Northwood Participating Provider Manual

For

Health New England

November 1, 2020

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TABLE OF CONTENTS

KEY CONTACTS DIRECTORY

Chief Operating Officer
Lisa Wojno
lisaw@northwoodinc.com

Claim Manager
Tracey Amormino
traceya@northwoodinc.com

Director of Health Benefit Operations
Kara Jones, BSW
karaj@northwoodinc.com

Provider Affairs Manager
Debbie Skattebo
debbie.skattebo@northwoodinc.com

Nurse Manager - Utilization Management
Carol Dimech, LPN
carol.dimech@northwoodinc.com

Information Technology Director
Brian M. O'Neil, CPA
bmoneil@northwoodinc.com

Manager, Health Benefit Operations
Dana MacAuley
danam@northwoodinc.com

Asst. Mgr., Health Benefit Operations
Tracy Kryszkiewicz
tracyk@northwoodinc.com

President
Kenneth G. Fasse
kgf@northwoodinc.com

Quality Assurance
qualityassurancegroup@northwoodinc.com

OFFICE HOURS
FOR PROVIDER INQUIRIES:
Monday-Friday
8:30 a.m. – 5:00 p.m. (EST)

CLAIMS/INQUIRIES:
Northwood, Inc.
ATTN: HNE Claims
P.O. Box 510
Warren, MI 48090-0510

Provider Portal

https://providerportal.northwoodinc.com

Provider Inquiry Line:	**(877) 807-3701**
Provider Inquiry Fax:	**(877) 552-6551**
Member Inquiry Line:	**(877) 807-3701**
Business Line:	**(586) 755-3830**
Business Fax:	**(586) 755-3733**
Website:	**www.northwoodinc.com**

INTRODUCTION

Northwood, Inc. (Northwood) is the exclusive contracted administrator of Durable Medical Equipment (DME), Prosthetic and Orthotic (P&O) devices and Medical Supplies (DMEPOS) for Health New England.

The information contained in this provider manual will assist you when providing DMEPOS services to Health New England members.

Northwood's Participating Supplier Agreement and Health New England Addendum (Vendor Subcontractor Affiliation Acknowledgment Agreement) to the Participating Supplier Agreement require network providers to adhere to Northwood's Policies and Procedures. Policies and procedures include, but are not limited to:

- Northwood's Health New England Fee Schedule
- Assignment for All Services Provided By Your Company
- Authorization
- Member Billing
- Claims Processing
- Quality of Service/Member Satisfaction
- Provider Allows Northwood/Health New England to Use Provider's Performance Data
- 24-Hour Emergency Service

SECTION I - BENEFIT/COVERAGE CRITERIA

Northwood administers Health New England's DMEPOS Program for all plan members in accordance with Health New England's benefits and applicable medical policy guidelines. Additional details outlined below:

- Covered DMEPOS benefits for Health New England members must be obtained from and provided by a Northwood contracted provider.

- Providers may not subcontract services to other providers without the consent of Northwood.

- Equipment and supplies provided under the program are based upon the most medically appropriate and cost-effective, standard item(s). For example, this includes prefabricated items versus those that are custom made.

- Shipping, handling, and sales tax are not eligible for separate reimbursement, nor can they be billed to the member.

- All services must be prior-authorized (except in emergencies as further set forth described herein).

- Providers should contact Northwood for medical criteria questions.

PROVIDER RESPONSIBILITIES PRIOR TO RENDERING EQUIPMENT OR SUPPLIES

Prior to providing equipment or supplies, the provider is responsible for obtaining and verifying all necessary information, including the following:

- Verify member eligibility for each date of service.

- Review for appropriateness and cost effectiveness.

- Documentation to support the medical need for customized services.

- Confirming that equipment is to be provided in the member's home or qualifying place of residence. With a few exceptions, this program does not generally cover equipment provided in a hospital or skilled nursing facility.

- Other Coordination of Benefits (COB) information (auto liability, workers compensation, etc.)

DELIVERY TIMELINES

Northwood requires providers to:

- Provide covered equipment (excluding custom fitting or design services) on the same day services are requested, unless the request is received after 12:00 PM EST.

- Provide orders received after 12:00 PM within 24 hours.

- Have on-call servicing available 7 days a week and 24 hours a day for respiratory and other necessary services.

- Deliver covered emergency services to member's place of residence (or hospital pending discharge) within 2 hours of receipt.

- Provide emergency services requested outside of Northwood's regular operating hours and obtain authorization within the next two (2) business days. (See Section II Authorization).

ASSIGNMENT – NONDISCRIMINATION

Northwood providers are required to:

- Provide covered equipment and supplies to Health New England members in the same manner, quality and promptness as services that are provided to other customers, including after-hours and emergency servicing.

- Accept assignment on covered equipment or supplies routinely provided by the provider to Health New England members.

- Render equipment and supplies in a manner consistent with professionally recognized standards of health care.

EQUIPMENT AND SUPPLIES NOT NORMALLY CONSIDERED A COVERED BENEFIT, INCLUDING DELUXE PRODUCTS/UPGRADES

- Member health care benefits are determined by the structure of their benefit package.

- A requested service normally considered "not a covered benefit" must be forwarded to Northwood for case review.

- All requests for services and medical review must be processed through Northwood. Do not forward requests directly to Health New England or deny service to the member prior to case review.

- It is the responsibility of the provider to inform the member that there are standard products available that meet Health New England's policy.

- If applicable based on the member's benefits/cost-sharing, a member must be advised of his/her estimated payment responsibility and the provider must obtain the member's signed consent indicating he or she has been informed of his or her responsibility for any outstanding balance.

    - This must take place prior to ordering a product or before a product is delivered (refer to Northwood Waiver Form – Section XII).

