergency.com
Health Systems	ORLANDO HEALTH®	https://www.orlandohealth.com/

South Florida

Primary Care	Sanitas A Keralty Company	https://www.mysanitas.com/
	PEDIATRIC ASSOCIATES®	https://www.pediatricassociates.com/
Health Systems	Bethesda Hospital East BAPTIST HEALTH SOUTH FLORIDA Boca Raton Regional Hospital BAPTIST HEALTH SOUTH FLORIDA	Bethesda Hospital East https://www.bethesdaweb.com/ Bethesda Hosptial West https://www.bethesdawest.org/ Boca Raton Regional Hospital https://www.brrh.com/
	Cleveland Clinic Florida	https://my.clevelandclinic.org/florida
	JUPITER MEDICAL CENTER	https://www.jupitermed.com/
	Wellington Regional Medical Center	https://www.wellingtonregional.com/

Truli at-a-Glance

Health ID card

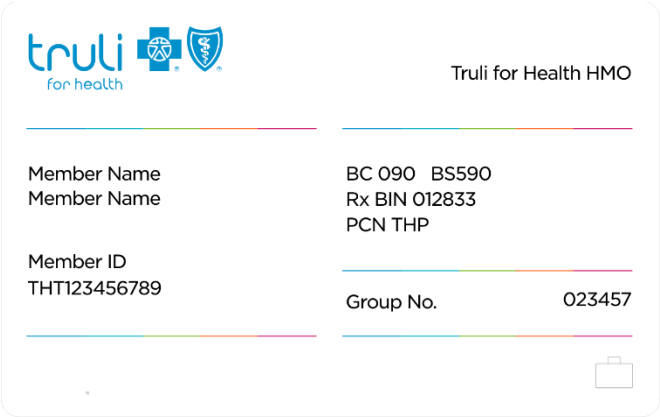
Each member has access to a paper ID card and digital card. The nine-digit ID number is listed on the card. Use this number to communicate with us about a member.

You can find the following member information on the card:

- Member's ID number
- Member's benefit plan
- Other important information, such as where to submit a claim and the group information

Note: Presenting an ID card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits.

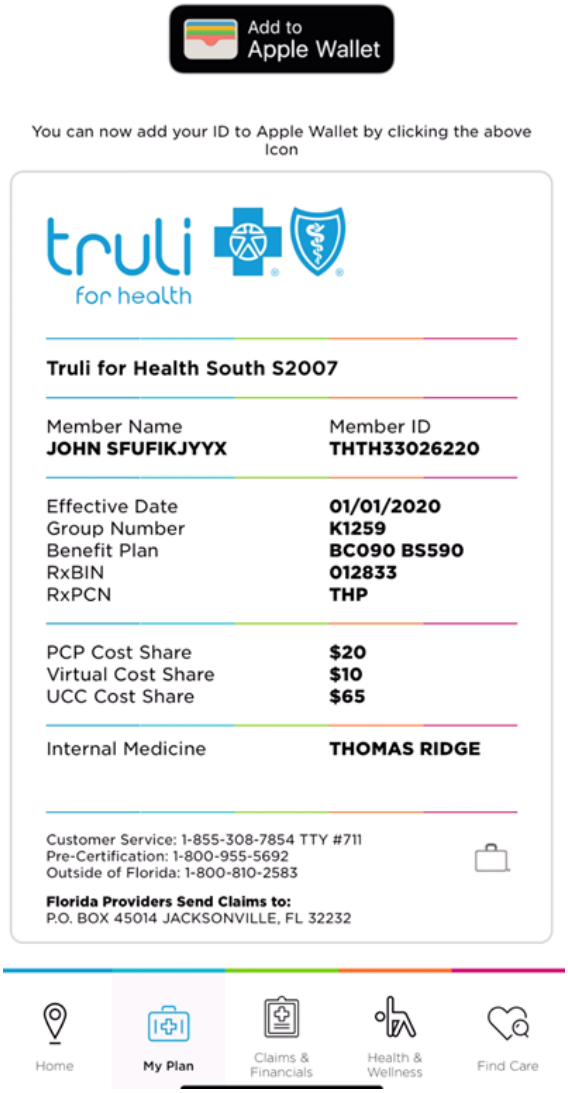
Paper ID Card



Front

Back

Digital



Truli for Health HMO Network

The Truli collaborative network includes primary care physicians, specialists, facilities, ancillary providers and related services within the same health system and select community providers.

Primary Care Physicians

All members are required to select a primary care physician (PCP). The PCP will manage and coordinate the member's care and services. We always support development of a strong personal relationship between members and their PCP, and we have designed our care and utilization management programs and processes to keep the PCP engaged with the member.

While our plans are open access, which allows our members to self-refer to participating specialists, our utilization management program requires specialists to submit prior notification for a member visit not initiated by a member's assigned PCP with a referral.

Truli will routinely evaluate continued participation in the PCP network to ensure PCPs maintain satisfactory quality, efficiency and member satisfaction results.

PCP Member Panel Status

Truli encourages its participating PCPs to maintain an open and active panel. However, in the event you must change your panel status, contact the Provider Contact Center at 833-238-8144.

Closed

A closed panel will prevent any member, whether an existing patient of the PCP or not, from selecting the physician as a PCP. Truli requires at least a 30-day advance notice to close or open a panel.

Closed to new patients

A Panel status of Closed to New Patients will also prevent members from selecting the physician as a PCP. This panel status requires the PCP to contact the plan to have members added to their panel.

