Heraya Health
Provider Billing Manual

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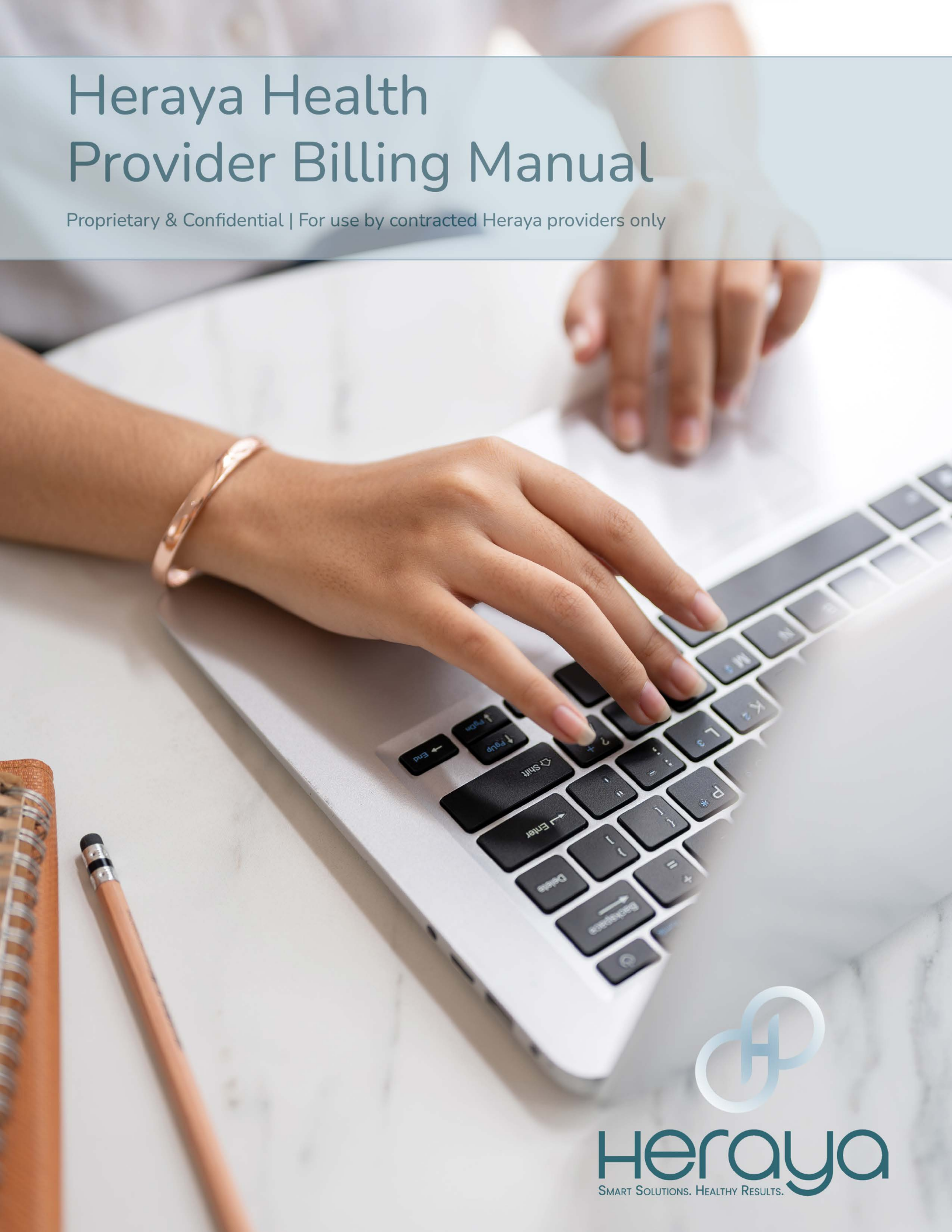

Heraya
Smart Solutions. Healthy Results.

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Section One – Welcome

Heraya Health

Heraya Health is a provider-founded, provider-focused network of chiropractic physicians, licensed acupuncturists, naturopathic physicians, and massage therapists that provide patients with seamless access to high-quality integrative healthcare. Our ongoing commitment to quality care is reflected throughout our operations, clinical policies, and practice guidelines.

About This Billing Manual

This manual is designed to be a provider's first resource for Heraya billing or claims questions. The layout provides general information about the billing process for health plans, employer groups, and other organizations (referred to as "plan(s)" in this document) contracted with Heraya. Each plan has its own section in this manual as billing requirements may vary by plan. Refer to the specific section when billing for a particular plan.

Proprietary Information

The information in this manual is proprietary and may not be distributed, shared, or copied for use outside the office of a Heraya participating provider or for purposes other than rendering services to Heraya members.

Amendments to This Manual

This manual may be amended from time to time. It is updated as needed in response to changes in plan requirements, as changes in regulations occur, and as internal Heraya processes are updated. The most current version of this manual is located in the Provider Hub behind the Provider Login on the Heraya website at https://www.herayahealth.com/.

Note: In some situations, Heraya may only be delegated to provide a fully credentialed provider network and may not be responsible for claims payments, Remittance Advice statements, Explanation of Benefits, denials, appeals, or member complaints. Refer to the specific plan contract section to determine who is responsible for claims management.

Questions

For billing, claims, or eligibility questions, call the Heraya Claims & Customer Service Department at 503-203-8333 or 800-449-9479.

Thank you for your participation with Heraya Health. When you succeed, we succeed.

Section Two – General Information

2.1 Electronic Claims Submission Requirements

Electronic Claim Submission / Electronic Data Interchange (EDI)

Heraya only accepts electronic claims via Heraya's approved clearinghouse (see below). If you utilize a different billing clearinghouse, provide the applicable approved Heraya payer code (see below) to your clearinghouse to facilitate EDI claim submission to Heraya.

- Office Ally – www.officeally.com
    - Heraya Payer code is **HRYA1**.

Claim Submission Standards

In order to comply with administrative simplification provisions and to streamline provider reimbursement, electronic claims submitted to Heraya must contain accurate and complete information. *Claims submitted with inaccurate or missing information may result in delay in payment or denial of claims.* Common examples of inaccurate or missing information include:

- **Common Error:** A clinic NPI Type II number is listed in box 24j as the rendering provider.
    - **Appropriate Entry Should Be:** NPI Type I should be entered in box 24j for the rendering provider.
- **Common Error:** NPI Type I is in box 32a and/or 33a.
    - **Appropriate Entry Should Be:** NPI Type II should be in box 32a and/or 33a.
- **Common Error:** An Incorrect Federal Tax Identification Number or Social Security Number has been entered in box 25.
    - **Appropriate Entry Should Be:** Enter the Federal Tax Identification Number or Social Security Number registered to the entity name to whom the check is payable. This is the entity who will pay taxes on payments received by Heraya.
- **Common Error:** Signed name in box 31 does not match rendering provider name attached to the NPI Type I in box 24j.
    - **Appropriate Entry Should Be:** The signed name in box 31 should match the rendering provider name attached to the NPI Type I in box 24j.
- **Common Error:** "No" is selected in box 27 (Accept Assignment).
    - **Appropriate Entry Should Be:** "Yes" is the required selection in box 27.
- **Common Error:** Entering data in box 23 (pre-auth number).
    - **Appropriate Entry Should Be:** The pre-auth or referral field should be left blank.
- **Common Error:** Frequency code 7 is entered in box 22 (Resubmission Code) for a new claim (i.e., it is not a resubmitted claim).
    - **Appropriate Entry Should Be:** Frequency code 7 in box 22 should only be utilized for resubmitted or corrected claims.

For the above examples, each of the box numbers used are associated with the CMS-1500 form. However, please note that we only accept electronic claims composed of ANSI-837 fields and loops that correspond to the box numbers from the CMS-1500 form. To obtain or view a CMS-1500 form crosswalk to ANSI-837 electronic claim fields and loops, please go to the following website: https://www.cgsmedicare.com/pdf/5010_jobaid.pdf

Timely Filing Policy

Timely filing periods vary by lines of business which are outlined in this manual. The patient may not be held responsible for claims submitted outside of the timely filing period.

Multi-Disciplined Providers

If a provider is contracted with Heraya for more than one discipline, a separate electronic claim for each discipline must be submitted. This enables Heraya to administer the applicable fee schedule for the corresponding discipline. A separate co-payment or co-insurance must be collected from the patient for each separate claim.

For example, if both naturopathic and acupuncture services are rendered to a patient on the same date of service, the provider must submit two electronic claims: one for the naturopathic services and one for the acupuncture services. Note: In this scenario, two co-payments or separate co-insurance must be collected from the patient, one for each type of service.

Multiple Dates of Service

Heraya providers may submit multiple dates of service per patient, rendered in the same year, on the same electronic claim submission, but can only submit one date of service per claim line. This ensures Heraya's ability to process your claim accurately and efficiently in a timely manner.

X-Ray and Laboratory Billing Procedure

Heraya is contracted with various radiology and laboratory facilities that will bill Heraya directly for services rendered to Heraya patients. Refer to the Contracted Facilities section for more information.
Note: There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

2.2 Required Electronic Claim Fields

Provider Responsibility

Heraya providers are responsible for the accuracy of electronic claims billed to Heraya, even in situations where billing functions are performed by another party.

Electronic Claim Submission Guidance

The following is designed to assist you in the submission of electronic claims to Heraya.

Field	Instructions
Box 1: Carrier	• Enter the payer's name and address to whom the claims are being sent. • Enter a 9-digit zip code. • Do not use punctuation or symbols.
Box 1a: Insured's ID Number	• Enter the Insured's ID Number as shown on insured's ID card for the payer to whom the claim is being submitted. • If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field. • Do not make modifications to the number, i.e., adding dashes or letters.
Box 2: Patient's Name	• Enter the patient's name exactly as it is shown on the insurance card, using last name, first name, and middle initial (if any). • Do not use a space or periods in any portion of the last name. • For hyphenated names, such as Smith-Jones, capitalize both names and separate them by a hyphen.
Box 3: Patient's Date of Birth and Sex	• Enter the patient's 8-digit birth date (MM/DD/YYYY). For example: May 1, 2004, should be entered as 05/01/2004. • Place an X in the appropriate field to indicate the patient's gender. If the gender is unknown, leave this field blank.
Box 4: Insured's Name	• If the insured is the same as the patient, then enter the patient's name in this field; in order of last name, first name, and middle initial (if any). • The Insured's Name identifies the person who holds the policy, which would be the employee of the employer that sponsors the health insurance.
Box 5: Patient's Address	• Enter the patient's current mailing address, including the street address on the first line, the city and state on the second line. Enter the patient's 9-digit zip code (include a hyphen) and telephone number (include the area code) on the third line. • Do not use punctuation. • Use the two-character post office code for the state.

