PARTICIPATING PROVIDER MANUAL

Dear Provider:

We are proud to welcome you to the Evolutions Healthcare Systems, Inc. Preferred Provider Organization. Our mission is to provide innovative managed care solutions for the benefit of everyone. The corporation's philosophy is to deliver unmatched quality in managed care services responsive to the needs of patients, health care providers and payers.

As a new provider, we have developed this Provider Manual in an effort to address your questions and concerns. Please look through and familiarize yourself with the information contained herein. If you have any questions, please refer to our website at www.ehsppo.com or call 800-308-2749 and ask for the Customer Service Department. A representative will gladly assist you.

On behalf of our Evolutions Team, thank you for choosing to join the Evolutions Healthcare Systems family of Providers!

Sincerely,

Constance Cranford
President

About Evolutions Healthcare Systems

Founded in 1992, Evolutions Healthcare Systems ("EVOLUTIONS") takes pride in being a leader in customized network configurations, such as narrow and high-performance networks as well as other health claims saving solutions which provide substantial discounts and operational savings to:

- Self-Insured Employers
- Insurance Carriers
- Third Party Administrators
- Other Managed Care Entities

We accomplish this through our direct network of Local, Regional and National Hospitals, Physicians, and Specialists.

Today we have more than 200,000 health care providers under contract across the country for our group health plans, Workers' Compensation and International Health plan networks.

With a strong focus on customer service, EVOLUTIONS offers a comprehensive suite of health plan solutions and claims processing services. The EVOLUTIONS PPO access and repricing solution is powered by TRX (Transaction Re-pricing & eXchange) service architecture. TRX is a proprietary system developed by EVOLUTIONS and offers clients an open-architecture, HIPAA compliant, claims management and E-business solution for automated claims management, repricing, reporting, transaction routing, and EDI services.

Our Mission Statement

To Provide Innovative Managed Care Solutions for the Benefit of Everyone.

Our Purpose

Our purpose is to promote the highest quality healthcare at the lowest possible costs. We accomplish this by making it easier for our members, clients, and providers to do business. Evolutions is committed to providing a truly outstanding service experience for those using, managing, or providing PPO healthcare services. As a progressive company with more than 30 years' experience in healthcare cost management, we specialize in promoting convenience and value through the use of technology, competitive products, and attention to detail.

CONTACT EVOLUTIONS

Corporate Address

Evolutions Healthcare Systems, Inc.
8406 Massachusetts Ave. #A-1
New Port Richey, FL 34653

Claims Address

Evolutions Healthcare Systems, Inc.
PO Box 5001
New Port Richey, FL 34656
or
Via EDI Payor #59313

Website

www.ehsppo.com

Contact Numbers

Local: 727-938-2222 Toll Free: 800-881-4474 FAX: 727-938-2880

COMMONLY ASKED QUESTIONS AND ANSWERS

Who is Evolutions Healthcare Systems, Inc. ("EVOLUTIONS")?

EVOLUTIONS is an independently owned boutique Preferred Provider Organization focused on customized provider network management.

What does Evolutions Healthcare Systems offer?

Provider Recruitment, Provider Relations and Education, Claims Re-pricing, Claims Imaging and Data Collection.

Where do I send claims?

Most plans are set up for claims to be sent directly to Evolutions. ***Please refer to the back of the member's ID card to confirm appropriate claims routing.***

EVOLUTIONS prefers to receive claims via EDI Payor #59313

For other correspondence:

Evolutions Healthcare Systems, Inc.
Attentions: Claims Department
PO Box 5001
New Port Richey, FL 34656

For more information see section: Claims Administration

Who pays the claims?

EVOLUTIONS works with over 100 Payors nationwide. Claims are re-priced according to the contracted reimbursement rate within 24-48 hours and posted on our secure FTP site for the Payer to download and adjudicate.

When will payment be made?

EVOLUTIONS requires the payors to reimburse in-network providers within thirty (30) days of the receipt of a "clean claim".

Whom should I call for pre-certification, benefit and eligibility information?

EVOLUTIONS is only offered as an open access network and not utilized as a gatekeeper model. However, some of our payors may use a form of referral system for specific services.

