Harbor Health

2027 Provider Manual

Your guide to Harbor Health Insurance Company

Welcome to Harbor Health Insurance Company

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01 Introduction

Harbor Health Insurance Company ("Harbor"), an affiliate of Harbor Health Medical Group, is licensed in the state of Texas to provide fully insured benefit plans to individuals, families and employer groups.

Harbor contracts with provider groups and other organizations to provide an adequate network for members to obtain covered health services. This manual is designed to help network providers understand applicable policies, procedures, and protocols.

Key partners include:

- **Health Axis:** an experienced third-party administrator partnering with Harbor to process and pay claims.
- **Nokomis Health:** provides payment integrity services. Nokomis reviews claims before payment to identify coding and billing errors, using a combination of technology and expert clinical coder review. Its reviews apply guidance published by CPT, the State of Texas, CMS, and other industry organizations that set the standards for correct coding and billing.

  Nokomis may request medical records to verify that line charges are supported by documentation. Providers are notified of record requests in two ways: (1) the remittance advice will indicate when records are required, and (2) Nokomis will send a letter to the provider with all information needed to submit the records.

  Together, Harbor and Nokomis help ensure claims are accurate and paid appropriately.
- **Medical Review Institute of America (MRIoA):** conducts medical, mental health and substance use disorder utilization reviews and appeals. MRIoA also provides proactive second opinions and appropriate utilization analytics.
- **Judi Rx:** a pharmacy benefits manager partnering with Harbor Health to process and pay pharmacy claims, conduct drug utilization reviews and appeals, and provide member services with respect to pharmacy benefits.
- **OneCred:** a third-party credentialing and roster management partner for groups who elect delegated credentialing or have deemed credentialing status through a third party accreditation firm or licensure agency. Groups that are considered Hospital Based Providers (HBPs) by the Texas Department of Insurance will work with OneCred in the same manner as groups that have elected delegated credentialing.
- **First Health:** a national network managed by Aetna that Harbor partners with for its members who live outside its current service area, or for in-area members in need of emergency care when traveling. In some instances, Harbor may use parts of the First Health Network inside its current service area for in-area members.
- **Harbor Health Network with Cigna Healthcare® PPO Network*:** a national network that Harbor Health utilizes for certain employer-sponsored health plans. Providers should refer to the member ID card for applicable network and claims guidance.

If your Participation Agreement differs from the policies outlined in this provider manual, your Participation Agreement will prevail.

If you have any questions or concerns, please contact *ProviderRelations@HarborHealth.com*

**The Cigna Healthcare® PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration. Cigna Healthcare® is an independent company and not affiliated with Harbor Health. Access to the Cigna Healthcare PPO Network is available through the contractual relationship between Harbor Health and Cigna Healthcare. All Cigna Healthcare products are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.*

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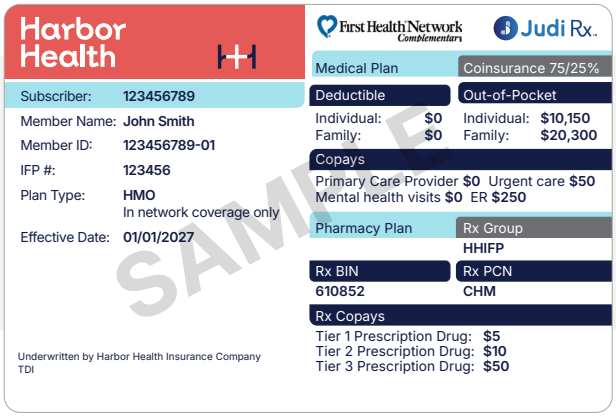
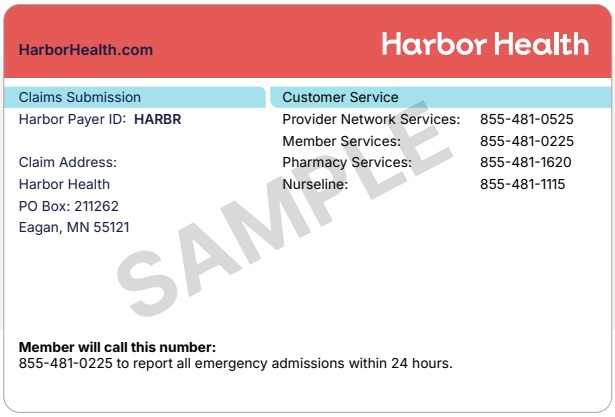
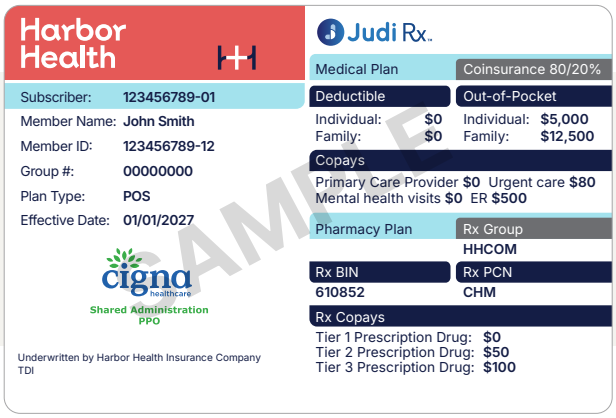
Member ID cards