Field	Instructions
Box 6: Patient Relationship to Insured	The Patient Relationship to Insured refers to how the patient is related to the insured. • "Self" would indicate that the insured is the patient. • "Spouse" would indicate that the patient is the husband, wife, or qualified partner as defined by the insured's plan. • "Child" would indicate that the patient is a minor dependent as defined by the insured's plan. • "Other" would indicate that the patient is other than self.
Box 7: Insured's Address	• Enter the insured's current mailing address, including the number and street address on the first line, the city and state on the second line. • Enter the insured's 9-digit zip code (include a hyphen). • Do not use punctuation. • Use the two-character post office code for the state.
Box 9: Other Insured's Name	• This indicates that there is a holder of another group health policy that may cover the patient. • Enter the other insured's name exactly as it is shown on the insurance card, using last name, first name, and middle initial (if any).
Box 9a: Other Insured's Policy or Group Number	• Enter the insured's other insurance identification number, including the identifier.
Box 9d: Insurance Plan Name or Program Name	• Enter the complete name of the other insurance carrier or program name, if applicable.
Box 10: Patient's Condition Related To	This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. • (10a): "Employment" (current or previous) would indicate that the condition is related to the patient's job or workplace. • (10b): "Auto Accident" would indicate that the condition is the result of an automobile accident. Include the 2-letter state abbreviation in the space labeled "Place." • (10c): "Other Accident" would indicate that the condition is the result of any other type of accident. • Enter the date of injury (DOI) if applicable.
Box 11: Insured's Policy, Group, or FECA Number	• Enter the insured's policy or group number as it appears on the insured's health care identification card.
Box 11a: Insured's Date of Birth and Sex	• Enter the insured's date of birth and sex.
Box 11c: Insurance Plan Name or Program Name	• Enter the complete name of the insurance company in this space.

Field	Instructions
Box 11d: Is There Another Health Benefit Plan?	• This space must be filled in for secondary billing purposes.
Box 12 & 13: Patient's or Authorized Person's Signature	Gives permission to release medical records to the insurance carrier (box 12) and to release payment directly to the provider or facility where the services were rendered (box 13). • Enter "signature on file", "SOF" or obtain signature of authorized person in this space. The patient or patient's representative have signed a form giving permission to use "signature on file" when authorizing payment directly to the facility. • When using "signature on file", enter the same date as the date the services were rendered.
Box 14: Date of Current Illness, Injury, or Pregnancy	• The Date of Current Illness, Injury, or Pregnancy refers to the first date of onset of illness, the actual date of injury, or the last menstrual period for pregnancy. This box also contains a field for the applicable qualifier.
Box 15: Other Date	• Enter the additional date information and applicable qualifier about the patient's condition or treatment.
Box 16: Dates Patient Unable to Work in Current Occupation	• If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be entered for the "from – to" dates that the patient is unable to work. • An entry in this field may indicate employment-related insurance coverage.

Box 17: Name of Heraya Referring Provider or Other Source	Heraya requires utilization of this box for Call Coverage Providers as follows:
	• (Box 17a): Enter the name of the Call Coverage provider.
	• (Box 17b): Enter the 10-digit NPI Type I number of the Call Coverage provider.
	• Note the following:
	  ○ Approved Call Coverage providers may not bill Heraya directly but must identify themselves.
	  ○ Heraya pays the Heraya provider, not the Call Coverage provider.

Field	Instructions
Box 21: Diagnosis or Nature of Illness or Injury	The Diagnosis or Nature of Illness or Injury refers to the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. • ICD Ind. box – Enter "0" for ICD-10. • Enter the patient's ICD-10 diagnosis/condition in box A-L as appropriate. o Use the chief complaint for the first code. o List at least one but no more than nine ICD-10 diagnosis codes. • Note the following: o Box 21 must be completed for consideration of payment. o Enter a valid ICD-10 code. o For Massage Therapists, the use of ICD-10 codes on a billing form does not constitute the process of "diagnosis".
Box 22: Resubmission Code	• Enter "7" in this box for corrected or resubmitted claims. This claims frequency code indicates the claim is a corrected or resubmitted claim. **This box should not be used for new claims.**
Box 23: Prior Authorization Number	• Heraya has no pre or prior authorization requirements; therefore, to avoid delays in claims processing it is imperative that this field remain blank.
Related to boxes 24a-24j, enter up to 6 claim lines as appropriate for services rendered. The following will provide more detailed instruction for boxes 24a-24j.	
Box 24a: Date(s) of Service	• This indicates the month, day, and year the service(s) was provided. • Enter the 8-digit date of service (MM DD YYYY) utilizing spaces, not slashes, between the month, day, or year. • For services rendered on the same date, the "To" and "From" must be identical.
Box 24b: Place of Service	• Enter the 2-digit code, from the list below, indicating the location where the service was rendered. o Enter "11" for services rendered at a provider's office. o Enter "02" for services rendered via telehealth. o Enter "03" for services rendered at an integrative health university.

Field	Instructions
Box 24d: Procedures, Services or Supplies	• Enter the 5-digit CPT® code and applicable modifiers that best describe the services provided for the patient. The codes and modifiers selected must be supported by documentation in the patient's clinical record. • Modifiers show that the procedure, service, or supply has been altered in some way but not changed in its definition or code. For example, if a patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided, e.g., 98940, this circumstance may be reported by adding modifier -25 to the appropriate level of E/M service. Refer to the CPT® codebook for a description of modifiers. • Each CPT® code for a date of service should be listed on a separate line.
Box 24e: Diagnosis Pointer	This relates to the reason the service(s) was performed. • Enter the diagnosis code reference letter (pointer) that relates the date of service and the procedures performed to the primary diagnosis. • When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. • The reference letter(s) should be A–L or multiple letters as applicable. ICD-10 diagnosis codes must be entered.
Box 24f: Charges	• Enter the billed amount for each service line. For example, if line 1 indicates 4 units of 97124 at $20 per unit, the total amount of $80 would be entered in this field for line 1. • Do not use additional characters, such as commas or dollar signs. • Enter 00 in the cents area if the amount is a whole number.
Box 24g: Days or Units	• Days or Units refers to the number of days corresponding to the dates entered in 24a or units as defined in CPT® or HCPCS coding manual(s). • Enter the number of visits, units, or services rendered. • Multiple units of the same procedure code performed during the same visit should be billed on one line. For example, if a massage therapist rendered four (4) units of 97124, all four units are required to be entered on the same claim line.
Box 24j: Rendering Provider ID Number	• Enter the NPI Type I number of the individual provider who rendered the service. • The NPI Type I must match the provider's name listed in box 31. An NPI Type II number is not appropriate for this box.
Box 25: Federal Tax ID Number	• Enter the Federal Tax Identification Number or Social Security Number registered to the entity name to whom the check is payable. This is the entity who will pay taxes on payments received by Heraya.

Field	Instructions
Box 26: Patient's Account Number	• Enter the patient's account number assigned by the provider or supplier.
Box 27: Accept Assignment	• Enter "yes". Accept Assignment indicates that the provider agrees to accept assignment under the terms of the payer's program, including Heraya provider contract obligations.
Box 28: Total Charge	• Enter the total amount of the provider's charges. This amount should be the total of each line of service listed in column 24f, lines 1 through 6. • Do not use additional characters, such as commas or dollar signs. • Enter 00 in the cents area if the amount is a whole number.
Box 29: Amount Paid	• Enter total amount the patient and/or other payers paid on the covered services only. • In the case of secondary billing, enter the amount the first carrier paid. • Do not use additional characters, such as commas or dollar signs. • Enter 00 in the cents area if the amount is a whole number.
Box 31: Signature of Provider or Supplier Including Degrees or Credentials	• Enter the legal signature of the provider rendering services including the provider's Degrees or Credentials. "Signature on file" is acceptable. • Enter the 8-digit date in this format: MM DD YYYY

Box 32: Service Facility Location Information	• Enter the name and address of the facility where services were rendered.
	• Enter the name of the facility, street address, city, state, and 9-digit ZIP code (include a hyphen).
	  o Do not use punctuation (i.e., commas, periods) or other symbols in the address.
	  o Enter a space between the city name and state code; do not include a comma.
	  o Use the two-character post office code for the state.

Box 32a: NPI Number of Facility Where Services Were Rendered	• Enter the NPI number that matches the name of the location where the services were rendered. This can be a Type I or Type II NPI number.
Box 32b: Other ID number	• Enter the two-digit qualifier identifying the non-NPI registry to the name of the location where the services were rendered. • This can be Type I or Type II number; typically, an NPI Type II number would be entered in this field.

Field	Instructions

Box 33: Billing Provider Info and Phone Number	• Enter the entity name registered and assigned by the IRS to the TIN number listed. This is the entity that receives the payment and pays taxes on the payment.
	• Enter a physical address to include the city, state (two-character post office code) and the 9-digit zip code (include a hyphen).
	  ○ Enter a space between the city name and state code; do not include a comma.
	  ○ Do not use punctuation (i.e., commas, periods) or other symbols in the address.

Box 33a: NPI Number of the Billing Provider or Clinic	• Enter the Type 1 or Type II NPI number that matches the name of the entity registered to the TIN with the IRS (who is receiving payment).
Box 33b: Other ID number	• Enter the two-digit qualifier identifying the non-NPI number followed by the ID number of the billing provider.

For the above electronic claim submission guidance, each of the box numbers used are associated with the CMS-1500 form. However, please note that we only accept electronic claims composed of ANSI-837 fields and loops that correspond to the box numbers from the CMS-1500 form. To obtain or view a CMS-1500 form crosswalk to ANSI-837 electronic claim fields and loops, please go to the following website: https://www.cgsmedicare.com/pdf/5010_jobaid.pdf.

2.3 Claims Processing Information

Heraya adheres to all applicable federal and state regulations regarding claims payment requirements. Heraya processes clean and complete claims within 30 days of receipt. Providers can typically expect receipt of their Remittance Advice within 30 days of the date Heraya receives a clean claim.

A clean claim is defined as a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made.

To verify receipt of a claim, call the Heraya Customer Service Department at 503- 203-8333 or 800-449-9479 to inquire about the status of the claim.

"Lesser of" Reimbursement Provision

Heraya reimburses the lesser of the allowed amount or the billed amount. Any co-payments, coinsurance, deductibles, or any other cost sharing will be offset against the allowed (or billed amount if less than allowed) for covered services, without regard to whether the provider has collected such amounts.

For example, if a claim indicates a billed amount of $38 for a service that Heraya would reimburse at $40, Heraya will reimburse the lesser billed amount of $38 less the patient cost share portion (co-payment, coinsurance, deductible).

