Provider Resource Guide

Revised: April 2024

The information in this guide should align with the terms of the agreement(s) between you and Promise Health Plan. However, in the event of any inconsistency between information contained in this guide and those agreement(s), the terms of such agreement(s) shall govern.

Promise Health Plan Network Provider:

This provider resource guide outlines key plan details for health insurance plans offered by Promise Health Plan. In this guide, you will find information regarding provider support & accessibility, claims and member benefit management, precertification process, and more. We want to ensure that you have all the resources at your fingertips to provide high-quality and efficient care to our members.

To ensure all people we serve live their healthiest lives, Promise Health Plan, a Prisma Health Company, allows health systems and employers to collaborate and coexist to overcome their health insurance challenges. Born in South Carolina, built for our communities, and backed by a Clinically Integrated Network, Promise Health Plan offers employee benefit solutions that are designed to reduce costs, ensure the highest quality care, and provide an exceptional experience.

Details on how to access the information you may need are included on the following pages.

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Provider Portal

Accessing Your Provider Portal

Login in to your provider portal with Promise Health Plan by either visiting the Providers section of our website at www.promisehealthplan.com/providers/ or by accessing it directly at www.myPromiseHealthPlan.com

Portal User Guide

For assistance in navigating the provider portal, our User Guide can be reviewed at www.promisehealthplan.com/providers/ by selecting it from the Provider Resources section or accessing it within your links section in the portal.

Portal Provider Services

Access the following provider services within your portal:

- View claims
- Check patient eligibility and benefits
- Submit precertification requests
- Contact Support
- And more

Claims & Eligibility

Accessing Plan Benefits

Information about member benefits is available through the following channels:

- Promise Health Plan Provider Portal at www.myPromiseHealthPlan.com
- Payer ID for Benefits and Eligibility: CRSMD

Verification of Benefits:

Online verification of benefits can be accessed through Electronic Data Interchange (EDI):

EDI can be used to:

- Verify member eligibility
- Obtain member ID number
- Obtain copay, and YTD deductible amounts
- Obtain Coordination of Benefits (COB) information

Payer ID for Benefits and Eligibility: CRSMD

Benefit Plan Design:

The Promise Health Plan medical benefits package offers a narrow network design. The table below explains the tier structure and benefit level.

Tier	Network	Description
1	Promise Health Plan Provider	Highest benefit level
2	National Provider Network	Standard savings
3	Out-of-Network	Lowest benefit level

Claims Submission and Timely Payment:

All medical claims must be sent to:

Luminare Health Benefits, Inc.
P. O. Box 4278
Clinton, IA 52733-4278

Payer ID for Claims Submission: 35182

Claims must be submitted within twelve (12) months of the date of service. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full, with all the requested information. A complete claim must include the following:

- Name of patient
- Patient's date of birth
- Name of employee
- Address of employee
- Name of employer and group number
- Name, address and tax identification number of provider
- Employee Member Identification Number
- Date of service
- Diagnosis and diagnosis code
- Description of service and procedure number
- Charge for service
- The nature of the accident, injury or illness being treated.
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical Necessity of the treatment or service being provided to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL ALL REQUIRED INFORMATION IS RECEIVED.

Claims will be paid within 30 days from when all necessary information is received.

Provider Support

Promise Health Plan Provider Support is available from 8am-8pm EST, Monday through Friday. You can access support by either giving us a call at the number below or by accessing support via your portal at the link below.

Promise Health Plan's Provider Support: (855) 504-6363
www.myPromiseHealthPlan.com

Promise Health Plan's Provider Support can help you:

- Check claim status
- Submit an administrative appeal
- Get copies of EPPs
- Check a member's Deductible/Out-of-Pocket Maximum Accumulation Status

Promise Health Plan utilizes Luminare Health Benefits, Inc. for Third-Party Administration (TPA) services.

Sample Member ID Cards

Member
JOHN SMITH

Member ID	012345678
Employer	ABC Company
Group ID	LX0000
Customer Service	855-504-6363 www.myPromiseHealthPlan.com

Member Responsibility

	Tier 1: Promise Network	Tier 2: First Health Network
Primary / Specialty Provider Copay	$0 / $0	$0 / $0
Urgent Care / Emergency Room	$0 / $0	$0 / $0
Deductible (Indv / Fam)	$0 / $0	$0 / $0
Out-of-Pocket Max (Indv / Fam)	$0 / $0	$0 / $0

Your Pharmacy Plan

RXBIN	004336	Pharmacist	800-364-6331
RXPCN	ADV	Member	800-334-8134
RXGRP	RX21CB	Web	www.caremark.com

CVS caremark

SUBMIT CLAIMS TO
Payer ID Number 35182
Mail P.O. Box 4278
Clinton, IA 52733-4278
Claims Status Inquiry Payer ID CRSMD

Call Customer Service at 855-504-6363

- Member Support
- Precertifications
- Provider Services

MEMBER NOTICE
Carry this card at all times. Before hospital admission or surgery (outside the physician's office) or for other services as specified in your plan your physician must call for pre-treatment authorization (precertification). Failure to comply may result in a reduction of benefits. Emergency hospital admissions must be reported within 48 hours or by the next regular business day following admission.

