Provider Manual

curative

Table of Contents

Section 1 | How to Contact Us

Welcome to Curative, a new kind of health plan with no copays, no deductibles and no out-of-pocket costs, including many generic, brand name and specialty medications.* The full cost-transparency not only means better access to care for your patients, but more time for you to provide high-quality care that you saved from bill collections.

**Members must complete a Baseline Visit with Curative in the first 120 days of enrollment to qualify for $0 copays and deductibles.*

Curative Member Eligibility	curative.com/eligibility
Provider Relations	General Info: providerrelations@curative.com Support: 855-414-1083
Credentialing	General Info: credentialing@curative.com
Clinical Care and Medical Management Prior Authorizations OR Notifications	Curative P.O. Box 1587 | Austin, Texas 78767 OR Main: 855-414-1089, Fax: 877-942-4448
Claims Submission Address and Reconsideration	Curative P.O. Box 1786 Austin, Texas 78767
Appeals Submission	Fax: 877-734-6537
Curative Pharmacy	curative.com/drugs
Curative News and Updates	curative.com/blog
Curative Health Plan	curative.com

Need help or have a question?

We're here to make health insurance coverage easy. Please reference the key points of contacts for each department.

Section 2 | Our Products

Provider Manual Updates

Curative may periodically update this Provider Manual. We will provide written notice of material changes to any policy or procedure in this Manual if specified in your Agreement with us. We encourage you to contact your **Curative** Provider Representative for any needed clarification on any information.

Regulatory Requirements

Curative complies with all Federal and Regulatory requirements. Refer to Section 11 to review the policies and procedures in place which demonstrate compliance with such requirements.

Our Plan

In-Network and Out-of-Network benefits apply to eligible employees and their dependents and services are limited to the allowable amount as determined by Curative. All In-Network providers have agreed to accept the Curative allowable amount. For Out-of-Network providers, any charges over the allowable amount for services are the patient's responsibility, in addition to the deductible and coinsurance.

If the member completes their Baseline Visit within 120 days of their effective date in the **Curative** Plan, most copays, deductibles and coinsurances will be waived. In-Network providers will receive the Curative allowable amount, as defined by the contract. Maximum visits and limitations will continue to apply.

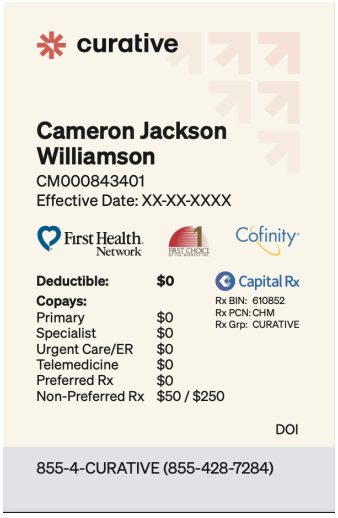
The Baseline Visit is an appointment with a **Curative** Clinician for the Clinical Assessment related to the member's current health status to help them optimize their health care. The Assessment will also include an Evaluation of Preventive recommendations indicated by United States Preventive Services Task Force (USPSTF) and whether immunizations are up to date.

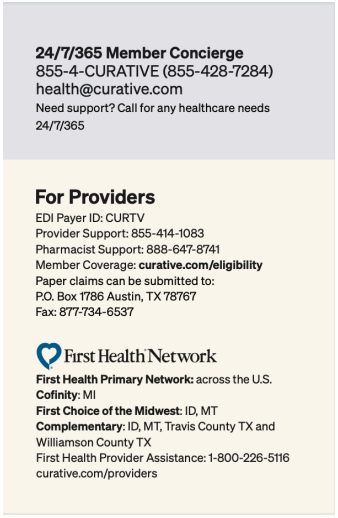
Section 3 | Member Identification Card

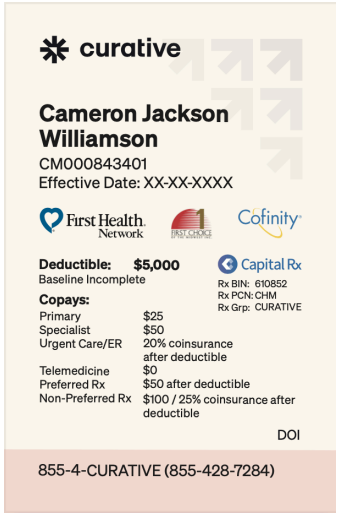
Sample ID Card

Fully Insured Plans

Baseline Visit Completed - All new Curative members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.

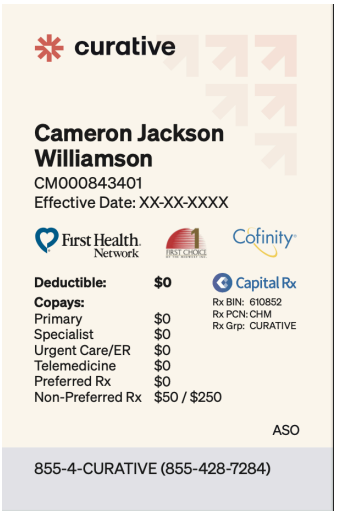






Baseline Visit Incomplete - Effective 1/1/23, if the Curative member does not complete the Baseline Visit in 120 days from from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.