Plan-initiated panel closure

Truli reserves the right to close a provider's panel. Truli will notify physicians in the event of a plan-initiated panel closure.

Panel age restrictions

Submit age restrictions in writing to Truli. Truli's standard restrictions are as follows:

- Children only: Newborn to 18 years
- Adolescent and adults: 12 and older
- Adults only: 18 years and older

Member-initiated PCP Change

Members have a right to change their PCP.

The actual date of the PCP change is prospective. The date we receive the request will determine the effective date of the change.

PCP Change Request Received	PCP Change Effective
On or before the 5th day of the month	The same day as the request
After the 5th day of the month	The first day of the following month

The Plan may expedite a PCP change if it is determined to be in the best interest of the member or current PCP.

PCP-initiated Member Transfer

Truli will collaborate with the PCP and member to attempt to resolve an issue between a member and PCP before transferring a member to another PCP. Reasons for a PCP to request Truli to remove a member from their panel may include:

- Patient is consistently non-compliant with the PCP's medical advice
- Patient is consistently disruptive in the office
- Patient consistently misses scheduled appointments without cause or without notice to the office
- Irreconcilable differences between the physician and patient

PCPs should call the Provider Contact Center at 833-238-8144 to begin panel changes.

Specialist

Our specialty network is a high-performing network of practitioners who are always expected to collaborate with the member's assigned PCP on a member's planned and ongoing treatment. This collaboration is so important that we require our specialists to submit prior notification for scheduled member visits not initiated by a member's assigned PCP with a referral.

Truli will routinely evaluate continued participation in the specialty network to ensure that specialists maintain satisfactory quality, efficiency and member satisfaction results.

Specialist Visit Notification Requirement

Truli doesn't require a PCP referral for a specialist visit. However, if a PCP referral is not on file for a specialist visit, *the specialist must submit a notification* to Truli of a scheduled visit at least two (2) business days before a member's scheduled visit. *We will deny* specialist claims that have no PCP referral on file and no plan notification on file.

Instructions for how to submit a Specialist Notification is listed in the Truli for Health Programs section of this manual.

Physician Extenders

Physician Extender is defined as: Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Nurse Specialist, Physician Assistant and Registered Nurse First Assistant. They are health care providers who practice in collaboration with or under the supervision of a physician.

Except for Physician Extenders directly contracted with Truli for Health (i.e., the Provider Agreement is between Truli and the Physician Extender or a group that consists solely of Physician Extenders), reimbursement for Covered Services rendered by Physician Extenders is subject to a fifteen percent reduction from the Provider's contract rate where a relative value unit exists.

Third-Party Networks

The following vendors provide network and other services on behalf of Truli

	Provider	Service Area
Chiropractic	American Specialty Health	Statewide
Dental	FCL/LSV Dental Management	Statewide
Home Care Services (such as durable medical equipment and home health services)	CareCentrix®	Statewide
Lab (Clinical reference lab and pathology)	Quest Diagnostics℠	Statewide
Pharmacy (specialty drugs)	Caremark Specialty Pharmacy	Statewide
Vision	Davis Vision	Statewide
Pathology	IRL Pathology Services	Central Florida
Dermatology	Dermatology Network Solutions	South Florida
Dialysis	Fresenius	South Florida
Ophthalmology	Eye Management Inc. Ophthalmology	South Florida
Podiatry	Podiatry Network Solutions	South Florida

Electronic Capabilities

Availity

Truli encourages providers to conduct business with us electronically through Availity®[1] whenever possible. You can use Availity to easily and quickly do the following:

- Check member eligibility and benefits

- Submit claims for payment
- Check the status of a claim
- Communicate with Truli

Check eligibility and benefits

You can verify a member's eligibility and benefits by:

- Going to the Eligibility and Benefits application in Availity at availity.com.
- Using electronic data interchange (EDI) Eligibility & Benefit Inquiry and Response (270/271) transactions.
- Calling the Provider Contact Center at 833-238-8144.

Updating your information through Availity

Go to the Truli for Health Payer Space in Availity and select **View and Manage your Record**.

Note: Some changes may affect credentialing. You must tell us about changes to credentialing information promptly to avoid claim processing issues.

Provider Directory

Providers who participate in the Truli for Health HMO network are listed in the Truli for Health Provider Directory.

Provider demographic changes

Tell us immediately about any demographic changes so our members have access to accurate information. This is required by law, regulatory requirements and accrediting bodies, such as the National Committee for Quality Assurance (NCQA). Maintaining an updated provider record will prevent operational issues, such as issuing Notifications or obtaining referrals and requesting and obtaining authorizations.

Health Information Exchange

Truli requires its contracted providers to keep written or electronic medical records that comply with industry standards and applicable federal, state and local laws, rules and regulations.

Electronic medical records

Providers who use electronic medical records must have a system in place that complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act, and other federal and state laws.

[1]Availity, LLC is a multi-payer joint venture company. For more information or to register, visit availity.com.

Quality Performance Measures

Truli's goal is to create a best-in-class experience and ensure quality health care for our members. To do this, we use claims, encounter and medical record data in our Quality Improvement (QI) programs. These programs address:

- Quality of care issues.
- Health management and wellness activities.
- Grievance and appeal resolution.
- Performance measures.

Your Participation and Feedback

As a participating provider, you may offer input on QI programs by QI Committee representation and through your Truli provider service advocate.

Quality performance indicators

We have designed a robust, Truli-administered quality program to align with HEDIS®[1] related measures from the 2019 Centers for Medicare & Medicaid Services guidance for commercial plans regarding its Quality Rating System. We've selected 32 objective HEDIS measures from the 2019 measure set—including adult and pediatric measures—to assess "process of care" and "outcome of care" dimensions for each important aspect of care and service.