PROVIDER NOTICE
Precertification must be obtained for services as specified in the member's plan. For precertification, call the number shown on this card. Possession of this card or obtaining precertification does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on this card to verify eligibility.

Promise Health Plan is administered by Luminare Health.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT

Pharmacy Support

Pharmacy Benefits Manager Details and Contact Information

Our members may have different pharmacy benefits managers based on their employer's selection. Please confirm the appropriate PBM on the member's ID card and review their ID card for group specific items as well.

	Caremark	Express Scripts, Inc.	Optum	Liviniti
RxBIN	004336	610014	610011	015433
Rx PCN	ADV		IRX	SSN
RXGRP	RX21CB	Group specific	RXBENEFIT	Group Specific
Hours	M-F, 7am – 7pm EST (Managed by RxBenefits) Overflow and weekends (Managed by PBM)			M-F, 7am-9pm EST Sat., 9am-7pm EST Sun., 9am-6pm EST
Phone	(800) 364-6331	(800) 334-8134	(800) 334-8134	(800) 710-9341
Fax	(888) 836-0730	(877) 895-1900	(800) 491-7997	(318) 214-4190
Website	www.caremark.com	www.express-scripts.com	www.optumrx.com	https://liviniti.com

Provider Directory

Accessing Provider Directory

The Promise Health Plan Provider Directory can be seen by searching for providers under the "Find Care Now" section at https://www.promisehealthplan.com/member-login/.

Precertification Process

You can request precertification through the following channels:

Online: www.MyPromiseHealthPlan.com
Phone: (855) 504-6363
Fax: (717) 295-1208

Precertification, also known as prior authorization or prior approval, by Promise Health Plan is required for inpatient services and some outpatient services and surgeries. Please refer to the precertification list below.

Services Requiring Precertification

Services Requiring Precertification
Inpatient Services Inpatient Hospital (excludes observation setting) Skilled Nursing Facilities Rehabilitation Facilities Long Term Acute Care Facilities Psychiatric Treatment Facilities Chemical Dependency Treatment Facilities Organ and Tissue Transplants in all settings
Outpatient Services Partial Hospitalizations Home Health Care/Home Infusion Therapy
Outpatient Surgeries
Spinal Procedures Lumbar Laminectomy Cervical Laminectomy Lumbar Diskectomy, Foraminotomy, or Laminotomy Cervical Diskectomy or Microdiscectomy, Foraminotomy, Laminotomy Cervical Fusion, Anterior Disk Arthroplasty, Cervical Vertebroplasty and Kyphoplasty Disk Arthroplasty, Lumbar Automated Percutaneous Lumbar Discectomy (APLD), Low Back Pain
Cosmetic Procedures Reduction mammoplasty Breast Reconstruction- Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander Blepharoplasty Rhinoplasty Septoplasty Abdominoplasty Panniculectomy
Joint Replacements Knee, Hip
Orthognathic Procedures LeFort I, LeFort II, LeFort III
Varicose Vein Sclerotherapy plus Ligation, Saphenofemoral Junction, Saphenous Vein Stripping, Sclerotherapy-Legs Saphenous Vein ablation, Radiofrequency and Laser
Cochlear Implants