Self Insured Plans	
Baseline Visit Completed - All new Curative members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.	**Baseline Visit Incomplete -** Effective 1/1/23, if the Curative member does not complete the Baseline Visit in 120 days from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.


curative

Cameron Jackson Williamson
CM000843401
Effective Date: XX-XX-XXXX

First Health Network · First Choice · Cofinity

Deductible: $0
Capital Rx
Rx BIN: 610852
Rx PCN: CHM
Rx Grp: CURATIVE

Copays:
Primary $0
Specialist $0
Urgent Care/ER $0
Telemedicine $0
Preferred Rx $0
Non-Preferred Rx $50 / $250

ASO

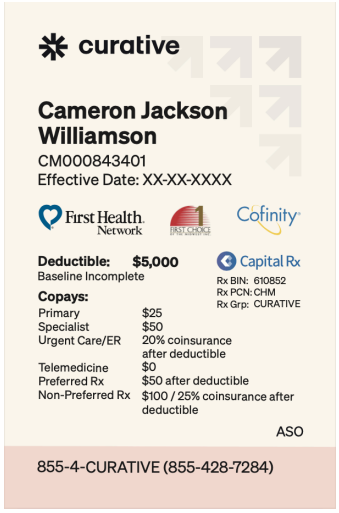
855-4-CURATIVE (855-428-7284)


24/7/365 Member Concierge
855-4-CURATIVE (855-428-7284)
health@curative.com
Need support? Call for any healthcare needs 24/7/365

For Providers
EDI Payer ID: CURTV
Provider Support: 855-414-1083
Pharmacist Support: 888-647-8741
Member Coverage: **curative.com/eligibility**
Paper claims can be submitted to:
P.O. Box 1786 Austin, TX 78767
Fax: 877-734-6537

First Health Network

First Health Primary Network: across the U.S.
Cofinity: MI
First Choice of the Midwest: ID, MT
Complementary: ID, MT, Travis County TX and Williamson County TX
First Health Provider Assistance: 1-800-226-5116
curative.com/providers


curative

Cameron Jackson Williamson
CM000843401
Effective Date: XX-XX-XXXX

First Health Network · First Choice · Cofinity

Deductible: $5,000
Baseline Incomplete
Capital Rx
Rx BIN: 610852
Rx PCN: CHM
Rx Grp: CURATIVE

Copays:
Primary $25
Specialist $50
Urgent Care/ER 20% coinsurance after deductible
Telemedicine $0
Preferred Rx $50 after deductible
Non-Preferred Rx $100 / 25% coinsurance after deductible

ASO

855-4-CURATIVE (855-428-7284)


24/7/365 Member Concierge
855-4-CURATIVE (855-428-7284)
health@curative.com
Need support? Call for any healthcare needs 24/7/365

For Providers
EDI Payer ID: CURTV
Provider Support: 855-414-1083
Pharmacist Support: 888-647-8741
Member Coverage: **curative.com/eligibility**
Paper claims can be submitted to:
P.O. Box 1786 Austin, TX 78767
Fax: 877-734-6537

First Health Network

First Health Primary Network: across the U.S.
Cofinity: MI
First Choice of the Midwest: ID, MT
Complementary: ID, MT, Travis County TX and Williamson County TX
First Health Provider Assistance: 1-800-226-5116
curative.com/providers

Eligibility Verification

All participating providers are responsible for verifying a member's eligibility at each and every visit. Providers can verify member verification through one of two methods:

- Contact Curative Provider Services at 855-414-1083
- Navigate to https://curative.com/eligibility
  - Enter the Member ID, Last name, DOB
  - Click 'See Coverage'
  - You'll see the member's coverage dates, basic copays and deductible information

Section 4 | Prior Authorization and Notification

Curative Clinical Care Management (CCM) includes the following services:

- Prior Authorization of certain services is required.
- Notification only of certain services is required.
- Concurrent review of members in hospitals, SNF, and LTAC.

Access to the services requiring the above listed levels of authorization, notification and/or concurrent review may be accessed at https://curative.com/provider-resources.

Any time you have Clinical Care Management questions and/or concerns regarding a Curative member, we encourage you to call us at 855-414-1083. The Clinical Care Management department maintains a toll-free fax line 24 hours daily. The fax number is 877-942-4448.

Prior Authorization Process

- **Review Criteria Source**: Prior authorization requests are reviewed utilizing decision guidelines based on reasonable evidence. Curative uses MCG (formerly Milliman Care Guidelines) which is a national approved care guidelines entity to perform prior authorization.

- **Contact Information**: The Clinical Care Coordinators may receive prior authorization requests via telephone, fax, or HIPAA secure encrypted email from the provider's office. The guidelines are applied and the services are authorized by the Clinical Care Coordinator, or referred to the Medical Director or Physician Reviewer for approval.

- **Physician Review:** The physician reviewer reviews all cases where the potential for denial is possible. In any instances where the medical necessity or appropriateness of the requested service is questioned, the medical director or physician reviewer will make every reasonable effort to contact the requesting provider in order to afford him/her the opportunity to discuss the plan of treatment and the clinical basis for the decision, prior to a final determination.

- **Adverse Determination:** Any Adverse Determinations will follow established policies prior to final determination and communications of the Adverse Determination to the member and providers.

- **Prior authorization Numbers**: Curative will provide prior authorization numbers that fully comply with the format for federal and state requirements and currently utilizes ANSI ASC X12 837 claim form format.

Notification

Prior Authorization for medical necessity of services does not guarantee the network level of benefits. Even if approved by Curative, non-network providers paid at the Curative allowable amount may balance bill for charges in excess of this amount. The member is responsible for these charges, which can be significant.

Certain services, such as emergency admissions, maternity admissions, only require notification to **Curative**. Prior Authorization and Notification Requirements may be accessed at https://curative.com/provider-resources.

Prior Authorization and Notification Contact Number

- Clinical Care Management Fax 877-942-4448

Prior Authorization Form: Curative accepts the Texas Standard Prior Authorization Request Form in lieu of the **Curative** Prior Authorization Form. The form may be accessed at https://curative.com/provider-resources.

The **Curative** Prior Authorization may be accessed at https://curative.com/priorauth.

Concurrent Review

Curative performs concurrent review and discharge planning on inpatient admissions and observations, consistent with health plan benefits. **Curative** will work closely with the attending physician and hospital discharge planners to coordinate the use of home health care and other health care alternatives, which may decrease a hospital's length of stay.