There will be no payment to the provider by Northwood when the provider fails to follow the Case Review process detailed above. Additionally, members may not be charged for services when providers fail to follow the above process. Please see the "Hold Harmless" Section (5.5) of the Northwood Participating Supplier Agreement and Section (4) of the Health New England Addendum to the Northwood Participating Supplier Agreement for Health New England (Subcontractor Affiliation Acknowledgement Agreement).

OXYGEN EQUIPMENT

The following oxygen requirements apply for all Health New England members:

- The minimum manufacturer oxygen output concentration level at any flow rate must be 87%.

- The concentrator must have a built-in continuous flow analyzer feature with automatic sensor alarm.

- The concentrator must have, at a minimum, a five-year manufacturer warranty.

- Northwood expects a typical oxygen patient to use no more than five (5) portable fills per month. If a member requires more than five (5) fills in a given month, the provider should contact Northwood's Benefit Coordinator staff via Northwood's online authorization portal and request an individual consideration review for E0443.

- Health New England will cap oxygen payments at 36 months for Commercial and Medicare members.

CPAP/BIPAP EQUIPMENT AND SUPPLIES

The following Positive Airway Pressure (PAP) requirements apply for all Health New England members:

- eviCore manages the authorization requests for CPAP/BiPAP and related supplies for all Health New England members.

- Providers must request authorizations for CPAP/BiPAP and related supplies directly from eviCore at https://www.evicore.com/pages/providerlogin.aspx.

- The PAP device must include, as standard equipment, integrated heat and humidification. To further clarify, as a standard feature included under HCPCS E0601, the CPAP should incorporate in-built or all-in-one heat and humidification. Examples of such CPAPs are available upon request.

- The PAP device must have, at a minimum, a 2-year manufacturer warranty.

- Northwood recognizes there are numerous PAP masks and nasal applications available on the market. As of the date this manual has been published, the following are examples of standard/basic PAP masks and nasal applications:

    - Respironics Comfort Gel Mask, Respironics Comfort Classic Mask, Respironics Simplicity Nasal Mask, Respironics Comfort Full Mask, Resmed Mirage Activa Mask, Resmed Mirage Vista Mask, Resmed Mirage Swift LT Nasal Mask, Respironics Comfort Select Nasal Mask, Resmed Mirage Swift Nasal Mask, Invacare Twilight Nasal Mask and other similar models.

SECTION II – AUTHORIZATION

Northwood must review all equipment and supply requests to determine coverage. Northwood makes all approval and initial denial determinations. Coverage is based upon the member's benefit document.

Prior authorization is required for all Health New England member services with the exception of equipment or supplies requested and provided after regularly scheduled Northwood business hours due to urgent/emergent situations (see After-Hours Retrospective Authorizations).

- Urgent/emergent situations are defined as situations where a member's physical condition is such that imminent or serious consequences could result to the member's health or, if in the opinion of the physician, the member would be subjected to severe pain if a DMEPOS request is processed within the routine decision-making time frame.

AUTHORIZATIONS - GENERAL

Routine authorization requests must be submitted online:

- **Online (required method for all routine requests) –** Providers are required to submit requests online at https://providerportal.northwoodinc.com and will receive a confirmation that a request has been submitted and received. For further information, please follow instructions outlined on webpage (www.northwoodinc.com).

- **Phone (urgent/emergent only)** - Call Northwood on the dedicated Health New England provider line at (877) 807-3701 during normal business hours (8:30 a.m. to 5:00 p.m. EST, Monday through Friday), or within the next two (2) regularly scheduled business days if emergent/urgent services are provided.

- **Fax** (upon request from Northwood staff only) - Submit a completed Prior Authorization Fax Form to Northwood at (877) 552-6551. If sent after-hours or on weekends, Northwood will respond on the next regularly scheduled business day.

The following information is required when requesting an authorization:

- Provider ID Number
- Member Name/Address/Telephone
- Provider Contact/Telephone
- Referral Source/Telephone
- Member ID Number
- Other Insurance Information (if any)

- Diagnosis - ICD-10-CM Code and Description
- Date of Service
- Referring Physician
- Primary Care Physician
- Level II HCPCS Code
- Description of Product/Service
- Service Type (Purchase or Rental)
- Quantity
- Duration of Need

Authorizations for services will be provided:

- For equipment and supplies deemed to be covered benefits under the Health New England program

- When use of the equipment or supply does not exceed the quantity limitation and medical necessity guidelines (monthly, yearly, replacement period, etc.)

- For medically supported over-quantity requests approved through case review

- For the most appropriate, cost-effective, standard and basic equipment or supply

Reimbursement will be limited to the authorized equipment or supply based upon the allowable fee for the procedure code(s) approved.

Payment consideration for equipment and supplies includes:

- Member eligibility at the date of delivery

- Medical necessity clinical criteria are met and documented on the physician's written order

- Most cost-effective standard and basic equipment or supply

- Benefit coverage

AUTHORIZATION TIMEFRAMES

Rental DME equipment is authorized based upon medical necessity and the appropriate duration of need for the diagnosis provided at the time of rental.

- Authorizations may be extended for up to 13 months, at which time the equipment rental may reach purchase.

- A limited number of items will reach purchase in less than 13 rental months.

- Requests for quantities of supplies that exceed standard amounts are based on a review of medical documentation.

- Renewal authorizations for over-quantity amounts will require updated documentation.

- It is the provider's responsibility to verify member eligibility and cost-sharing (copayments, coinsurance and/or deductibles) information for the effective period of an authorization or for continuing services, on a monthly basis. You can do so by visiting Northwood's online authorization portal at **https://providerportal.northwoodinc.com.**

- Neither Northwood nor Health New England is responsible for payment of services provided to Members whose coverage has changed or terminated.

