Provider Manual

CENTIVO.

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Introduction

Welcome to the Centivo Network. Centivo partners with clinically integrated high-performing providers and health systems to deliver value-based insurance products to national employers. Centivo's mission is to bring lower cost, higher quality healthcare to the millions of working Americans. We deliver solutions that reduce costs and improve outcomes.

Employers can be assured of realizing benefit savings without compromising quality patient care. Centivo does not underwrite insurance plans and is not at risk for the payment of claims.

We have prepared this Provider Manual to provide you with helpful administrative and other information relating to your important role with the covered Members. We hope to minimize your administrative interaction and maximize your time with patients.

The purpose of this Manual is to serve as a resource for policies and procedures that affect you as a Centivo Provider. This Manual is meant to supplement your Provider Services Agreement ("Agreement"); nothing in this manual is intended to alter the terms and conditions of the Agreement. The Agreement, along with state or federal law formally guide our contractual relationship. In addition to the obligations specified in your Agreement, this Manual provides information about contractual obligations for Centivo Network Participating Providers.

Please note that if a provision in the Manual conflicts with state or federal law or the terms of the Agreement, the state or federal law or the Agreement takes precedence. Unless otherwise defined herein, all capitalized terms shall have the same meaning as ascribed to them in the Agreement.

Our Product Solutions

Centivo Health Plan

Centivo delivers health benefit plans and solutions to provide administration, coverage, and innovative care, i.e., Centivo Partnership Plan. As a third-party administrator for self-funded employer groups, Centivo provides claims processing, customer service, care management services, business intelligence, and other related functions for an administrative fee while the employer groups retain all the financial risk for plan performance (i.e., claims expense). Centivo is not the insurer for these employer groups. Benefit coverage(s) is determined by the client, with the client responsible for the claims expense/risk.

Credentialing and Re-credentialing

Centivo has engaged with an accredited vendor to conduct the credentialing and re-credentialing process for new and existing networks. For questions, please submit in writing to **cvoservices@rtwelter.com** or call **1-866-405-2057.**

Centivo supports both non-delegated and delegated credentialing.

Updating your data helps patients find you. We include provider data information in our directories to help patients find care. Being in our directories allows new patients to find out if you are accepting new patients, where you are located, and how to reach you. In addition, by making sure we have your current information, we can send you timely communications and reminders.

Non-Delegated Credentialing:

For non-delegated credentialing, the following elements will be requested, tracked, reviewed and verified.

Initial Application:

- Application request and tracking.
- Application review and follow up.

Primary Source Verification for Initial Credentialing and Re-Credentialing Process:

- Verification of licensure in the state where the provider has a primary office. The practitioner holds a valid, current license to practice which is verified directly from the state licensing agency to include sanction information where available.
- Verification of clinical privileges. Oral or written confirmation from the institution designated by the healthcare provider as the primary admitting facility (as indicated on the application) or the first one listed on the application. Verification to be completed by attestation.
- Obtain copy of DEA, and when appropriate a CDS certificate, for providers and facilities that can:
  - prescribe or dispense controlled substances. The provider's certificate or verification from the NTIS
  - must be effective at the time the credentialing file is finalized.
- Verification of education when not board certified. Must be verified in accordance with NCQA or URAC standards.
- Verification of nationally recognized board certification for practitioners that state they are board certified.
- Document a minimum of five years' work history. This information can be collected on the application or curriculum vitae with dates which include the month and year. Gaps in work history of six (6) months or greater will be identified. Verification of work history is not required from primary sources.
- Verification of malpractice insurance by obtaining face sheets. A copy of the current malpractice coverage that shows the dates and amounts of coverage will be obtained from the provider.
- Verification of malpractice claims history. Can be completed by collecting history of malpractice settlements from the National Practitioner's Data Bank (NPDB) or the insurance carrier when available.
- Verification of Medicare and Medicaid sanctions. Verify the status of the practitioner about Medicare and Medicaid sanctions which can be done by completing a query of the NPDB.
- Final review of provider credentialing file by Centivo Medical Director. Centivo Medical Director will recommend approval, pending, or denial of file.