Disease Management

Disease Management is available for qualifying members identified with high-risk diseases, such as diabetes, COPD, and other conditions as identified.

Case Management

Case Management is available for members with high-risk issues, non-compliance, or multiple acute disease processes. **Curative's** Case Management utilizes close monitoring, patient / family education to achieve patient acceptance and compliance. Case Management encourages the interventions of other health care providers, social services and other resources as indicated. The Case Manager works closely with the physician and the alternative care providers to assist the patient and family in understanding the care needs and limitations of the patient. If a Provider identifies a member that may be a candidate for Case Management services, please notify our Clinical Case Management Department by contacting Provider Services at 855-414-1083.

Discharge Planning

Discharge Planning is available to provide assistance to any member being discharged while assuring quality and continuity of care. **Curative** evaluates and assists in identifying the patient's needs for transition from the

acute hospital to home or to the most appropriate setting and is coordinated with the patient and their family, Case Manager, and attending physician working as a team to identify the needs of the member.

Management of Members With Special Circumstances

Some members may require services that fall outside of the ordinary scope of Clinical Care Management or Clinical Case Management. Under these special circumstances, **Curative** may identify the member's special circumstances which include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness and will gather the facts of the case and forward to the Medical Director who will develop a plan of action to assist the member with special circumstances.

Section 5 | Adverse Determination

Contact Information

If you have questions and/or require clarification regarding an adverse determination and/or the appeal process, please do not hesitate to contact **Curative's** Provider Services Department at:

- **Provider Services** 855-414-1083
- **Fax** 877-942-4448

Adverse Determination

An **Adverse Determination** is an instance where **Curative** is questioning the medical necessity or appropriateness or the experimental or investigational nature of health care services.

All **Curative** Prior Authorization requests will be reviewed for medical necessity. Requests for services may be denied for the following reasons:

- Not medically indicated (Adverse Determination).
- Services are considered experimental or investigative (Adverse Determination).
- Services can be safely provided in an alternative setting or level of care (Adverse Determination).
- Services rendered were not determined to meet the definition of emergency care (Adverse Determination).

Adverse Determinations may only be issued by the Medical Director or Physician Reviewer. All requests for services that do not meet the predetermined criteria are forwarded to the Medical Director or Physician Reviewer for consideration. The Medical Director will make every reasonable effort to discuss the case with the requesting physician prior to issuing an Adverse Determination.

Administrative Denials may be issued by the Clinical Care Coordinators which relate to cases, such as an employee is not eligible, or benefits are not a covered service.

Notification of Denial of Service

Provider Notification: The requesting provider shall be notified via phone call or electronic transmission. The written notification will be provided no later than the third (3rd) working day after the date of the phone call or fax. If related to acquired brain injury, provider notification will be via phone call.
All other notifications will be in writing. Such communications will include the following:

- A clear and concise statement of the specific medical or contractual reasons for the resolution shall be sent to the requesting provider and include a request for further information or action.
- The information regarding the appeal process and the right to appeal the decision, including instructions and how to file a complaint to Curative.

Member Notification: Members will be notified of the denial of services via the United States Postal Service. Notification will include a description of the procedure for filing a complaint and for filing an appeal. It will include a notice to the member of the member's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department Insurance.

Curative will use the following notifications:

Hospitalization

If a patient is hospitalized at the time of the adverse determination, **Curative** will notify the Provider of record:

- Within one (1) working day by phone or electronic transmission,
- Will follow with a letter within three (3) working days to notify the member and the provider of record of this determination.
- The letter shall state that benefits will be terminated at a stated date and time after notification.
- The notification letter will also inform you as to the right of appeal and the process to follow.

Medical (No Hospitalization)

If the patient is not hospitalized at the time of the adverse determination, **Curative** will notify the member and the provider of the record within three (3) working days in writing.

Post Stabilization

If the adverse determination is related to denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, **Curative** shall provide the notice to the treating physician or other health care provider no later than one (1) hour after the time of the request followed by a letter within three (3) working days to all parties.

Retrospective Review

If an adverse determination is related to a retrospective review, **Curative** will notify the provider of record and the member within a reasonable period, but not later than thirty (30) days after the date on which the claim was received.

Adverse Determinations Appeal

A member, a person acting on behalf of the member, or the member's provider may appeal an adverse determination orally or in writing for an adverse determination for a prior authorization, concurrent review, retrospective review, or any appeal of an adverse determination made by **Curative.** All appeals for reconsideration of an adverse determination will be processed within set time frames and must fulfill the requirements as follows:

- All appeals must be submitted to **Curative** orally or in writing.
- The appealing party will be allowed not less than 120 calendar days (or as noted in your contract with **Curative**) after the date of issuance of written notification of an adverse determination to file an appeal.
- In a circumstance involving a member's life-threatening condition, the member is entitled to an expedited appeal or an immediate appeal to an IRO and is not required to comply with procedures for an internal review by **Curative**.
- **Curative** may not require exhaustion of internal appeals prior to external review if:
    - **Curative** fails to meet its internal appeal process timelines as above, or
    - The claimant with an urgent care situation files an external review before exhausting **Curative's** internal appeal process.
- Within five (5) working days from the receipt of the appeal, **Curative** will send an acknowledgment letter to the patient or a person acting on the patient's behalf and the patient's physician or other health care provider.
- Appeal decisions will be made by a physician who has not previously reviewed the case.
- Once a determination of an appeal is made, written notice will be sent to all relevant parties of the determination of the appeal as soon as practicable, but not later than the thirtieth (30th) calendar day, after the date **Curative** receives the appeal.
- If an appeal is denied and, within ten (10) working days from the denial, the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty that typically manages the medical or specialty condition, procedure, or treatment under discussion. The specialty review must be completed within fifteen (15) working days of receipt of the request.
- After **Curative** has reviewed the appeal of the adverse determination, a letter will be sent to the member or an individual acting on behalf of the member, and the provider of record, explaining the resolution of the appeal.

