Updates will be made to the information in this guide. Refer to the Revision Log as a reference to revisions.

# Non-Contracted Provider Guide

This guide is for non-contracted providers who have provided covered services to a patient enrolled in WellFirst Health or WellFirst Health – Provided by SSM Health Plan benefit plans. Non-contracted providers are those who do not have a legally binding agreement with WellFirst Health to provide services to WellFirst Health members.

Depending on the circumstances in which services are rendered and the type and coverage of a patient's benefit plan, patient protections and processes under the provisions of the No Surprises Act (NSA) may apply. Topics pertaining broadly to non-contracted providers are in Section I of this document and topics specific to NSA are in Section II of this document. Links are placed throughout to direct to relevant information within the NSA sections.

Refer to our glossary for an overview of key terminology in this document. Click links in this document for resources where there are variations by benefit plan and/or region.

## SECTION I – Non-Contracted Provisions

### Our Products

WellFirst Health offers a variety of benefit plans that can vary in coverage, applicable federal and state requirements, claim submission, reimbursement rates, and Customer Care Center resources.

- WellFirst Health Affordable Care Act (ACA) Individual plans
- WellFirst Health – Provided by SSM Health Plan ACA Individual Plans
- WellFirst Health – Provided by SSM Health Plan – Medicare Advantage plans
- WellFirst Health SSM Health Employee Health Plan Administrative Services Only (ASO), for SSM Health employees and administered by Dean Health Plan

### Wrap Network

WellFirst Health contracts with First Health as a wrap network to deliver health care services to our members who have to seek care outside of the WellFirst Health's provider network service area. For members enrolled in a PPO benefit plan, additional wrap networks may be offered as part of their primary provider network and these logos appear on the **front** of member ID cards.

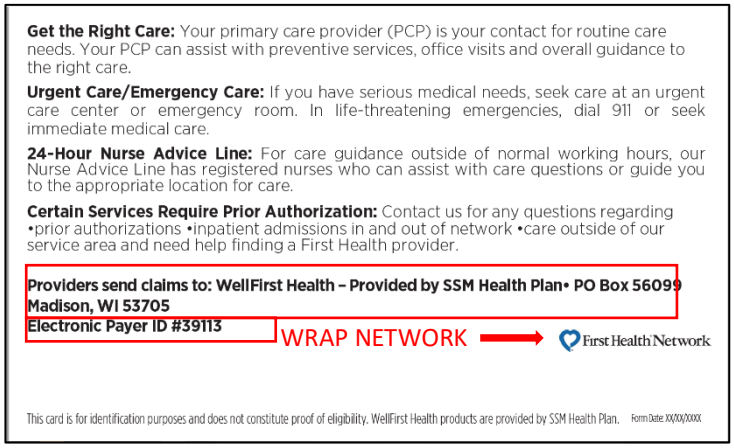
For non-contracted providers who have a contract with First Health, WellFirst Health applies those contracted reimbursement rates for covered services.

### Member ID Cards

Member ID cards include health plan logo, benefit plan, customer care number, payer ID, and wrap network logo. The member ID card images on the next page are examples only as cards vary and may differ from the images shown on the following page.

