



Medical Network, Inc.

Preferred Provider Manual

This provider manual describes your participation in Medical Network, Inc. (MedNet), Maine's only statewide physician-owned and directed preferred provider network. The manual is intended to serve as a guide for you and your office staff by providing answers to the questions that may arise as a result of your participation.

Comments and suggestions to improve this manual are welcomed and encouraged.

Should you have any questions regarding the content of this manual, please contact:

Provider Relations
MedNet
P.O. Box 15253
Portland, ME 04112
Tel. (207) 773-5116, option 4, or (800) 556-1144
www.MaineMedNet.com

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FORWARD

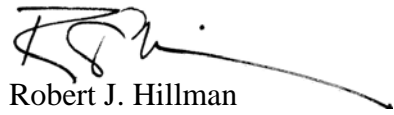
Welcome to the MedNet Preferred Provider Network.

Your many health care colleagues welcome you as a participant in MedNet. We're delighted that you share our commitment to high quality, accessible and affordable health care.

To ensure a smooth transition into MedNet, every attempt has been made to accommodate your present office procedures. Please review the manual carefully, share it with your office staff and retain it in a convenient location for quick reference. **Each member of your office staff should be encouraged to become familiar with the contents of the manual.** It is important that you and your staff understand your membership in MedNet and its operating procedures, so that MedNet patients feel welcome in your office. We value very highly our close working relationship with network providers, and our experienced Provider Relations Representatives stand ready to assist you in all aspects of your participation.

MedNet is committed to further align health care providers in the coordinated delivery of cost-effective, high quality patient care with the goal of improved medical outcomes. As providers, this is our opportunity to preserve the best features of Maine's health care delivery system and, in the process, to compete effectively in the changing health care environment.

MedNet appreciates your support.



Robert J. Hillman
Chief Executive Officer
MedNet

SECTION I - General Information

A. MEDNET PHILOSOPHY

MedNet represents a partnership approach in the delivery of quality health care. MedNet's program of managing health care cost relies on selective contracting with providers, positive incentives to ensure patient participation, appropriate facility use, and a utilization review programs which assure accountability of provider practice patterns. The centerpiece of the MedNet philosophy is to unite providers, payers, employers and employees to work together to reduce health care costs without eliminating an employee's choice of provider or sacrificing health care quality.

B. USE OF THIS MANUAL

This manual has been designed to help you understand MedNet's policies and procedures. **These policies and procedures are based on the contractual requirements MedNet has with its payers and on the agreement signed by each provider.**

SECTION II - Health Maintenance Organizations

One of MedNet's contracted payers, Harvard Pilgrim Health Care (HPHC), is an HMO. As a MedNet provider you may also participate with HPHC and will receive HPHC's Provider Manual directly from Harvard Pilgrim. This manual is designed specifically for their plans. Please feel free to call HPHC at (888) 476-2463 if you do not receive this information.

SECTION III - Credentialing

A. CREDENTIALING CRITERIA

MedNet has as its primary goal, the delivery of quality health care services. To ensure this goal, physicians and other health care providers will be invited to participate in MedNet only after their qualifications have been reviewed and accepted by the Credentials Committee. In considering providers for participation in the network, the Credentials Committee reviews the information provided in the Application for Provider Participation. The following are among the criteria reviewed:

- The applicant must be a healthcare practitioner.
- The applicant must be licensed to practice in MedNet's service area.
- The applicant, if an allopathic or osteopathic physician, must meet American Medical Association (AMA) or American Osteopathic Association (AOA) approved levels of education, training and experience.
- The applicant must provide professional references.
- The applicant must provide a work history.
- The applicant must provide all relevant and requested information about malpractice claims, disciplinary actions, complaints to any licensing Boards and Medicare and Medicaid sanction

activity brought against him/her.