These measures help consumers and the public evaluate how well Truli's delivery system meets customer needs in these areas. Providers can use these measures to evaluate and improve member care and service.

[1]Healthcare Effectiveness Data and Information Set

How we measure your performance

We will assess your performance based on your Truli members with diagnoses that align with associated measures. We will rate you against industry benchmarks and then compare your performance to your Truli neighborhood peers and other established regional providers.

To be included in a measure, you must have at least 25 members who meet the measure's clinical criteria. On these qualified measures, you must achieve 90 percent of the regional average in at least 50 percent of the qualifying measures to be eligible for a total cost of care reduction bonus.

How we review your results

Truli will review your performance results on a rolling, 12-month schedule using HEDIS-like measurements through our third-party vendor. We will develop your initial results three months after the end of your first contract year. Then, we will update the results quarterly.

Clinical Practice and Preventive Health Guidelines

Truli uses national, state and specialty clinical practice guidelines, preventive health guidelines and other internal criteria to offer direction and standards for preventive, acute and chronic health care services relevant to our members.

We review clinical practice guidelines against utilization management criteria and member education materials to ensure consistent and aligned communications. These guidelines include factual and appropriate medical recommendations. Local physician committees also recommend how we use these guidelines.

Standard Reports and Information

Truli will provide reports to certain providers on a recurring basis. Following is a sample of the information we may share.

Contract Reconciliation Results	Premiums, expenses and all applicable credits and deductions. Recast views by month with totals by quarter and year
Contract Reconciliation Results – Quality Scorecard	Results for quality measures applicable to the contract for the reconciled period, delivered along with the contract reconciliation results
Membership Roster	Operational and analytical (recast) views of a PCP panel The operational views will have the necessary formats to identify new members each month, days since last visit, etc. Analytical views will have different data points for recast membership
Quality Measures	Results by quality measure
Quality Measures – Target List	Member-level reports, gaps in care, etc.
IP Census	Admits, discharges and transfers for a member panel
Medical Expenses – Cost Trends	Utilization trends with a cost-by-service category of breakdown and different views to identify high-cost members, admits in the context of PCP visit frequency, etc.

Compliance and Confidentiality

Confidentiality and Protected Health Information

Truli and its participating providers are “Covered Entities” under the privacy rule portion of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Covered Entities must follow applicable federal and state standards for Protected Health Information (PHI) use and disclosure.

Truli expects its providers to keep current office policies and procedures to prevent the unauthorized or inadvertent disclosure of confidential information. This may include, but is not limited to, administrative, physical and technical controls to protect a member’s PHI.

Fraud, Waste and Abuse

When providers, members, health plans and employees commit fraud, waste and abuse, it hurts everyone. Truli asks that you help us detect and eliminate fraud, waste and abuse. Let us know about any potential fraud, waste and abuse you find. We also ask that you cooperate with any fraud, waste or abuse review.

We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for our members.

Understanding fraud, waste and abuse

Fraud is any type of intentional deception or misrepresentation a person makes knowing that the deception could result in their or some other person receiving an unauthorized benefit. The attempt itself is fraud, regardless of whether it is successful.

Waste includes activities that cause unnecessary expenses and resource mismanagement, such as careless, poor or inefficient billing or treatment methods.

Abuse is any practice inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the program or in payment for services that are not medically necessary or don't meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the program.

Examples of fraud, waste and abuse

Provider

- Altering or falsifying medical records.
- Direct billing or balance billing Medicaid members.
- Billing for services they didn't give.
- Billing for medically unnecessary tests.
- Billing professional services untrained personnel performed.
- Misrepresenting diagnoses or services.
- Overutilization.
- Soliciting, offering or receiving kickbacks or bribes.
- Unbundling.
- Under-utilization.
- Billing more than once for the same service.
- Billing or charging the member for services Truli for Health paid.
- Dispensing generic drugs and billing for brand-name drugs.
- Performing and/or billing for inappropriate or unnecessary services.
- Trading prescription drugs for sexual favors.
- Offering a prescription or prescription drugs without seeing or treating the member.
- Offering gifts, a prescription, prescription drugs or money to members in exchange for receiving treatments or services.

Members

- Disruptive or threatening behavior.
- Frequent emergency room visits for non-emergent conditions.
- Forging, altering or selling prescriptions.
- Lying about the amount of money or resources the member has to get benefits.
- Lying about a medical condition to get medical treatment.
- Obtaining controlled substances from multiple providers.
- Using more than one provider to obtain similar treatments and/or drugs.

Reporting fraud, waste and abuse

You do not have to give proof, but if you suspect medical billing fraud, waste or abuse, you have a

responsibility and a right to report it.

You can report suspected fraud, waste, or abuse by calling the Provider Contact Center at 833-238-8144 or send a message through the Availity message center.

Truli for Health Programs

Our Medical Policies and Medical Coverage Guidelines

Truli processes claims based on a member's eligibility, their effective benefits and the evidence-based medical necessity of the services providers give. Our decision process includes using evidence-based medical policies and medical coverage guidelines (MCGs) and the medical necessity provisions found in the member's benefit agreement and certificate of coverage.

Find the latest policies and guidelines

You can find our medical policies and guidelines at *truliforhealth.com* under the Medical and Pharmacy Policies and Guidelines section.

We will add any new information to the guidelines' "What's New" section.