- A Northwood authorization is not a guarantee of payment for service(s) provided.

IF THE PROVIDER FAILS TO OBTAIN A REQUIRED AUTHORIZATION, THE MEMBER MAY NOT BE BILLED. SEE "HOLD HARMLESS" SECTION (5.5) OF THE NORTHWOOD PARTICIPATING SUPPLIER AGREEMENT AND SECTION (4) OF THE HEALTH NEW ENGLAND AGREEMENT TO THE NORTHWOOD PARTICIPATING SUPPLIER AGREEMENT FOR HEALTH NEW ENGLAND (SUBCONTRACTOR AFFILIATION ACKNOWLEDGEMENT AGREEMENT).

CHANGE TO INITIAL AUTHORIZATION

Claims will be denied if the services provided do not match the authorization.

- If a change to an equipment item or supply originally authorized becomes necessary, contact a Northwood Benefit Coordinator via the Northwood online authorization portal/update feature to request review for a revised authorization. The following information must be included when requesting a review:

    - Current authorization number
    - Patient name
    - Health New England ID Number
    - Documented reason for change of equipment or supply

- Providers are responsible for maintaining the original authorization. Northwood will not provide duplicate copies of authorization for billing purposes or after payment has been made.

AFTER HOURS - RETROSPECTIVE AUTHORIZATIONS

Authorizations are provided during regular business hours: 8:30 a.m. to 5:00 p.m., Monday through Friday.

If an urgent request for services occurs after-hours or on weekends/holidays the provider should request an authorization within two (2) business days. If the item is dispensed after-hours or on weekends/holidays through point-of-service providers (stock/bill, loan closets) identified by Northwood, the request should be submitted within ten (10) business days.

Urgent/emergent and non-routine retrospective authorization requests must be submitted on line to Northwood along with supporting documentation for case review.

Retrospective authorizations will only be provided for after-hours service due to urgent/emergent situations or non-routine circumstances. Urgent/emergent situations are defined as situations where a member's physical condition is such that imminent or serious consequences could result to the member's health or, if in the opinion of the physician, the member would be subjected to severe pain if a DMEPOS request is processed within the routine decision-making time frame. The provider shall proceed as listed below:

- Under these conditions, the member should be serviced.
- The provider must obtain authorization within the next two (2) business days.
- Members should be informed of their potential financial responsibility for cost-sharing (copayments, coinsurance and/or deductibles). The provider must maintain a signed agreement/member acknowledgement of the financial responsibility to include the cost-share amount. See attachment "Patient Advance Notice/Waiver of Liability of Non-covered Services or Higher Grade/Deluxe Equipment or Supplies."

Northwood may issue retrospective authorizations for urgent/emergent and non-routine circumstances. However, for routine requests retrospective authorizations will be denied for provider's failure to obtain authorization prior to delivery or completion of services.

SECTION III - MEMBER SERVICES

Covered DMEPOS benefits for Health New England members must be obtained through Northwood's contracted providers and prior authorized by Northwood.

Members and referral sources may contact Northwood during regular business hours for questions and inquiries regarding:

- Provider locations
- General benefits and/or coverage criteria
- Financial responsibility
- Appeal and grievance procedures

Members may contact Northwood's dedicated Health New England toll-free line at (877) 807-3701. Members (non-English speaking) requiring language services may contact a Northwood Benefit Coordinator who will coordinate translation services.

Providers should utilize Northwood's online authorization portal.

MEMBER BILLING

- Northwood providers are bound by contract to accept assignment for all covered equipment and supplies rendered to Health New England members.
- Members are only financially responsible, and may be billed, for applicable cost-sharing (co-payments, coinsurance and/or deductibles); retroactive eligibility terminations by Health New England due to regulator/regulatory requirements or contractual standards; and for non-covered services in accordance with Northwood's Participating Supplier Agreement ("PSA") and Health New England Addendum/Subcontractor Affiliation Acknowledgement Agreement to the PSA for Health New England.

MEMBER HOLD-HARMLESS PROVISION

According to Northwood's Participating Supplier Agreement ("PSA") and the Agreement to the PSA for Health New England (Subcontractor Affiliation Acknowledgement Agreement) providers agree to abide by Northwood Policies and Procedures and to look solely to Northwood for payment of authorized covered equipment and supplies rendered under the Health New England Program.

Members are financially responsible only for applicable cost-sharing (copayments, coinsurance and/or deductibles) for equipment and supplies that have been approved by Health New England and Northwood. Providers are prohibited from billing the member for any of the following:

- The difference between the provider's submitted charge and Northwood's fee
- Reduced fee differential amounts on down-coded or adjusted items based upon medical necessity or the least costly alternative

- When medical documentation provided conflicts with the information supplied during the authorization request
- Provider's failure to obtain required authorization (within the applicable timeframes) for covered equipment and supplies
- Claims submitted past Northwood's filing limitations
- Provider's failure to follow Northwood Policies and Procedures

SECTION IV - PRESCRIPTION REQUIREMENTS

It is the provider's responsibility to obtain a valid prescription for requested equipment and supplies (note: For Medicaid or Commercial members this requirement is not applicable to custom wheelchair repairs for those chairs that were initially approved by Northwood/HNE). Verbal orders are acceptable for initial set-up of equipment and supplies; however, a prescription must be obtained and provided to Northwood upon request. Providers must have a faxed, photocopied, original signed order or electronic prescription in their records before they can submit a claim for payment to Northwood. Providers must maintain valid prescriptions on file for equipment and supplies.