Resubmission Policy

For commercial plans, Heraya may allow an additional 30 days for resubmission of claims from the date of the original Remittance Advice (RA) for the following reasons:

Reason	Steps for Resubmission
The claim was sent to wrong Payer.	• Submit an electronic claim submission to Heraya within 30 days from the date on the other payer's RA or Explanation of Payment.
The claim had a billing error.	• Upon correcting the errors, please enter resubmission code 7 in box 22 and resubmit the claim electronically to Heraya within 30 days from the date on Heraya's RA of the affected claim.
The claim required clinical records.	• Submit the clinical records within 30 days from the date on Heraya's RA of the affected claim indicating clinical records are required.
The claim required Coordination of Benefit (COB) Information.	• Please enter resubmission code 7 in box 22 and resubmit an electronic claim to Heraya within 30 days from the date on Heraya's RA that includes the electronic COB amounts from the primary carrier's RA or Explanation of Payment. o Note that via your practice management or billing software, COB amounts can be entered to be uploaded to the electronic claim (837).

Reason	Steps for Resubmission
The claim was denied due to Timely Filing	• There may be occasions where claims were submitted timely; however, Heraya did not receive them within the timely filing period. In these situations, follow the Claims Reconsideration process under section 2.6 of this manual.

Third Party Liability Claims

Third Party Liability Claims may result from automobile liability insurance, Workers' Compensation claims, or other third-party liability circumstances. Below are Heraya's guidelines:

- For Kaiser self-referred plans handled by Heraya, work-related claims (Workers' Compensation) are denied. The only exception to this would be if Workers' Compensation denies the claim as not being work related.
- Kaiser self-referred plans, handled by Heraya, do not have subrogation or third-party lien rights. Heraya pays third-party liability claims as the primary carrier.

Overpayments

In the event your office identifies a claims overpayment, please notify Heraya immediately, in compliance with your Professional Services Agreement. Heraya will provide written notification of the overpayment to the provider along with the options for satisfying payment and in accordance with the applicable state and federal regulations.

Missed Appointments or Late Cancellation Fees

Fees for missed appointments or late cancellations are not covered by Heraya or the patient's insurance. If a patient misses an appointment or does not cancel the appointment within at least a specific time frame (e.g., 24 hours) advance notice to you/your office, you may charge the patient a reasonable fee (e.g., $25). These fees must be set forth in your office Financial Policies, which must be reviewed and signed by the patient. The fees charged cannot vary by the patient's insurance plans. The only exception to this policy is for Medicaid patients. Providers are not allowed to charge missed appointments or late cancellation fees to Medicaid patients.

2.4 Coordination of Benefits (COB) & Maintenance of Benefits (MOB)

Heraya administers COB, MOB, and "order of benefit determination" in accordance with state and federal regulations as well as industry guidelines. For clarity, refer to the definitions below:

- Coordination of Benefits (COB)
    - This relates to establishing the order and methodology by which insurance plans pay claims when an individual (e.g., a Heraya patient) has coverage under more than one plan. There typically is a primary plan and secondary plan. When there are more than two plans involved, there can be a primary plan, secondary plan, and tertiary plan.
- Maintenance of Benefits (MOB)
    - This relates to one of several methodologies utilized to determine the maximum reimbursement a plan will reimburse or allow as the secondary plan. The following is the MOB methodology utilized for all Kaiser self-referred plans administered by Heraya:
        - Heraya as a secondary plan first determines what benefits would be payable in the absence of other group prime insurance. That amount will be reduced by the amount the primary plan paid. If the amount the primary plan paid is more than what Heraya as the secondary plan would have paid in the absence of other group prime insurance, Heraya as the secondary plan would pay zero.

Order of Benefit Determination

Heraya uses NAIC Coordination of Benefits Rules for determining the order in which plans pay as the primary, secondary, and tertiary. There are several rules; however, the most common rules for determining the order of payment are listed below:

- Non-dependent/Dependent Rule: The plan covering the individual as an employee, member or subscriber is the primary payer over a plan that covers the individual as a dependent.
- Active/Inactive Rule: A plan covering an individual as an active employee is the primary payer over the plan covering the individual as a retired or laid off employee. This rule also applies to dependents covered under two plans.
- Birthday Rule: This is a method used to determine when a plan is primary or secondary for a dependent child when covered by both parents' benefit plan.
    - The parent whose birthday (month and day only) falls first in a calendar year is the parent with the primary coverage for the dependent.
    - If both parents have the same birthday, then the plan that has been in effect the longest pays as primary.
    - If an individual is covered under two active plans as the employee, member or subscriber, the plan that has been active the longest is primary.
- Medicare Rules: There are many rules and scenarios regarding Medicare and other types of health coverage. To find a list of rules and scenarios please go to www.medicare.gov . The following are the most common:
    - Member is retired and neither the member nor their spouse has any active group health plan coverage,

        - Generally, Medicare pays first.
    - Member is 65 or older and has active (current employment status) group coverage through the member or the member's spouse, and the current employer has 20 or more employees.
        - Generally, the active group health plan pays first, and Medicare pays second.
    - Member is 65 or older and has active (current employment status) group coverage through the member or the member's spouse, and the current employer has fewer than 20 employees.
        - Generally, Medicare pays first, and the active group health plan pays second.
    - Member is under 65 and disabled:
        - Member has active group health plan coverage through member or spouse and the employer has 100 or more employees. Generally, the active group health plan pays first, and Medicare pays second.
        - Member has active group health plan coverage through member or spouse and the employer has fewer than 100 employees. Generally, Medicare pays first and the active group health plan second.

In cases where:

- A patient is covered by multiple plans administered by Heraya (dual coverage).
    - For patients with dual coverage (two or more Heraya administered plans), it is not necessary for your office to submit the secondary claim.
    - Heraya's claims processing system automatically generates and processes the secondary claim after the primary claim has been processed. You can identify these claims as the 6th position of the claim ID contains a "5" vs. an "E" (e.g., 12345500123 vs 12345E00123).
- A patient's primary claim is payable by another carrier other than Heraya.
    - If a patient has primary coverage with another carrier and secondary coverage through a Heraya administered plan, the following process applies:
        - Within 30 days of the date on the primary carrier's Explanation of Benefit or Remittance Advice (EOB/RA), submit an electronic claim to Heraya that includes the Coordination of Benefits (COB) amounts from the primary carrier's EOB/RA. Note that COB amounts can be added to an electronic claim submission.

2.5 Remittance Advice

The provider Remittance Advice (RA) is the document that summarizes the claims processed by Heraya. Below provides an explanation of the various fields contained on Heraya's RA.

Payment and Program Details

The top portion of the form shows the payment and program details for the RA.

Payee	This is the organization or provider that receives the payment and pays taxes on the payment. This is the name supplied to Heraya on the W-9 Form given by the Heraya provider.
Pay Date	The date Heraya printed and issued the check.
Program	The name of the specific plan under which the claims were processed.
Payment ID	The number assigned to each RA by Heraya's claims system.

The information below the top portion of the form shows the detail of each claim.

Provider	The name of the provider rendering services to the Heraya patients.
Patient	The name and patient number of the patient receiving services.
Claim Number	The number assigned by Heraya's claims system to the particular claim.
Status	The status of the claim, e.g., Paid or Denied.
Line	The line number that corresponds to the line in Field 24 on the CMS 1500 form.
Service Date	The date(s) the provider rendered services to the patient.
Proc Code- Mod	The CPT® code, and applicable modifier, describing the specific service rendered to the patient and billed on the CMS 1500 form.
Billed Amount	The amount the provider's office has billed for the specific service provided.
Contractual ADJ	The amount the provider must write-off that is above Heraya's contracted rate. The member cannot be billed for this amount.
COB Applied	The amount paid to the provider by the carrier/payer on the primary claim.
Contract Amt	The amount allowed according to the applicable Heraya fee schedule.
Patient Copay/Ded/Coins	The amount that is deducted from the allowed amount due to co-pay, coinsurance, and/or deductibles. The patient is responsible to pay the provider's office this amount for covered services rendered.
Not Covered	Excluding co-pay, co-insurance, deductible amounts, and additional amounts the member is responsible for.
Benefit Amount	The difference between the contract amount and the patient co-pay/ deductible/co-insurance that is applied to the member's benefit.
Discount/Penalty	Discounts that may apply or interest payments.
Withheld Amt	Recoupment of overpaid amounts.
Paid	The net reimbursement to the provider for services rendered.

Messages

If services are denied, a message is displayed to provide an explanation.

Disbursement of Funds by Check Number Section

- The payments for each claim are totaled reflecting the collective billed amounts, allowed amounts, co-pays, co-insurance, deductibles, other charges, and net payment of all services listed on the RA for the specified check number.
- When inquiring about an RA, reference the check number to Heraya staff to assist in locating the specific RA.
- **Overpayment Applied:** This is the amount that has been deducted/recouped, due to a prior overpayment, from the total due (check) tied to the RA.
- **Overpayment Due:** This is the total overpayment due related to claims that have been reprocessed or reversed that appear on the RA. You will receive overpayment letters for this amount. Typically, these overpayment letters will be in the same envelope as the check and RA.

2.6 Claims Reconsideration Process

The Claims Reconsideration Process involves instances where new information or a clarification of information becomes available relating to a disputed finalized claim.

To appeal a utilization management (UM) decision, refer to Heraya's Provider Operations Manual under the Utilization Management section for the UM Appeals process.

Claims Reconsideration Procedures

Written Submission

Submit a written Request for Claims Reconsideration Form within 30 days from the date of the original Heraya Remittance Advice (RA) of the disputed claim to include the following information:

1. A completed Request for Claims Reconsideration Form which is located in the Provider Hub behind the Provider Login on the Heraya website, www.herayahealth.com, and at the end of this manual in Appendix - Forms.
2. A copy of Heraya's RA for the disputed claim. Be sure to include the applicable pages.
3. Any new information or additional explanation to support the Request for Claims Reconsideration.

Mail or fax the Request for Claims Reconsideration Form including all supporting documentation to:

Mail	Fax
Heraya Health Attn: Claims Reconsideration PO Box 278 Beaverton, OR 97075-0278	503-203-8522 Attn: Claims Reconsideration

Heraya Acknowledgment

Heraya will acknowledge the receipt of a Request for Claims Reconsideration by letter to the provider within five (5) business days.

Heraya Claims Reconsideration Decision/Notification

A written decision regarding the Request for Claims Reconsideration will be sent to the provider within 30 business days from receipt of the request.

2.7 Administrative Claim Appeal Process

If you have new information concerning a finalized claim or need to clarify information that accompanied a finalized claim, see the Claims Reconsideration section.