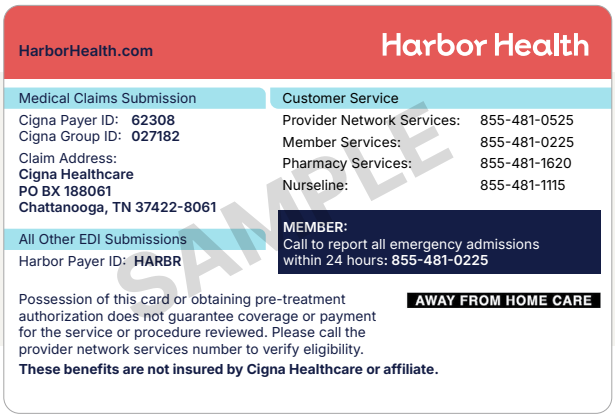
First Health Network



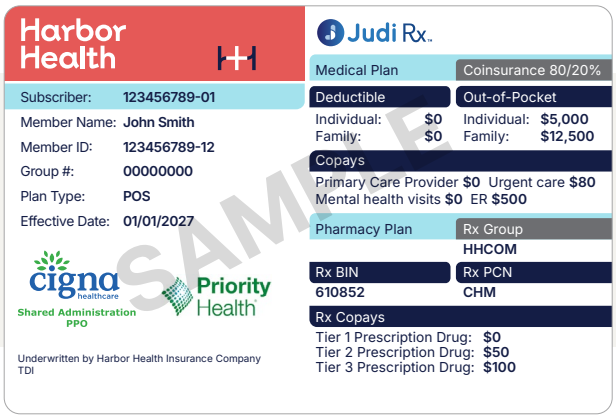


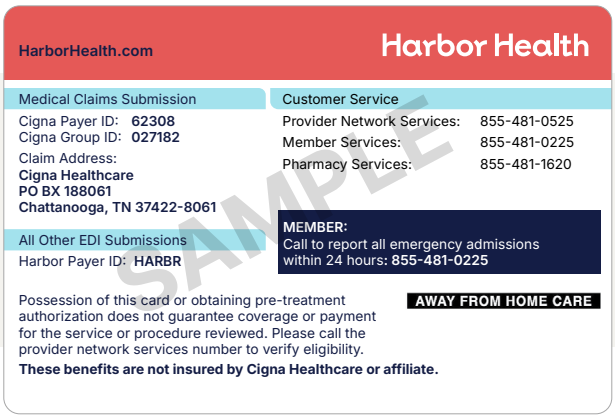
Cigna Healthcare® PPO Network in-area





Cigna Healthcare® PPO Network out-of-area





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Who is Harbor Health?

Our team is committed to building and creating product offerings that ensure the highest quality access, with knowable pricing for consumers. We collaborate with employer groups to deliver benefit solutions aligned to their goals, and extend that same commitment to families and individuals through the ACA Marketplace by connecting members to affordable coverage and a carefully curated network of high-value providers.

Here are some of the highlights:

- We encourage consumers to select Harbor Health Medical Group or one of our in-network primary care groups as their primary care provider. Harbor Health Medical Group staff offer health coaches and treatment plans (often called care pathways) that are co-created with members
- Many Harbor Health benefit designs have no deductible and offer no cost or low cost primary care visits
- Members receive the highest benefit level available when they are referred to other providers by a Harbor Health Medical Group provider or another in-network primary care group

This provider manual is intended to serve as a general reference outlining the core administrative policies and procedures that apply to providers participating in the Harbor Health network. It is designed to remain stable over time and is not updated frequently.

For the most current operational guidance, service updates, policy changes, and provider resources, please visit the provider landing page at **HarborHealth.com/Partner/Provider**. Harbor Health maintains the provider landing page as a dynamic resource to reflect evolving organizational practices, regulatory changes, and enhancements to our provider services. Providers are encouraged to refer to the landing page regularly to stay informed.