Adverse Determinations Expedited Appeal Process

Curative provides a method for expedited appeals for emergency care denials, care for life-threatening conditions denials, and/or continued stays for hospitalized member denials.

- Expedited appeals will be reviewed by a specialist who has not previously reviewed the case and is of the same or similar specialty, as would manage the member condition under review. In addition, the specialist reviewer may interview the member, an individual acting on behalf of the member, or the provider to make a decision.
- The expedited appeal will be completed based on the immediacy of the condition and not later than one (1) working day for the date all the information necessary to complete the appeal is received and communicated by phone. A letter will always follow up oral notification of the expedited appeal decision within three (3) working days from the date of the decision.
- All correspondence with the appealing party/parties will be in writing and signed by the Medical Director or designee.
- In any circumstance involving a member's life-threatening condition, the member is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review or expedited appeal.

Specialty Review Appeals for Adverse Determinations

A provider of record may request that a particular type of specialist review an adverse determination by providing a good cause explanation for such request.

Section 6 | Member Complaints and Appeals

Member Complaints

If you are dissatisfied with any aspect of the operation of **Curative**, including but not limited to dissatisfaction with plan administration, you may either start a complaint or file an appeal. Dissatisfaction or disagreement with an Adverse Determination should be resolved through the Adverse Determination Appeals process in Section 5: Adverse Determinations of this Provider Manual. Complaints should be directed to **Curative** Provider Services at 855-414-1083 or in writing to:

Curative
ATTN: Complaints and Appeals Department
P.O. Box 1786
Austin, Texas 78767

When **Curative** is notified orally or in writing of a complaint, we will, not later than the fifth business day after the date of the receipt of the complaint, send to the person making the complaint a letter acknowledging the date we received the complaint. If the complaint was received orally, **Curative** will enclose a Complaint Form clearly stating that the Complaint Form must be returned to us for prompt resolution.
After receipt of the written Complaint or Complaint Form, we will investigate and send a letter with our resolution within 30 calendar days.

A complaint concerning ongoing emergencies or denial of continued stay for hospitalization will be resolved in one business day of receipt of the complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

If you are not satisfied that your complaint is resolved or if you do not want to file a complaint, a member or their representative or rrovider can file an appeal.

Member Appeals Process

Curative provides an appeal process for a member who is not satisfied with the resolution of the complaint. The appeals process allows the member (or a person acting on their behalf) to appear before a **Curative** Appeal Panel. Appeals must be made in writing and submitted to the following address:

Curative
ATTN: Complaints and Appeals Department
P.O. Box 1786
Austin, Texas 78767

Curative will send an acknowledgment letter to the member not later than the 5th business day after the date the written request for appeal is received and will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

Contact Information

If you have questions and/or require clarification regarding a complaint and/or the appeal process, please do not hesitate to contact **Curative's** Provider Services Department.

Provider Services 855-414-1083
Fax 877-942-4448
P.O. Box 1786
Austin, TX 78767

Section 7 | Claims Processing and Payment

Claims Processing

We work hard to ensure that your claims are processed timely and accurately. To be paid promptly for the services you provide, please follow these procedures:

- Submit claims within 95 days (or as noted in your **Curative** contract) from the date of service/date of discharge unless otherwise indicated in your Agreement. Additional time will be available when **Curative** is the secondary payor for a claim when Coordination of Benefits is applicable.
- To check member eligibility by phone, call **Curative** Provider Services at 855-414-1083.
- When applicable, obtain prior authorization or notify us for planned procedures and services.
- Prepare a complete and accurate claim form.
- Facilities may submit interim billings for extended services.
- Submission of claims that include drugs must also include the NDC Code, Quantity and Dosage provided.

Claims Submission

You have the option of submitting claims electronically or by mail. We encourage use of electronic claims submission methods to help you:

- Prepare a complete and accurate claim form.
- Receive explanations of payment and your reimbursements more quickly.
- Save time.

Electronic Claims
Providers choosing electronic submission must use the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. **Curative** utilizes TriZetto as an allowable clearinghouse. Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse to establish EDI with Curative. Please contact Provider Relations if assistance is needed.

Paper Claims
Paper claims can be submitted to the address on the member Identification Card noted below:

Curative
P.O. Box 1786
Austin, Texas 78767

Electronic Payment Methods (EFT/ERA)

Curative offers the ability to receive claims payments and remittance advices electronically. Both options offer benefits over paper transactions. The EFT form can be accessed from our Provider Relations Representative.

- **Electronic Funds Transfer (EFT)**
  Electronic Funds Transfer (EFT) is the electronic exchange of claims payments. It is safe, secure and quicker than paper check payments. EFT allows payments to be deposited electronically directly into a bank account once a claims payment is released. There is no need to manually deposit checks.
  https://curative.com/electronic-claims-processing

- **Electronic Remittance Advice (ERA)**
  Electronic Remittance Advice (ERA) enables you to receive claims payment information electronically. ERA files are transmitted in the HIPAA mandated ASC X12 835 5010 A1 format. ERA allows providers to post claims remittances electronically to your billing software vendor or clearinghouse to automate manual processes.

Clearinghouse	Payer ID	Contact Information
TriZetto www.trizettoprovider.com	CURTV (Professional Claims) CURTV (Institutional Claims)	Phone: 1-800-556-2231 Email: physiciansupport@cognizant.com

Claims Status Inquiries

Providers can verify the status of their submitted claim status telephonically by contacting **Curative** Provider Services at 855-414-1083.