Certificate of Medical Necessity forms

To hasten the medical review process for certain requests, Truli gives you Certificate of Medical Necessity (CMN) forms. We have matched each CMN form with one of our MCGs. Instead of sending required documentation to us, you can attest to information within the member's medical documentation.

Finding MCGs with CMNs

When an MCG has an associated CMN form, a blue document icon appears after the 9-digit MCG policy number in the top left corner of the document. You can find information about each CMN form in the Position Statement section of the MCG.

Truli for Me Programs and Features

Chronic condition management

Our wellness and preventive programs help you support our members living with reoccurring or chronic conditions. We have listed the most common of these illnesses below. Under your direction, the program uses a highly effective, personalized care team approach to increase the likelihood that members will follow the treatment plans you recommend. This program helps members engage in healthy behaviors, such as following treatment plans and taking medication properly and consistently, while also closing care gaps.

- COPD/Asthma
- Diabetes
- High cholesterol
- Hypertension

Truli for Me Drugs

Truli for Health has lowered the cost share on generic (and some brand name) drugs used to treat the conditions listed above. When you prescribe from the Truli for Me Drug List, our members pay a reduced cost share for the drugs.

Truli for Me Drug List

Truli for Me Rewards

Your guidance and management of our members is important in helping them stay healthy. We have built the Truli for Me Rewards program to give members the opportunity to earn reward dollars when they meet health success measures. Members can use these dollars to pay for doctor visits, prescription drugs and other health-related services. You can find a list of rewardable activities on the Truli for Me website.

Truli for Me Rewards link

Virtual visits

Virtual visits give members convenient access to care. If you are an in-network PCP or behavioral health specialist that offers virtual visits through two-way interactive video conferencing, you can bill services that we have defined on a pre-approved list of covered virtual codes. Providers must give these services through a mobile device, tablet or computer and/or telephone. A virtual visit may include:

- Providing care, treatment or services to a patient virtually instead of in person.
- Establishing initial and providing ongoing, clinical medical or behavioral health services.
- Giving online assessment and management services for an established patient.

Truli covers only the following virtual visits codes:

Procedure Code	Service	Modifier	Place of Service
99201 – 99215	Office or other outpatient visits	95	02
G0108 - G0109	Individual and group diabetes self-management training services with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	95	02
96150 – 96154	Individual and group health and behavior assessment and intervention	95	02
90832 – 90838	Individual psychotherapy	95	02
G0459	Telehealth pharmacologic management	95	02
90791 – 90792	Psychiatric diagnostic interview examination	95	02
G0270 **97802 – 97804**	Individual and group medical nutrition therapy	95	02
96116	Neurobehavioral status examination	95	02
G0436, G0437, 99406, 99407	Smoking cessation services	95	02
G0396, G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	95	02

Procedure Code	Service	Modifier	Place of Service
G0442	Annual alcohol misuse screening, 15 minutes	95	02
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	95	02
G0444	Annual depression screening, 15 minutes	95	02
G0445	High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	95	02
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	95	02
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	95	02
99495	Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	95	02
99496	Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	95	02
99497	Advance care planning, 30 minutes	95	02
99498	Advance care planning, additional 30 minutes	95	02
90845	Psychoanalysis	95	02
90846	Family psychotherapy (without the patient present)	95	02
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	95	02
99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	95	02
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT; service is for eligibility determination and shared decision making	95	02
90785	Interactive complexity psychiatry services and procedures	95	02
96160, 96161	Health risk assessment	95	02
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management	95	02
90839, 90840	Psychotherapy for crisis	95	02
99441	Telephone evaluation and management service by a physician or other qualified health care professional 5-10 minutes	95	02

Procedure Code	Service	Modifier	Place of Service
99442	Telephone evaluation and management service by a physician or other qualified health care professional 11-20 minutes	95	02
99443	Telephone evaluation and management service by a physician or other qualified health care professional 21-30 minutes	95	02
99444	Online evaluation and management service provided by a physician or other qualified health care professional to an established patient or guardian, Internet or similar network	95	02
99402	Lactation consultant (initial visit)	95	02
99404	Lactation consultant (follow-up visit)	95	02
99202	Office/outpatient visit new	95	02
99354	Prolonged service office	95	02

Referrals vs. Prior Authorization and Notification

The referral process, specialist notification process and prior authorization process are separate processes. All providers must follow notification and/or prior authorization requirements when providing a service that requires a notification and/or prior authorization.

If you do not follow these processes when required, it may result in a denial of your claim, and the service will not be billable to the member.

PCP Referrals

As an open access plan, referrals are not required for members to see a specialist. However, a member's assigned PCP is expected to manage their care. If their PCP determines the member should see a specialist in the network who is not part of the member's current PCP group (i.e. different TIN), then the member's PCP should submit a referral to Truli. Referrals are valid for the named specialist or any other providers billing under the same TIN.

How to submit a referral

You can quickly add a referral, submit a referral inquiry and check a referral status using Availity.

- Referrals must be submitted electronically.
- Referrals are effective immediately.
- They are viewable online within 48 hours.
- We do not accept referrals by phone, fax or paper, unless state law requires us to.
- We can backdate them up to five calendar days from the date of submission.
- Web users must have access to the Referral Submission role on their user profile to submit and verify referrals.
- Only the member's PCP or another PCP practicing under the same TIN can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

Specialist Notification Requirements

Truli does not require a PCP referral for a specialist visit. Prior to any specialist visit, specialists should verify whether the member's assigned PCP has issued a referral for the specialist visit. If a PCP referral is not on file, the specialist must submit a notification to the plan at least two (2) business days prior to the scheduled visit (e.g. If the visit is scheduled for Thursday, notification must be submitted to the plan no later than end of business Monday.)