Harbor may provide periodic communications highlighting key updates to the provider landing page or any material changes to this manual.

Thank you for partnering with us to provide our members with excellent service, and most importantly, to help Texans thrive.

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02 Credentialing

Standard credentialing application

The following section applies to groups who are directly contracted with Harbor Health. If your group is part of one of Harbor's national partner wrap networks, please refer to that network's resources to ensure the appropriate process is followed.

Prior to acceptance into the Harbor network, providers must either undergo a formal credentialing process or elect delegated credentialing and be approved for it. Each group that is approved for delegated credentialing must sign a Delegated Credentialing Agreement (DCA) in addition to the appropriate Participation Agreement. For groups who are not eligible for delegated credentialing, Harbor operates primary source verification through its partnership with OneCred. OneCred operates its credentialing program in compliance with NCQA standards, to the extent that those standards do not conflict with applicable state or federal law.

Unless practitioner's organization has agreed to a Credentialing Delegation Addendum, practitioners must submit an application or reapplication to OneCred in order to participate in Harbor's network.

That application may include the following:

1. Attestation with respect to:
    a. Reasons for inability to perform the essential functions of the position
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitation of privileges or disciplinary actions
    e. Current and signed attestation confirming the correctness and completeness of the application
2. Release of Information used for primary source verification
3. Form for Professional Liability Action explanation(s)
4. Notice to Practitioners of Credentialing Rights/Responsibilities

Providers have the right to review information obtained by Harbor and OneCred from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. Harbor Health is not required to make available:

- References
- Recommendations
- Peer-review protected information

Providers have the right to correct erroneous information in the application. Providers will be informed by the credentialing staff if it appears that there is erroneous information in their application, verifications, or any other data in their credentialing file. Once this notification occurs,

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the provider generally has 15 days to submit any corrections via phone, email, or a provider portal, although the process may vary by each delegated partner. Harbor Health is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure. Harbor Health documents receipt of corrected information in the practitioner's credentialing file.

Providers have the right to be informed of the status of their credentialing application upon request. Providers are notified of this right when the process of credentialing begins and are notified of the information that is allowed to be shared. Providers are able to request updates on their application status by:

- Emailing ***ProviderRelations@HarborHealth.com*** or calling **(855) 481-0525**. Providers will receive an update with the status of their application within 3 days.
- Viewing their application on a provider portal, when applicable.

Credentialing criteria

Harbor utilizes a selective criterion to ensure that providers who apply to participate meet basic credentialing and contracting standards. Harbor is committed to ensuring neither it nor its partners discriminate on the basis of race, ethnic/national identity, gender, age, sexual orientation or type of procedure or patient for which the provider specializes, and such will not be considered during the credentialing and re-credentialing process.

The Credentialing Committee ("Committee") members will use their clinical judgment and usual community standards to make credentialing decisions. The Committee may, where it so decides, ask for more information or interview the applicant prior to taking action.

The Committee uses a peer review format to assess credentialing decisions. It will typically meet by video conference, but in-person attendance or audio-only participation is considered acceptable for voting members. The Committee must have a quorum of at least 75% of voting members present, and credentialing decisions require a simple majority vote. In the event that a 50% vote occurs an additional meeting with missing members may occur or an ad hoc member of the same field as the practitioner in question (after attesting to confidentiality and non-discrimination policies) may be used. Criteria will focus on ensuring that the provider is properly trained, qualified and experienced and that the provider is able to provide safe and effective care according to standards of care.

Providers that are known to be ineligible based on the above "scope" criteria will be informed they are ineligible and will not be permitted to complete a credentialing application.

Where concerns exist about the provider's qualifications, the provider will be required to produce evidence to resolve doubts about their qualifications and produce additional references or other information.

The provider applicant has the sole burden of producing adequate documentation for a proper evaluation of their qualifications and for resolving any doubts related thereto. The provider will be advised that they have 15 days to respond. If the applicant fails to respond adequately within this time the application will be deemed to have been withdrawn.

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Providers may not be excluded, suspended, and/or disqualified from participating in Medicare, Medicaid, or any other government health-related program.

Delegated credentialing

Groups, health systems, or provider organizations with resources dedicated to credentialing may wish to accept a delegation of responsibility to perform credentialing functions that are otherwise coordinated through Harbor. The following are some of the functions that may be delegated:

- Ongoing monitoring of providers between credentialing events, in compliance with state and federal law
- Primary source verification

Delegates will provide Harbor with reporting on credentialing activities no less than quarterly. The reporting will include the number of completed initial and re-credential files and standard and readily accessible in-platform dashboard reports and analytics. Harbor will maintain responsibility for monitoring and evaluating delegate's performance. Groups who wish to adopt delegated credentialing must sign Harbor's delegated credentialing addendum as part of their participation agreement prior to being approved for delegated credentialing.