Delegated Entities Credentialing:

For delegated credentialing, the following elements will be requested, tracked, reviewed and verified to determine if the Delegated Entities credentialing, and re-credentialing written policies and documented procedures conform to National Committee for Quality Assurance ("NCQA") and/or Utilization Review Accreditation Commission ("URAC") standards; and (b) Delegated Entity has the capacity to perform the specific functions identified here;

- Pre-Delegation Assessment

  - On-site evaluation of the potential delegates ability to perform required PRIOR to signing an agreement.
  - Policies & procedures, file review
- Delegation Agreement Monitoring for Compliance
  - Responsibilities of each party/activities being delegated
  - Reporting frequency per Delegated Agreement
  - Performance evaluation process
  - Remedies for non-compliance
  - Right of plan to make final decision
- Annual Assessment
  - Annual reviews are performed to ensure that standards continue to be met
  - Semi Annual review of reports determined by Delegated Entity Agreement
    - Policies and procedures
    - Plans standards and requirements
    - File Review; audit process required

Provider Additions, Changes, Terminations, and Panel Closure

Provider Data Integrity Information on a provider's location, specialty, contact information, and availability is essential for care coordination throughout the healthcare system. Ensuring high-quality provider data has positive implications for patient care and organizational efficiency.

All provider adds, changes and termination requests must be submitted promptly in writing to **providerrelations@centivo.com.**

Provider changes and updates include, but are not limited to the following:

- Change in practice location;
- Change in practice affiliation;
- Change of address, phone or fax number;
- Change in hours of operation;
- Retirement or leave of absence exceeding 30 days;
- Leaving network area

Any change to a provider's status should be communicated immediately to Centivo Provider Relations Department.

All provider profiles are reviewed for credentialing requirements, including but not limited to the following:

- Provider specialty(ies) and credentials (e.g., MD, DO, MFT, etc.)
- Medical license number and expiration date;
- DEA number and expiration date;

- NPI number;
- Board Certification status;
- Professional liability insurance

A new provider may not submit claims for services until approval has been obtained through Centivo Provider Relations.

Provider Compliance

One of the roles as a provider is to identify which plan a Member is assigned to ensure that the correct referral, prior authorization, and pre-certification guidelines are followed. To help you and your staff identify the specific plan solutions that are offered, it is imperative to review and copy the ID card for each covered person.

Each ID card contains information and requirements specific to each Member's plan. We recommend checking the Member's ID Card at every visit to verify correct coverage.

The claims address is determined by the primary network of the Member. Please refer to the Covered Person's ID Card. ID Card examples can be found in applicable sections within this Manual.

Each employer group has a separate customer service number. Please refer to the contact information on the ID Card for the appropriate customer service number for eligibility and identification information.

Network Quality Assurance

The following is intended to provide clarification/additional information regarding your Participation Agreement.

Nondiscrimination

You must not discriminate against any patients with respect to the delivery or accessibility of services. Your practice must maintain written policies and procedures related to non-discrimination.

This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience

- Medical history
- Genetic information
- Type of payment

Quality and Patient Safety Activities

You are expected to support quality improvement and patient safety activities and programs.

Specifically:

- Providing timely access to medical records when requested.
- Providing timely responses to queries and/or completion of improvement action plans related to quality-of-care investigations.
- Support audits and data gathering, including site visits, medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Allow use of practitioner and provider performance data.

SECTION 1: Centivo Health Plan

Centivo is a third-party administrator of health plans for self-funded employers committed to promoting the importance of primary care and engaging covered Members to make well-informed decisions. The Centivo model emphasizes the partnership between individuals and their Primary Care Team as the proper model to coordinate healthcare needs. Members are encouraged to choose high-value care, adhering to the guidance from their Primary Care Team and supported through a state-of-the-art digital app and Member Care team.