Overpayments

We will inform you in writing of an overpaid claim within 180 days of the date of payment and you will have 45 calendar days (unless otherwise indicated in your Agreement) from receipt of notice to refund the money back to us. If your payment is not received by that time, we may offset the overpayment against future claim payments, or in accordance with the terms of your Agreement.. *For further details, please refer to your **Curative Provider Agreement**.*

All overpayment refunds should be sent to the address below. In the case that you identified an overpayment and are refunding the amount, please provide sufficient documentation (Member ID, Date of Service, Claim Number, Overpayment Amount and Reason for Overpayment, if known) to enable us to research the overpayment.

Curative
Attn: Refunds
PO Box 1786
Austin TX 78767

Coordination of Benefits and Subrogation

Coordination of Benefits
Curative shall coordinate payment with the terms of a member's benefit plan and applicable state and federal laws. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to **Curative** (when **Curative** is secondary). Any balance due after receipt of payment from the primary payer should be submitted to **Curative**. The claim must include information verifying the payment amount received from the primary. If Medicare is the primary payer, we will use the Medicare Allowed Amount.

Subrogation
In the event if one of our members is injured by the act of a third party, **Curative** reserves the right to recover payments for items or services provided to that member to the extent permitted by applicable laws. Providers shall cooperate in our effort to recover reimbursement from the responsible third party. Upon receiving payment from the responsible party, the provider shall refund the amount of payment up to the amount paid by the third party for the items or services involved.

Claim Reconsideration

Providers are encouraged to submit a Claim Reconsideration if you feel a claim was not processed correctly. You have up to 90 days from the date of the original Explanation of Benefits (EOB) or Providers Remittance Advice (PRA) to request reconsideration of a claim. A claim reconsideration request is appropriate if you believe **Curative** underpaid you or if you are disputing claims denials for timely filing, missing information or coordination of benefits. A Claim Reconsideration must be resubmitted before a claims appeal can be submitted. If you feel that your claim was denied in error, you may request a reconsideration of your claim verbally by calling 855-414-1083.

*For further details, please refer to your **Curative Provider Agreement**.*

Appeals

Please provide any supporting documentation with a copy of the EOB or the denial letter to the address below or fax to: 877-734-6537.

Curative
Attn: Claim Reconsiderations
PO Box 1786
Austin TX 78767

Curative will make every effort to resolve the reconsideration within 45 business days. *For further details, please refer to your **Curative Provider Agreement**.*

If you disagree with either the claim reconsideration determination or payment adjustment, you have 90 days from the date of the original Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) to file a formal appeal of the decision. Please include a copy of your denial, a detailed explanation for your appeal as well as all supporting documentation. *For further details, please refer to your **Curative Provider Agreement**.* An appeal must be submitted to the address provided below or fax to 877-734-6537.

Curative
Attn: Provider Appeals
PO Box 1786
Austin TX 78767

Curative will consider the appeal request and issue a written decision to you within 30 days of receipt of the appeal request. Your appeal will be reviewed by a claims representative not involved with the initial decision.

Charging Members for Non-Covered Services

When the service the provider is furnishing is not covered by **Curative** and the provider has informed the member that the service is non-covered before providing the service, the provider may bill the member.

A service may be non-covered for one of three reasons:

1. It is excluded from **Curative** coverage.

2. It would be covered by **Curative**, but it exceeds a benefit limit, such as a limited number of occupational therapy visits.

3. If the services have been deemed to not be medically necessary or experimental, it may be considered a non-covered service. If a provider has documentation that **Curative** has denied a request for prior authorization because the service is not medically necessary or is considered experimental, the provider may bill the member if the provider has informed the member prior to delivering the service that will not be covered by **Curative** and the patient has agreed to pay.

Section 8 | Provider Dispute Resolution

Claims Dispute Resolution Process

If a Claims Reconsideration is not satisfactorily resolved, Providers may file a formal appeal of the decision. **Curative** will consider the appeal request and issue a written decision to you within 45 days of receipt of the complete appeal request. Your appeal will receive an independent review by a **Curative** representative not involved with the initial decision. A detailed explanation of the Claims Dispute Resolution Process can be found in Section 6: Claims Processing and Payment of this Provider Manual. All appeals and resolutions must be submitted and completed within 12 months of the service date.

When **Curative** does not receive all necessary information to make a decision, we shall request in writing within 30 calendar days of receipt of the request the additional information needed. **Curative** shall allow 30 calendar days from the date of the request to receive the requested information. If the provider does not respond within the 30 calendar day timeframe, **Curative** shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

Arbitration

If either party remains dissatisfied after following the claims dispute resolution procedures in this section, an arbitration proceeding may be filed unless otherwise stated in your Agreement with **Curative.** In the event that arbitration becomes necessary, such arbitration shall be initiated by making a demand of the other party. The shared fees and costs of arbitration (fee of the independent arbitrator, etc.) will be shared equally between the parties or as indicated in the Agreement. Each party shall be responsible for the payment of that party's specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.).

Prior Authorization Dispute Process

Providers who have a dispute that involves Clinical Care Management's review for denied service prior authorizations can first attempt to resolve the dispute by contacting **Curative** Clinical Care Management. The appropriate individual(s) in **Curative** Clinical Care Management will reconsider concerns and notify you of the outcome. Also or instead, providers may appeal Clinical Care Management decisions in accordance with the appeals process defined in this Provider Manual under Section 5: Adverse Determinations.

Section 9 | Credentialing

Introduction

Curative requires Providers to be credentialed and recredentialed at periodic intervals. Credentialing and Recredentialing applies to contracted physicians, institutional providers and other allied health practitioners as defined by Texas state or federal law/regulation.