Credentialing decisions

Any significant discrepancies between the information provided by the applicant and the information provided by any source, will be communicated to the applicant within 10 business days of the review of the file. The applicant will have 10 business days from receipt of notification to correct any erroneous or incomplete information. Corrections must be submitted in writing to the attention of the Committee, or directly to their provider profile, if one exists.

For initial credentialing and re-credentialing, providers will be notified within seven calendar days of the committee action. Notification will either be via written notification (email) or an update to the provider portal, or both. If a provider is denied initial credentials they will be offered the right to appeal the decision. In instances of termination, the provider will be informed of the reason for termination and given the right to appeal the decision.

Credentialing appeals

Any provider who has their network participation denied or terminated has the right to an appeal. After the Committee's decision to deny or terminate a provider, they will have 30 days from the receipt of their letter to submit additional information as a request for reconsideration.

The provider will be notified of the Committee's decision to uphold or overturn the previous decision based on the reconsideration request:

If the Committee makes the decision to uphold the denial, the provider will be notified by the medical director of the decision in writing.

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Confidentiality

All Committee members, credentialing partners, and credentialing delegates, as well as any other individuals attending the Committee meetings will be required to maintain strict confidentiality of all information communicated during the course of credentialing activities, except for those administrative tasks like payer feeds that are required for normal business. All participants of the Committee shall sign a confidentiality statement to be kept on file and updated annually.

If a decision to impose adverse action is related to an offense that is reportable under law, the Committee chair will make the report as required, and shall issue all required communications and notifications.

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03 Medical claims and eligibility

Before submitting a claim or providing services, always refer to the member's current Harbor Health ID card for the applicable network and claims submission instructions.

The member's ID card provides important information regarding:

- Claims submission and applicable Payer ID
- Member eligibility and benefits
- Network information
- Contact information for assistance

Claim Requirements for professional services

- **Correct coding**—Providers must use the appropriate CPT, HCPCS and ICD codes, including appropriate modifiers on all claims.
- **National Drug Code (NDC) billing guidelines for professional claims**—we require NDCs and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.
- **CMS-1500 Claim form (when filing paper claims)**—we require a CMS-1500 (02/12) Claim form as the only acceptable document for participating professional providers for filing claims completed in accordance with industry standards.
- **Return of claims with missing NPI number**—Claims that do not have the billing provider's NPI number listed correctly in the appropriate block on the claim form will be returned to the provider. To avoid delays, please list the billing provider's NPI number in block 33 on the standard CMS-1500 (02/12) claim form.
- **Referring provider**—provide the name of the referring or ordering physician, if applicable, in field #17 of the CMS-1500 Claim Form.
- **Billing address**—The provider's billing address on the claim must match the address we have on file. Harbor may limit PO Box addresses if a PO Box address prevents accurate claims payment.
- **Taxonomy**—we require taxonomy codes for billing and rendering providers, when submitting claims. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment is included on all electronic and paper transactions. If a claim is submitted without the pertinent taxonomy information, the claim risks being rejected if taxonomy missing or denied or priced incorrectly if taxonomy information is incorrect.

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Claim requirements for institutional services

- **UB-04 Claim Form**—The electronic ANSIX12N 8371-Institutional or the Uniform Bill (UB-04) is the standardized billing form for institutional services. For information on the UB-04 billing form, or to obtain an Official UB-04 Data Specifications Manual, visit the National Uniform Billing Committee (NUBC) website at www.nubc.org. All claims must include all information necessary for adjudication of claims.
- **Failure to submit necessary data elements**—Failure to submit data elements that Harbor Health or Health Axis has identified as potentially necessary for claim adjudication could result in payment delays to receive the additional information from the provider in order to adjudicate the claim. All claims must include all information necessary for adjudication of claims.
- **NPI**—Some facilities may have several NPI numbers (i.e., substance abuse wings, partial psychiatric day treatment). It is important to bill with the correct NPI for the services provided or this could delay payment or even result in a denial of a claim.
- **Patient status**—The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.
- **Occurrence code/date**—All Institutional claims require the appropriate occurrence code and the date(s) of service.
- **Taxonomy**—taxonomy codes for billing and rendering providers, when submitting claims. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment is included on all electronic and paper transactions. If a claim is submitted without the pertinent taxonomy information, the claim risks being rejected if taxonomy missing or denied or priced incorrectly if taxonomy information is incorrect.
- **Fields 78 and 79**—Enter the referring or ordering provider's ID and first/last name, if applicable.