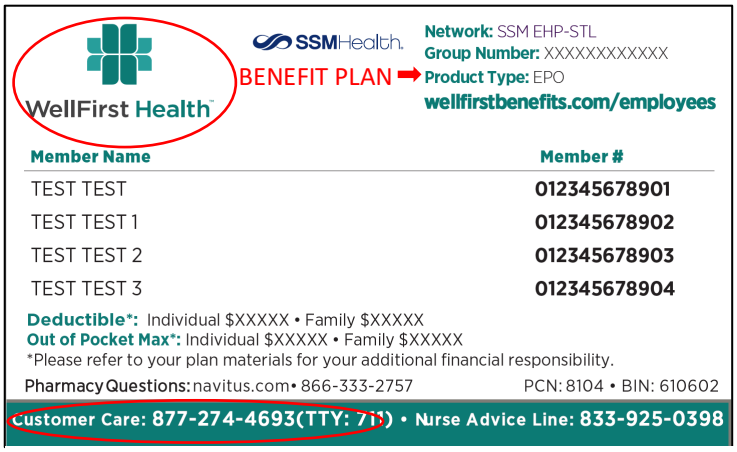

**Front**

WellFirst Health ACA Card Sample



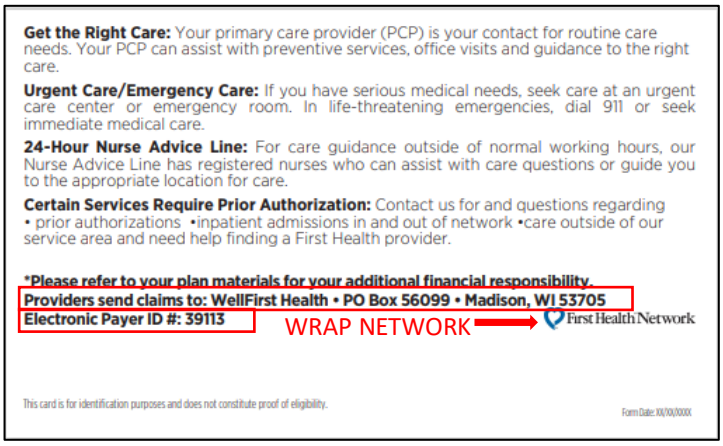

**Back**

WellFirst Health ACA Card Sample




**Front**

WellFirst Health SSM Health Employee Health Plan Card Sample




**Back**

WellFirst Health SSM Health Employee Health Plan Card Sample

## Member Eligibility

Providers are encouraged to always obtain real-time details about a member's enrollment using the 270/271 Eligibility and Benefit Inquiry and Response Transaction. Refer to our HIPAA Transactions web page to sign up to exchange 270/271 transactions with WellFirst Health.

## Authorizations and Notifications

### *Non-Emergency Services*

Authorization requests for non-emergency services for members enrolled in a benefit plan with a restricted provider network (e.g., HMO) must be submitted by an in-network provider on behalf of an out-of-network provider. Dean Health Plan must approve the request before that provider can deliver services to a WellFirst Health member. Prior authorization requests for all benefit plans must be submitted as soon as the service is recommended.

For WellFirst Health members in Illinois, an authorization request must be submitted by the member's designated primary care provider or in-network OB/Gyn provider for consideration of coverage, in compliance with Illinois-mandated requirements.

### *Emergency Services*

Prior authorization is not required for emergent services. Most of the time, WellFirst Health members will receive emergency care from a WellFirst Health contracted provider. If members are unable to reach a contracted provider, they are advised to go to the nearest medical facility

for emergent care. Depending on the type of benefit plan a patient is enrolled in and the circumstance in which emergency services are rendered, NSA provisions may apply.

### *Emergent Inpatient Admissions*

If a WellFirst Health member is admitted to a non-contracted facility through an emergency admittance, WellFirst Health should be notified within 48 hours (or when the facility is able to obtain the necessary information from the member) to allow for concurrent review and assistance with discharge planning related to the member's stay.

Notification should include the following information, when available:

- Member name with middle initial, if available, and date of birth
- Member ID number (include a scanned image of the member ID card, if possible)
- Admission date (the actual date the member was admitted to inpatient status)
- Name of attending provider and facility
- Admitting diagnosis
- Tax ID
- Contact name and phone number for questions

If a non-contracted provider has determined that the member may travel safely taking in consideration the member's medical condition, has provided notice and consent for the member, and has received informed consent from the member, then the member may be transferred to a contracted facility for continuation of covered services.

## Claims

### *Submission*

Non-contracted providers may submit claims to WellFirst Health electronically or on a current paper CMS-1500 or UB-04 claim form. Claims must be submitted within 365 days from the date of service.

Electronic claim submission is preferred. Refer to our HIPAA Transactions web page to sign up to exchange 837 Health Care Claim transactions or to access our free EDI claim submission alternative.

- For WellFirst Health products, the Payer ID is 39113.

Submission information for paper claims can vary by WellFirst Health Product.

### *Acknowledgement*

From our HIPAA Transactions web page, sign up to receive a 277 Claims Acknowledgement (277CA) to verify that submitted 837 claims have been accepted for processing.

Also available from our HIPAA Transactions web page, sign up to exchange 276/277 Health Care Claim Status Request and Response transactions to receive status of submitted 837 claims.

### *Explanation of Payment/Remittance Advice*

WellFirst Health will communicate the claim payments and/or denials in the Explanation of Payments (EOP) or Health Care Claim Payment/Advice (835) to the submitting provider.