Centivo does not underwrite insurance plans and is not at risk for the payment of claims. Centivo administers its clients' benefit plans in accordance with the employer's applicable Plan Documents. Copies of Plan Documents and less detailed Summaries of Benefits and Coverage are available on the Provider Web Portal.

1.1 Centivo Information and Contact Information

Centivo Support is available Monday-Friday 8:00am to 9:00pm Eastern Time or any time at providers@centivo.com.

For questions regarding benefits, eligibility, claims status, or claims support:

- Phone: Back of the Member's ID Card
- Email: providers@centivo.com
- Provider portal: provider.centivo.com

For claims submissions:

- Centivo electronic payer ID: 45564
- Submit all claims to the following address:

  Centivo

  P.O. Box 211681

  Eagan, MN 55121

If you require additional communication or to send form and documents, you may:

- Email: providers@centivo.com
- Phone: Back of the Member's ID Card
- Fax to Centivo Support: **716-219-1946**
- Mail to:

  Centivo Provider Support

  77 Goodell Street, Ste 510

  Buffalo, NY 14203

1.2 Centivo Plan Design

The Centivo Partnership Plan emphasizes the partnership between a Member and their Primary Care Provider to coordinate the Member's care. Members are required to elect a Primary Care Provider and care must be received from or referred by their elected PCP to ensure the highest level of benefit, in

accordance with their health benefit plan (see details and exceptions in Section 1.5). Claims for Members who do not receive care or referrals from their elected PCP may be penalized, incur an increased Member cost share or result in denial. Only the Member's elected PCP may submit referrals for the Member.

To ensure that you are referring Members appropriately please use the Provider Referral Portal or call Centivo Support using the number on the Member's ID card.

1.3 Primary Care Provider

A Primary Care Provider ("PCP") with Partnership Plan is responsible for providing, arranging, and coordinating all aspects of the Member's health care for those Members assigned to the PCP, and for directing and managing appropriate utilization of health care resources. The PCP is the focal point of all care management for Members. Centivo recognizes Family Practice, General Practice, Internal Medicine, Pediatric and Geriatric Physicians as PCPs.

A PCP is expected to provide all necessary care required by a Member that is within the scope of his or her practice and expertise. Centivo supports Patient-Centered Medical Home (PCMH) concepts and recommends all PCPs achieve PCMH certification from NCQA or URAC. Partnership Plan PCPs must demonstrate PCMH- level care delivery, which is most readily demonstrated by certification.

Requirements to be a Partnership Plan PCP include:

- Appropriate in-office access is necessary for PCPs that provide on-site primary care. Appropriate levels of access include minimum office hours of 30 hours per week, office hours outside of normal business hours, same-day appointments (when medically necessary) and reasonable waiting times.
- The provision of qualified, consistent, easily accessible on-call coverage 7 days a week, 24 hours a day, either personally by a clinical care team Member or by a reasonable call coverage arrangement with other appropriate individuals. It is expected that all on-call providers have access to the patient's medical records and callback time be reasonable. Members are instructed to contact their PCP first when they need any care. The PCP is responsible for evaluating the Member's needs and directing their care, including working them into the schedule during normal office hours when at all practical.
- Technology that supports high quality, consistent team-based care including the use of a certified electronic health record technology (CEHRT) system, a secure electronic system for two-way communication to provide timely clinical advice and the capability to exchange patient information with the hospital during a patient's hospitalization.
- The development of medical neighborhoods of specialists whom to refer to, which are in the Partnership Plan network.
- A defined process to review and actively manages panel size.

1.4 Centivo Virtual Primary Care

Centivo VPC is a virtual practice of licensed physicians, advanced practice providers, and patient care coordinators. VPC Providers deliver physician services in a digital and/or telephonic modality to Members. Any physical care will be coordinated and referred by VPC.