Please contact the payor by calling the benefits and eligibility number on the member's identification card.

Whenever possible providers should refer patients to an Evolutions Healthcare Systems' participating provider. The participation status of colleagues or potential referrals may be obtained at our website, www.ehsppo.com or by contacting our customer service department at 1.727.938.2222 or 1.800.308.2749.

When should I call the payor?

You should call the payor when:

- You need benefits, eligibility or plan pre-certification information requirements.
- You have not received an explanation of benefits within 45 days after submitting a claim.
- To check on the status of a claim.
- If you feel a claim has not been adjudicated appropriately based on quoted benefits.

When should I call EVOLUTIONS?

If you have questions regarding your contract.

If you have a claim that was denied or paid as though you were not a participating provider:

- EVOLUTIONS will contact the payer to confirm your participation status and request that the claim be reconsidered.

What EVOLUTIONS network product am I participating in?

EVOLUTIONS HAS SEVERAL NETWORK PRODUCTS

- **Customized Networks** specified on the ID Card. Require a Logo and Explanation of Benefits form ("EOB") language identifying the network accessed for the repricing of your claim.

- **Prime Tier 1, Prime, Select and International** products require a Logo and Explanation of Benefits form ("EOB") language identifying the network accessed for the repricing of your claim.

- The **Choice, Auto and Worker's Compensation** products do not require EVOLUTIONS Logo's. However, they do require EOB language identifying the network repricing your claim.

To determine your status as a participating provider in one of these network products, please visit our website at www.ehsppo.com or contact our customer service department 1.727.938.2222 or 1.800.308.2749. Website instructions are provided within this manual.

How often is the directory updated?

EVOLUTIONS refreshes the provider information on the website daily.

How can I obtain a copy of contracted rates?

For a copy of your contracted rates, you may submit a request to Contracting@ehsppo.com

If your contract is based on CMS Fee schedules, you may obtain a copy of the current fee schedule from your States' Medicare website or from CMS.

ADMINISTRATION

Purpose of this Manual

EVOLUTIONS is providing your office with this manual with business guidelines and requirements necessary to conduct business transactions with EVOLUTIONS and clients of EVOLUTIONS. Periodically, this manual will be updated with the most recent versions posted on our website at www.ehsppo.com.

Protocols and Guidelines

The provider acknowledges that all decisions of whether a service is a covered service by the health plan, are made solely by the payor. Providers should encourage members under their care to review the coverage of their health plan with their employer and/or payor for benefits, procedures, exclusions, or limitations prior to receiving treatment.

Identification Cards

All members utilizing EVOLUTIONS' primary group health networks will be issued identification cards. The members are required to present their ID card at the time services are rendered. The ID may include the following information:

- Member name and identification number
- Group name and number
- Benefit plan type
- Evolutions Network Name accessed
- Applicable copayment or coinsurance
- Important telephone numbers for eligibility, benefit verification, pharmacy, mental health and utilization management

Benefits and Eligibility

Benefits, eligibility and pre-certification requirements should be verified with the claim's payor. The phone numbers for those entities are located on the back of the member's card.

Claim Submission

Claims should be submitted via the EDI Payor number or physical address on the ID card.

Patient Responsibility

Any applicable Deductibles, Co-payments, Co-insurance or non-covered services (benefit ineligible) are the responsibility of the patient.

PROVIDER RESPONSIBILITIES

Providers may contract directly with EVOLUTIONS or indirectly through an IPA/PPO/PHO or an affiliated Network (Dimensions Healthcare, PHCS, Multiplan, etc.) In each case Providers have the following responsibilities:

- Provider agrees to deliver quality health care services in an efficient and cost-effective manner as stated in the provider agreement with EVOLUTIONS.
- To refer members to the appropriate source of care when necessary.
- To provide patients with information in terms they can reasonably understand regarding a diagnosis, treatment plan, prognosis and available options.
- To submit to the appropriate contracting entity all provider demographics changes and updates in a timely manner.
- To treat patient records with confidentiality.
- To submit claims appropriately.