A valid prescription, paper or electronic, must include:

- Patient Name
- Prescription Date (the original date of service must be within 30 days of the RX date)
- Item Description
- Duration of Need
- Diagnosis
- Quantity
- Physician Signature (stamped signatures are not valid)
- Physician Printed Name
- Physician NPI

PRESCRIPTION DURATIONS

- Most prescriptions are valid for 12 months but may vary according to medical necessity.

SECTION V - CLAIMS

FILING PROCESS

- Northwood claims must be submitted electronically, primary or secondary, or on a CMS 1500 Claim Form.

- DMEPOS provider must have their National Provider Identifier (NPI) on all claims.

- ELECTRONIC claims must be completed according to HIPAA 837 transaction requirements detailed on Northwood's website **www.northwoodinc.com**.

- PAPER claims must be completed in entirety and include:

    - NORTHWOOD'S AUTHORIZATION NUMBER
    - Remittance advice for secondary claims – do not staple to claims
    - Manufacturer's name, description, and product number documented in Box 19 of the CMS claim form for not otherwise classified (NOC) items

As paper claims are scanned, please do not staple, fold or write on claims. Claims do not need to be sent with prescriptions or authorizations. When sending secondary paper claims, only the primary EOB/remittance advice is needed – but, please do not staple.

Claims submitted without the required information will be rejected and must be resubmitted within the filing limitation timeframe (see below).

CLAIMS FILING LIMITATIONS

- Claims for Health New England Commercial, Self-funded and Medicaid members must be submitted to Northwood within 180-days from the date of service, unless awaiting a payment and/or remittance advice from a primary payor via coordination of benefits. If the member has other health insurance that is primary, then timely filing limitation begins from the date of the Explanation of Payment (provider remittance) of the other carrier. This deadline applies to first-time claims, corrected claims, and adjustments to claims. If claims are received after the timely filing limit, claims will be denied.

- Claims for Health New England Medicare Advantage members follows Medicare claims submission guidelines. To be eligible for reimbursement, claims must be filed within one year (365 days) from the date of service (DOS). This deadline applies to claims, corrected claims, and adjustments to claims. If claims are received after the timely filing limits, claims will be denied.

- Approved gradient compression surgical stockings for Medicare Primary/ Health New England secondary members do not require submission to Medicare for denial; however, providers must obtain prior authorization and bill Northwood within the 180-day filing limitation.

- Filing limitations apply to all claims, including claims previously submitted and returned for missing or incomplete documentation. Northwood and the Plan are not responsible to provider for claims not submitted in a timely manner. In addition, provider may not bill, charge or seek remuneration from member for claims denied due to late submission.

- A claims status (claim denials or corrected claims) must be submitted to Northwood within the claim filing limitations noted above per business line.

- Electronic claims are preferred; however, submit paper claims to the following address:

NORTHWOOD, INC.
ATTN: HEALTH NEW ENGLAND CLAIMS
P.O. BOX 510
WARREN, MICHIGAN 48090-0510

CLAIMS PAYMENT CYCLE

- Northwood will process claims and remit payment for clean claims within 30 days of receipt.

- A clean claim consists of the following information:

    - Northwood Authorization Number
    - Provider Name/Address/NPI Number
    - Member Name/Address/Telephone
    - Health New England ID Number
    - Date of Birth
    - Other Insurance Information (if any)
    - Diagnosis (ICD-10-CM Code and Description)
    - Date of Service
    - Referring Physician Name
    - Referring Physician NPI and TIN
    - Level II HCPCS Code
    - Manufacturer name, description and product number for NOC items
    - Service Type (Purchase or Rental)

- Quantity
- Duration of Need
- Modifier
- Provider Charge
- Other Payment

- Claims payment shall be limited to Northwood's allowable fee less any member cost-sharing (copayments, coinsurance and/or deductibles) or primary payment amount.

- Northwood maintains the right to request proof of delivery or hard copy prescription upon request. Payment will be suspended pending requested documentation.

- Payment is contingent upon provider's compliance with all applicable documentation requirements.

OTHER PARTY LIABILITY CLAIMS

- Claims must first be submitted to the primary carrier. Secondary claims submitted to Northwood electronically must include primary payment information pursuant to Northwood electronic claims submission procedures (available at www.northwoodinc.com). If a secondary claim is submitted via paper, a hard copy of the provider remittance advice must be submitted with your hard copy claim to Northwood and include the primary payment information in the appropriate boxes or the claim will be mailed back requesting that information.

- **If providers receive information that indicates that the member is pursuing settlement from a liable party for accident and trauma claims the provider must notify Northwood immediately.**

- Northwood's payment for a service or supply as the secondary payer will be based on the difference between what the primary payer paid and what Northwood would have paid as the primary payer up to Northwood's allowed amount. If the primary payer's payment is less than Northwood's allowed amount, Northwood will pay the difference not to exceed its allowed amount.

- Northwood does not reimburse for the difference between the billed and primary insurance allowable.

PROVIDER REMITTANCE ADDRESS

- Northwood maintains an all-electronic payment system for contracted providers. Claim remittances will be emailed to the remittance contact on file (obtained during credentialing).

- Providers need to notify Northwood in writing on company letterhead of any address changes to primary billing address.

- Providers must supply Northwood with an updated W-9 form for address changes.

- Providers are responsible for maintaining the original Northwood payment vouchers and providing copies to branch locations. Northwood is not responsible for re-issuing duplicate vouchers. Providers may search for provider remittances via Northwood's Provider Portal at https://providerportal.northwoodinc.com.

COORDINATION OF BENEFITS (C.O.B.)

- Providers are required to obtain all insurance information from the member, including Worker's Compensation insurance.