For more information, please visit vpc.centivo.com

1.5 Referrals for Specialty and Ancillary Care

Centivo Members must coordinate their care needs with their Primary Care Provider to obtain the best coverage and keep their out-of-pocket costs low. As such, Members are required to get a referral from their Primary Care Team before going to specialists or facilities (see details and exceptions below).

Role of the Primary Care Provider:

- Provide all routine, preventive, and medically necessary primary care services, and coordinate all other covered services with referrals.
- Use clinical protocols to determine when a referral to a specialist is necessary.
- Ensure required referrals are submitted for the Member, using the Centivo Referral Portal or by calling Centivo Support.
- Keep a record of any referrals.
- Monitor the timeliness and quality of the referral response.
- Work with the referred specialist to develop a care plan, if required.

Role of the Specialist Provider:

- Ensure required referrals are on file and active, before providing care to a Partnership Plan Member, either by checking with the Member, Centivo Support, or via the Centivo Referral Portal.
- Provide results of medical evaluations, tests, and treatments to the Member's PCP, as authorized.

Other Referral Guidelines:

- Standard duration for referrals for most plans is 365 days.
- A referral is not a substitute for pre-certification (see Section 9).

Referral exemptions

Referral submissions are not required for the following services:

- Emergency services
- Services from obstetrical or gynecological care clinicians
- Mental health/substance use disorder services with behavioral health clinicians
- Services rendered in an emergency room or urgent care center
- Observation services
- Diagnostic services (including labs and imaging) in an outpatient, independent or freestanding facility
- Services from a pathologist or radiologist
- Chiropractic care services
- Alternative care services (e.g., acupuncture)
- Re/habilitative services with physical therapists, occupational therapists, or speech therapists
- Preventive immunization services

Requirements for Primary Care Providers

The following is intended to supplement and clarify the requirements for Primary Care Providers under the Centivo Network program:

The role of a Centivo Network primary care provider is to deliver appropriate preventive and other primary care services within the scope of your practice.

These services might include, but are not limited to:

- Accepting all Members who elect them as the Primary Care Team
- Establishing and managing patient-specific care plans.
- Coordinating care among various health care practitioners and facilities.
- Delivering routine preventive care (e.g., wellness visits, immunizations, blood tests).
- Treating Members with routine sick care.

Call Coverage/Off-Hours Access

Centivo Network PCPs are expected to provide coverage for Centivo Members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure they have coverage from either another participating primary care provider (preferred), or a provider that agrees to accept the same rates and ensure continuity of care. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers, unless Centivo approves a specific request for an exception by a provider.

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so that you can appropriately respond to Members and other providers concerning after-hours care. The use of recorded phone messages instructing Members to proceed to the emergency room or urgent care during off hours is not an acceptable level of care.

1.6 Utilization Management

Participating providers are required to observe the protocols of the Centivo Utilization Management Program, referred to as “UM.” UM requirements may vary by Client or program, and may include, but is not limited to, hospital admission, pre-authorization, continued stay review, length of stay determination, discharge planning, prospective, concurrent, and retrospective review. UM programs may also include case management, disease or condition management (referred to as “DM”), maternity management, and management of behavioral health conditions services.

Centivo may choose to employ Delegated Vendors for the administration of various UM programs. Contact Centivo Support to submit or track UM requests at the number on the Member’s ID card.

Standard In/Outpatient Pre-Certification List

Pre-certification by the Centivo UM vendor is required for all criteria listed. If you have any questions about this list, please contact Centivo Support. Provider and Facility acknowledge that Centivo may deny or apply a monetary penalty to claims for services as a result of Provider's or Facility’s failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under the Agreement. The precertification list is updated annually and/or as care management guidelines necessitate.