Services Requiring Precertification
Additional Services and Procedures
DME over $2,500
Radiation Therapy Brachytherapy IMRT Radiofrequency Ablation of Tumor Radionuclide (Strontium, Samarium, Radium) Therapy of Bone Metastases Stereotactic Body Radiotherapy Proton Beam
Bariatric Surgery
Dialysis Peritoneal, Hemodialysis, Home visit for Dialysis
Genetic Testing Breast Cancer: BRCA, Breast Cancer (Hereditary) - Gene Panel; Breast Cancer - HER2 Testing; Breast Cancer Gene Expression Assays; Breast or Ovarian Cancer, Hereditary - BRCA1 and BRCA2 Genes Prostate Cancer: Prostate Cancer - BRCA1 and BRCA2 Genes; Prostate Cancer - Genetic Profiles; Prostate Cancer - HOXB13, MMR, PTEN, and TMPRSS2-ETS Fusion Genes; Prostate Cancer - PCA3 Genes; Prostate Cancer Gene Expression Testing – Decipher; Prostate Cancer Gene Expression Testing - Oncotype DX; Prostate Cancer Gene Expression Testing – Prolaris Non-small Cell lung Cancer: Non-Small Cell Lung Cancer - Anaplastic Lymphoma Kinase (ALK) Fusion Gene Testing; Non-Small Cell Lung Cancer - EGFR Gene Testing; Non- Small Cell Lung Cancer - KRAS Gene Testing Melanoma: Malignant Melanoma (Cutaneous) - BAP1, CDK4, and CDKN2A Genes; Malignant Melanoma (Uveal) - BAP1, CDK4, and CDKN2A Genes; Malignant Melanoma - BRAF V600 Testing; Melanoma (Cutaneous) - Gene Expression Profiling; Melanoma (Uveal) - Gene Expression Profiling Hereditary Colon Cancer: Colorectal Cancer (Hereditary) - Gene Panel
Interventional Radiology Percutaneous Revascularization, lower extremity Carotid Artery Angioplasty with Stent Placement Endovascular Intervention, Iliac and Femoral Popliteal Endovascular Repair (EVR), Thoracic Aorta Vertebral Artery Angioplasty, with or without Stent Placement
MRI/MRA/PET Scans (Not done in the ER)
Intensive Outpatient Treatment
Outpatient Therapies (Reviewed after the first 12 visits) Physical Therapy, Occupational Therapy, Speech Therapy

Requirements for Initial Certifications

When you call for precertification, be prepared to provide all the following information:

- Member name, address, phone number, and the ID number shown on the front of the member's ID card
- the patient's name, address, phone number (if not the member)
- admitting physician's name and phone number
- name of facility or home health care agency
- date of admission or proposed date of admission
- condition for which patient is being admitted

Time Frames for Initial Certifications

For non-urgent care, you or your authorized representative should call Promise Health Plan at least 15 calendar days prior to initiation of services or continuation of services after Medicare benefits are exhausted. For urgent care, you or your authorized representative may call Promise Health Plan within 48 hours or the next business day, if later, after the initiation of services. If no additional information is required, the determination of coverage will generally be completed within a reasonable period of time, but no later than 15 calendar days from receipt of the request.

In the event Promise Health Plan receives a communication that fails to follow the precertification procedure described above but communicates at least your name, a specific medical condition or symptom, and a specific treatment, service, or product for which precertification is requested, you (or your authorized representative) will be notified orally (and in writing, if requested) within five calendar days of the failure to follow the proper procedure.

If Promise Health Plan needs additional time to make a decision due to circumstances beyond its control, you will be notified within the 15 calendar days of the circumstances and the date by which Promise Health Plan expects to render a decision. If the circumstances include a failure on your part to submit necessary information, the notice will specifically describe the needed information. You will have 45 calendar days to provide the information requested and Promise Health Plan will complete its determination of the claim for certification no later than 15 calendar days after receiving the requested information.

Failure to respond in a timely and complete manner will result in a denial of the requested certification.

Time Frames for Certification Extensions

If you request an extension of a previously approved hospitalization, skilled nursing facility stay, or ongoing course of treatment, and the request involves non-urgent care, the extension request will be processed within 15 calendar days after the request is received. If the inpatient admission or ongoing course of treatment involves urgent care and the request is received at least 24 hours before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified as soon as possible but no later than 24 hours after the request is received. If the inpatient admission or ongoing course of treatment involves urgent care and the request is received less than 24 hours before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified no later than 72 hours after the request is received.

If a Certification Changes

If Promise Health Plan determines that the hospital or skilled nursing facility stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, we will:

- notify you of the proposed change, and
- allow you to file an appeal and obtain a decision before the end of the fixed number of days and/or treatments or the fixed time period that was previously approved.

If a Certification Is Denied

If your request for a certification or certification extension is denied in whole or in part, we will provide you with a written Notice of Certification Denial within the time frames indicated above.

The Notice of Certification Denial will include an explanation of the denial, including:

- the specific reason(s) for the denial
- reference to the Medical Plan provisions on which the denial is based
- if the denial is due to a lack of information necessary for certification, a description of any additional material or information needed and an explanation of why such material or information is necessary
- a description of the Medical Plan claim review procedure and applicable time limits
- if the denial relies upon an internal rule, guideline, protocol or other similar criterion, either a copy of that criterion or a statement that such criterion was relied upon and will be supplied free of charge, upon request
- if denial was based on custodial care, medical necessity, experimental/ investigational treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances, or a statement that such explanation will be supplied free of charge, upon request
- a statement that you have a right to appeal.