Providers who have signed up to receive electronic funds transfer (EFT) payments deposited directly into their organization's designated bank account, may also sign up from our HIPAA Transactions web page to receive 835 Health Care Claim Payment/Advice transactions. If not, WellFirst Health will mail EOP information and a paper check. Payments and/or denials for services that fall under the NSA provisions will be denoted.

***Correcting Claims***
Non-contracted providers may submit a corrected claim, when necessary (e.g., changes or corrections needed to codes, dates of service, etc. due to error), within 365 days from the date the original claim finished adjudication.

Steps for submitting a corrected claim:

1. Create a new claim with the corrected claim detail(s).
2. Include all lines billed on the original claim on the corrected claim.
3. Include the Claim Frequency Code ('7' for replacement claims) and the Payer Claim Control Number (original claim ID).
4. When replacing/deleting original procedure code, send the original billed code in the 2300 loop.
5. Add a note in the NTE segment about what has been changed from the original claim.
6. Submit the corrected claim using the same submission method of the original claim.

***Reimbursement***
Reimbursement to non-contracted providers for non-NSA eligible claims is provided under WellFirst Health's reimbursement fee schedules based on state and federal government program reimbursement policies and requirements.

### Continuity of Care

WellFirst Health follows continuity of care rules according to state and federal laws. This means that in certain situations, we offer members continued coverage for a set period of time to see their provider who continues employment in the geographic area but is no longer considered a contracted provider as long as that provider is willing and able to continue care for that member.

## SECTION II- Non-Contracted Provisions Under the No Surprises Act

### NSA Overview

As of January 1, 2022, portions of the No Surprises Act, part of the Consolidated Appropriations Act, and the Transparency in Coverage Final Rule from the Tri-Agencies (U.S. Departments of Health and Human Services, Labor, and Treasury) became effective. These requirements establish federal standards for both providers and insurers/health plans to provide transparency in health care price information and help protect patients from unexpected medical bills from non-contracted providers. The NSA applies to medical bills related to the following services:

- Covered emergency services at a non-contracted hospital or free-standing facility.
- Covered services and items provided by a non-contracted provider at a contracted facility.
- Covered services and items provided by a non-contracted provider in connection with a visit to a contracted facility, even if furnished offsite (e.g., laboratory and telemedicine services).
- Non-contracted air ambulance services

The NSA prohibits balance billing patients for the services listed above and establishes processes to resolve disputes between non-contracted providers and insurers/health plans, when necessary.

These federal requirements apply to individual, small group, and large group fully insured products, and self-insured group plans. Additionally, requirements in the NSA apply to grandfathered plans. As such, the following WellFirst Health product types are subject to NSA regulations:

- WellFirst Health Affordable Care Act (ACA) Individual plans

- WellFirst Health – Provided By SSM Health Plan ACA Individual Plans
- WellFirst Health SSM Health Employee Health Plan Administrative Services Only (ASO), administered by Dean Health Plan

## Coverage, Cost Share, and Balance Billing for Non-Contracted Services Under NSA

Patients receiving services that are covered under the NSA from a non-contracted provider cannot be balance billed. Members are only responsible for cost-share amounts no greater than what they would pay for covered services from a contracted provider. Additionally, the NSA requires cost sharing for these non-contracted services to count toward the patient's deductibles and out-of-pocket maximums.

The NSA does **not** apply if there is documented consent, detailed in the Notice and Consent section below, from the patient to receive and be personally responsible for payment of services from a non-contracted provider. Furthermore, the NSA does not protect a patient from balance billing for ground ambulance services.

## Notice and Consent

The Department of Health and Human Services has developed Standard Notice and Consent Documents. Under NSA, a provider must use the Standard Notice and Consent Documents to secure a patient's documented consent to receive services from a non-contracted provider which would allow the non-contracted provider to bill the cost of the services to the patient. Refer to CMS NSA information for notice and consent requirements.

## NSA Claim Payments

### *Qualifying Payment Amount*

WellFirst Health may apply the qualifying payment amount (QPA) for provider reimbursement of NSA-eligible claims. QPA amounts are calculated in compliance with requirements in Section 102 of the NSA and the Surprise Billing Part I Interim Final Rule (IFR). Additionally, the QPA is used to calculate NSA member cost sharing amounts which cannot be greater than what a member would pay for covered services from a contracted provider.

Patients enrolled in a benefit plan subject to NSA provisions who receive services from a non-contracted provider that fall under the NSA provisions cannot be balance billed.