The Administrative Claim Appeal Process applies to situations where you are disputing specific Heraya claims administration procedures or outcomes regarding a finalized claim.

If you are disputing a medical necessity denial or decision, refer to Heraya's Provider Operations Manual under the Utilization Management (UM) section for the UM Appeals process.

Procedure for Administrative Claim Appeals

First Level Appeal

Submit a written claim appeal within 30 days from date of the Heraya Remittance Advice for the disputed claim or 30 days from the date of Heraya's claims reconsideration determination letter with the following information:

1. Appellant name, phone number, and address.
2. A copy of Heraya's remittance advice(s), which should contain:
    a. Rendering provider's name.
    b. Patient's name.
    c. Patient's health record number.
    d. Heraya's claim number(s).
    e. Date(s) of service.
3. If applicable, a copy of Heraya's claims reconsideration determination letter.
4. A cover letter with an explanation to support the claim appeal.
5. If applicable, any supporting documentation to support the claim appeal.

Mail or fax the claim appeal to:

Mail	Fax
Heraya Health Attn: Claims Appeals PO Box 278 Beaverton, OR 97075-0278	503-203-8522 Attn: Claim Appeals

Acknowledgment

Heraya will acknowledge the receipt of a claim appeal by letter to the appellant within five (5) business days.

Heraya Claim Appeals Committee

Heraya's Claim Appeal Committee will review the claim and all relevant information associated with the appeal to include Heraya records and the information submitted by the appellant.

Heraya Claim Appeals Decision/Notification

A written decision regarding the claim appeal will be sent to the appellant within 30 business days from the receipt of the claim appeal. If a more extensive review is required, the appellant will be notified of the delay within the 30 day period. The final claim appeal decision will be made within 45 business days.

Second Level Claim Appeal

In cases of a second level claim appeal, all relevant documentation is reviewed by the Second Level Appeals Committee which would have not been involved in the original claim appeal decision. The process and timeframes outlined in the first level appeal above apply to the second level appeal process.

2.8 CPT® Codes Requiring Documentation

Claims submitted with the following CPT® codes and CPT® code combinations require clinical documentation that supports medical necessity as defined below. Without this documentation, the claim will be denied, and the provider's Remittance Advice will provide a message indicating clinical documentation is required.

CPT® Codes & Units	Kaiser		
	DC	LAc	ND
99205, 99215	✓	✓	
More than 2 radiology codes per date of service	✓		✓
More than 4 units of modalities per visit			✓
All codes specific to diabetes management during the period of each pregnancy (gestational diabetes) beginning with conception and ending six weeks post-partum	✓	✓	✓

Definitions

Medical Necessity

"Medically Necessary" or "Medical Necessity" means health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, duration, and considered effective for the patient's illness, injury, or disease; and
- Not primarily for the convenience of the patient or the health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Maximum Therapeutic Benefit

The state where the patient's symptoms/condition have failed to improve significantly following an appropriate therapeutic trial. During a course of treatment, Maximum Therapeutic Benefit is when the patient's health status has returned to a pre-clinical/pre-illness condition or the patient's condition no longer shows progressive improvement toward a return to a pre-clinical/pre-illness condition.

Medically Necessary Supportive Care

Treatment of a patient's condition that has reached maximum therapeutic benefit, but when the periodic trials of withdrawal of care fail to sustain previous objective and subjective improvement. In addition to passive therapies, appropriate supportive care includes education, active care, lifestyle modification, exercise programs, and other self-care techniques.

2.9 Discipline-Specific CPT® Code Information

Chiropractic Manipulative Therapy (CMT) Codes

Heraya adheres to the use of CMT codes 98940-98943 as described in the current edition of Current Procedural Terminology (CPT®) manual.

A component of evaluation and management is built into the CMT codes. If there is a significant, separately identifiable evaluation and management service by the same provider on the same date of service as the CMT procedure, an appropriate modifier should be used when billing for this service. For example, modifier -25 should be used when an additional Evaluation and Management service is provided in conjunction with the CMTF codes.

Acupuncture Codes

Heraya adheres to the use of acupuncture CPT® codes (97810-97814) as described in the current edition of Current Procedural Terminology (CPT®) manual.

A component of evaluation and management is built into the acupuncture codes. If there is a significant, separately identifiable evaluation and management service by the same provider on the same date of service as the acupuncture procedure, an appropriate modifier should be used when billing for this service. For example, modifier -25 should be used when an additional Evaluation and Management service is provided in conjunction with the acupuncture codes.

Naturopathic Manipulative Codes

Use of CPT® codes 98940, 98941, 98942 and 98943 for chiropractic manipulative therapy (CMT) by naturopathic physicians is inappropriate. There is no specific naturopathic manipulative therapy code. The use of CPT® code 97140 for manipulation and other manual therapies may be used by NDs as qualified. This code is defined in CPT® as:

"Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes."

While one unit of time is 15 minutes, the individual service is allowed to vary between 8 minutes (just above the midpoint between 0 and 15) to 22 minutes (just below the midpoint between 15 and 30) thus, a single unit of service may be billed when the involved time reaches 8 minutes. However, when additional time-based services are performed, only the last unit of service is subject to the range of time adjustments and all other units are billed based on the 15-minute definition. For example, two units of 97140 would require 15 minutes for the first unit; the second unit could range between 8 and 22 minutes (total time of service to correctly bill for two units would be from a low of 23 to a high of 37 minutes). The provider must account for the total time involved in rendering these services documenting start and stop times. Such coding will encompass any manual traction or mobilization techniques as well as the manipulation service(s). The CMT codes have an evaluation and management component built into the code. The manual therapy code does not. Therefore, Heraya recommends that the appropriate evaluation and management component be billed in addition to the manual therapy portion of the visit. The manipulation is thereby treated as a therapeutic procedure.

2.10 Covered Radiology and Laboratory Services

Contracted Facilities

For the convenience of our providers, Heraya is contracted with various radiology and laboratory facilities in Oregon and Southwest Washington. If the provider is unable to perform a radiology or laboratory service within their office, providers may send their patients to these facilities. These facilities will bill Heraya directly. Refer to the Contracted Facilities section for further information. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

Fee Schedules

Heraya Chiropractic and Naturopathic Physicians have agreed to applicable fee schedules which outline the radiology and/or laboratory services that are covered by Heraya. To obtain copies of the fee schedules for which the provider is contracted, contact the Provider Relations Department at 503-203-8333 or 800-449-9479. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to the Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

2.11 Patient Consent for Non-Covered Services

Heraya covers medically necessary care under the provider's contract. In the event the member wishes to pay for non-covered services, the Professional Services Agreement signed between the provider and Heraya require the following information documented in writing prior to services being rendered or referred out for (e.g., non-covered lab or radiology/imaging services):

- Member name.
- Specific service(s) and/or supplies.
- Date(s) of service.
- Cost of service(s) and/or supplies.
- Why the services and/or supplies are not covered by the payer.
- The consent form must be signed and dated by the member or member's legal guardian prior to the provider rendering the service or supply, or referral out for non-covered services. The form should be maintained in the member's clinical record.

Patient Non-Covered Services Form

For your convenience, Heraya has created a Patient Consent for Non-Covered Services form which covers the above requirements. The purpose of this form is to protect both the patient and the provider in the event non-covered services are disputed. This form is located behind the Provider login on the Heraya website at www.herayahealth.com and in Appendix – Forms of this manual. A generic form advising that the patient will be responsible for all charges not covered by their insurance does not meet the requirements.

The use of Heraya's form is not required; however, your documentation must capture the required elements noted above. According to the signed Professional Services Agreement between Heraya and the provider, failure to secure the patient's consent in writing and with the required information, prior to services rendered, could result in the provider being responsible for the cost of the non-covered services. This requirement also includes referral for services that are not covered such as lab or radiology/imaging services.

For additional information, be sure to review the Coverage of Integrative Healthcare Services and Limitations and Exclusions sections of this manual.

2.12 Coverage of Integrative Healthcare Services

Credentialing Requirements for All Plans

Heraya providers rendering services to Heraya patients must be credentialed and contracted with Heraya for the patient's benefits to cover the services rendered.

Co-Payments and Co-Insurance

When a patient is receiving services of more than one discipline, a separate co-payment or co-insurance is required per discipline. For example, in the case where a patient receives both chiropractic services and a one-hour massage rendered by a licensed massage therapist at the same office visit, each provider collects the patient's co-payment or co-insurance for each service rendered. Each provider also submits their respective electronic claim for services rendered to the patient. For dual-disciplined providers, refer to the Multi-Disciplined Providers section.

Covered Integrative Healthcare Services

For clarification on reimbursable covered services refer to the fee schedules included in your contract.

Chiropractic Services

- Members have direct access to chiropractic physicians (DC) contracted with Heraya, subject to payer contract.
- All services must be medically necessary.
- New patient examinations and all therapeutic services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the DC are covered, except as specifically excluded under Limitations and Exclusions. As per CPT® code definitions, a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.
- For members with self-referral benefits, Heraya will reimburse up to two "established patient" examinations per member per rolling 12 months.
- Diagnostic x-rays as listed on the applicable Heraya fee schedule that are performed by a contracted provider or contracted facility are covered. **Note:** There may be a separate co-pay or co-insurance for x-ray services depending on the patient's benefit plan.
- Massage in conjunction with chiropractic manipulation:
    - When a Washington or Oregon Kaiser member does not have a massage therapy rider benefit and care is being administered by a chiropractor, the member is allowed:
        - Massage when in preparation for a chiropractic manipulation. Advise the member that "massage is included in your benefit only in preparation for manipulation, and if deemed medically necessary, and performed by the chiropractor."
        - Other modalities deemed medically necessary and described on the fee schedule.
    - The units of massage and other modalities covered are included in the bundled reimbursement in the specified combinations.

Naturopathic Medicine Services

- Members have direct access to naturopathic physicians (ND) contracted with Heraya, subject to payer contract.
- All services must be medically necessary.
- New and established patient examinations and all therapeutic services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the ND are covered, except as specifically excluded under Limitations and Exclusions. As per CPT® code definitions, a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.
- Diagnostic x-rays as listed on the applicable Heraya fee schedule that are performed by a contracted provider or contracted facility are covered. **Note:** There may be a separate co-pay or co-insurance for x-ray services depending on the patient's benefit plan.
- Clinical laboratory tests as listed on the applicable Heraya fee schedule when performed by a contracted provider or contracted facility are covered. **Note:** There may be a separate co-pay or co-insurance for lab services depending on the patient's benefit plan.