Contact Information

If you have questions and/or require clarification regarding credentialing or recredentialing, please do not hesitate to contact **Curative's** Credentialing Department: credentialing@curative.com

Credentialing
P.O. Box 1786
Austin, TX 78767

Non-Discrimination

Curative will not discriminate against any applicant for participation in its network on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein.

Credentialing Committee

Curative's Credentialing Committee is a standing committee and is responsible for administering the Credentialing Plan on behalf of Curative.

Curative's Credentialing Committee is a peer review body and makes decisions to accept, retain, deny or terminate a network contracted Provider. The number of voting members present constitutes a quorum.

Curative's Medical Director, or a designee, will chair the Credentialing Committee. All members of the committee are in network, credentialed **Curative** Providers. The Chair may appoint additional providers, as deemed necessary to form broad based knowledge for peer review. In addition, other Provider specialists may be consulted as needed to complete a provider's credential and/or recredential review.

Providers

Curative credentialing and recredentialing includes, but not limited to the following providers:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO),
- Doctors of Podiatry (DPM),

- Psychiatrists and other physicians
- Doctoral or master's-level psychologists who are state certified or licensed
- Master's-level clinical social workers who are state certified or licensed
- Oral Surgeons (OMS),
- Speech Therapists (ST), Occupational Therapists (OT) and Physical Therapists (PT),
- Independently contracted Pathologists and Radiologists,
- Independently contracted Telemedicine practitioners, and
- Institutional Providers listed in the organization's network directories including, but not limited to, Hospitals, Skilled Nursing Facilities, Rehabilitation Facilities, Free Standing Surgery, Behavioral Health Facilities, Laboratories and Radiology facilities.

Curative practitioners have the right to review information submitted to support their credentialing application, attestation and Curriculum Vitae (CV). This could include information obtained from any outside source with the exception of references, recommendations of other peer-review protected information. They also have the right to correct erroneous information from another source by submitting a request in writing (including email) within sixty (60) calendar days to the **Curative** credentialing representative.

This written request is added to the credentialing file and verified by credentialing personnel with date and signature. With direction from the Medical Director and within ten (10) calendar days the practitioner will be notified of receipt of the correction request along with the accepted correction.

Curative practitioners are also notified of their rights to receive the status of their credentialing or Recredentialing application upon request in writing (including email).

Initial Credentialing

Each applicant must complete the Texas Standardized Credentialing Application in CAQH and provide their up-to-date CAQH number. CAQH attestation must not be older than 30 days. Institutional Providers must complete the **Curative** Institutional Provider Application.

The completed form must include a certificate of insurance or the declaration page of the applicant's current professional liability insurance policy and the applicant's professional liability claims history.

In addition, **Curative** credentialing staff will also ask the applicant to provide the following documents:

- A copy of the applicant's current professional license(s).
- A copy of the applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") Certificate, if applicable.
- Copy of board certification (if applicable).

Credentialing and Recredentialing Verification

Primary Source: Provider credentialing information is verified by either primary source or other designated method. Verification from the primary source is obtained for a current state license to practice, education or training, board certification, NPI number and hospital privileges. Verification from other sources includes DEA or DPS, work history and professional liability coverage.

Curative will verify elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process.

National Practitioner Data Bank: The history of professional liability claims that resulted in paid judgments by or on behalf of a provider is obtained from the National Practitioner Data Bank.

All verifications must be current and verified within one hundred eighty (180) calendar day period prior to the Credentialing Committee making its credentialing decision.

Recredentialing Criteria

Credentialed providers are required to go through the recredentialing process every three (3) years. Providers are notified prior to the recredentialing date that continuation of participation is dependent upon successful completion of the recredentialing process within 36 months of the previous credentialing decision.

Six (6) months prior to the recredentialing date, a request for an updated credentialing application is sent by email to the provider. The recredentialing date is defined by the date the provider was previously credentialed plus 36 months. Five (5) months prior to the recredentialing date, a second request is sent to the provider. If the requested information is not received within ten (10) working days, **Curative's** provider relations will contact the provider's office to request the recredentialing packet.

If **Curative** does not receive the recredentialing information, a third request letter is sent, return receipt requested, notifying the provider will be terminated. Providers terminated for failure to return recredentialing documents may re-apply, but the provider is treated as a new applicant for credentialing.

Recredentialing Application

All individual practitioners applying for recredentialing must complete the Texas Standardized Credentialing Application (TSCA) or provide their up to date CAQH number. The TSCA includes a current, signed attestation by the applicant. By signing the attestation, the applicant acknowledges that omissions or nondisclosure of information may result in denial or termination. Presentation to the credentialing committee includes information regarding substantial omissions of information regarding areas including:

- Work history covering at least five (5) years.
- Limitations in ability to perform the essential functions of the position.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges, sanctions, or other disciplinary activity.
- Current professional liability insurance coverage.

- Lack of present illegal drug use.
- Signed attestation confirming correctness and completeness of the application.

The attestation date on the credentialing application is within 180 calendar days prior to the date the credentialing committee makes an eligibility decision. Institutional Providers will also be recredentialed every three years.

Delegated Credentialing

Curative may delegate authority to perform the function of provider and institutional credentialing and Recredentialing to contracted groups. Even when credentialing and Recredentialing is delegated, **Curative** retains the responsibility of credentialing and Recredentialing contracted providers. **Curative** reserves the right to decline or terminate providers credentialed or recredentialed by delegates.

Appeal of Credentialing or Recredentialing Determination

If the Credentialing Committee recommends acceptance with restrictions or the denial of an initial or recredentialing application, the provider shall be entitled to appeal the recommendation. An appeal will be heard by the Appeals Committee. If the applicant chooses to appeal, the applicant must request a hearing in writing and the request must be received by **Curative** within thirty (30) days of the date **Curative** gave notice of its decision to the applicant.