### *Remittance*

While claim information (e.g., EOPs and 835s) and payment for NSA claims are issued from the WellFirst Health, WellFirst Health has contracted with Healthrisk Resource Group, LLC (HRGi), an independent healthcare technology and services company, to manage questions regarding NSA claims and reimbursement as well as to manage the open negotiation and independent dispute resolution (IDR) processes, when needed.

Providers may contact HRGi in the following ways:

- Phone: 888-361-5327
- Email: NSAServices@hrgi.com
- Mail: HRGi, 9711 Washingtonian Blvd., Suite 300, Gaithersburg, MD 20878

Claim payments and/or denials for NSA services will be denoted. Providers will see the following text on their EOPs for NSA-related payments:

> The Qualifying Payment Amount (QPA) applies for purposes of establishing the recognized amount (or, in the case of air ambulance services, for calculating the member's cost sharing). The recognized amount will appear as the allowed amount on your EOP. Each QPA shared with your organization was calculated in compliance with 45 CFR § 149.140.If your organization desires to initiate a 30-day open negotiation period for purposes of

determining the total amount to be paid by the plan, you may contact HRGi by phone at 888-361-5327.

Alternative contact information:
HRGi
9711 Washingtonian Blvd. Suite 300
Gaithersburg, MD 20878

NSAServices@hrgi.com

The 30-day negotiation period must be initiated within 30 days of receipt of this document. If the 30-day open negotiation period does not result in a determination for payment, your organization may initiate the Independent Dispute Resolution (IDR) process within 4 days after the end of the open negotiation period.

The EOP text includes available options that may be taken to initiate negotiation with HRGi, if a provider chooses to dispute an NSA-related claim payment or denial.

## Negotiating Remaining Bill

The NSA prohibits providers from balance billing the patient and requires that providers work with the patient's insurer/health plan to negotiate any remaining bills for services. If a provider feels it is necessary to dispute a claim denial or payment amount for services protected under the NSA, WellFirst Health has established open negotiation and IDR processes detailed below for non-contracted providers to work on directly with HRGi.

During these processes, providers may initiate open negotiation on an individual claim or batches of claims, as long the batched claims have all of the following in common:

- The items and services were furnished by the same provider or facility.
- Payment for the items and services are required to be made by the same insurer or plan.
- The items and services are related to the treatment of a similar condition.
- The items and services are on the same EOP or 835 and therefore within the same 30-day open negotiation from receipt timeframe.

If a provider wishes to dispute multiple claims that cannot be batched according to the above, they must submit each disputed claim for negotiation individually.

### *Open Negotiation*

If a provider chooses to dispute NSA claim payments or denials, they may initiate an open negotiation which must be actively initiated within 30 days of receiving their EOP or 835. Providers may initiate open negotiation by contacting HRGi through one of the following ways:

- Phone — 888-361-5327
- Email — NSAServices@hrgi.com
- Mail — HRGi, 9711 Washingtonian Blvd., Suite 300, Gaithersburg, MD 20878

Once initiated, the open negotiation period is a full, 30-day timeframe to be used by the provider to negotiate claim payments or denials with HRGi. If an agreement cannot be reached during this time, either party may opt to initiate the Independent Dispute Resolution (IDR) process within four days after the full 30-day open negotiations period ends. The IDR process cannot be initiated once the four-day period has passed.

### *Independent Dispute Resolution*

If necessary, the IDR process is available to be enacted only when the parties cannot reach an agreement during the open negotiations period. HRGi will work with the provider and WellFirst Health to select an IDR Entity. Both parties are required to pay a non-refundable administration fee of $50 when the decision is made to enact the IDR. Additionally, each party must also pay a separate IDR entity fee at this time. The party whose offer is chosen will have their entire IDR

entity fee refunded. The party whose offer is not chosen will not have their IDR entity fee refunded. The parties may continue to negotiate for an agreed upon claim payment while the IDR Entity reviews both parties' offers.

Once an IDR process is activated, the following timeframes apply:

- **Within 3 days** — both parties must agree on an IDR Entity.
- **Within 10 days of agreement of the IDR Entity** — both parties must submit an offer to the IDR Entity.
- **Within 30 days from the date offers are submitted** —IDR Entity makes and notifies both parties of final decision.
- **Within 30 days after the final decision is rendered** — any additional payments as a result of the IDR Entity decision are due.

## Revision Log

The table below will list future updates to this guide for historical reference.

| Revision | Date |
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