Acupuncture Services

- Members have direct access to licensed acupuncturists (LAc) and MD/DO's contracted with Heraya to provide acupuncture, subject to payer contract.
- All services must be medically necessary.
- New patient examinations and all therapeutic services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the LAc are covered, except as specifically excluded under Limitations and Exclusions. As per CPT® code definitions, a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.
- For members with Self-Referral benefits, Heraya will reimburse up to two "established patient" examinations per member per rolling 12 months.

Massage Therapy Services

When a plan specifically includes massage therapy services provided by a licensed massage therapist (LMT), these services may be accessed in one of two ways: self- referred or physician referred. Please note massage therapy is not a covered benefit under Medicare Senior Advantage plans.

Self-Referred. Certain plans include a self-referred massage therapy benefit. In these plans, massage therapy is covered as follows:

- Members can self-refer (no referral is required) to Licensed Massage Therapists (LMT) who are contracted with Heraya to provide massage therapy, subject to payer contract.
- Up to a one-hour massage is covered.
- All massage therapy services must be appropriate.
- Massage therapy services that are within the legal scope of practice and are listed on the

applicable Heraya fee schedule for the LMT are covered, except as specifically excluded under Limitations and Exclusions.

Physician-Referred. Certain plans include coverage of a referred massage therapy benefit. Referred massage is covered as follows:

- Members may receive massage therapy from an LMT credentialed and contracted with Heraya only with a referral from a Heraya credentialed chiropractic or naturopathic physician, subject to payer contract.
- The referral must specify the treatment plan including the diagnosed condition, the number of visits, and the goals of the treatment.
- Referred massage therapy must be medically necessary.
- Massage therapy services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the LMT are covered, except as specifically excluded under Limitations and Exclusions.

Note: When a member is receiving both chiropractic services and a one-hour massage at the same visit, each provider collects the member's co-payment or co-insurance for the services rendered. Each provider also submits an electronic claim for services rendered to that member. For example, the chiropractor submits an electronic claim for chiropractic services and the massage therapist submits an electronic claim for the massage services.

2.13 Limitations and Exclusions of Integrative Healthcare Services

Heraya contracts with our clients to specify certain limitations and exclusions on the benefits available to members. The treatment of certain conditions and the use of certain procedures may be limited or excluded from coverage as determined by each payor's benefit. The general limitations and exclusions noted below only apply to benefit plans administered by Heraya.

General Limitations and Exclusions

Integrative healthcare services described below are not covered. This list is not exhaustive:

1. Services that are not medically necessary.*
2. Services from a non-participating provider.
3. Services not provided in a participating provider's contracted office and/or contracted facility.
4. Services rendered by a participating provider who is a member of the insured member's family.
5. Examinations for purposes other than to determine treatment. These services include, but are not limited to, examinations for vocational rehabilitation, evaluation, and reports for employment, licensing, schools, sports, premarital, or those required by a court.
6. Experimental or investigational services. Services that are considered experimental or investigational, including procedures, equipment, drugs, devices, and supplies are excluded.
7. Transportation services.
8. When there is other coverage. Services are not covered under this plan for which coverage can be obtained in whole or in part from other sources, including but are not limited to:
    a. Service-Related Conditions. The treatment of any condition caused by or arising out of service in the armed forces of any country or from an insurrection, and disorders connected to military service, any treatment or service to which the enrollee is legally entitled through the United States government or for which facilities are available.
    b. Veteran's Administration. Services and supplies the member or member's enrolled dependent could have received in a hospital or program operated by a government agency or authority; unless the member or member's enrolled dependent is a veteran of the armed forces, in which case covered services and supplies which are furnished by the Veterans' Administration of the United States and which are not service-related are eligible for payment according to the terms of this policy.
    c. Prepaid or Non-Payment of Services. Charges for services and supplies for which the member or member's enrolled dependent cannot be held liable because of an agreement between the provider rendering the service and another third-party payer which has already paid for such service or supply; or services and supplies for which no charges are made, or for which no charges are normally made in the absence of insurance.
9. Expenses incurred before coverage begins or after coverage ends. Expenses for services and supplies which a member or enrolled dependent receives either before coverage under this policy begins or after coverage under this policy ends.
10. Minor surgery, proctology, obstetrical or routine gynecological services.
11. Secondary documentation and/or interpretation of x-rays.
12. Hearing, vision, dental.

13. Over the counter or prescription medications, dietary supplements, herbal and other natural medicines.
14. Durable medical equipment, devices or appliances, orthotics, or prosthetics.
15. Environment enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment.
16. Personal lodging, travel expenses, or meals.
17. Health or exercise classes, aids, or equipment.
18. The following diagnostic tests:
    a. Advanced diagnostic imaging including, but not limited to, MRIs, diagnostic ultrasound, CT scans, bone scans, and other special imaging studies.
    b. Electrodiagnostic testing including, but not limited to, nerve conduction studies, electromyography, and electroencephalography.
    c. Computerized testing including, but not limited to, surface electromyography (sEMG), thermography, range of motion testing, computerized muscle testing.
19. Intravenous therapy.
20. Injection therapies including vitamins, other substances, and proliferant therapies.

* Self-Referred massage therapy does not have a medical necessity requirement.

2.14 Utilization Management

Heraya's Utilization Management program is in place to ensure the quality and medical necessity of health care services provided to patients of contracted plans and is guided by the following:

Definitions

Medical Necessity

"Medically Necessary" or "Medical Necessity" means health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, duration, and considered effective for the patient's illness, injury, or disease; and
- Not primarily for the convenience of the patient or the health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Maximum Therapeutic Benefit

The state where the patient's symptoms/condition have failed to improve significantly following an appropriate therapeutic trial. During a course of treatment, Maximum Therapeutic Benefit is when the patient's health status has returned to a pre-clinical/pre-illness condition or the patient's condition no longer shows progressive improvement toward a return to a pre-clinical/pre-illness condition.

Medically Necessary Supportive Care

Treatment of a patient's condition that has reached maximum therapeutic benefit, but when the periodic trials of withdrawal of care fail to sustain previous objective and subjective improvement. In addition to passive therapies, appropriate supportive care includes education, active care, lifestyle modification, exercise programs, and other self-care techniques.

Massage Therapy Services

When a health plan specifically includes massage therapy services provided by a Licensed Massage Therapist (LMT), these services may be accessed in one of two ways: self-referred or physician referred. Please note massage therapy is not a covered benefit under Medicare Senior Advantage plans.

Self-Referred. Certain plans include a self-referred massage therapy benefit. In direct access plans, massage therapy is covered as follows:

- Members can self-refer (no referral is required) to Licensed Massage Therapists (LMT) who are contracted with Heraya to provide massage therapy, subject to payer contract.
- Up to a one-hour massage is covered.
- All massage therapy services must be appropriate.

- Massage therapy services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the LMT are covered, except as specifically excluded under Limitations and Exclusions.

Physician-Referred. Certain plans include coverage of a referred massage therapy benefit. Referred massage is covered as follows:

- Members may receive massage therapy from an LMT credentialed and contracted with Heraya only with a referral from a Heraya credentialed chiropractic or naturopathic physician, subject to payer contract.
- The referral must specify the treatment plan including the diagnosed condition, the number of visits, and the goals of the treatment.
- Referred massage therapy must be medically necessary.
- Massage therapy services that are within the legal scope of practice and are listed on the applicable Heraya fee schedule for the LMT are covered, except as specifically excluded under Limitations and Exclusions.

Two Modalities or Therapeutic Procedures Limitation (Chiropractic Physicians Only)

Heraya will cover up to two (2) units of physical medicine modalities or therapeutic procedures with or without a chiropractic manipulative treatment code and/or an appropriate evaluation and management (E/M) code per date of service. The physical medicine modalities and therapeutic procedures include CPT® codes in the range 97010 to 97530 (for codes 97110, 97112, and 97530, up to one (1) unit/visit/day combined allowed).

Providers may bill the patient for non-covered services only if the patient is notified prior to treatment that the services to be rendered are not covered and the patient signs a Patient Consent for Non-Covered Services form agreeing to be financially responsible for payment. This form is located in the Provider Hub behind the Provider Login on the Heraya website at www.herayahealth.com and in the Appendix - Forms section of this manual. For additional information, refer to Patient Consent for Non-Covered Services section. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

CPT® Codes Requiring Documentation

Refer to the CPT® Codes Requiring Documentation section for CPT® codes requiring documentation to determine medical necessity.

Section Three – Self-Referred

3.1 Kaiser Permanente Self-Referred: (Commercial & Medicare Senior Advantage)

Kaiser Permanente (Kaiser) members may access providers contracted with Heraya for the Kaiser Self-Referred benefit as described in this section.

Self-Referred members may access any contracted Heraya provider directly and obtain services that are covered under the member's plan/benefits. Members are responsible for applicable co-payments, co-insurance, or deductibles at the time of service until they reach their dollar or visit limit, as determined by the benefit purchased by the member's employer group. Please note that massage therapy is not a covered benefit under Medicare Senior Advantage plans.

Kaiser Protocols

1. Chiropractic Services
    a. Bundled Reimbursement
        i. CMT Codes (98940-98943)
            1. Reimbursement will be paid on a "bundled" basis and will include modalities outlined on the fee schedule provided in Exhibit C-2.
        ii. E/M Codes
            1. Heraya will reimburse a new patient E/M code. As per CPT® code definitions, a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.
            2. Heraya will reimburse up to two established visit E/M codes per rolling 12 months.
2. Acupuncture Bundled Reimbursement
    a. Acupuncture Codes (97810-97814)
        i. Reimbursement will be paid on a "bundled" basis for two or more units of acupuncture as outlined on the fee scheduled provided in Exhibit C-3.
    b. E/M Codes
        i. Heraya will reimburse a new patient E/M code. As per CPT® code definitions, a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.
        ii. Heraya will reimburse up to two established visit E/M codes per rolling 12 months.
3. The Self-Referred plans require the patient to be seen by a provider on the Heraya network. No referral is required. Keep in mind not all Kaiser members have a Self-Referred benefit and may therefore not have this benefit coverage.
4. A co-pay, co-insurance, or deductible is required from the patient for each office visit. The co-pay, co-insurance, or deductible should be collected at the time of service.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to the Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

Lab and Radiology Services

Fee Schedules

Heraya chiropractic and naturopathic physicians have agreed to applicable fee schedules which outline the radiology and/or laboratory services that are covered by Heraya. To obtain copies of the fee schedules that a provider has agreed to feel free to contact the Provider Relations Department at 503-203-8333 or 800-449-9479. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to the Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

Contracted Facilities

For the convenience of our providers, Heraya is contracted with various radiology and laboratory facilities in Oregon and Southwest Washington. If the provider is unable to perform a radiology or laboratory service within their office, providers may send their patients to these facilities. These facilities will bill Heraya directly. Refer to the Contracted Facilities section of this manual for details. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

Eligibility Verification

Verification of the member's benefit coverage before treatment is critical. While the member may provide this information, the provider is responsible to verify the accuracy of the member's coverage directly with Heraya. This protects the provider's office and ensures they are collecting the correct monetary amount from the member and provides clarity to the member about their out-of-pocket costs. Refer to Heraya's Patient Eligibility Verification Form in the Appendix– Forms section to assist in gathering complete eligibility information on a new patient prior to services rendered.