- For Health New England Medicaid claims, Health New England Medicaid is the payer of last resort when any other type of insurance exists. For Commercial Plans, as applicable, Northwood follows Coordination of Benefits guidelines from the National Association of Insurance Commissioners (NAIC) and applicable law.

- A claim may be rejected if a provider does not complete the section of the claim form regarding other insurance coverage.

HIPAA EDI CLAIMS INQUIRY

Electronic claim submitters may submit a HIPAA 276 transaction, Health Care Claim Status Request, for claims inquiry.

- Requests will be accepted in batch and can be uploaded using the same secure connection as with electronic claims.

- Northwood will respond with a HIPAA 277 transaction, Health Care Claim Status Response, which can be retrieved using the same secure connection that is used for electronic claim acknowledgements.

- Submitters will be notified by email when a new transaction batch is ready for download.

HIPAA EDI CLAIMS PAYMENT/ADVICE

Electronic claim submitters will receive HIPAA 835 transactions, Health Care Claim Payment/Advice, using the same secure connection that is used for electronic claim acknowledgements.

- Electronic payment /advice transactions will only apply to electronic claims.
- A payment/advice batch of transactions will be available on the day that Northwood prepares cash disbursements.
- Submitters will be notified by email when a new transaction batch is ready for download.

For the latest details related to HIPAA EDI transactions, please see the Northwood Provider EDI Manual, which is available in the Provider section of the Northwood website at https://www.northwoodinc.com.

CLAIMS INQUIRY

A provider may make a claim inquiry under the following circumstances:

1. PAYMENT OTHER THAN ANTICIPATED

- If payment received is other than anticipated and not in accordance with the Northwood fee schedule, please submit a completed Claims Status Form in Section XII within 90 days from the date of service or primary payer's provider remittance advice; not to exceed 180 days and include the following;
  - Copy of the original claim
  - Supporting documentation
  - Northwood's remittance voucher

2. NO RESPONSE TO CLAIMS SUBMISSION

- If you have not received a response to your original claim submission in accordance with Northwood's claim payment turnaround time, please verify that the claim was submitted by going to Northwood's provider portal at **https://providerportal.northwoodinc.com**. If you do not see the claim on Northwood's portal, please resubmit.
- If you have not received a response within 45 days of submission, please make sure all information is correct and resubmit your claim.

Post payments and resolve rejections prior to resubmitting claims to Northwood.

CLAIM PAYMENT RECOVERY

From time to time, Northwood may be required to request a refund from the provider for reasons such as: retroactive terminations, coordination of benefits (COB), eligibility

changes, etc. Northwood will retract payments in those scenarios as provider level adjustments and providers will see the reason on their remittance advice.

ELECTRONIC FUNDS TRANSFER

Northwood maintains an all-electronic payment system. All disbursement will be made via Electronic Funds Transfer (EFT). To set-up electronic funds transfer (EFT), please visit the Northwood, Inc., website at www.northwoodinc.com.

SECTION VI - QUALITY

IT IS THE RESPONSIBILITY OF CONTRACTED PROVIDERS TO ENSURE THAT THEIR EMPLOYEES UNDERSTAND NORTHWOOD POLICIES AND PROCEDURES, INCLUDING SERVICING AND QUALITY ISSUES AS THEY MAY PERTAIN TO THE HEALTH NEW ENGLAND PROGRAM.

Quality issues include but are not limited to:

- Substandard care
- Deviations from standards and guidelines from generally accepted industry practices as they pertain to the provision of equipment and supplies in accordance with health plan provisions
- Member discrimination related to plan coverage
- Inappropriate behavior of staff, as perceived by the member, provider, Northwood or Health New England

PROVIDER COMPLAINT, APPEAL AND QUALITY IMPROVEMENT PROCESS

Northwood strives to provide quality service in a professional and timely manner. In the event a provider believes that Northwood has not satisfactorily resolved a problem or concern, providers may utilize Northwood's Complaint and Grievance Process.

- Providers may contact Northwood in writing regarding quality issues/concerns such as those outlined in the Quality Section of this Provider Manual.
- Northwood encourages providers to participate in the continuous quality improvement process by submitting quality concerns in writing.
- Periodically, Northwood will perform Provider Satisfaction Surveys to determine provider satisfaction with Northwood administrative services and to identify opportunities for improvement.
- A Provider may submit a provider appeal to Northwood, in writing, to request reconsideration of a previous decision
- Timeframes for the 1st level appeal:

  Provider's must submit an appeal within 30 days from date of denial. Northwood will provide an appeal decision within: 30 days from date of receipt of the appeal. The provider will receive a letter from Northwood, if the appeal is denied. The letter will be mailed within 24 hours from date of decision and will not to exceed 30 days from date of receipt of the appeal.

- Written appeals should be submitted in letter format including any additional information or details deemed necessary. Appeals should be directed to:

Northwood, Inc.
P.O. Box 510
Warren, Michigan 48090-0510
Attn: Provider Appeals

- Provider appeals filed beyond the above-described timeframes will be denied and both Northwood and Health New England will be held harmless. For more information on submitting a provider appeal, please contact Northwood at 1-877-807-3701. Appeal decisions are usually rendered within 30 calendar days of receipt of an appeal.

- If an initial provider appeal (Level I) as outlined above results in a denial, a provider may file a second (Level II) provider appeal.

- Timeframes for the 2nd level appeal:

  Provider's must submit an appeal within 15 days from the date of upheld denial. Northwood will provide an appeal decision within 15 days from date of receipt of appeal. If the denial is upheld, Northwood will mail a letter within: 24 hours from date of decision; and will not to exceed 15 days from date of receipt of the appeal.

- Providers shall follow the procedure described above and clearly indicate that their submission is a second (Level II) provider appeal. Second (Level II) provider appeal decisions are considered final.