- The applicant must possess a minimum of \$1 million per occurrence and \$3 million in the aggregate of professional liability insurance coverage.
- The applicant must indicate whether he/she has ever been denied professional liability insurance, and if so, the circumstances of such denial.
- The applicant must participate in an AMA or AOA approved level of continuing medical education (CME) programs.
- The applicant must be willing to abide by the Terms of Agreement (see Appendix B).
- The applicant must abide by the professional ethics of the AMA or the AOA, as the case may be, and by the ethical norms, if any, established by his/her appropriate medical specialty society.
- The applicant must be Board Certified in the specialty for which he/she is applying.
- The applicant must state whether he/she has ever been convicted of a felony, and if so, indicate the circumstances of such conviction(s).
- The applicant must provide a statement that he or she is free from any physical or mental health impairments that interfere with, or present a reasonable probability of interfering with, the applicant's ability to perform the responsibilities of a practitioner in the applicant's field.
- The applicant must state whether he/she has ever been denied a professional license whether full, limited or temporary.
- The applicant must state whether his/her professional license has ever been suspended, revoked, limited or surrendered in any jurisdiction.
- The applicant must hold a current and valid DEA registration, excepting specialties that do not normally require DEA registration, and must indicate whether his/her ability to prescribe controlled substances has ever been voluntarily or involuntarily suspended or revoked in any jurisdiction.
- The applicant must authorize release to MedNet, of all information held by others which is relevant to the review of his/her application.
- Provider must attest that all information contained within and attached to the MedNet (MHA) Preferred Provider Application is true and complete.

In addition to the above, there are specialty specific criteria for particular types of providers. Information that is supplied to MedNet is verified and you may be asked to provide supporting documentation. On a periodic basis, MedNet recredentials its participating providers.

Please note, a provider can be denied participation in MedNet solely because there are sufficient numbers of providers already in the network, either representing the applying provider's specialty or total number of providers within a defined market area.

B. APPLICATION FOR PROVIDER PARTICIPATION

To be considered for participation, providers must submit a complete Application for Provider Participation. MedNet uses the standard Maine Physician Application for all doctoral level providers, the Maine Professional Staff Application for mid-level providers, and our own proprietary application for clinical nursing specialties. Applications, and instructions can be obtained online at www.mainemednet.com, or call MedNet's Provider Relations Department if you do not have access to the internet.

SECTION IV - Provider Obligations

A. PROVIDER OBLIGATIONS

As a MedNet provider you have agreed to:

1. Cooperate with and participate in the billing procedures established by MedNet and its participating payers.
2. Accept the fee schedules or other payment mechanisms negotiated by MedNet.
3. Comply with requirements of the utilization review programs established with participating payers by MedNet. Such programs may require pre-authorization or pre-certification of specified services, by the PCP or provider of service.
4. Give a 60 day notice of intention to close your practice to new patients. This requirement allows MedNet time to notify all payers in advance. *Please Note: Closed Practice must be to all new patients, not strictly MedNet patients.*
5. Make every attempt to schedule covered individuals for an appointment within seven business days.
6. Twenty-four hour coverage by another MedNet participating provider must be arranged.

B. ONLINE PROVIDER DIRECTORY

MedNet's directory of participating preferred providers is maintained in our administrative offices at 59 middle Street, 3rd Floor, Portland, ME 04101. As required, and when notified MedNet will make necessary modifications and corrections to its list of preferred providers. Changes to a participating provider's record and subsequent listing can only occur after MedNet is notified in writing. MedNet's online directory is available through our website at www.MaineMedNet.com. Please inform MedNet at least 60 days in advance of any changes in your name, address, phone or specialty information so that your online listing can be updated timely and accurately.

C. VERIFICATION OF PROVIDER NETWORK STATUS

MedNet can verify the participation status of any MedNet provider. This information is made

available to MedNet participating providers, contracted payers and employers, and covered individuals. Verification of provider network status can be obtained by calling MedNet at (207) 773-5116 or (800) 556-1144 or via online searchable directory of providers. Participating Providers should always verify the network status of referral providers whenever possible.

D. PROVIDER REFERRALS

MedNet's online provider directory should be utilized for all MedNet patient referrals. When medical conditions necessitate a referral outside of MedNet, you may be required to obtain pre-approval. When a MedNet-covered individual is referred to a provider who is not a MedNet Provider, their benefit level may be lower. To assure patient satisfaction with you and your office, where appropriate please make every effort to see that the health care provider to whom you refer the patient is a member of MedNet. If not, you should explain to your patient the reason for referring out of the Network and to anticipate lower benefit levels.

SECTION V - Communications

A. PROVIDER REFERRAL SERVICE

Employees, covered dependents, or providers who are in need of provider referral service can go online to www.mainemednet.com, or call MedNet at (207) 773-5116 or (800) 556-1144 to obtain a listing of participating providers who are available to meet their medical needs.

B. PROVIDER/PATIENT MISUNDERSTANDINGS

To ensure patient satisfaction and to reduce the frequency of disputes between providers and payers, MedNet -- through its administrative offices -- will attempt to resolve misunderstandings between MedNet providers, covered individuals and their administered health benefit plans*. MedNet's administrative offices, working with you and your office personnel, will help to resolve misunderstandings or problems which may arise from time to time in the care of MedNet patients.

