PARTICIPATING PROVIDER MANUAL

Revised and Restated March 2021

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 provide unmatched quality in delivering managed care services responsive to the needs of patients, health care providers and payers.

As a new provider, we have enclosed 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 ("EHS") 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, EHS offers a comprehensive suite of health plan solutions and claims processing services. The EHS PPO access and repricing solution is powered by TRX (Transaction Re-pricing & eXchange) service architecture. TRX is a proprietary system developed by EHS 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 28 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 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?

EHS 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?

EHS 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 EHS?

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:

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

Am I a participating provider with Evolutions Healthcare Systems?

To determine your status as a participating provider, 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?

EHS 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

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

Protocols and Guidelines

Provider acknowledges that all decisions of whether or not a service is a covered service, are made solely made by the member's payor to determine if payment of benefits under applicable member contract is appropriate. Providers should encourage members under their care to review the coverage of their health care with their employer and/or payor for benefits, procedures, exclusions or limitations prior to receiving treatment.

Identification Cards

Depending on the product(s) you are enrolled in, identification cards will have an Evolutions logo on the front of the card clearly identifying members who are able to access you as an Evolutions Preferred Provider. The insured should present the identification card prior to services being rendered;

- Prime product requires a Logo and Explanation of Benefits form ("EOB") language identifying the network pricing your claim
- Select product requires a Logo and EOB language identifying the network pricing your claim
- International product requires a Logo and EOB language identifying the network pricing your claim
- The Choice and Worker's Compensation products do not require EHS Logo's however they do require EOB language identifying the network pricing your claim
- 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.
- Claims should be sent to EHS via the EDI Payor number or physical address on the ID card.

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

Provider Responsibilities

Providers may be contract directly with EHS 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 EHS
- 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 EHS 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 EHS, 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 EHS of the change.

If your network participation is directly with EHS 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, we prefer updates to be submitted via email to providerchanges@ehsppo.com in the following format:
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- For individual changes a Provider Update form may also be downloaded from our 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 EHS if additional information or clarification is required.

Member Identification and Acceptance: All members utilizing EHS' 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
- Applicable copayment or coinsurance
- Important telephone numbers for eligibility, benefit verification, pharmacy, mental health and utilization management

Verification of Eligibility and Benefits: Prior to rendering services, EHS 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 Provider with EHS, 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.

EHS 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 EHS 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

Utilization Management

Not all EHS 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 predominately 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

EHS encourages timely submission of clean claims to EHS 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 EHS 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:*** EHS is fully HIPPA compliant with respect to the transmission of claims. Per HIPPA mandates, EHS utilizes ANSI X12 837 – 4010 and the new 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 pertaining to:

Version 5010 - the new version of the X12 standards for HIPAA transactions;

Version D.0 - the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;

Version 3.0 - a new NCPDP standard for Medicaid pharmacy subrogation.

These versions are required by the modifications made to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in January 2009.

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

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

Failure to Submit a Clean Claim*:* If EHS 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 EHS contract rates used to price a claim may be directed to the EHS 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 EHS, 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	