Note: See Section VII for information regarding member appeals. Appeals filed by a member or by a member's Authorized Representative should be directed to Health New England.

Northwood monitors the quality and performance of its network providers through its Member Satisfaction Surveys and complaint processes.

- Northwood routinely performs Member Satisfaction Surveys**.**

MEMBER COMPLAINTS

- Member complaints may be received through the survey process, provider, referral source, health plan, member or patient advocate.

- To register a complaint or concern, members should be directed to contact:

    - Health New England Member Service department at:
        - Commercial members: (800) 310-2835 (TTY: 711)
        - Medicare members: (877) 443-3314 (TTY: 711)
        - Medicaid members: (800) 786-9999 (TTY: 711)

- Members are encouraged to discuss their concerns with their Northwood provider who often can correct the situation to the member's satisfaction.

- Providers are required to notify Northwood of all member complaints to ensure activation of the Member Complaint and Grievance Process.

- **See Section VII, below, for Health New England's Member Grievance and Appeal Rights information.**

SECTION VII – *Health New England* GRIEVANCE and APPEAL RIGHTS

MEMBER APPEALS, INQUIRIES AND GRIEVANCES
(*Below is Health New England's statement given to Members*)

Important Information about Your Appeal Rights

What if I don't understand this denial? If you have any questions, please call Health New England Member Services at the number listed on the notice of denial. You also may request a copy of the specific plan requirements relating to this denial.

What if I don't agree with this denial? You have a right to appeal. You may appeal any decision not to approve or pay for an item or service (in whole or in part). You also may appeal a rescission. A rescission is a retroactive cancellation of coverage. Rescission does not include termination for non-payment of premiums.

How do I file an appeal? Based on your plan type, you only have the following number of days from the date of this notice to file an appeal:

Plan Type	Filing Limit
Fully & Self-funded	180 calendar days
Medicaid	60 calendar days

You may submit your appeal by telephone or in writing. The phone number to call is included on the Notice of Denial.
Fax: (413) 233-2685
Mail or in person:

Health New England
Attention: Complaints and Appeals
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

Who may file an appeal? You may file an appeal. You also may appoint someone to file an appeal for you. We call this person your authorized representative. To appoint someone to act for you, contact Health New England Member Services at the number listed on the notice of denial. You also may visit healthnewengland.org/forms to download the Authorization of Personal Representative Form.

What if my situation is urgent or if I am in the hospital? Health New England will conduct an expedited review. Generally, an urgent situation is one in which:

- Your health may be in serious jeopardy, or
- Your physician believes you may experience pain that cannot be controlled while you wait for a decision on your appeal.

If you believe your situation is urgent, you may request that your appeal be expedited when you submit your request.

What information should I submit with my appeal?

- Your name
- Your member ID number
- Your daytime phone number
- A description of your appeal
- The outcome you are requesting
- Any documents that are relevant to your appeal, such as medical records or billing statements

What happens next? If you appeal, we will review our decision. We will provide you with a written decision. If we uphold our denial or do not make a timely decision, you may be able to request an external review of your claim by an independent third party.

How long will it take to review my appeal?

Type of Appeal	*Review Time*
Pre-service	within 30 calendar days
Post-service (Fully-funded)	30 calendar days
Post-service (Self-funded)	60 calendar days
Post-service (Medicaid)	30 calendar day
Expedited	within 24 to 72 hours

Other resources to help you: For questions about your appeal rights, this notice or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA, extension 3272, or Health Care for All at (800) 272-4232.

If you have employer-sponsored coverage, you may also have the right to bring a civil action under Section 502(a) of ERISA. Normally, you must exhaust Health New England internal review procedures before you can initiate a civil action under Section 502(a) of ERISA.

Fully funded members can ask for an external appeal by filing a written request with the Health Policy Commission, Office of Patient Protection (OPP). The OPP's toll-free phone number is (800) 436-7757.

Can I request copies of information related to my claim? Yes, you may request copies (free of charge) by submitting your request in writing to:

Health New England
Attention: Legal Department
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

SECTION VIII - CONFIDENTIALITY

CONFIDENTIALITY OF MEDICAL RECORDS

In accordance with applicable state and federal laws and regulations:

- Health New England, Northwood and Northwood contracted providers shall not disclose medical records or information except to an authorized representative of Health New England, Northwood or to a properly identified and authorized government agent and as otherwise specifically provided in the Northwood Participating Supplier Agreement and the Health New England Addenda to the Participating Supplier Agreement for Health New England (Subcontractor Affiliation Acknowledgement Agreement).

- Both Northwood and Northwood contracted providers are required to maintain accurate and timely medical records for members describing covered equipment and services and related financial records. These records must be kept for at least six (6) years (children's records must be retained up to age of majority) from the last date of provision of covered equipment, or longer if required by law, regulation or applicable contract. Such records must be kept in a manner that safeguards the privacy of any information that may identify a particular member.

- Northwood and Health New England have the right to inspect and obtain, at no additional charge, copies of all medical records of members.

In addition to the above, Northwood providers shall:

- Have a central file location where records are stored in an adequate filing space and patient records are available and retrievable

- Ensure patient records are stored and accessed according to the Health Insurance Portability and Accountability Act (HIPAA)

- Store patient records securely in a separate area or room that is accessible only to authorized personnel. If feasible, records area should be locked.

CONFIDENTIALITY OF BUSINESS INFORMATION

In accordance with Northwood's Participating Supplier Agreement ("PSA") and Health New England's Addenda to the PSA (Subcontractor Affiliation Acknowledgement Agreement), Northwood providers are bound to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated in the above named agreements.