Timely Filing Policy

Kaiser Permanente Self-Referred claims are to be electronically submitted to Heraya for processing. From the date of service, Heraya's timely filing policy is 60 days for commercial plans and 365 days

for Medicare Senior Advantage plans. The patient may not be billed for any claim(s) that are denied for exceeding the 60-day or 365-day timely filing policies.

Kaiser Permanente Self-Referred Summary Sheet Handled by Heraya	
Provider Types may include	Heraya chiropractic physicians. Heraya naturopathic physicians. Heraya acupuncturists. Heraya massage therapists. Please note massage is not a covered benefit under Medicare Senior Advantage plans.
Claims Paid by	Heraya Health
Claims Submission	Electronic Submission Only to Heraya. See Section 2.1 and 2.2 for electronic claim information.
Eligibility	Heraya Health: 503-203-8333 or 800-449-9479
Billing Questions	Heraya Health: 503-203-8333 or 800-449-9479
Initial Timely Filing Period	• 60 days from the date of service for commercial plans. • 365 days from the date of service for Medicare Senior Advantage plans.
Resubmission Timely Filing Period	• Commercial plans: 30 days from the original remittance advice. • Medicare Senior Advantage plans: 365 days from the date of service to submit initial or resubmitted claims.
Deductible	Varies by plan.
Co-pay and/or Co-insurance	Required for all office visits and collected at the time of service. Co-pay or co-insurance varies by plan. **Note:** There may be a separate co-pay for x-ray and/or lab services depending on the patient's benefit plan.
Benefits Limits	Varies by plan. The plan will have either a visit limit or a dollar limit or a combination of both.
Referral	Not required.
Service Area	Specified by zip code. Generally, covers the I-5 corridor in Oregon and Southwest Washington.
Clinical Records	Some CPT® codes require clinical records. Refer to CPT® Codes Requiring Documentation section of this manual for details.
Non-Covered Services	Referred massage therapy is not covered under the Basic Chiropractic-only Plan, even if ordered/referred by the chiropractor. However, massage therapy performed by the chiropractor in conjunction with manipulation is covered. Additionally, be sure to review the Limitations and Exclusions section for a complete list of non-covered services, as well as the Patient Consent for Non-Covered Services section.
Claims Reconsideration Sent to	Heraya Health. Refer to the Claims Reconsideration section of this manual for the address and details.
Administrative Claims Appeal Sent to	Heraya Health. Refer to the Administrative Claim Appeal Process section for the address and details.

Section Four – Referral Programs

4.1 Kaiser Permanente Referral Program

In certain cases where a Kaiser Permanente (Kaiser) member's health coverage does not provide for self-referred integrative healthcare benefits or those benefits are exhausted, an authorized Kaiser physician or qualified healthcare provider may choose to make a referral to an integrative healthcare provider if, in the opinion of the provider, such services would be beneficial and are consistent with Kaiser referral protocols. The referral program may also be used to provide select original Medicare services by qualified providers, e.g., chiropractic services by a DC (manual manipulation of the spine to correct subluxation), acupuncture services by a qualified MD/DO for chronic low back pain.

It is up to the Kaiser provider to determine when and if it is appropriate to refer the patient. Such services are covered by Kaiser; they are not paid for by the patient and are not part of the employer's benefit plan.

It is important that Heraya providers not encourage Kaiser patients to solicit referrals from their Kaiser healthcare provider. Generating the expectation for the patient with regards to a referral may jeopardize the relationship between the patient and their providers and may undermine Heraya's relationship with Kaiser providers.

Once a Kaiser provider elects to make a referral for a condition, the request is reviewed using the Kaiser Permanente Medical Necessity criteria. Services are authorized for a specific condition, number of visits with specified coverage limits, and timeframe. The Heraya provider may only treat the patient for the condition for which they have been referred.

The following steps are recommended upon receiving a direct referral from a Kaiser provider:

1. Review the referral noting the designated provider, the number of visits allowed and coverage limits, the period of time covered by the referral, and the condition for which the patient was referred. If you do not receive the written referral, contact the Kaiser Permanente Community Medicine Integration Center (CMIC – see table below for contact information), and request the necessary information.
2. Only the Heraya contracted provider designated on the referral authorization may treat a Heraya patient under this coverage. Non-Heraya providers, such as call coverage providers, may not treat Kaiser referral program patients.
3. After completion of treatment, send a brief letter or treatment summary to the referring Kaiser provider via the CMIC thanking them for the referral and describing the outcome of treatment. This information should not be sent directly to the Kaiser provider.
4. Refrain from requesting additional treatment until all authorized treatment has been rendered.

Treatment Extension Request for Referral Program

Heraya providers may make requests for additional care/treatment extensions. Such requests must be sent directly to the CMIC, not to the referring Kaiser provider. Clinical staff at the Center will coordinate the extension review process. To request additional care, use the following steps:

1. ***Submit a Treatment Extension Request (TER) to Kaiser***
   Complete a Kaiser Permanente Northwest Treatment Extension Request (TER) for these referrals. This TER and the accompanying summary of treatment **must be typed**. A fillable version of this form can be found in the Provider Hub behind the Provider Login on the Heraya website at www.herayahealth.com and in the Appendix - Forms section of this manual. This information is scanned into the patient's permanent medical record at Kaiser. The Heraya provider's request can be faxed or emailed via secure methods to the CMIC.

2. ***Decision***
   There is a two-business day turnaround at the CMIC if the treatment extension request information is complete. A prompt response by the Heraya provider when Kaiser requests additional information will expedite patient care.

   If the referring Kaiser provider does not feel the additional treatment is necessary, the referral will be denied. Inquire with Heraya to confirm if the patient has self-referred benefits; otherwise, the patient then has the option to seek treatment from the Heraya provider at their own expense given:
   a. The patient must be informed that the care will be at their personal expense.
   b. It is the responsibility of the Heraya provider to obtain a written consent for payment for such services from the member prior to continuing treatment to care for an insured patient.

3. ***Requesting Radiology or Additional Clinical Information***
   When a Heraya provider needs additional clinical information from Kaiser such as a radiology report, the actual radiology films, lab results, or any other additional clinical information, the provider must contact the CMIC directly. The CMIC staff will retrieve the information and forward it to the provider's office in a timely manner.

4. ***Requesting Additional Services***
   Pre-authorization from Kaiser is required when diagnostic testing, additional visits, or other services not included in the initial referral are being requested. For example, if a patient needs additional radiology or laboratory work, the provider must call the CMIC before initiating treatment. A CMIC staff person will process the request for additional services and ensure that the authorization, denial information, and/or test results are forwarded back to the Heraya provider in a timely manner.

Expediting Clinical Follow-up with PCP

The Heraya provider should call CMIC directly when treating a Kaiser referral patient and finding something on examination that needs follow up by the patient's Kaiser provider. The Heraya provider should request the information be forwarded to the Kaiser provider. CMIC staff will ensure the issue is addressed and any necessary information is communicated back to the Heraya provider in a timely manner.

The Kaiser provider should be kept apprised of all additional service requests, treatment requests and information pertaining to the member through the CMIC.

Caution: It is inappropriate to request that the patient advocate for additional treatment. The patient should not be encouraged to request a referral. The following are recommended ways to assist Kaiser members in addressing questions and concerns regarding services:

- Suggest the member call Kaiser Permanente Member Services (503-813-2000 or 800-813-2000) to determine if they have coverage for integrative healthcare services.
- If the patient speaks to the provider or the provider's staff about obtaining a referral, state that it is entirely up to the Kaiser provider; offer to send the patient's chart notes (with a signed Release of Information) to the provider with a letter describing your care. The cover letter should indicate that the patient requested the notes be directed to their Kaiser provider.
- If the patient reports to you that treatment rendered has been effective, suggest they report this information to their Kaiser provider at the next visit.

Benefit Verification

You do not need to verify eligibility for patients who have a direct referral. The Kaiser referral office verifies the eligibility when making the referral. It will be necessary to verify eligibility for a direct referral older than three (3) weeks if the patient has not been under your care during that time.

Kaiser Permanente Referral Program Summary Sheet	
Claims Paid by	Kaiser Permanente
Claims Mailing Address	Kaiser Permanente 500 NE Multnomah Ave. #100 Portland, OR 97232-2099
Eligibility Questions	Portland & Vancouver: 503-813-4560 Salem: 503-813-4560 Longview: 360-636-6211
Billing Questions	800-813-2000
Timely Filing Period	Contact Kaiser Permanente for this information
Referral, Authorization or Questions	Kaiser Permanente CMIC Phone: 503-813-3437 or 866-813-2437 Fax: 503-813-2286 E-mail: referral-center-nurse@kp.org
Service Area	Specified by zip code. Generally covers the I-5 corridor in Oregon and Southwest Washington.
Appeals	Kaiser Permanente (address noted above)

4.2 Kaiser Permanente Self-Funded Groups

Kaiser Permanente (Kaiser) self-funded group members may access any self-funded contracted Heraya provider directly and have their care covered by paying a co-payment at the time of service until they reach their dollar or visit limit, as determined by the benefit funded by the employer group.

Kaiser Protocols

Self-funded plans require the patient to be seen by a self-funded provider on the Heraya network. No referral is necessary. Not all Kaiser self-funded groups have purchased an integrative healthcare benefit and may therefore not have this benefit coverage.

Verify Benefits

Call Kaiser Self-Funded Customer Service directly to verify benefits and eligibility.

Kaiser Permanente Self-Funded Groups	
Claims Paid by	KPIC, SF Plan Administrator
Claims Mailing Address	KPIC, SF Plan Administrator PO Box 30547 Salt Lake City, UT 84130-0547
EDI Payer ID#	94230
Eligibility	Call Kaiser Self-Funded Department at 866-800-3402
Billing Questions	866-800-3402
Timely Filing Period	Contact KPIC for this information.
Deductible	Varies according to employer plan.
Co-pay	Required for all office visits and collected at the time of service. Co-pay varies by plan.
Benefits Limits	Varies according to employer plan.
Referral	Not required.
Service Area	Specified by zip code. Generally covers the I-5 corridor in Oregon and Southwest Washington.
Non-Covered Services	Varies according to employer plan.
Appeals	KPIC (address noted above)

4.3 Kaiser Permanente On-The-Job Referrals

This section gives Heraya providers and their staff information about referrals and billing for the treatment of injured workers referred from Kaiser Permanente (Kaiser). Heraya provides the integrative healthcare network for Kaiser Permanente On-the-Job for Oregon and Washington state injured workers through three programs:

- Kaiser Permanente On-the-Job, Managed Care Organization - Oregon
- Washington Labor and Industries (L&I) and self-funded Washington employers
- Federal Office of Workers' Compensation

While these programs have requirements specific to each (described below), the general policies and procedures for referrals and billing are the same.