Appeals & Disputes

If you have a question about how a claim was processed or on a precertification request denial, you can call Promise Health Provider Support at (855) 504-6363 to get more information about the determination or try to resolve the issue or obtain further clarity. In some cases, issues can be resolved by providing additional information, as requested by Promise Health Plan.

If your issues cannot be resolved informally, as a provider you have the right to appeal the determination of any denied services or claim by filing an appeal with us.

You can find information on how to proceed with an appeal on your Explanation of Provider Payment (EPP), or you can contact Promise Health Plan's Provider Support at (855) 504-6363.

Timeframes for filing an appeal vary depending on applicable state or federal requirements.

Care Management Programs

Promise Health's Care Management team shall provide case management for all members through the following methods:

- Members identified through utilization management review;
- Members post discharge from an inpatient facility affiliated with the Promise Health Network;
- Members identified through provider referrals; or
- Currently managed Members

Members within South Carolina will also have access to our Integrated Care Management Programs through our Clinically Integrated Network.

Referrals to our Care Management Team

If you have a Promise Health member as a patient who would benefit from care management services, please refer them to us for care coordination by accessing referral instructions and forms at https://www.promisehealthplan.com/providers/ by selecting Provider Resources.

Integrated Care Management Program Details

Integrated Care Model (ICM)

The interdisciplinary ICM team includes nurse care managers for patients with complex medical conditions, health coaches, social workers, pharmacists, behavioral health professionals, and others. Advanced data analytics powers a patient identification and risk stratification process to identify patients with rising healthcare risk in real-time. This multi-dimensional risk assessment utilizes multiple data sources, including electronic medical record data, to determine medical complexity, patient activation level, social determinants of health, and other factors contributing to accurately assessing the real time risk of patients. As patients are identified, a simultaneous automated assignment process will ensure that the appropriate ICM team member is alerted to begin coordinating the efforts of the multidisciplinary ICM team. The patient's primary care provider will be immediately alerted to lead the integrated care of their patient. The goal of the ICM is to ensure that patients receive the best care at the most critical time of need while reducing unnecessary healthcare utilization and cost.

Complex Care Management

Complex Care Managers assist patients with multiple or complex conditions to obtain access to care and services, as well as coordinate their care in order to meet health goals and improve outcomes. Care Management (CM) is provided to patients who have experienced an event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. It is a collaborative process of assessment, planning, facilitation, care

coordination and evaluation. The CM Program provides advocacy for options and services to meet the comprehensive medical, behavioral, psychological, social and spiritual needs of a patient and the patient's family/caregiver, while promoting quality and cost-effective outcomes. Since CM is considered an opt-out program, all eligible patients have the right to participate or decline participation. The Care Transition Program focuses on evaluating and coordinating post-hospitalization needs for patients who may be at risk of readmission.

Condition Management

Condition Management programs are offered to all eligible patients identified with one or more of the following conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, hypertension and hyperlipidemia.

The Condition Management Program is a proactive, multidisciplinary, systematic approach of coordinating healthcare utilizing targeted evidence-based interventions and communications for defined patient populations with conditions where self-management efforts can be implemented. The program is designed to empower patients, working with their health care provider(s), to manage their condition, prevent exacerbations and complications, with the goal of slowing the progression of the condition, minimizing its effects and improving quality of life for patients.

The Condition Management Program identifies patients who can benefit from condition management and determines the best plan of care for each patient based on their individualized health needs utilizing targeted, evidenced-based interventions and communications. The goal of the Condition Management Program is to identify and support patients, caregivers and their health care provider(s) to manage their condition(s) by providing tools and resources to empower patient's participation in their plan of care to improve their health and quality of life. The program objectives are to:

- Promote consistency in long-term management approaches and optimize treatment for patients with targeted conditions
- Achieve optimal levels of wellness in these targeted patients
- Improve the patient's basic understanding of his/her condition process
- Increase provider awareness and participation with recommended treatment modalities
- Monitor patient's condition, including consideration of other health conditions and addressing lifestyle issues
- Provide early collaborative care management or health care provider intervention when specific patient indicators exceed the established threshold
- Attain increased compliance with treatment regimen
- Reduce emergency room utilization and frequency of inpatient admissions.
- Reduce and delay late-stage condition manifestations

Case Management

Promise Health provides case management for members outside of South Carolina which include assessment, planning, implementation, coordination, monitoring, and evaluation of options and services that meet an individual’s health needs using communication and available resources that promote high-quality, cost-effective outcomes.