Precertification – all criteria listed require pre-certification
All Inpatient stays for Medical/Surgical benefits and Mental Health/Substance Use Disorder
Arthroscopy or any joint surgery
Implants of any type
Laminectomy/Spinal Surgery
Pet scan
Chemotherapy
Infusion (infusion therapy) of any type > $3,000
Epidural / facet and trigger point injections
Any drug over $1,500/dose
Biologic drug
Dialysis
Genetic testing
Radiation Treatments
Skilled Nursing Facility/Residential Treatment
Extended Nursing Facility
Long Term Acute Care (LTAC)
Home Health Care/Intensive Outpatient Program/Partial Hospitalization
Inpatient Rehabilitation
Gastric Bypass/Panniculectomy/Abdominoplasty
Cosmetic surgery potentials, such as, but not limited to: • Mammoplasty • Blepharoplasty • Varicose veins stripping and ligation
Ongoing wound care

Retro Review > 30 days post discharge or with extensive case notes are reviewed by Case Management

Standard Appeals Process

Dispute Resolution:

1. Requests may be made by phone or letter within 180 days of discharge outlining the reason(s) for the appeal.
2. Please mail a copy of the complete medical record for review, obtained at your expense to the address listed on the letter you received. This allows us to review the case on all available information. If you are unable to obtain a copy of the medical record, we will review the case on the information previously provided.
3. The appeal process will be completed within 30 days of receipt of the request for appeal unless you are informed in writing to the contrary.

Members should refer to their Summary Plan Description for more detail on appeals, grievances, or complaints.

Providers should contact Centivo Support with any questions about Eligibility, Benefits, or Claims Review.

1.7 Case Management

Plans administered by Centivo include case management services to Members with complex health conditions. The case manager will interact with patients and providers in ensuring that services are delivered effectively subject to the terms of the Member's self-funded Plan. This may include assistance in understanding the applicable health benefits and in navigating resources available to them. The complex case management program is a collaborative process among the Member, the provider(s) and Centivo, as such, we will periodically report progress to a Member's Primary Care Provider. The goal of these programs is to achieve better health outcomes while managing health care costs.

Most case management will originate from UM programs and identification through medical and prescription drug claims. If you believe a Member is appropriate for Case Management, please contact the Centivo Support at the number on the Member's ID card. Following your referral, the Case Manager will contact the Member, family Members (if appropriate), and any related providers (if appropriate).

1.8 Eligibility/Member ID Cards

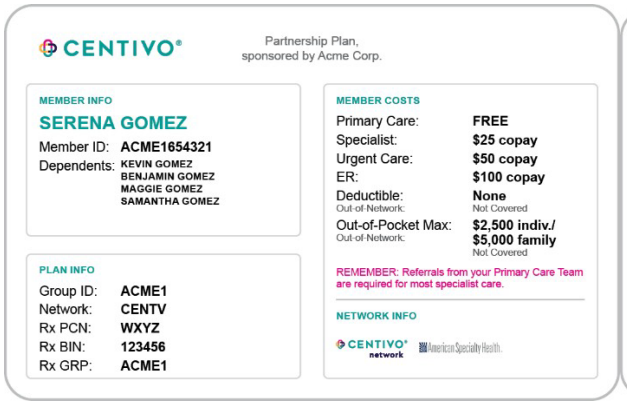
The Member ID and information about verifying eligibility are on the Centivo ID Card. The following are ways to identify whether a patient is a Centivo Member:

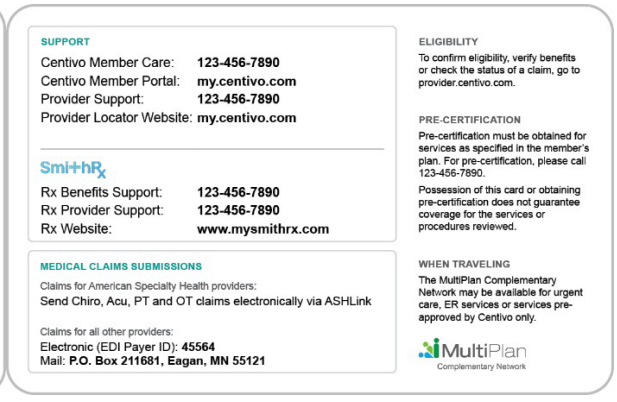
Digital ID cards: Members can access and view their digital ID cards after the effective date (listed on the card) using the Centivo app, or the Member website at **my.centivo.com**. Members can easily print replacement ID cards from these portals.