Changes in Status

Providers will inform EVOLUTIONS directly or indirectly through their IPA/PPO/PHO or affiliated Network as to changes in their status to include:

- Tax identification number (may require new contract and will require an updated W-9)
- Office or Billing Addresses
- Telephone Number(s)
- Additions of new Providers to Practice
- Licensure
- Hospital Privileges
- Closing of Practice

To Report Changes in Your Status

If your network participation is through an IPA/PPO/PHO or an affiliate network that holds the contract with EVOLUTIONS, please contact them regarding their requirements for submitting

changes. They may require changes to be submitted to their attention as the contracted entity and then they will notify EVOLUTIONS of the change.

If your network participation is directly with EVOLUTIONS please give us at least Sixty (60) days' notice prior to any change listed above.

There are a few options in submitting changes:

- For multiple provider changes, please submit via email to providerchanges@ehsppo.com in a csv or excel spreadsheet.

- For individual changes a Provider Update form may also be downloaded from our website at www.ehsppo.com The form is located in the Provider section.

Please attach any additional documentation that may be required to support the requested change. (i.e. W-9 form for TIN change)

You will be contacted by EVOLUTIONS if additional information or clarification is required.

Verification of Eligibility and Benefits

Prior to rendering services, EVOLUTIONS encourages you to contact the payor listed on the members' identification card to verify their eligibility and benefits.

Care and Treatment of Members

As a contracted Provider with EVOLUTIONS, you are responsible for meeting certain requirements for participation. These responsibilities include the care and treatment of members choosing you as their health care provider. Providers must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification and privileges.

Providers must also comply with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of Protected Health Information and taking all precautions to prevent the unauthorized disclosure of such member's medical and billing records.

Providers understand that:

- Authorizations for treatment within the Provider's practice may need to be obtained from the member's payor.
- Authorization is not a guarantee of payment.
- Authorizations must be requested in a timely fashion.

EVOLUTIONS suggests the follow as appropriate access to care and services:

- Twenty Four (24) to Forty Eight (48 hours) for urgent appointments
- Four (4) weeks for specialty care appointments
- Six (6) weeks for routine appointments

Provider Rights

- To expect payment on clean claims within the guidelines established by the EVOLUTIONS contract and applicable state statutes.
- To expect clear guidelines regarding the authorization and pre-certification process from the payors or utilization management companies.
- To expect payment of any applicable co-payments from the patient at the time of service.
- To expect payment of applicable co-insurance and or deductible amounts from the patient after receipt of an explanation of benefits detailing payment and patient responsibility.
- To have patient and credentialing information treated with confidentiality.

GRIEVANCE POLICY

The Network will serve as an intermediary when addressing patient concerns with a provider or facility. The process involves investigating, educating and promoting communication so that all parties can work toward an acceptable resolution. If there is a concern about the safety of patients, it is immediately forwarded to the appropriate state oversight agency.

When the Network is contacted regarding a concern or grievance, the following occurs:

- With permission, the Network will contact the provider or facility on the grievant' s behalf to resolve the concern.
- A grievant may remain anonymous throughout the investigation of a concern; however, it may limit the Network's ability to investigate the specific concern.
- The Network will advocate for the patient's rights.
- The Network will make suggestions/recommendations to both the grievant and the provider or facility.
- The Payor will work in conjunction with the Network and may require the provider or facility to forward documentation (treatment sheets, progress notes, etc) for review.
- The Network will follow-up, as needed.

The Network cannot:

- Mandate that a physician or facility accepts a patient.
- Request that a specific staff member provide care.
- Change or direct provider or facility policies or procedures.
- Override Federal Regulations.

UTILIZATION MANAGEMENT

Not all EVOLUTIONS Payors are required to use medical management or utilization review. Those who have programs use multiple sources. Although the sources differ, the general program is predominantly consistent among utilization review organizations. The typical program includes pre-certification of elective hospital admissions, concurrent review of the patient stay at intervals determined by the clinical findings and treatment of the patient, retrospective review and large case management. Utilization review is a key element to assure that your patients receive health care services that are medically necessary and that the claims for these services are properly submitted for payment.

Pre-certification and concurrent reviews are primarily telephone assessment processes. Pre-certification is initiated by the provider upon notification that an inpatient confinement is imminent. The utilization review company then contacts the admitting physician to gather the clinical findings and anticipated length of stay for the proposed admission for the reported clinical findings. The criteria used are similar to those used regularly in today's health care market. On-site visits are rarely performed and used only when circumstances warrant.