The Explanation of Payment will include the details of the medical review determination. Providers may request an appeal in accordance with the Appeals section of this provider manual.

Reimbursement

The claims system determines the member's eligibility, benefit coverage, and if the services require prior authorization.

Once a claim is determined to be payable, the maximum allowable amount is determined from the provider's Participation Agreement for participating providers or the maximum allowable amount as determined by Harbor for non-participating providers. Payment is the lesser of the maximum allowable amount or the provider's billed charges, less any applicable member responsibility. An Explanation of Payment statement (EOP) is generated when a claim is finalized and includes: a summary of the allowed amount and payment and the member's responsibility, and/or non-payment, reason for denial, or additional information that may be required.

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Member liability

The only charges for which the member may be liable for and for which provider may bill the member are:

- Copayments and coinsurance amounts as specified in the member's plan documents,
- Services that are not medically necessary, or
- Services that are not covered by the member's plan where the member has specifically agreed in advance, in writing, to accept financial responsibility.

Many Harbor Health plans reduce a member's cost share when a PCP refers the member to a specialist and the referral includes the specialist's NPI and TIN. Because the reduction may apply, providers should not assume standard coinsurance is due. Contact Member Services to confirm the member's cost share before collecting. See Section 7 for referral requirements.

The member is financially responsible for all cost shares as specified in the member's plan documents. Copayments and coinsurance may be collected at the time the services are rendered or upon receipt of the explanation of payment.

To determine the member's financial responsibility (i.e., copayment amounts), contact Member Services at the toll-free number listed on the member's ID card. The information is valid only as of the time the information is provided and is subject to change as additional claims are processed.

If the provider receives an overpayment from a member, the provider must refund the amount of the overpayment to the member no later than the 30th day after the date provider determines that an overpayment has been made.

In the event of a determination that an overpayment has been made, we may seek recovery of all excess payments from the payee to whom the check was made payable including, but not limited to, recoupment or off-sets against future payments to payee. In the event the terms of the provider's Participation Agreement or state or federal laws or regulations differ from the process outlined above, the terms of the Participation Agreement or state or federal laws or regulations will prevail.

Coding guidelines

Harbor uses standard claim guidelines that are current as of the date the claim is processed. These guidelines have been developed in part using such references as including, but not limited to, the AMA position statements from its official publication "CPT assistant," which is published monthly; other official AMA publications, such as "CPT changes" which is published annually; Medicare Guidelines, which are updated quarterly; and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, the American College of Cardiology, and the American College of OB/Gyn. Harbor Health also utilizes industry standard claim editing software in the evaluation of a claim.

Providers must implement mechanisms to ensure that: (a) billing forms, CPT codes, ICD-10 codes, modifiers, "medical necessity", etc. are supported by appropriate and timely medical record documentation; (b) all claim forms and patient statements are transmitted properly; (c) instances

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of “code gaming”, “unbundling”, “up-coding”, and other improper activity designed to increase reimbursement, which may constitute fraud, waste or abuse, are avoided; (d) arrangements with other providers adhere to anti-kickback and self-referral statutes; and (e) all provider marketing efforts do not improperly induce members to use services and are conducted with adherence to any and all applicable state and federal regulations.

Changes to the original claim for any reason must be supported by documentation in the member’s medical record. A provider’s billing staff shall not routinely change CPT or diagnostic codes or attach modifiers to bypass claims processing edits without warranted justification; any code changes must be supported by documentation in the member’s medical record.

Providers should ensure that compensation for billing department coders and billing consultants does not provide a financial incentive to up-code claims improperly. In addition, all compensation arrangements with physicians on the provider’s staff must comply with all state and federal laws and regulations, including the “Stark II” regulations.

Providers should obtain prior authorization for certain injectables, biologics and non-formulary drugs by contacting Judi Rx.

Coverage for some drugs may be limited to specific dosage forms and/or strengths. The benefit design determines what is covered and applicable member cost sharing. The medications listed on this formulary are subject to change pursuant to the formulary management activities of Judi Rx. The presence of a medication on the formulary list does not guarantee coverage. To determine the most up-to-date formulary status, please visit the Judi Rx website or call member services at the number listed on the member’s ID card.

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04 Pharmacy

Pharmacy claims

Harbor Health uses Judi Rx as our pharmacy benefit manager (PBM) to administer certain core services in our pharmacy program that will help contain rising drug costs and maintain and improve the quality of care delivered to members.