SECTION IX - PARTICIPATION REQUIREMENTS AND CREDENTIALING

PROVIDER CRITERIA

Northwood requires its providers to meet the following minimum requirements for participation in its network:

- Centers for Medicare and Medicaid Services (CMS) approval/supplier number
- Accreditation by an independent accrediting organization adopted by CMS
- National Provider Identifier (NPI)
- State required licensure (if applicable)
- Any required DMEPOS licensure (if applicable) must be in good standing
- Enrolled in its state Medicaid (i.e. MassHealth)
- Liability insurance minimums of $1,000,000 per occurrence/$2,000,000 annual aggregate
- Notification to Northwood of changes or termination of such insurance
- Sound financial standing
- Possession of manufacturer's warranties on equipment
- Ability to service equipment according to warranty specifications
- Available skilled and/or credentialed staff to support services provided
- Appropriately staffed business hours (8 hours per day)
- Staff available twenty-four hours per day, seven days per week for emergency services
- After-hours answering service/paging system
- Providers must use the OIG List of Excluded Individuals Entities (LEIE) and SAM Excluded Provider List (EPLS) upon initial hiring and on an ongoing monthly basis to screen employees to determine if any are excluded from participation in federal health care programs.

- Not currently excluded, terminated or suspended from participation in MassHealth Medicaid

    - Under its contracts, if Northwood receives a direct notification from Health New England (via MassHealth Medicaid) to suspend or terminate a provider, Northwood is required to suspend or terminate the provider from its network if the provider contracts with Northwood for Health New England Medicaid members. (Northwood is not permitted to authorize any providers terminated or suspended from MassHealth Medicaid to treat members and must deny payment to such providers.)

- Provider has a formal policy that states it does not compensate employees/consultants/contractors or health care providers in bonuses, reimbursement or incentives, based on member utilization of health care services. During orientation of new staff and annually, provider reviews potential scenarios that may result in conflict of interest or ethical situations, including those involving financial incentives of staff.

- Participation in quality assurance/utilization review programs, including reviews involving:

    - Determination of appropriate equipment
    - Complete and detailed member treatment records, available to Northwood/Health New England for review
    - Emergency visits to member's home/place of residence
    - Two-hour provision for emergency equipment/service delivery
    - Member education, including written patient instructions on proper use and maintenance of equipment
    - Physician contact when necessary to review prescriptions and changes in patient's conditions
    - Scheduled follow-up visits to member's home or by appointment in provider's facility
    - Integrity and ethical business practices
    - Solid community standing

PROVIDER CREDENTIALING

Providers must submit and update the following credentialing information to Northwood during the initial credentialing process:

1. A copy of your National Supplier Clearinghouse (NSC) document indicating CMS's approval and assignment of your Medicare supplier number(s)
2. A copy of your accreditation letter or certificate for Durable Medical Equipment issued by an independent accrediting organization adopted by CMS (e.g., Joint Commission)

3. A copy of your Prosthetic/Orthotic certification/accreditation (e.g., ABC) if applicable
4. A copy of your state license, i.e. limited retail drug license (if applicable)
5. A copy of your Business License
6. A copy of your Certificate of Liability Insurance with Northwood named as a Certificate Holder
7. A complete copy of your current liability insurance certificate or declaration page (face sheet) of your insurance policy. The document should include the name of the company, name of applicant, policy number, dates of coverage and amounts of coverage (with a minimum of coverage outlined in Section X Liability Insurance Requirements).
8. A copy of your National Provider Identifier (NPI) notification
9. A copy of your Sales Tax License (if applicable)
10. Copies of any other certifications held

Northwood provides an annual summary of provider demographics and other information it maintains in the provider database. Providers must review and make any changes to data, provide certificates or other information as requested and return to Northwood by the return date indicated on the form.

RE-CREDENTIALING PROCESS

It is the responsibility of the provider to notify Northwood in writing of any changes to the information initially supplied on the Northwood Participating Provider Application including:

- Additions or deletions to locations
- Address changes, phone, fax, key personnel
- Changes to remittance address
- Changes to ownership
- Insurance coverage changes
- Federal Tax ID numbers

Northwood will make its best efforts to accommodate the addition of newly added locations of the provider. Requests should be directed to the Northwood Provider Affairs Manager.

Changes to ownership will require reapplication into the network. Upon notification from Northwood, providers will be required to submit a completed re-credentialing application and all requested supporting documentation.

Failure to respond to the credentialing notice may result in termination from Northwood as a contracting DMEPOS services provider.

SECTION X - LIABILITY INSURANCE REQUIREMENTS

The following insurance minimums are required for contract participation in accordance with Northwood's agreements with Health New England:

- General/professional liability insurance and products and completed operations liability insurance, each with minimum annual limits of $1,000,000 per incident and $2,000,000 in the aggregate

    - Such coverage shall include provider, its employees and agents at all sites and for all activities related to provision of covered equipment.

- Provider is required to promptly notify Northwood:

    - Upon discovery of any loss, or impairment of required coverage, or;
    - When more than half of any required annual limits have been exhausted or reserved by the applicable insurance carrier;
    - Annually of all Products/Completed Operations losses incurred by provider, including those reported to provider's insurers regardless of whether any such losses have been paid.

- If liability coverage is secured on a "claims made" policy:

    - Provider must purchase a "tail" policy covering a period of not less than five (5) years following termination of the coverage or termination of your agreement with Northwood/Health New England, whichever is later, or;
    - Agree to continue to provide the certificate of insurance as outlined in this request for a period of five (5) years after termination of your agreement with Northwood/Health New England.

- Providers are required to name Northwood as a certificate holder and immediately notify Northwood in writing of any lapse or change in coverage. Failure to do so may result in termination from network participation.