Truli will deny specialist claims that have no PCP referral on file and no prior notification on file. Claims submitted for specialist visits will be denied and not billable to the member when submitted without a referral from the member's assigned PCP or a timely specialist notification on file.

How to submit a specialist notification

Specialist notifications are only required when a PCP referral is not on file for a specialist visit. You can quickly submit a specialist notification by using Availity.

Services that do not require a referral or notification

Referrals are not needed for the following services:

- Services from network physicians in the same TIN as the member's PCP or their covering network physicians
- Services from network obstetrician/gynecology (OB/GYN) specialists, including nurse

practitioners, nurse midwives and physician assistants

- Routine refractive eye exam from a network provider
- Network optometrists
- Mental health/substance use services with network behavioral health clinicians
- Services rendered in any emergency room, network urgent care center, network convenience care clinic or designated network online “virtual visits”
- Services billed as observation
- Admitting physician services for emergency/ unscheduled admissions
- Services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons
- Services from a network pathologist, network radiologist or network anesthesia physician
- Outpatient network lab, network x-ray, or network diagnostic services
- Other services for which applicable law does not allow us to impose a referral requirement

Utilization Management

Utilization management (UM) programs focus on optimizing our members’ health and well-being. They are a collaborative effort between providers and Truli to make sure we coordinate our members’ medically necessary services efficiently and timely. This helps our members to access health care services they need when they need them and assures providers are delivering medically appropriate care.

For a complete list of services that require prior authorization, access the Truli Provider Portal.

You should use the Truli Provider Portal to:

- Obtain a complete list of services that require prior authorization.
- Request prior authorization.
- Check the status of an authorization.

UM program activities

Registered nurses and clinicians perform retrospective, concurrent or prospective UM activities under medical director supervision.

Medical prior authorization (prospective review)

Truli requires prior authorization for certain covered services before you render them. If we require prior authorization for a service and you do not obtain it before you render the service, we may reduce or deny coverage. Truli maintains an Authorization Requirement List for your reference. We review and update this list periodically.

The patient and their treating provider make decisions about the patient’s health care and treatment. Truli’s decisions about requested treatment or services simply reflect our determination of coverage.

Service categories that require prior authorization

Truli requires prior authorization for the following service categories:

Service	How to Obtain Authorization
Behavioral Health Services Inpatient Admissions, Partial hospitalization, IOP and Substance Abuse Rehabilitation	Contact New Directions Behavioral Health – 855-888-5001
Cardiology Services (Non-Emergent)	Submit authorization requests to AIM Specialty Health: • Single sign on through Availity® • Direct link www.aimprovider.com/cardiology • Call 844-423-0879
Chemotherapy Physician Administered Drugs	Refer to Physician Administered Drug section of this guide • If the drug is in the **PADP list**, call Magellan Rx Management at 800-424-4947 • If drug is not in the **PADP list**, call Truli for Health at 800-955-5692
Chiropractic	Chiropractic providers participating in the American Specialty Health (ASH) network should call 800-972- 4226.
Diagnostic Tests Outpatient Setting	Submit authorization requests electronically through Availity
Durable medical equipment	Submit authorization requests to CareCentrix: • Web Portal www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
ECG, EEG, EKG, EMG, Electrophysiology	Submit authorization requests to AIM Specialty Health: • Single sign on through Availity • Direct link www.aimprovider.com/cardiology • Call 844-423-0879
End-Stage Renal Disease (ESRD) Dialysis Services Services for treating end-stage renal disease, including outpatient dialysis services	Submit authorization requests electronically through Availity
Home Health / Home Infusion	Submit authorization requests to CareCentrix: • Web Portal www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Hospice	Submit authorization requests electronically through Availity

Service	How to Obtain Authorization
Hyperbaric Chamber Treatment Hyperbaric oxygen treatment (99183, A4575, C1300) requires authorization.	Submit authorization requests electronically through Availity
Injectable Medications A drug capable of being injected intravenously through an intravenous infusion, subcutaneously or intra-muscularly	Refer to Physician Administered Drug section of this guide • If the drug is in the **PADP list**, call Magellan Rx Management at 800-424-4947 • If drug is not in the **PADP list**, call Truli for Health at 800-955-5692
Insulin Pumps and Supplies	Submit authorization requests to CareCentrix: • Web Portal www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Intensity Modulated Radiation Therapy (IMRT)	Submit authorization requests to AIM Specialty Health: • Single sign on through Availity • Direct link http://www.aimproviders.com/radoncology • Call 844-423-0879
Inpatient - Acute and Long-Term Acute Care (LTAC) Newborn admissions require separate authorization from the mother if the baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Truli.	Submit authorization requests electronically through Availity
Licensed Nurse Midwife	Submit authorization requests electronically through Availity
Oral Maxillofacial	Submit authorization requests electronically through Availity
Orthotic / Prosthetic	Submit authorization requests to CareCentrix: • Web Portal www.carecentrixportal.com/ProviderPortal • Call 877-725-6525
Outpatient Hospital Services (Includes 23-hour observations)	Submit authorization requests electronically through Availity All outpatient psychiatric and substance abuse admissions should be coordinated through New Directions Behavioral Health – 855-888-5001
Pain Management	Submit authorization requests electronically through Availity
Pharmacy Provider Administered Drugs	Refer to Physician Administered Drug section of this guide • If the drug is in the **PADP list**, call Magellan Rx

Service	How to Obtain Authorization
	Management at 800-424-4947 • If drug is not in the **PADP list**, call Truli for Health at 800-955-5692
Radiation and Oncology	Submit authorization requests to AIM Specialty Health: • Single sign on through Availity • Direct link http://www.aimproviders.com/radoncology • Call 844-423-0879
Skilled Nursing Facility	Submit authorization requests electronically through Availity
Sleep Studies Laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders	Submit authorization requests to CareCentrix: • Web Portal www.carecentrixportal.com/ProviderPortal • Call 855-243-3326
Surgical Procedures Outpatient Facility	Submit authorization requests electronically through Availity
Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation	Submit authorization requests electronically through Availity

For additional information or Current Procedural Terminology (CPT) Code level details, please see the Prior Authorization List document.