Drug formulary

Drug formulary for both our large group and individual and family plans can be found here: **HarborHealth.com/Partner/Provider/Resources#PharmacyProgram**

Electronic PA

CoverMyMeds Website: CoverMyMeds.Health

To ensure members receive high-quality medications, the prescription drug plan has a list called a formulary. This list includes preferred drugs chosen for their therapeutic effectiveness, safety and value. It includes many common brand-name and generic drugs, all approved by the Food and Drug Administration (FDA).

Using a non-preferred drug means members may pay a higher copay.

When a brand-name drug has a new generic version become available, the brand-name may be replaced by its generic. The brand-name drug then loses its preferred drug status.

The formulary offers access to medications in all therapeutic areas. If a medication is not covered, there may be a more affordable alternative. If a member has tried all alternatives, a provider can work with Harbor Health to see if an exception can be made. For help finding alternatives, please contact Judi Rx at **1 (855) 481-1620**.

Generic equivalents vs. Brand-name drugs

- Generic drugs save members money. They have the same active ingredient and quality as brand-name drugs but cost less.
- Brand-name drugs are more expensive because they are made by only one manufacturer holding the patent.
- Once the patent expires, other manufacturers can make and sell the drug as a generic.
- The FDA ensures generics meet the same standards as brand-name drugs.

If a generic is available, the pharmacist may dispense it. If a member or their provider request the brand-name drug when a generic is available, a member may have to pay the cost difference.

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Pharmacy network

The member's prescription drug coverage includes a nationwide retail pharmacy network, mail order pharmacy, and specialty medication pharmacy.

Retail network pharmacy

Harbor Health has thousands of retail pharmacies across the country. Visit **HarborHealth.com/Plans** to find local pharmacies.

Mail order pharmacy

Members can have medications delivered to their home. Ordering a 90-day supply of maintenance medication, like those for high cholesterol, high blood pressure, or diabetes, offers savings and convenience. Members can choose to fill long-term prescriptions at a retail pharmacy or have them mailed to their home. Please call **(855) 481-1620** for assistance in using a mail order pharmacy.

Specialty pharmacies

For chronic or serious illnesses, a member might need a specialty drug that requires special storage and handling. While many retail and mail order pharmacies can provide these drugs, if a member is having a hard time locating a pharmacy for their particular medication needs, call **(855) 481-1620**. A pharmacy specialist will assist them in finding a suitable pharmacy.

Drug utilization review

Judi Rx's Safety Alerts is a comprehensive Concurrent Drug Utilization Review Program powered by a proprietary adjudication platform, JUDI. This program ensures the safe and effective use of medications right at the point of sale. This system contains a variety of edits that check for drug interactions, over utilization (i.e., early refill attempts), and therapeutic duplications. The system will also alert the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment, in consultation with the prescribing provider, to determine if changes to therapy may be needed.

Recall management

Judi Rx's Recall Management Program is fully compliant with the standards set by the Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA). This program continuously monitors the U.S. Food and Drug Administration (FDA) for notices of recalled products and safety-related market withdrawals. Upon identifying such notices, the program promptly notifies affected members, prescribers, and pharmacies.

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05 Medical management

If and when required under a health plan or applicable payer protocols, Medical Group agrees to obtain prior authorization in advance of providing covered services, except for emergency services. Medical Group acknowledges that failure to obtain a required prior authorization or referral will impact Medical Group's compensation for said covered services. For a situation involving emergency services, Medical Group agrees to ensure that Harbor is notified as soon as possible, but no later than one business day after the provision of covered services or the ordering of other covered services.

Find a complete list of services and procedures that require prior authorization, along with instructions for submitting prior authorization requests, at **HarborHealth.com/Partner/Provider/Resources**

Requirements and processes vary by the member's network, so refer to the applicable network's prior authorization document on that page.

- **Responsibility for prior authorization:** The Medical Group shall be responsible for obtaining prior authorization for services provided to patients when required. This includes ensuring that all necessary documentation, clinical information, and other required materials are submitted in a timely and accurate manner. This also includes understanding the specific services requiring authorization, the appropriate channels for submission, and the necessary supporting documentation.
- **Timeliness of requests:** The Medical Group agrees to submit all requests for prior authorization at least seven days before the admission or service date for elective, non-emergency admissions and outpatient services, or within the timeframe required by the health insurance company. This ensures services are authorized before they're rendered and helps avoid denial of coverage.
- **Patient notification:** The Medical Group shall inform the patient of the need for prior authorization prior to submitting the request. The patient shall be notified of any potential delays, denials, or additional steps required to obtain authorization.
- **Authorization for services rendered:** The Medical Group shall ensure that authorization is received prior to rendering services that require prior authorization. Services rendered without the necessary authorization may be subject to denial of payment by the insurance company, and the Medical Group acknowledges that it will bear the responsibility for any unpaid claims if authorization was not obtained.
- **Documentation and record keeping:** The Medical Group will maintain accurate records of all prior authorization requests, communications with the insurance company, and any approvals or denials. These records shall be available for review upon request from the insurance company, regulatory bodies, or as part of an audit process.