There are a few Payors who have integrated several outpatient procedures into the utilization review program for certain surgical or diagnostic procedures. In these programs, the Pre-certification of the procedure is initiated and reviewed in the same manner as an inpatient hospital confinement. Once again, the medium for these reviews is typically telephonic and seldom includes on-site visits.

For questions regarding pre-certification requirements, please contact the Utilization Management Company. The phone number is located on the back of the member's identification card.

CLAIMS ADMINISTRATION

Timely Submission and Payment of Claims

EVOLUTIONS encourages timely submission of clean claims to EVOLUTIONS for repricing and forwarding to the appropriate payor. Any payments due by payors shall be reduced by any applicable Co-payments, Deductibles, and/or Co-insurance, if any, specified by the member's benefits. Payment is subject to industry standard coding and bundling rules, if any.

Provider understands that EVOLUTIONS is not an administrator, insurer, underwriter, guarantor, or payer of claims and is not liable for any payment of claims for services.

Most plans are set up for claims to be sent directly to Evolutions. ***Please refer to the back of the member's ID card to confirm appropriate claims routing.***

When claims are to go to Evolutions

Submitting Claims by Mail: Claims must be submitted using HCFA-1500 or CMS-1500 claim form to:

Evolutions Healthcare Systems, Inc.
Attention: Claims Department
Post Office Box 5001
New Port Richey, FL 34656

Submitting Claims Electronically: EVOLUTIONS is fully HIPPA compliant with respect to the transmission of claims. Per HIPPA mandates, EVOLUTIONS utilizes ANSI X12 837 – 5010 format.

https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance?redirect=/home/regsguidance.asp

The link above directs you to the Centers for Medicare & Medicaid Services (CMS) website containing information and educational resources and standards:

Providers may submit claims for processing using our Payor ID# 59313. EVOLUTIONS re-prices the claims according to the contractual agreement and posts them daily on our secure FTP site for downloading by our payors.

Disputing a Claim

As a Provider with EVOLUTIONS you have the right to dispute a claim. If you dispute is with the discounted allowance, please contact EVOLUTIONS at 1-727-938-2222 or send an email to CONTRACTING@ehsppo.com. All other disputes should be addressed to the appropriate payor listed on the member's ID card.

Failure to Submit a Clean Claim

If EVOLUTIONS receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication or the payor has some other reason to dispute the claim will be returned to you via US Mail with an explanation.

Inquiries

If your inquiry is regarding a denial of benefits, claim status, or if you believe the claim was not paid appropriately, please contact the claims payor listed on the patient's identification card.

Inquiries regarding EVOLUTIONS contract rates used to price a claim may be directed to the EVOLUTIONS Customer Service Department at 1-727-938-2222 . A representative will provide immediate assistance in resolving your concerns or will refer you to the appropriate in-house party for resolution.

Inquiries may also be submitted in writing from you or your authorized representative and should outline your concerns. The inquiry must identify the pertinent issue and include supporting documentation. For prompt consideration include the patient's name, date of birth, a copy of the claim which includes service dates, and billed amount, the member number and a copy of the EOB if necessary.

If your network participation is through an IPA/PPO/PHO or an affiliate network that holds the contract with EVOLUTIONS, please contact them regarding their requirements pertaining to contract concerns.

PROVIDER INFORMATION CHANGE FORM

This form is to be used for any pertinent changes/additions to your file including TID# and Address (TID# changes should be accompanied by a new W-9)

Provider Name:	Specialty:
New TID#:	Previous TID#
New Address:	Previous Address:
New Phone #:	Previous Phone #:
New Fax #:	Previous Fax #:
New Email Address:	Previous Email Address:
Provider Termination:	Group Affiliation:
Mail or Fax to: Evolutions Healthcare Systems, Inc Attention: Provider Maintenance PO Box 5001 New Port Richey, FL. 34656 Phone: 727.938.2222 or Toll Free: 800.308.2749 Fax: 727.938.2880	
Form Completed by: (please print)	Date:
Please make photocopies if additional forms are required	