Member ID cards: At each visit, the office should ask to see the Member's ID card and collect the appropriate copayment, if applicable. Note: Some covered Members may only have digital ID cards. These Members may present their mobile device or a printed copy when seeking health care services.

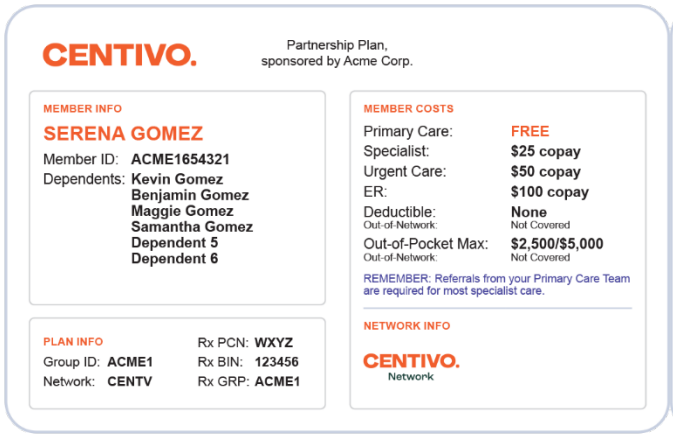
All Members enrolled in the Centivo Network receive a Member ID card. A sample ID card can be found below.

Existing Members





As of 1/1/2024



1.9 Member Financial Responsibility and Collections

For specialists and other non-primary care practitioners, we anticipate that the vast majority of visits will be referred to through the Member's PCP. It is recommended that you:

1. Check to make sure that the Member has a referral on file when required by using the Centivo Referral Portal or by calling Centivo Support.
2. Collect the appropriate copayment as outlined on the Member ID card, as applicable.

Centivo will be closely monitoring activity here and will quickly address any concerning trends through targeted education or other means. Contact Centivo Support to confirm benefits or address any questions.

1.10 Claims Submission

To be reimbursed for services rendered to a Centivo Network Member, providers must submit a clean claim within the timely filling guidelines. Centivo requests that providers file claims electronically for faster services. When submitting claims, please include all required information. Centivo requires that all claims be submitted on a UB-04 or CMS-1500 claim Form. Instructions for filing using either method are reflected below as well as on the reverse side of the Member's ID card. When submitting electronic claims, use Centivo's clearinghouse payer ID*: 45564. If you are currently submitting paper claims via

mail and would like to submit them electronically, please call the Centivo Support and we will assist you.

When Centivo is the primary payor, providers must submit claims for payment within ninety (90) days from the date of service or date of payment received by primary payer unless it is otherwise required by state or federal law or your Provider Services Agreement.

The following information must be included on the claim:

- Current National Provider Identifier (NPI);
- Current Tax Identification Number (TIN);
- Member's name, address, telephone number, gender, and date of birth;
- Centivo Network Member ID number;
- Centivo Network Member group number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes;
- ICD-10 procedure and DRG codes for all UB-04 claims;
- Referral provider (indicate ordering provider on UB-04);
- Billing provider's name and remit address;
- Date of service;
- Current Coordination of Benefits (COB) information or other insurance information such as motor vehicle, worker's compensation, or other third-party liability insurance information.

1.11 Claims Payment

Centivo employs an electronic payment (ePayment) platform to accelerate and add efficiency to our claims payment process. This provides a no-fee ACH delivery of claim payments with access to remittance files via download in the ePayment Center. Delivery of 835 files to clearinghouses is also available directly through the ePayment Center enrollment portal.

