

ALLOWABLE (ELIGIBLE) CHARGES

Allowable (known as Eligible Charges or Usual, Customary and Reasonable (UCR))

The charges on which benefits are based and which are subject to any deductible, copay or coinsurance. Previous allowable charges have also been referred to as excess UCR (usual, customary and reasonable) charges. That standard has been changed to reflect current methodology which establishes allowable charges based on what is typically accepted for the same service within a given geographical area in accordance with the Claim Instant Audit (CIA) Specialty Review Process which is used for all out of network charges or charges where PPO fees have not been negotiated or there is no established fee. Charges in excess of allowable charges are handled in one of two ways depending on the type of provider:

- ◆ **PPO providers:** Excess charges are discounted (written off) and are not balance billed to the member. Eligible charges are limited to the negotiated PPO fee. The PPO discount is to be credited by the provider and members are not responsible for any PPO discount and may not be balance billed. PPO providers will be paid based on the following priority: NHAI PPO, Magnacare, Three Rivers (TRPN) and MultiPlan when a provider is in multiple networks. NHAI reserves the right to determine a “reasonable” allowance for the actual cost of any item, supply or medical equipment that is outside the PPO Contract using the CIA Specialty Review Process.
- ◆ **NPPO Providers:** Excess charges “may” be balance billed to the member who in turn may negotiate a reasonable fee with the Provider for final payment. Members should be aware of potential charges and liability if they choose to go out of network. NHAI reserves the right to make a reasonable determination based on all facts and circumstances to determine a “reasonable” allowance for the actual cost of any item, supply, or medical equipment outside the PPO Contract and for any inpatient/hospital charges by out of network providers. NHAI reserves the right to utilize the **Claim Instant Audit (CIA) Special Review Process** for determining allowable charges on any high dollar claims, primarily for hospital and surgical charges or on any claim where it appears that there may be abusive billing practices or unreasonable charges for any item. The allowable charges for all **non-audited claims** will be based on the usual, customary and reasonable (UCR) charges determined by Ingenix at the 80th percentile.
- ◆ **Vaccines – Major Medical Prescriptions with No Established Medicare Fee.** Reimbursement rates will be limited to 130% of the Average Sales Price (ASP) as established for Medicare Reimbursement or the amount determined under the Claim Instant Audit (CIA) Specialty Review both PPO and NPPO providers. If the ASAP rates are not available, reimbursement will be limited to Red Book AWP at 120%. This shall not apply to Accredo Specialty drugs or Major medical injections that exceed \$1,000.
- ◆ **When Durable Medical Equipment is Purchased.** The maximum allowed purchase price will generally be equal to 12 month’s rental fee, unless another fee is negotiated and approved in advance of purchase. All DME expected to cost over \$500 must be preapproved.

Claims Instant Audit (CIA) for Determining Allowable Charges

CIA uses a number of different automated protocols to objectively reduce bills to fair, unbiased payment recommendations where there is no applicable fee schedule, no contractual discount available, or “gaps” in the state fee schedule exist on certain bill types. The Office of Inspector General in 2003 in an effort to bolster new anti-fraud regulations defined a fair and equitable payment for medical services to be one based on reimbursement data for the services rendered¹.

This “prevailing payor rate” philosophy is a marked paradigm shift from the prevalent usual and customary charges mentality. Bill review based upon analysis of what the provider is actually being paid for the service should be the standard – not the highly biased provider charge amounts.

CIA integrates a proprietary database of over 20 million claim transactions of provider payment data into our software to create accurate, consistent, and defensible savings for our clients. The process is unique enough to be supported by the US Patent Office who has accepted the patent application for the innovative data metrics and analysis techniques involved to ensure a fair payment.

¹Federal Register, Volume 68, No. 178, 09/15/03, p. 53939

CIA includes extensive research regarding the applicable standards for re-pricing medical bills in each state. These standards include:

- ◆ Definitions of reasonable reimbursement specific to that jurisdiction
- ◆ Allocations to other payers for costs of treatments for unrelated conditions
- ◆ Application of retrospective utilization review for medical necessity when state rules permit

CIA Phase 1 -Charge Verification Compliance

Every claim is reviewed for:

- ◆ Coding errors and inappropriate up-coding
- ◆ Billing errors (unbundling, mutually exclusive, etc)
- ◆ Clinically inappropriate items. Depending on the rules of the applicable jurisdiction, this may also include screening for billings for unrelated/pre-existing conditions, iatrogenic injuries, etc.
- ◆ Items that have been inappropriately charged. (Note: This is typically done manually by nurse reviewers and is highly subjective – we have automated this function.)

CIA Phase 2 – Proprietary Data Benchmark Pricing Model

- ◆ Every bill is compared to the cost of service for similar services by other providers in the local area
- ◆ Every bill is benchmarked to our proprietary database of payer reimbursement data
- ◆ Every bill is weighed against the provider's average contractual discounts and charge data
- ◆ Every bill is evaluated as to our previous claim savings history with that provider

CIA Phase 3 – Price Determination

- ◆ Evaluation of the provider's own usual charge and reimbursement totals for the service
- ◆ Pricing benchmarks are analyzed and a reasonable payment recommendation produced -instantly

CIA Phase 4 – Verification of Provider Profit Margin

- ◆ Our recommended reimbursement is automatically compared to the provider's fully-loaded direct and indirect costs plus average profit margin trended over 3 years to ensure profitability for the provider.

Important Notice to Members:

Members should request that providers accept as full payment the plan benefit plus the normal NPPO deductible, copay, and/or coinsurance. However, NHAI has no control over what a provider's billing practices will be and members should be prepared in advance of the possibility of being responsible for significant extra charges when using an out of network hospital or provider, even when they are enrolled Out of Area, since Out of Area members are still responsible for excess charges over the Allowed Charges by this Plan.

Dental Providers Not Enrolled as Medical Providers are Out of Network Providers

Dental PPO Providers are considered Out of Network for purposes of any Medical services unless they are also in the Medical PPO Network. Oral Surgeons perform both medical and dental procedures.

Medicare Primary Members

Allowable charges for Medicare covered expenses are limited to the Medicare Allowable Charge. For purposes of benefit payment, Medicare providers are treated the same as NHAI PPO providers. For charges where there is no established Medicare allowable fee or non Medicare services, the allowable charge shall be based on the allowable charge for providers who are PPO Providers or the allowable charges under the CIA Specialty Review Process.

Member Responsibility

Members are responsible for verifying a provider's PPO status prior to service. Members who fail to maximize their Primary Plan benefits by using a provider not covered by their Primary Plan will receive benefits from this Plan based on what this Plan would have paid had the Primary Plan paid its normal benefit. This Plan will never pay more than the allowed charge less the Primary Plan payment.