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- **Change in coverage or insurance plan:** In cases where the patient's insurance coverage or plan changes, the Medical Group shall re-initiate prior authorization requests as required by the new insurance provider or plan to ensure coverage for the necessary services.
- **Coordination with patients:** The Medical Group will make reasonable efforts to ensure that patients are kept informed of the authorization process and any necessary steps to ensure coverage. If any additional information is required from the patient, the Medical Group will notify the patient promptly.

Services requiring prior authorization

Examples of services requiring prior authorization of benefits include, but are not limited to:

- Inpatient admissions, except for normal vaginal and C-section deliveries
- Certain outpatient surgical procedures
- Home health care

Decisions for prior authorization and concurrent review requests will be made in accordance with state and federal timeframes.

Medical Management staff of licensed providers will determine benefits according to the criteria for medical necessity set forth in the member's Evidence of Coverage. These medical necessity determinations may be made prospectively, or concurrently, or retrospectively. The review criteria consider local, regional, and national professionally acceptable standards for quality medical care in accordance with state or federal laws and regulations. Some services that providers may recommend are not necessarily covered as a part of a member's health benefit plan.

A copy of the criteria used to make a medical necessity determination is available upon request. Providers may request a copy of the criteria by contacting ***ProviderRelations@HarborHealth.com*** or calling **1 (855) 481-0525**.

Providers will receive an authorization number for internal tracking and provider billing. Please note that this authorization number is not a guarantee of coverage or payment. A final determination will be made following receipt and review of the request and verification of benefits and eligibility. If the authorization request is approved, the authorization number must be referenced on the claim to avoid denial.

Following the benefit determination, the treating provider will receive a letter advising that the service was or was not authorized. Members will also receive a letter advising them whether the service was authorized or not authorized.

Care coordination

We partner with in-network primary care providers to offer a unique, provider-led care coordination program to help members navigate complex health situations and focus on goals and opportunities to improve their health. Harbor Health uses a partnership and team-based approach for members that includes physicians, advanced practice providers, nurses, medical assistants, pharmacists,

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physical therapists, registered dietician, mental health counselors, etc. The care team will work closely with the member, caregivers, other specialists, etc. to develop a care plan that meets the needs of the member and their family.

Members are identified for care management through referrals from providers and/or family/caregivers, medical records, health risk assessments, disease management reports, and other targeted approaches. The amount of care management a member receives is based upon an individual member's needs and goals.

Some factors that indicate a need for care management include:

- Frequent use of the emergency department for situations where a primary care visit would have been medically appropriate
- Multiple hospitalizations in a short period of time
- Diagnosed with serious chronic illness e.g. congestive heart failure (CHF), diabetes, etc. and having difficulty adhering to the recommended treatment regimen care pathway
- Pregnant with high-risk conditions

Activities that the care team may work with members include:

- Facilitating access to specialists and therapies
- Triaging and coordinating care needs with additional providers and specialists
- Advocating for, informing, and educating to support and accomplish the care goals set with the member

Care coordinators work with providers to coordinate care for complex catastrophic cases and are available to consult with providers about difficult or unusual situations. In the event that a member needs services not available through the member's benefit plan network, care coordinators can work with providers to locate an appropriate setting.

Call the Member Services phone number on the member's ID card to reach a care coordinator to obtain more information, or to refer a member to care coordination, including the Harbor Health complex case management program.

Continuity of care requirements

In accordance with the No Surprises Act, when a provider leaves the Harbor Health network they may be required to continue seeing members currently undergoing a course of treatment for the following conditions:

- Pregnancy or undergoing course of treatment for pregnancy
- Surgery scheduled or recently performed
- Undergoing postoperative care
- Post Transplant or on the Transplant list
- Undergoing institutional or inpatient care from the provider

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- Having been determined to be terminally ill
- The provider has special expertise not available with in-network providers

Continuity of care typically lasts for the following timeframes:

- **Pregnant members:** Through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after delivery.
- **Terminal illness:** Up to 12 months following contract termination.
- **All other conditions:** Up to 90 days following contract termination.

During the continuity of care timeframe, providers must continue to accept their contracted reimbursement rate and collect the member's normal in-network cost share. Providers must also cooperate with medical record transfer, treatment planning, and HHIC coordination to prevent care disruption.