How to submit prior authorization requests

To start the prior authorization process, providers should follow these steps:

1. Review the Prior Authorization List to determine if we require a prior authorization for the requested service.
2. Once authenticated in Availity, select the **Authorization** section
3. Select Truli for Health as the Payer
4. Complete the **Request Information** section
5. Complete the **Provider Performing Service** section
6. Complete the **Facility** section
7. Submit the form

Updating prior authorization requests

To check the status or update an authorization request, use the authorization section on Availity.

Authorization review timeline

Within 15 business days from the date we receive your request, we will review the clinical information you submitted and decide on the outcome. We will process any authorization review requests you make after hours, on weekends or on holidays the following business day.

Concurrent inpatient review

Truli conducts concurrent inpatient reviews to ensure services a member receives:

- Are medically necessary
- Meet Truli evidence-based criteria
- Are provided in the appropriate care setting

This review also uncovers any continuity of care gaps before discharge.

Truli performs focused retrospective reviews when certain factors suggest a review is warranted.

How we communicate UM decisions

Truli sends all UM decisions (approvals and denials) to the requesting provider in writing. When we deny a service, you will receive the decision in writing, including the clinical reasons for the decision and the supporting evidence-based criteria, including medical guidelines we used to determine medical necessity.

Financial incentives are not a factor in coverage decisions

Truli for Health has a financial incentives policy in place that is designed to assist practitioners, providers, employees and supervisors involved in (or who supervise those involved in) making coverage and benefit utilization management or utilization review (UM/UR) decisions, where relevant. The policy states:

- UM/UR decision-making is based only on the factors set forth in Truli for Health's definition of medical necessity (for coverage and payment purposes) in accordance with Truli for Health's medical policy guidelines, then in effect, and the existence of coverage and benefits under a particular contract/ policy/certificate of coverage. Truli for Health is solely responsible for determining whether expenses incurred, or to be incurred, or medical care are, or would be, covered or paid under a contract or policy. In fulfilling this responsibility, Truli for Health shall not be deemed to participate in or override the medical decisions of any Truli for Health member's practitioner or provider.
- Truli for Health payment policies are not designed to reward practitioners or other individuals conducting UM/UR for issuing denials of coverage or benefits.
- Financial incentives for UM/UR decision makers are not designed to encourage decisions that result in underutilization. Rather, the intent is to minimize coverage and payment for unnecessary or inappropriate health care services, reduce waste in the application of medical resources, and to minimize inefficiencies that may lead to the artificial inflation of health care costs.

Submitting Claims

Providers should submit electronic claims to us through Availity. You can:

- File claims to us through Availity at availity.com and submit them in real time. Within minutes, Availity confirms they received the claim and forwarded it for processing.
- Create claims in a billing system and send them using Availity's Electronic Data Interchange (EDI) batch submission. Within minutes, Availity replies with information about accepted or rejected claims. You must correct and resubmit any rejected claims.
- Work with a billing service or clearinghouse to send claims to us through Availity.

You will also manage claim corrections and edits through Availity.

For detailed information on the claim submission process, review the Claims and Reimbursement document.

Pharmacy

Drug Lists

Truli offers three different drug list options to our members. The member's digital card will show which drug list applies to the member's coverage.

- Truli Rx Choice
- Truli Rx Flex
- Truli Rx Basic

Home Delivery

Our convenient mail order pharmacy service through AllianceRx Walgreens Prime® can help members save time and money, increase adherence, and promote better health outcomes. Members can get up to a 90-day supply of their medication shipped to their preferred location when ordering through Home Delivery.

Specialty Drugs

Specialty drugs are injectable, oral, inhaled or infused therapies used to treat complex medical conditions. Local pharmacies and provider offices may not carry or stock these drugs because they:

1. Require more complex handling than traditional drugs
2. Are high-cost
3. May need frequent dosage adjustments

Specialty pharmacy network

Members must fill their specialty drugs at one of the following specialty pharmacies:

CVS/Caremark Specialty Pharmacy Services
All Products
Phone: 866-278-5108
Fax: 800-323-2445

CVS/Caremark Hemophilia Services
Hemophilia Products
Phone: 866-792-2731
Fax: 866-811-7450

Only the pharmacies listed above are in-network for specialty drugs. A pharmacy can be in-network for retail or home delivery drugs and still not be in-network for specialty drugs.