Centivo is pleased to announce a partnership with Zelis in delivering ePayment. For this reason, it is important that providers register using the Centivo ePayment Center link, even if they already have an account with Zelis. Registering through the Centivo-specific link will tie in the account to the Centivo EPC arrangement with Zelis and allow Centivo to cover the cost of EFT and ERA on behalf of the provider. If you have any questions or want to connect directly with Zelis, you can reach out to 855-774-4392 or email at **help@epayment.com**. Click here to access a copy of the **EPC Payment Welcome Brochure and User Reference Manual**. Provider should enroll by going to: **Centivo ePayment Center and following the registration instructions.**

Upon completion of the registration process, your bank account will undergo a pre-notification process to validate the account prior to commencing the EFT delivery. This process may take up to six business days to complete. Registration is at the TIN level and the process must be repeated for all billing TINs

1.12 Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Centivo Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome.

Claim Payment Reconsideration

The first step in the Centivo Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facility's initial request to investigate the outcome of a finalized Claim. Centivo cannot process a Claim Payment Reconsideration without a finalized Claim on file.

Claim Payment Reconsiderations can be submitted via phone, the web portal, or in writing. Providers and Facilities can submit if they are within 180 days from the issue date of the EOP (or such other period as set forth in their Provider or Facility Agreement.)

A determination will be made and the initial payment on the Claim will either be upheld or overturned.

Required Documentation for Claims Payment and Coding Disputes

Centivo requires the following information when submitting a Claim Payment Dispute (Claim Payment Reconsideration):

- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and their Centivo ID number
- A listing of disputed Claims, which should include the Centivo Claim number and the date(s) of service(s)
- All supporting statements and documentation, including but not limited to Medical Records.

How to Submit a Claim Payment Dispute

Claim payment disputes are submitted either to Zelis or to Centivo:

Submitting a claim payment dispute to Zelis:

We partner with Zelis for clinical editing. For questions or concerns regarding a Zelis clinical edit, please contact them directly. Not sure if your question is for Zelis or Centivo? If the reason code on your provider EOB starts with the letter "Z", direct your question to Zelis.

Via Fax:

855-787-2677

Via Secure Email:

Appeals.Integrity@Zelis.com

Via Phone:

866-489-9444

Submitting a claim payment dispute to Centivo:

All other claim payment disputes should be directed to Centivo.

Via Fax:

716-219-1946

Via Mail:

Centivo Claims Dispute

77 Goodell Street Suite 510

Buffalo New York 14225

Via Secure Email:

providers@centivo.com

If you need to check on the status of Claims Dispute, you can call Member care (number on the back of the Member's ID card) or email providers@centivo.com.

1.13 Pharmacy Management

Centivo will follow the pharmacy benefits set forth in the applicable Health Benefit Plan and plan document. Such benefit plans/plan documents may utilize a prescription drug formulary to help maintain access to quality, affordable prescription drug benefits for your patients. For more information on a Member's pharmacy benefits, please follow the instructions on the Member's ID card.

1.14 Serious Adverse Events

Hospital Acquired Conditions

Participating Providers will not be permitted to receive or retain reimbursement for inpatient or outpatient services related to Never Events. Members will be held harmless for any services related to Never Events. Unless the diagnosis is exempt per the "POA Exempt Diagnosis" list as published by CMS, all participating providers must populate Present on Admission (POA) indicator on all acute care inpatient hospital claims.

Nonpayment for Serious Adverse Events

The 14 categories of Hospital Acquired Conditions listed below include the following. For the complete list see the "Centers for Medicare and Medicaid Services (CMS) Hospital-Acquired Conditions" link below.