- *Oregon*
    - Kaiser Permanente On-the-Job. Kaiser's MCO, like all Workers' Compensation programs in Oregon, requires that chiropractic and naturopathic physicians must certify they have read informational materials about the Oregon Workers' Compensation system before treating any patient with an Oregon Workers' Compensation claim. This requirement applies to both Washington and Oregon DCs and NDs who want to treat MCO and non-MCO Oregon Workers' Compensation cases.
    - Providers certify by using the online certification process at http://www.wcd.oregon.gov, click on "Health Care Providers" then on "Certification and Authorization."
- *Washington*
    - Washington State workers' compensation is a hybrid system of state-funded insurance (L&I) and self-funded employer plans. The referral documents from Kaiser will indicate the necessary information to bill the correct payer.

Federal Office of Workers' Compensation

Kaiser Occupational Health provides treatment for certain federal employees with a work-related injury. Kaiser can make referrals to contracted Heraya providers to render treatment to these workers.

Reimbursement for this treatment is provided by the Office of Workers' Compensation Program (OWCP). In order to receive reimbursement for treatment of a federal employee occupational injury, the provider must enroll with OWCP at https://owcpmed.dol.gov/portal/Provider/Enrollments.

The Referral Process

Heraya providers function as an outside referral specialist. DO NOT attempt to have the injured worker submit a change of attending physician to you.

Kaiser Permanente (Kaiser) has outlined the following steps to ensure Heraya providers are reimbursed when treating Kaiser members under a Workers' Compensation claim. Follow these procedures carefully to avoid any billing or reimbursement issues:

1. At the time of the referral, the injured worker will be asked to contact you to schedule an initial appointment. Kaiser Occupational Health Services will fax the referral to your office which will contain referral and claim information that will be helpful for contacting and billing the payer (insurer, self-funded employer, or federal agency).
2. The referral document contains:
    a. Name of the injured worker.
    b. KP Health Record Number (HRN).
    c. Employer of the worker.
    d. Insurer information.
    e. Claim number (if known).
    f. Date of injury.
    g. Date of referral.
    h. Appointment type (e.g., chiropractic, naturopathic, acupuncture, massage).
    i. Number of approved visits.
    j. MCO status (i.e., is worker enrolled in MCO).
3. The Heraya provider will perform an initial patient examination, conduct an assessment, and outline a treatment plan for the services to be provided consistent with the initial referral. This information will be documented in the clinical record as well as on the Kaiser On-the-Job Initial Treatment Plan form, located in the Provider Hub behind the Provider Login on the Heraya website at www.herayahealth.com and in the Appendix - Forms section in this manual.
4. Within seven (7) days of beginning treatment, the Heraya provider must send the initial treatment plan form to the following two entities:
    - The Insurer: see referral document for the insurer's information.
    - The prescribing provider: mail or fax the initial treatment plan on the Kaiser On-the-Job Initial Treatment Plan form.

Mail	Fax/Phone
Kaiser Permanente Occupational Health, 7201 N. Interstate Avenue, Suite 195, Portland OR 97217	Fax: 866-559-3561 Phone: 503-735-7443 (if questions)

5. The treatment plan will be reviewed and incorporated into the prescribing Kaiser provider's treatment plan. The treatment plan will be signed by the prescribing Kaiser provider and returned to the Heraya provider as well as submitted to the insurer within 30 days of the beginning of treatment.
6. Within seven (7) days upon completion of the treatment plan, the Heraya provider must complete and submit the Kaiser On-the-Job Treatment Summary form, located in the Provider Hub behind the Provider Login on the Heraya website at www.herayahealth.com, and in the Appendix - Forms section in this manual.
7. If additional treatment is recommended, the provider should also complete the applicable section of the treatment summary form. These should be submitted to Kaiser Permanente Occupational Health at the mailing address or fax number above and the applicable insurer.

Some Worker's Compensation insurance plans are stricter than others regarding these rules. Refer to local state, and federal Workers' Compensation programs for additional and more specific information about treatment, treatment plans, requirements for pre-authorization, billing, claims processing, etc.

For more information contact Kaiser Permanente Occupational Health:

- General Questions/Utilization Management: 503-735-7443
- Claims Questions: 888-238-1255
- Billing Questions: 844-320-3481
- Billing Fax Number: 866-558-5124

4.4 Providence Managed Care Organization (MCO)

The Providence MCO program is a Workers' Compensation program utilizing Heraya contracted providers. The Providence MCO provider network is determined by Providence, not Heraya; therefore, not all Heraya providers are contracted for this network.

Providence MCO Protocols

Call Providence at 503-574-7640 or call the Worker's Compensation carrier if you have questions.

All claims require clinical records.

Section Five – Administrative Services Only or Network Lease

Heraya offers administrative services to self-insured employers and other health plans desiring to provide their employees/covered members with various levels of benefits that may include chiropractic, naturopathic, acupuncture, and massage. Each contract varies regarding covered benefits.

The employee/covered member will present with an identification card that will provide information about their coverage. These members generally access Heraya providers directly and have a co-payment or co-insurance at the time of service up to a dollar or visit limit, as determined by their benefit design. Verify coverage before rendering services.

Administrative Services Only

Administrative Services Only are contracts with payers, e.g., health plans, that include access to the Heraya provider network as well as administrative services such as, but not limited to, utilization management, credentialing services, and claims processing. Typically claims will be submitted to Heraya under this contract.

Network Lease

Network Lease contracts with payers, e.g., health plans, include access to the Heraya provider network. This contract does not include additional administrative services. Typically, Heraya providers submit claims to the payer, e.g., health plans.

5.1 Samaritan Health Plans

Samaritan Health Plan members have direct access to Heraya's provider network of providers for medically necessary services. You can identify these members as they present with a Samaritan Health Plan ID card, denoting a "Y" in the ALTCARE column.

Samaritan Health Plans	
Provider Types	Chiropractic Physicians Naturopathic Physicians Acupuncturists Massage Therapists
Claims Paid by	Samaritan Health Plans
Claims Mailing Address	Samaritan Health Plans PO Box 1310 Corvallis, OR 97339
Eligibility	Samaritan Health Plans Toll Free: 888-435-2396 Portland Metro area: 541-768-5207
Billing Questions	Samaritan Health Plans Toll Free: 888-435-2396 Portland Metro area: 541-768-5207
Timely Filing Period	365 days from the date of service.
Deductible	None
Co-Insurance	This plan has a 20% co-insurance to be paid by the member. Required for all office visits and collected at the time of service.
Benefits Limits	Varies according to plan purchased by individual.
Referral	Not required.
Service Area	Oregon
Non-Covered Services	Be sure to review the Limitations and Exclusions for a complete list of non-covered services. This does not cover massage therapy for relaxation, stress management, or wellness.
Appeals	Samaritan Health Plans (address noted above)

Section Six – Heraya Discount Programs

Heraya Discount Programs include the CAMaffinity Program and CAMplus Program. Discount programs are direct-access, 20% discounted fee-for-service programs contracted with a variety of organizations such as health plans, independent associations, third- party administrators, and employer groups. The following provides further detail:

- Heraya Discount Programs are provided to health plans and other organization members who do not have integrative healthcare benefits or to supplement additional care not covered under their current benefits.
- There is no contracted fee schedule for these members.
- Members pay 20% less than the provider's Usual and Customary fees (not 20% off of the provider's cash discount fees).
- The 20% discount does not include a provider's pharmaceutical supplies, x-rays, labs, or other medical supplies.
- If the provider's cash discount fees are lower than the 20% off of Usual and Customary fees, the provider may extend their discount.
- Members pay the provider directly at the time of service.
- There is no paperwork, referral, or authorizations required to treat these members.
- Members present with a health plan or organization member identification card or a Heraya CAMplus card.
    - Note that LifeMap Advantages members will NOT present with an identification card. They will indicate they are LifeMap Advantages members and have access to CAMaffinity through that program.
- Current Heraya Discount Program contracts include:
    - Heraya CAMplus
    - Kaiser Permanente (KP Affinity Program)
    - Regence Advantages
    - Asuris Advantages
    - LifeMap Advantages
    - Bridgespan Advantages
    - RGA Advantages
    - HMA Advantages

Questions about eligibility for Heraya Discount Programs may be directed to the Provider Relations Department at 503-203-8333 or 800-449-9479.

Section Seven – Contracted Facilities

7.1 Introduction to Contracted Facilities

If a patient is recommended to have lab or x-rays services and a chiropractic or naturopathic provider office does not have the lab or x-ray equipment, providers may send the patient to one of the contracted facilities found in this section. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

7.2 Contracted Facility Protocols

Fee Schedules

Heraya chiropractic and naturopathic physicians have agreed to applicable fee schedules which outline the radiology and/or laboratory services that are covered by Heraya. To obtain copies of the fee schedules that a provider has agreed to contact the Provider Relations Department at 503-203-8333 or 800-449-9479.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to the Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

Billing Entity

Contracted facilities have agreed to a fee schedule. These entities will bill Heraya directly for services rendered to the Heraya patient referred by the Heraya provider and collect a separate co-pay or co-insurance from the patient if applicable. Be sure the contracted facility is aware to bill Heraya directly and not any other entity, such as Kaiser Permanente.

7.3 Contracted Radiology Facilities

Verify Coverage

Be sure to refer to the radiology and laboratory services fee schedules agreed to by the provider at the time of contracting to verify covered services. **Note:** There may be a separate co-pay or co-insurance for x-ray services depending on the patient's benefit plan.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements

for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

Billing Entity

These facilities are contracted with Heraya and have agreed to a fee schedule. These entities will bill Heraya directly for services rendered to the Heraya patient that the provider referred and collect a separate co-pay from the patient if applicable. As Kaiser members only present with a Kaiser benefit card, be sure the contracted facility is aware to bill Heraya directly and not Kaiser Permanente.