Ordering provider-administered specialty drugs

Provider offices that administer covered provider-administered specialty drugs in their office can obtain them two ways:

Options	Option Descriptions
Order the injectable drug from our Specialty Pharmacy Network	Specialty suppliers provide specialty medications for in-office administration using one of two service options: • **Just-in-time service** – Order drugs one to two weeks before the service date to allow for eligibility and coverage review and shipping time. • **Stock replacement service** – Order drugs within 30 days of the service date the provider administered the drug in-office. The specialty supplier will contact the provider's office to confirm medication delivery. **Billing** The specialty pharmacy will bill Truli directly for the drug. The provider should: • Bill applicable office visit procedure codes, including drug administration codes, as is customary, and follow standard billing practices for the service. • Collect the office visit cost share (copayment and deductible, as applicable) according to a member's benefit agreement.
Provide the drug from your own supply	The provider should • File a drug reimbursement claim ("buy and bill") directly to Truli. • Bill applicable office visit procedure codes, including drug administration codes, as customary, and follow standard billing practices for the service. • Collect the office visit cost share (copayment and deductible, as applicable) according to a member's benefit agreement.

Retail Pharmacy Authorization Guidelines

Truli requires certain prescription and injectable drugs to meet specific clinical criteria before our pharmacy programs cover them.

Retail pharmacy drugs that are subject to prior authorization review can be found in the Prior Authorization Program Information guide. To request authorization for a retail drug, providers should complete and submit an electronic Prior Authorization (ePA) request through CoverMyMeds®.

Medical and Specialty Pharmacy Authorization Guidelines

Truli requires prior authorization for a wide range of drug services when being processed through the medical benefit through various utilization management programs. Prior authorization requests for medical and specialty pharmacy drugs are handled by different entities depending upon the circumstance.

Check the Medical Pharmacy Drugs Requiring PA list for help determining where an authorization request should be submitted and a current listing of drugs requiring prior authorization when processed through the member's medical benefit.

Provider Administered Drug Program (PADP)

Magellan Rx Management® helps manage our PADP. This program uses clinically accepted standards to maximize patient care in the most appropriate and affordable manner.

A member's benefits determine which drugs we cover. Drugs we do not cover through PADP may still require prior authorization. Providers can obtain authorizations through Availity.

PADP exclusions

PADP guidelines do not apply in the following scenarios:

- Drugs a patient receives in an emergency room
- Drugs a patient receives in an observation unit
- Drugs a patient receives during an inpatient stay
- Drugs a provider or patient orders through Truli's Specialty Pharmacy Program, such as "Just-in-Time" or "Drug Replacement"

How to submit prior authorization requests for PADP

Review the **PADP list** to determine if Magellan Rx Management manages the drug.

- If the drug is in the PADP list, call Magellan Rx Management at 800-424-4947
- If drug is not in the PADP list, call Truli for Health at 800-955-5692

Independent Clinical Laboratory

Providers should refer laboratory services to Quest Diagnostics℠ and Dermpath Diagnostics®. The preferred lab for anatomical pathology services in Florida is AmeriPath®.

Only the laboratory services listed below are eligible for payment when a participating Truli physician performs them in the office. Truli will deny payment for any other laboratory services a physician performs in the office, and the physician must not bill the member for these services. Draw fees are only eligible for payment when providers send lab services to Quest Diagnostics and Dermpath Diagnostics or another participating laboratory.

Codes	Descriptors
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel
80051	Electrolyte panel (CO2, Cl, K, Na)
81000	Urinalysis, by dip stick or tablet reagent, non-automated with microscopy
81001	Urinalysis, by dip stick or tablet reagent, automated with microscopy
81002	Urinalysis, by dip stick or tablet reagent, non-automated without microscopy
81003	Urinalysis, by dip stick or tablet reagent, automated without microscopy
81005	Urinalysis, qualitative or semi quantitative, except immunoassays Add 24 hours for urine collection
81015	Urinalysis; microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82270	Consecutive collected specimens with single determination, for colorectal neoplasm screening
82272	1 to 3 simultaneous determinations, performed for other than colorectal neoplasm screening
82565	Creatinine; blood
82803 General,	Gases, blood, any
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
83036	Hemoglobin; glycosylated (A1C)
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity

Codes	Descriptors
84703	Gonadotropin, chorionic (HCG); qualitative
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (HCT)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85610	Prothrombin time partial thorboplastin time (PT), international normalized ratio (INR)
86308	Heterophile antibodies; screening
86580	Skin test, tuberculosis, intradermal
87210	Wet mount for infection agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87400	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method, Influenza A or B, each
87420	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; respiratory syncytial virus
87425	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; rotavirus
87430	Infectious agent antigen detection by enzyme immunoassay technique, Streptococcus, group A
87804	Infectious agent detection by immunoassay with direct optical observation; influenza
87807	RSV assay w/ optic
87809	Infectious agent detection by immunoassay with direct optical observation; adenovirus
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
88172	Cytopathology. Evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s).

Codes	Descriptors
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis.
89051	Cell count, miscellaneous body fluids, except blood; with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, or body fluid (except urine)
89190	Nasal smear for eosinophils
89300	Semen analysis; presence and/or motility of sperm including Huhner test

Internal Dispute Resolution

Provider Appeal Process

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals. Truli will conduct a one-time appeal review. There are no second level appeal rights for a post-service provider appeal.

Truli has a defined provider appeal process for providers who are dissatisfied with how a claim processed, paid or denied.

Provider appeal categories:

- Clinical appeals
- Non-clinical appeals (coding appeals)
- Administrative appeals, appeal appropriateness

Providers may send an appeal if there is financial liability for the provider or the provider is sending the appeal on behalf of a member (patient). If the provider is sending a post-service appeal on behalf of a member, the Truli Appointment of Representation (AOR) form must be completed and accompany the appeal. The appeal will then process as a member appeal.