Provider Performance Monitoring

Curative monitors network providers to encourage the provision of safe, quality care to **Curative** members between providers credentialing cycles. **Curative** has an on-going monitoring process to determine providers' performance between periods of credentialing and recredentialing.

Provider Data Demographics

Federal provider directory regulations require **Curative** and providers to work together to maintain accurate provider directory lists. It is required by law for you and **Curative** to keep your information current and to confirm its accuracy every ninety (90) days. However, **Curative** may require confirmation upon request as well. 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. Remember to notify us of your data changes in accordance with state, federal and contractual requirements and guidelines.

Section 10 | Confidentiality

Curative Confidentiality / HIPAA Policy is based on the premise that adherence to the highest standards of ethical conduct is consistent with the goals and objectives of the organization. Consistent with this premise is the critical importance of maintaining confidentiality of the activities of the organization.

Information related to individual medical records of patients, provider credentialing / Recredentialing files, contract terms / rate arrangements and other sensitive issues are managed with the utmost respect for the confidential nature by all board, committee members and staff and in full compliance with Health Information Portability and Accountability Act (HIPAA) and other privacy regulations.

All Provider information obtained and/or documentation created during the credentialing and recredentialing process is treated in a confidential manner. **Curative** complies with HIPAA guidelines regarding the release of credentials information to third parties. **Curative** employees and committee members attending credentialing committees sign confidentiality agreements and are responsible to maintain confidentiality of credentialing and Recredentialing activities.

Section 11 | Texas Regulatory Requirements..

This section details the policies and procedures by which **Curative** abides to fulfill the Texas-specific regulatory requirements with respect to:

- Prior Authorization and Notification
- Goldcarding
- Notification of Denial of Service
- Hospitalization
- Medical (No Hospitalization)
- Post Stabilization
- Retrospective Review
- Adverse Determinations Appeal
- Adverse Determinations Expedited Appeal Process
- Life Threatening Condition Appeal
- Independent Review Organization (IRO) of Adverse Determination
- Right to File a Complaint With Texas Department of Insurance
- Overpayments
- Balance Billing
- Credentialing Introduction
- Initial Credentialing
- Recredentialing Application

Prior Authorization and Notification

Curative Clinical Care Management (CCM) includes the following services:

- ➔ Prior Authorization of certain services is required.
- ➔ Notification only of certain services is required.
- ➔ Concurrent Review of Members in hospitals, SNF, and LTAC.

Curative accepts the Texas Standard Prior Authorization Request Form in lieu of the **Curative** Prior Authorization Form. Access to the services requiring the above listed levels of authorization, notification and/or concurrent review may be accessed under 'Helpful Links' for Providers at www.curative.com.

Goldcarding

Curative, in compliance with HB 3459, the Gold Card Act, will provide notice of an initial exemption or denial of an exemption. A physician or provider must submit at least five eligible pre-authorization requests for the same health care service and **Curative** Health Plan must have approved at least 90% of the physician or provider's submitted eligible pre-authorization requests in order to qualify for an exemption related to the specific health care service. Qualified physicians or providers will be notified of an exemption by January 30th of each year. The notice will include a listing of health care services to which the exemption is applied. **Curative** may not deny or reduce payments for a health care service under the Gold Card exemption.

It is important to note that the exemption applies to the ordering/rendering physician or provider on a professional claim and the referring/rendering provider on an institutional claim which must be indicated on the claim submission. Claim submissions that do not include this information will be identified as not clean

claims and will be subject to **Curative's** prior authorization process. There will be instances when the ordering/rendering or referring/rendering physician/provider will be the same but in order for **Curative** to comply with this legislation both will be necessary to be included on the claim submission.

Notification of Denial of Service

Provider Notification: The requesting provider shall be notified via phone call or electronic transmission. The written notification will be provided no later than the third (3rd) working day (TIC 4201.304) after the date of the phone call or email. If related to acquired brain injury, Provider notification will be via phone call. All other notifications will be in writing. Such communications will include the following:

- A clear and concise statement of the specific medical or contractual reasons for the resolution shall be sent to the requesting Provider and include a request for further information or action.
- The information regarding the appeal process and the right to appeal the decision, including instructions and how to file a complaint to **Curative**.

Member Notification: Members will be notified of the denial of services via the United States Postal Service. Notification will include a description of the procedure for filing a complaint and for filing an appeal. It will include a notice to the member of the member's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department Insurance.

Curative will use the following notifications:

Hospitalization (TIC 4201.304 (1))

If a patient is hospitalized at the time of the adverse determination, **Curative** will notify the provider of record:

- Within one (1) working day by phone or electronic transmission,
- Will follow with a letter within three (3) working days to notify the member and the provider of record of this determination.
- The letter shall state that benefits will be terminated at a stated date and time after notification.
- The notification letter will also inform you as to the right of appeal and the process to follow.

Medical (No Hospitalization) (TIC 4201.304 (2))

If the patient is not hospitalized at the time of the adverse determination, **Curative** will notify the member and the provider of the record within three (3) working days in writing.

Post Stabilization (TIC 4201.304 (3))

If the adverse determination is related to denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, **Curative** shall provide the notice to the treating physician or other health care provider no later than one (1) hour after the time of the request followed by a letter within three (3) working days to all parties.

Retrospective Review (TIC 4201.305)

If an adverse determination is related to a retrospective review, **Curative** will notify the provider of record and the member within a reasonable period, but not later than thirty (30) days after the date on which the claim was received.