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility

- Stage III and IV pressure ulcers
- Falls and trauma
  - Fractures
    - Dislocations
    - Intracranial injuries
    - Burn
    - Crushing injuries
    - Other injuries
- Manifestations of poor glycemic control
  - Diabetic ketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
- Surgical site infection following bariatric surgery for obesity
  - Laparoscopic gastric bypass
  - Gastroenterostomy
  - Laparoscopic gastric restrictive surgery
- Surgical site infection following certain orthopedic procedures
  - Spine
  - Neck
  - Shoulder
  - Elbow
- Surgical site infection following cardiac implantable electronic device (CIED)
- Deep vein thrombosis (DVT)/Pulmonary embolism (PE) following certain orthopedic procedures
  - Total knee replacement
  - Hip replacement
- Iatrogenic pneumothorax with venous catheterization. The 3 wrong surgeries included in the list are:
  - Wrong surgical procedure performed
  - Surgery performed on a wrong patient
  - Surgery performed on a wrong body part

Centers for Medicare and Medicaid Services (CMS). **Hospital-Acquired Conditions (Present on Admission Indicator). IPPS FY 2013 Final Rule. Retrieved 11/21/23**

1.15 Provider Portal

Centivo's provider portal is available at **provider.centivo.com**. Use this portal to look up patient eligibility, check the status of a claim, initiate referral, search for in-network providers, and more.

Click here for a copy of the Centivo's **Provider Portal User Guide**

Centivo's Partnership Plan requires specialist referrals to be submitted using the Referral Management System.

This system is located within the Provider Portal. Within 48 -72 hours of gaining provider portal access, we will also grant you access to our referral portal at referrals.centivo.com.

Click here for a copy of the Centivo's **Referral Management System User Guide**

For further assistance, please email **providerrelations@centivo.com**

EXHIBIT A – Important Definitions

The following terms shall have the meanings as ascribed to them or referenced below (such terms shall be equally applicable to both the singular and plural forms of the terms defined):

1. **"Centivo Client(s)"** means any employer group, Plan Administrator, health plan, or insurance company that has an agreement with Centivo.
2. **"Claim"** means a request for payment for Covered Services rendered to a Member submitted in accordance with the terms of your Agreement and applicable Health Benefit Plan.
3. **"Clean Claim"** means a completed UB04 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client for adjudication, including but not limited to the submitting provider's National Provider Identifier (NPI) number.
4. **"Coordination of Benefits"** means a method of sequentially assigning responsibility for the payment for health care services rendered to a Member among two or more insurers.
5. **"Covered Services"** means those medical and hospital services, for which benefits are available to Members in accordance with the terms of the applicable Health Benefit Plan.
6. **"Delegated Vendor"** means any person or organization appointed by Centivo to administer managed care, utilization management, claims processing or other programs for its Health Benefit Plan.
7. **"Health Benefit Plan"** means the Health Benefit Plan of a Centivo Client which describes the costs, procedures, benefits, conditions, limitations, exclusions and other obligations to which Members are subject thereunder.
8. **"Medical(ly) Necessity(ary)"** means those services determined to be (a) preventative, diagnostic, and/or therapeutic in nature, (b) specifically related to the condition which is being treated/evaluated, (c) rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, and (d) not primarily for the Member's convenience or that of his or her physician.
9. **"Network"** means those Participating Providers, preferred provider organizations, specialty networks or other organizations that arrange for the delivery of health care services that contract with Centivo to arrange for the provision of health care services to Members.
10. **"Non-Covered Services"** means those medical and hospital services, supplies, products and accommodations provided to Members that are not designated as benefits to Members under the terms of the applicable Health Benefit Plan.
11. **"Member"** means any person who is eligible to receive benefits under a particular Health Benefit Plan as set forth in the applicable plan document.
12. **"Member Responsibility"** means deductibles, coinsurances, co-payments or other amounts for which Members are responsible to Participating Providers under the terms and conditions of the applicable Health Benefit Plan.
13. **"Participating Provider"** means a health care provider that is considered in-network under the terms of the applicable Health Benefit Plan.