- Rayus Radiology
  - Locations (see website): www.rayusradiology.com
  - To set up an appointment: Call 503-253-1105 for any Rayus Radiology facility.
  - Billing claims: Rayus Radiology will bill Heraya directly.
- Clearview MRI
  - Locations (see website): www.clearviewmri.com
  - To set up an appointment:
    - Mt. Scott - 503-774-7700
    - Bridgeport - 503-639-9700
    - Gresham - 503-661-6500
    - Cornell - 503-746-7858
  - Billing claims: Clearview MRI will bill Heraya directly.

Kaiser Permanente X-ray Facilities

Heraya providers may refer Kaiser members to Kaiser for x-ray services. The services must be covered and are included on the applicable fee schedule. The services would be applied to the patient's medical plan benefits.

Required elements for an x-ray order to be valid include the following:

- Member name.
- Member health record number.
- Provider name.
- Provider Number (provider number or UPIN).
- Provider address.
- Provider phone.
- Provider fax, if available.
- Diagnosis code.
- X-ray ordered must be a covered service as included on the applicable fee schedule.
- Provider signature (stamp is okay).

7.4 Contracted Laboratory Facilities (Naturopathic Physicians Only, appropriate CLIA certification is required)

Verify Coverage

Be sure to refer to the radiology and laboratory services fee schedules agreed to by the provider at the time of contracting to verify covered services. **Note:** There may be a separate co-pay or co-insurance for x-ray and/or lab services depending on the patient's benefit plan.

Non-Covered Services

If a provider recommends services not included on the fee schedule, such services are considered non-covered services. Heraya's Professional Services Agreement with the provider outlines specific protocols for handling non-covered services. Refer to the Patient Consent for Non-Covered Services section for further information. For additional information, review the Coverage of Integrative Healthcare Services and the Limitations and Exclusions sections. Not documenting the requirements for consent from the patient for providing or referral of non-covered services could result in the provider being held liable for payment of these services.

Billing Entity

These facilities are contracted with Heraya and have agreed to a fee schedule. These entities will bill Heraya directly for services rendered to the Heraya patient that the provider referred to and collect a separate co-pay or co-insurance from the patient if applicable. As Kaiser members only present with a Kaiser benefit card, be sure the contracted facility is aware to bill Heraya directly and not Kaiser.

Quest Diagnostic Laboratory

Heraya providers can refer Kaiser members to Quest Diagnostic Laboratory for services covered on the applicable fee schedule. Any non-covered services must include patient consent as indicated above under the Patient Consent for Non-Covered Services section. Providers can order these tests from Quest directly by going to their website at www.questdiagnostics.com and logging in with their account information as well as the member specific information, e.g., Name, DOB, and Member Record Number. For additional information:

- Locations (see website): www.questdiagnostics.com
- Customer Service: 866-MYQUEST (866-697-8378)
- Billing Claims: Quest Diagnostics will bill Heraya directly as well as the patient for any applicable co-pay or co-insurance.

Kaiser Permanente Labs

Heraya providers may refer Kaiser members to Kaiser for lab tests. The Kaiser lab formulary is provided to Heraya providers at the time of contracting or when amended. Contact the Provider Relations Department if you have questions at 503-203-8333 or 800-449-9479

Key points to remember when making a referral to Kaiser are:

- The lab must be a covered benefit. The services would be applied to the patient's medical plan benefits. If a member was referred or is using self-referred coverage for the visit to a naturopathic physician, then the labs would also need to be a covered benefit. For example, if a member uses their self-referred coverage to see a naturopathic physician for infertility, the labs would only be covered at a Kaiser laboratory if the member had a diagnosis of infertility as a covered benefit.
- The lab must fit the diagnosis code. For example, if the member was being treated for menopause, the ordered lab relating to menopause tests would be covered but an allergy lab test would not be covered.
- Required elements for a lab order to be considered "valid" at the Kaiser lab are:

- Member name.
- Member health record number.
- Provider name.
- Provider Number (provider number or UPIN).
- Provider address.
- Provider phone.
- Provider fax, if available.
- Diagnosis code.
- Tests ordered.
- Provider signature (stamp is okay).

Kaiser labs will accept all valid orders. Keep in mind only those tests on the lab formulary will be accepted.

Appendix – Forms

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Patient Eligibility Verification

Provider Name: Tax ID: Return Fax #:

Circle One (applicable to provider): DC ND LAc LM Date:

Patient relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Information	**Insured Information**
Name:	Name:
Address:	Address:
Date of Birth:	Date of Birth:
Phone Number:	Phone Number:
Contact Person:	Contact Person:

Insurance Carrier: Plan name:

Member ID Number:

Group Number:

Effective Date of Coverage:

Termination Date:

Co-pay: Co-pay required for x-rays:

Deductible: Has the deductible been met?

When is another deductible due?

Co-insurance: Percent paid by plan:

Dollar Limit (annual?):

Visit Limit (annual?):

Is a referral required? Referral telephone number:

Treatment extension request required?

Pre-authorization required?

Mail to: Heraya Health, PO Box 278 Beaverton, OR 97075-0278 **OR Fax to:** 503-203-8522

PATIENT CONSENT FOR NON-COVERED SERVICES

Not all services are covered by your health plan policy. All services must be medically necessary care, as defined by Heraya's Professional Services Agreement, is reimbursed by your health plan. All services provided to you are subject to co-pays, deductibles, co-insurance and prior approval in some cases. For all services covered under the provider's contract, the provider cannot bill the patient for the difference between billed charges and what the health plan reimburses the provider.

Certain services are not considered medically necessary by your health plan. They may be helpful to you, but the terms of your plan do not pay for these services. These non-reimbursable services and/or supplies are typically the responsibility of the patient. Listed below are services not covered under your current health plan contract but are being recommended by your provider:

LIST OF NON-COVERED SERVICES/ITEMS:

Durable Medical Equipment:	Cost:	$
Supplements:	Cost:	$
Vitamins:	Cost:	$
Prescriptions:	Cost:	$
Laboratory Services:	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
X-rays:	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
Other:	Cost:	$
TOTAL COST OF NON-COVERED SERVICES:		**$**

I, _____, a patient of _____ acknowledge and agree that part of my care is not a covered benefit of my health plan. I acknowledge and understand that I will be financially responsible for this part of my treatment. I also acknowledge and understand the information listed below:

- My provider and I have discussed the reasons for requesting non-covered services and what my alternatives are; my provider has allowed me to make the final decision regarding such services.
- I have been advised the recommended services will not be covered by my health plan and I will be solely responsible for payment of the recommended services.
- By signing this document, I am agreeing to pay for these services and charges prior to such services being rendered.
- I understand this is not an ongoing authorization but is specific to the treatment plan discussed with me. The treatment plan includes:

  Specific non-covered service to be provided at _____ (location) between ___/____/___/ and _____/____/____

Specific non-covered services provided by _____ (provider) including _____# visits between ___/___/___ and ___/___/___

I understand the treatment plan is for a period no longer than three months. Should the treatment plan extend beyond that time frame a new authorization or a re-signing of this agreement will be required after ___/___/___.

Patient/Member Signature Date

Patient/Member Printed Name Date

Please provide patients with a copy of this document

The following section to be completed by the Provider:

I have discussed all information listed above with my patient and provide the following reasons why services are not covered:

Provider Signature Date

Request for Claims Reconsideration Form

Today's Date:	**Health Plan Name: Heraya Health**
Provider Information	
Provider Name:	**Contact Name:**
NPI #:	**Contact Phone #:**
Member / Claim Information	
HRN#:	**Member Name:**
Date (s) of Service (MM/DD/YY):	
Claim Number (s):	
***Claims Reconsideration Type**	
Enter X in the box below to reflect the claims reconsideration type	
	Timely Filing
	Other
***Claims Reconsideration Explanation**	
Where to Send Information	

Mail: Heraya Health, 6600 SW 105th Avenue, Suite 115, Beaverton, OR 97008
Fax: 503-203-8522
For Questions call: 503-203-8333

Fax or mail the following information to Heraya:

- Request for Claims Reconsideration Form
- A copy of Heraya's Remittance Advice Denial
- Supporting documentation reflecting the new information

Kaiser Permanente Northwest Treatment Extension Request
(TER to KP Direct Referrals)

Referring Kaiser Clinician:	**Patient Name:**
Treating Heraya Provider:	**Kaiser I.D. #:**
Phone:	**Fax:**

Initial KP Referral (Check one): **Chiropractic** **Acupuncture** **Naturopathic**

Initial KP Auth #: **# of Authorized Treatments Used:**

# of treatments this calendar year:

Request for Additional (check one) **Chiropractic** **Acupuncture** **Naturopathic**

# of Additional Treatments Requested (check one) **1** **2** **3** **Dates: _____ to _____**

Initial Complaints and Pain Score(s)/Outcome Assessment Tool:

Initial objective findings:

Diagnosis (must relate to original referral):

Treatment Provided (including number, modalities, exercises, patient education, etc.):

Response to treatment:

Current complaints & Pains Score(s)/Outcome Assessment Tool:

Current objective findings:

Expected outcome/prognosis:

Signature Date

Please complete this form, typed with standard font/typeface. Forward to the Kaiser Permanente Community Medicine Integration Center via fax 877-800-5456**.** Questions about referrals should be directed to 503-813-4560 or 866-813-2437.

Clear Form

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Kaiser On-the-Job Initial Treatment Plan

Treating Heraya Provider: _____ KP Attending Physician: _____

Phone: _____ Patient Name: _____

Fax: _____ Kaiser I.D. #: _____

Work Status:

Medications:

History:

Subjective Reports:

Objective findings:

Diagnosis (must be consistent with the diagnosis noted on the referral):

Treatment Plan (consistent with KP referral):
Visits:_____ Duration: Start Date_____ End Date:_____
Modalities:

Measureable Goals (work capacity, pain scale, OATs)

Heraya Provider Signature:_____ Date:_____

KP Attending Physician Signature:_____ Date:_____

Forward to the Kaiser Permanente Occupational Health Department via fax at 866-599-3561
Questions about referrals should be directed to 503-735-7443

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Kaiser On-the-Job Treatment Summary

Treating Heraya Provider: _____ KP Attending Physician: _____

Phone: _____ Patient Name: _____

Fax: _____ Kaiser I.D. #: _____

Work Status:

Medications:

Subjective Reports:

Objective findings:

Diagnosis (must be consistent with the diagnosis noted on the referral):

Treatment History (including number, frequency, modalities, exercises, patient education, etc.):

Response to treatment:

Recommendation:

- ☐ Released from treatment to return to Attending Physician.
- ☐ Additional treatment proposed:

Treatment Plan (consistent with KP referral):
Visits:
Duration (Start-End date):
Modalities:

Measureable Goals (work capacity, pain scale, OATs):

Forward to the Kaiser Permanente Occupational Health Department via fax at 866-559-3561
Questions about referrals should be directed to 503-735-7443