SECTION XI – FINANCIAL INCENTIVE POLICY

Northwood does not reward practitioners, providers, or employees who perform utilization reviews for not authorizing health care services. No one is compensated or provided incentives to encourage denials or limited authorization or to discontinue medically necessary covered services. Denials are based on lack of medical necessity or because a benefit is not covered. Northwood does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood or the perceived likelihood that the practitioner or other staff member supports, or tends to support, "denial of benefits."

SECTION XII - FORMS

1. NORTHWOOD WAIVER OF LIABILITY
2. NORTHWOOD CLAIM STATUS FORM
3. FEE SCHEDULE/POLICY UPDATE ACKNOWLEDGMENT FORM

Northwood

PATIENT ADVANCE NOTICE/WAIVER OF LIABILITY OF NONCOVERED SERVICES OR HIGHER GRADE/DELUXE EQUIPMENT OR SUPPLIES

Provider Name:	NPI:
Member Name:	Contract/ID #:
Health Plan:	Date of Service:

Equipment/Supply Requested:

HCPCS Codes:

The equipment/supply being prescribed and requested will probably not be covered by your health plan because it is a:

□ Noncovered item
□ Reason not covered_____
□ Higher Grade/Deluxe Equipment
□ Standard Equipment:_____

Provider Charge: $.	Expected Insurance Payment: $.	Expected Member Liability: $.

Northwood Benefit Coordinator Name: Date Contacted:

If you believe a service will not be covered, you will need to contact Northwood and speak to a Benefit Coordinator.

This notice gives an opinion regarding nonpayment or noncoverage for equipment or supplies by your health plan. It is not an official decision by your plan. If you would like to receive an official decision from your health plan prior to receiving and paying for the prescribed and requested equipment/supply we can contact your health plan.

By signing and dating below, I understand that my insurance may not pay for the equipment/supplies I am receiving today or they may not pay the full amount (less any applicable deductibles, coinsurance, co-pays, etc. which are member responsibility). It is my decision to receive the equipment/supply irrespective of its coverage and that the charges will be my responsibility.

_____

Print Name Signature Date

If you have questions about this notice or about your plan billing or coverage, please call your health plan's customer service number.

PA-13
05-17-2013

FORM INSTRUCTIONS:

In order to bill a member for noncovered or deluxe equipment, the provider must first obtain a signed, appropriate advanced notice/waiver of liability. This form may be used to obtain the member's advanced permission to bill the member for noncovered/deluxe equipment.

If a provider believes that an equipment/service will not be covered, or is a higher-grade/deluxe item, Northwood must be contacted to verify benefits. If the determination is that the equipment is noncovered or deluxe, the member may choose to have the item dispensed without receiving a formal health plan determination/decision. Prior to dispensing the noncovered or deluxe equipment, the member must acknowledge liability in writing by signing an advance notice/waiver of liability. If a provider will be billing a member for noncovered or deluxe equipment, the provider must inform the member before services are rendered and the member must agree in writing to the arrangements regarding the cost of the equipment/service and payment terms.

This form must be filled out in its entirety. When indicating that the item is noncovered, providers must state a reason for noncoverage; i.e. not medically necessary, experimental/investigational, etc. Also, in the boxes provided fill in the equipment (including HCPCS codes) being provided, the charge for the equipment, any anticipated health plan payment and the potential amount of member liability. Document the name of the benefit coordinator that was contacted at Northwood and indicated that the item was noncovered/deluxe.

After completely filling out all the fields on the document - have the member print their name, sign, and date the document. After the member signs, give a copy of the signed notice/waiver to the member and keep the original on file in the Member's record.

OTHER INSTRUCTIONS:

If it is determined by Northwood that the item is noncovered or deluxe, a Member may be given the option to receive a formal decision from their health plan or continue with obtaining the equipment/service by signing an advanced notice/waiver. If the member chooses to receive a formal health plan decision, the provider must submit the request to Northwood and include supporting documentation, i.e. prescription, LOMN, etc.

PA-13
05-17-2013

Northwood

CLAIM STATUS FORM

Date of Status_____ Provider Contact/Statuses: _____

Provider Name and Tax ID: _____

Health Plan _____

Patient Name: _____

Contract/ID Number: _____

Claim Number _____

Procedure Code(s) Status: _____

Usual and Customary Charge(s): $_____

Date of Service: _____

Authorization Number: _____

Date of First Submission: _____

Reason for Claim Status: _____

_____

Additional Documentation Submitted (YES) _____ (NO) _____

Additional Comments:

_____

_____

Status forms are to be used for underpayment or rejected claims only.

Mail to: Northwood, Inc.
Attn: Claims
P.O. Box 510
Warren, MI 48090-0510

CL-04

FEE SCHEDULE/POLICY UPDATE ACKNOWLEDGEMENT FORM

Dear Northwood Provider,

Please review the enclosed Fee Schedule, Provider Manual Revisions and/or Policy Updates. One copy of the Fee Schedule, Provider Manual Revisions or Policy Updates has been mailed to the primary location listed on the contract agreement between Northwood, Inc. and the provider. Please copy and distribute to other branch locations as needed.

Northwood's Provider Relations Department requests that you acknowledge your receipt of the above referenced materials dated _____. Please sign, date and return a copy of this form via mail (P.O. Box 510, Warren, MI 48090) or fax (586 755 3733).

Acknowledgement of Receipt

I, _____ the _____of
Authorized Company Representative (Printed Name) *(Title)*

_____acknowledge receipt of the
Company Name

Northwood Fee Schedule effective _____

Northwood DME Manual or Policy Update effective _____

Signature: _____ Date: _____
Authorized Company Representative

PA-9
02-01-10