Adverse Determinations Appeal

A member, a person acting on behalf of the member, or the member's provider may appeal an adverse determination orally or in writing for an adverse determination for a prior authorization, concurrent review, retrospective review, or any appeal of an adverse determination made by **Curative.** All appeals for reconsideration of an adverse determination will be processed within set time frames and must fulfill the requirements as follows:

- All appeals must be submitted to **Curative** orally or in writing.
- The appealing party will be allowed not less than 120 calendar days (or as noted in your contract with **Curative**) after the date of issuance of written notification of an adverse determination to file an appeal.
- In a circumstance involving a member's life-threatening condition, the member is entitled to an expedited appeal or an immediate appeal to an IRO and is not required to comply with procedures for an internal review by **Curative**.
- **Curative** may not require exhaustion of internal appeals prior to external review if:
    - **Curative** fails to meet its internal appeal process timelines as above, or
    - The claimant with an urgent care situation files an external review before exhausting **Curative's** internal appeal process.
- Within five (5) working days from the receipt of the appeal, **Curative** will send an acknowledgment letter to the patient or a person acting on the patient's behalf and the patient's physician or other health care provider. (TIC 4201.355)
- Appeal decisions will be made by a physician who has not previously reviewed the case.
- Once a determination of an appeal is made, written notice will be sent to all relevant parties of the determination of the appeal as soon as practicable, but not later than the thirtieth (30th) calendar day, after the date **Curative** receives the appeal. (TIC 4201.359)
- If an appeal is denied and, within ten (10) working days from the denial, the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty that typically manages the medical or specialty condition, procedure, or treatment under discussion. The specialty review must be completed within fifteen (15) working days of receipt of the request. (TIC 4201.356)
- After **Curative** has reviewed the appeal of the adverse determination, a letter will be sent to the member or an individual acting on behalf of the member, and the provider of record, explaining the resolution of the appeal.

Adverse Determinations Expedited Appeal Process

Curative provides a method for expedited appeals for emergency care denials, care for life-threatening conditions denials, and/or continued stays for hospitalized member denials.

- Expedited appeals will be reviewed by a specialist who has not previously reviewed the case and is of the same or similar specialty, as would manage the member condition under review. In addition, the Specialist Reviewer may interview the member, an individual acting on behalf of the member, or the provider to make a decision.
- The expedited appeal will be completed based on the immediacy of the condition and not later than one (1) working day for the date all the information necessary to complete the appeal is received and communicated by phone. A letter will always follow up oral notification of the expedited appeal decision within three (3) working days from the date of the decision. (TIC 4201.357 (b))
- All correspondence with the appealing party/parties will be in writing and signed by the Medical Director or designee.
- In any circumstance involving a member's life-threatening condition, the member is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review or expedited appeal.

Life Threatening Condition Appeal

The member, individual acting on behalf of the member, or the member's provider may determine the existence of a life-threatening condition and initiate an appeal. Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by **Curative** may seek review of that determination or denial by an IRO assigned by Texas Department of Insurance (TDI). **Curative** must provide the IRO notification to the Provider of record or other health care provider no later than one (1) working day from the date the request is received. (TIC 4201.360)

Independent Review Organization (IRO) of Adverse Determination

At the time of notification of all adverse determinations, **Curative** will provide to the member and related parties, the notice of the IRO process and a copy of the Texas Department of Insurance Request for a Review by an IRO form. **Curative** will fully cooperate and facilitate the IRO review. **Curative** will comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature of the health care items and services for a member.

Right to File a Complaint With Texas Department of Insurance

Curative members may also contact the Texas Department of Insurance for more information about their rights or to file a complaint against **Curative.** TDI can be contacted at the following address and telephone numbers:

Texas Department of Insurance
Complaint Helpline 1-800-252-3439

Overpayments

We will inform you in writing of an overpaid claim within 180 days of the date of payment and you will have 45 calendar days (unless otherwise indicated in your Agreement) from receipt of notice to refund the money back to us. If your payment is not received by that time, we may offset the overpayment against future claim payments, or in accordance with the terms of your Agreement. (TIC 1301.132). *For further details, please refer to your **Curative Provider Agreement**.*

All overpayment refunds should be sent to the address below. In the case that you identified an overpayment and are refunding the amount, please provide sufficient documentation (Member ID, Date of Service, Claim Number, Overpayment Amount and Reason for Overpayment, if known) to enable us to research the overpayment.

Curative
Attn: Refunds
PO Box 1786
Austin TX 78767

Balance Billing

Balance Billing is not allowed according to the Texas Department of Insurance regulations for PPO Coverage by a **Curative** Contracted Network Provider.

Credentialing Introduction

Curative requires providers to be credentialed and recredentialed at periodic intervals. Credentialing and recredentialing applies to contracted physicians, institutional providers and other allied health practitioners as defined by Texas state or federal law/regulation.

Initial Credentialing

Each applicant must complete the Texas Standardized Credentialing Application in CAQH and provide their up-to-date CAQH number. CAQH attestation must not be older than 30 days. Institutional providers must complete the **Curative** Institutional Provider Application.

The completed form must include a certificate of insurance or the declaration page of the applicant's current professional liability insurance policy and the applicant's professional liability claims history.

In addition, **Curative** credentialing staff will also ask the applicant to provide the following documents:

- A copy of the applicant's current professional license(s).
- A copy of the applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") Certificate, if applicable.
- Copy of board certification (if applicable).

Recredentialing Application

All individual practitioners applying for recredentialing must complete the Texas Standardized Credentialing Application (TSCA) or provide their up to date CAQH number. The TSCA includes a current, signed attestation by the applicant. By signing the attestation, the applicant acknowledges that omissions or nondisclosure of information may result in denial or termination. Presentation to the credentialing committee includes information regarding substantial omissions of information regarding areas including:

- Work history covering at least five (5) years.
- Limitations in ability to perform the essential functions of the position.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges, sanctions, or other disciplinary activity.
- Current professional liability insurance coverage.
- Lack of present illegal drug use.
- Signed attestation confirming correctness and completeness of the application.

The attestation date on the credentialing application is within 180 calendar days prior to the date the credentialing committee makes an eligibility decision. Institutional Providers will also be recredentialed every three years.