***Disputes concerning benefit design, coverage and/or eligibility status can only be resolved through the applicable payer. MedNet will act as a liaison when appropriate between your office and a payer should such a problem arise.**

Misunderstandings or problems which arise should be directed to the administrative offices of MedNet, P.O. Box 15253, Portland, ME 04112; voice (207) 773-5116, fax (207) 773-1739 or toll free in Maine (800) 556-1144.

SECTION VI - Utilization Management

Provider agrees to comply fully with the requirements of any Utilization Management Program operated or adopted by MedNet or authorized participating payers.

SECTION VII - Provider's Office Procedures

A. COVERAGE

Twenty-four hour coverage by another MedNet participating provider must be arranged. Please keep in mind that if one of your patients covered by a MedNet contract sees a non-participating provider, their benefit level is usually lower.

B. OUT-OF-AREA CARE

As indicated earlier under "Provider Referrals," where appropriate every attempt should be made to refer a MedNet-covered individual to a participating provider in MedNet. It is recognized, however, that occasionally covered individuals may require services that are outside the geographic limits of MedNet. When a covered individual is referred to an out-of-area provider, that provider is reimbursed based upon the employee's benefit program. Payers, therefore, have an option of treating the out-of-area provider as a non-PPO provider or reimbursing the provider on a "UCR" basis. You may wish to advise your patient of these possibilities.

C. APPOINTMENTS

As a benefit, MedNet has indicated to its payers that it will attempt to provide covered individuals with an appointment with a MedNet provider within seven business days. Make every attempt to schedule covered individuals for an appointment within seven business days.

D. INSURANCE / CMS 1500 & UB92 FORM COMPLETION

1. Identification as a MedNet Provider. MedNet's payers have contractually agreed to expedite reimbursement to its providers. To accomplish this, each payer needs to be able to readily identify a claim submitted by a MedNet Provider. Always include accurate information in Box(s) 11 (a – c) on a CMS 1500 form, or Box(s) 50, 60, 61 & 62 on a UB-92. This will assure you of rapid claims processing and assure your patient a higher reimbursement.
2. Patient Identification. ID cards are issued to covered individuals by the payer and indicate the office visit co-pay (if any) and claims address. Sometimes there is a lag between the policy effective date and the issuance of patient identification cards. At any time you may call MedNet to verify that the policyholder has a MedNet plan. Covered individuals cards have the MedNet logo prominently displayed on their enrollee identification card.
3. Inclusion of Federal Tax ID. You must include your Federal Tax ID, in Box 25 of the CMS 1500 form or Box 5 of the UB-92, on all claims forms submitted to a payer in the MedNet program.
4. Group Billing Numbers. Group billing Tax ID numbers are acceptable. You must, however, identify the specific provider on a CMS 1500 claim form, in Box 31, by provider name.
5. Procedure Codes. The claim form must include the appropriate CPT procedure code. Failure to include the appropriate CPT procedure code will delay reimbursement.
6. Use of ICD-9-CM Diagnostic Codes. Please use ICD-9-CM diagnostic codes to avoid confusion over patient diagnosis and to expedite reimbursement.
7. Submission of Claim Forms by Provider. MedNet receives and processes claims to implement contract pricing prior to payer adjudication. In all cases, please submit claims using the standard CMS 1500 form to the billing address reflected on the patient's identification card. In the event that patient registration information is not available at the time of billing, you may cross reference our list of active Payers and employer groups and

their respective claim addresses using MedNet's Payer Client Summary. Questions regarding current claim addresses can also be directed to MedNet's Claims Repricing department at (800) 556-1144, option 5, or (207) 773-5116 locally.

E. BILLING

Billing patients (covered individuals) for amounts in excess of the agreed-upon maximum allowable charge is prohibited by your MedNet Participation Agreement. **You may bill patients for deductibles, co-insurance and non-covered services which may not be part of the covered individual's benefit plan. The deductible, coinsurance and other collectible amounts will be indicated on the explanation of benefits (EOB) which your office will receive from each payer. Only the office visit co-pay is collectible at the time of service.**

You may not bill the patient for covered services which are determined to be not Medically Necessary unless you obtain the patient's prior informed, written consent. The patient's consent will not be considered informed unless you explain to them before rendering the specific services in question that the patient will be financially responsible for those services, and that the payer will not pay for the services.

You should bill the payer at your regular "fee for service" rate. You will be reimbursed according to the schedule agreed to by MedNet or your billed rate, whichever is lower. You may collect only the appropriate amount of deductible or coinsurance in accordance with the patient's benefit plan.