Exception process

The provider may submit the appeal request without an AOR form when the following conditions are met:

1. The provider is unable to reach the member to complete the AOR form.
2. A member refuses to submit payment to a provider for services rendered and a claim has been denied.
3. If one or both these conditions are met, the provider can submit the appeal and must:
    a. Describe the contact attempts to the member with dates.
    b. Describe interaction with the member with dates about payments as indicated in number 2.

Please note:

1. Clinical appeals/non-clinical appeals: Providers must not appeal again for decisions Truli has already processed as an appeal. Providers are required to submit ALL documentation at the time of the appeal submission.
2. Administrative appeals: For reconsiderations of administrative appeals please follow the process noted in the Administrative Appeals process below.
3. Claim reprocessing is not an appeal.
4. A physician or physician group must submit all documentation needed within reason to decide an internal appeal to Truli for Health's Provider Appeal and Dispute Department.

Participating providers must submit appeals within one year of the date that appears on the respective remittance advice. Truli for Health will not overturn claim denials based on a provider's failure to comply with required procedures and time frames.

Providers may not balance bill members for covered services, including disputed amounts.

If an appeal is approved or denied, a letter will be sent informing you of the decision. If approved, the

claim will be forwarded for adjustment and/or payment.

Pre- and Post-service Appeals

Providers can request appeals for both pre-service and post-service adverse determinations by following the same rules as the general appeals process.

Clinical Appeals:

Clinical appeals encompass claims that require clinical review. Clinical appeal options (as referenced on the Provider Clinical Appeal Form) are:

- Utilization management appeals
- Adverse determination appeals (medical necessity or experimental / investigational appeal) non-clinical appeals

Providers have a right to appeal adverse determinations (denials) by submitting a request for reconsideration. Denials may be issued for several reasons that most commonly include:

Adverse determination appeals

A provider may file a written request for reconsideration when we have denied payment because a proposed or actual health care service or supply was:

- Not medically necessary.
- Experimental or investigational.
- Supportive of an experimental or investigational service.
- Supportive of a not medically necessary procedure (adverse determination appeal).

To request an adverse determination appeal for pre-service or post-service claims, the appeal must be in writing and a claim status request or telephone inquiry questioning how we applied benefits or allowed amounts.

Utilization management appeals

A utilization management (UM) appeal is a written request to review a claim that required an authorization, pre-service review or precertification.

UM appeals are not:

- Provider pre-service determination appeals (unless ERISA requires).
- Claims status requests, telephone inquiries or post-service claim reviews of how we applied benefits or allowed amounts.

Providers must file UM appeals within the lesser of the time frame contained in the provider's agreement or one year (365 days) from payment date. Truli will not overturn claim denials if the provider does not follow required procedures and timeframes.

How to request clinical appeals

Providers can request a clinical appeal two ways: electronically through Availity's automated appeals system or by mailing it to us.

Electronic submission (preferred method)

When a provider submits an appeal electronically, Availity includes all forms the provider must

complete.

1. Go to **Truli for Health Payer Space** on Availity.
2. Complete all required forms.
3. Upload any supporting documentation, as necessary.
4. Submit the appeal to us through Availity.

Written appeal (alternate method)

If a provider must send an appeal by mail, include the following:

- A completed Provider Appeals form.
  Note: Download and print the form from the Truli for Health Payer space on Availity.
- A copy of the EOP with the claim in question.
- A written explanation of the reconsideration.
- All supporting documentation.
- A completed <Truli for Health Appointment of Representation (AOR) form> if the provider is sending a post-service appeal on behalf of our member. We will process the appeal as a member appeal.

Send the appeal packet to the following address:

Truli for Health
Attn: Provider Disputes Department
P.O. Box 45014
Jacksonville, FL 32232

Questions? We are here to help.

Truli for Health Website

Our contracts generally require you to conduct business with us electronically. Using electronic transactions is fast and efficient and supports a paperless work environment. Our Truli website, truliforhealth.com, links you to self-service tools, medical policies, news bulletins and great resources to support administrative tasks including eligibility, claims, claims status and prior authorizations and notifications.

How we communicate updates

This manual is not a complete compilation of provider polices or procedures. We will share vital information and updates about policies and programs we do not include in this manual on our website or in special publications, such as letters, bulletins, or newsletters. If we change a website's location, a benefit plan name, our branding or the customer identification card identifier, we will also share that information with you.

Contact us

You can find a helpful list of current phone numbers, email addresses, operating hours, and more at *truliforhealth.com* > Contact Us.

Email Network Contract Support:	networkcontracting@guidewell.com
Call the Provider Contact Center:	833-238-8144
Hours of Operation:	Monday – Friday, 8 a.m. to 6 p.m. IVR Self-service Options 24/7/365

Member Rights

We encourage all our members to take part in their health and their family's health. Members have the right to:

- Be treated with respect, dignity and privacy.
- Expect Truli and its participating providers to keep medical information confidential according to the terms of their member's benefit booklet.
- Receive evidence-based medically necessary care.
- Have timely access to care and services.
- Expect timely information about Truli, its services and practitioners providing care.
- Participate actively in decision-making about their health care.
- Have a candid discussion regarding appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or grievances about their coverage or the care providers give according to the terms of their Health Care Agreement.
- Get medically necessary care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.

Provider Rights

Providers have the right to:

- Have your patients and other health care workers treat you with dignity and respect.
- Receive correct and complete information and medical histories for member care.
- Have your patients act in a way that supports the care you give to other patients and that helps keep the doctor's office, hospital or other offices running smoothly.
- Expect members to follow your directions, such as taking the right amount of medication at the right times.
- Help members make decisions about their treatment, including the right to recommend new or experimental treatments.