Utilization management (UM) decision timelines

Harbor Health renders UM decisions through the prior authorization process in accordance with Texas law. Network providers must request prior authorization and provide all clinical information necessary for Harbor to render a decision within the following timeframes:

- **Involving inpatient care:** Within 24 hours from receipt of the request
- **Involving an acquired brain injury:** Within 3 working days from receipt of the request
- **Involving post-stabilization care subsequent to emergency treatment, or a life-threatening condition:** Within 1 hour from receipt of the request

For all other requests:

- **Expedited prior authorization requests:** Within 24 hours of receipt of the request
- **Standard prior authorization requests:** Within 3 calendar days of receipt of the request

Harbor will communicate approvals, denials, and required clinical documentation within these regulatory timeframes.

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06 Appeals

Initiating appeals

Members or a person acting on behalf of a member, including a provider, may request an appeal when a request for an item or service is denied in whole or in part during the prior authorization or concurrent review process. This is referred to as an adverse determination. Scenarios that fall under the adverse determination appeals process include, but are not limited to:

- Service does not meet, or no longer meets, the criteria for medical necessity based on the information provided;
- Service is considered to be experimental or investigational;
- We approve less than the requested amount, scope or duration.

A member or person acting on behalf of a member, including a provider, can appeal the decision if a service was denied, reduced, or ended early. Harbor Health has one level of internal appeal and one level of external appeal, which typically may only be accessed by exhausting internal appeal options. The external review process may be started without first exhausting the internal appeal process if we failed to follow the internal appeal process described.

Instructions for filing an adverse determination appeal will be included in the prior authorization or concurrent review denial letter, which will be sent to the member and member's provider. For all other appeals, refer to our website at **HarborHealth.com/Partner/Provider** for instructions on how to appeal.

Appeal determinations

Once the appeal has been received, the provider will be notified if additional information is required to complete the review of the appeal. Providers will receive notification of the appeal decisions in a determination letter within the time frames required by state or federal law.

Refer to the Harbor Health provider contract for information on filing a complaint or appeal about provisions within the contract.

How a provider should challenge a denied claim depends on why the claim was denied. Harbor Health uses a structured process to ensure compliance with Texas Department of Insurance (TDI) rules while offering an easy-to-navigate experience for providers. Providers can submit all issues through the Harbor Health Provider Portal, accessible at: **HHProvider.Prod.HealthAxis.net**

Once logged in, providers can create a new service ticket by selecting a ticket type that best describes the issue they are reporting.

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Ticket types: Description and when to use them

These are the standard categories Harbor Health uses to manage post-service issues submitted by providers. When submitting a ticket in the portal, select the option that best matches your issue:

01 Clinical appeal

Use this if a claim or authorization was denied due to medical necessity or because the service was deemed experimental or investigational.

Examples include:

- A prior authorization for an inpatient admission was denied as not medically necessary
- A service was denied because it is considered investigational under the plan

Who can submit:

- Provider or member
- Must be submitted within 180 days of the EOP or denial letter

02 Member complaint (grievance)

Use this if the denial was not based on medical necessity, but due to plan limitations, such as exclusions or benefit limits.

Examples include:

- A service is excluded from the member's plan
- The member reached their annual or lifetime benefit maximum
- The plan was retroactively canceled (rescission of coverage)

Note: These are considered member complaints under Texas law. The provider must obtain written permission from the member to submit on their behalf.

Who can submit:

- Provider or member
- Must be submitted within 180 days of the EOP or denial letter

03 Provider Dispute

Examples include:

- Coding errors (e.g., claim denied due to modifier mismatch)
- Payment disputes (e.g., underpaid or incorrect reimbursement)
- Denial due to missing or late authorization (provider liability)

Who can submit:

- Provider only. Must be submitted within 180 days of the EOP.

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Appeal & dispute deadlines

All appeals and disputes must be submitted within 180 calendar days of the date the provider receives the Explanation of Payment (EOP) or denial notification.

Late submissions may not be reviewed unless otherwise required by applicable law or contract.

If you're unsure which type of ticket to submit or need portal assistance, please email ***ProviderRelations@HarborHealth.com*** or call **(855) 481-0525.**

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07 Provider responsibilities

Referral requirements for member cost share reduction

When you, as a primary care provider (PCP—including pediatrics and OB/GYNs), make a referral to a specialist, you are required to include both the National Provider Identifier (NPI) and the Tax Identification Number (TIN) of the provider you are referring to.

This step is essential for Harbor Health to correctly apply cost share reductions tied to PCP initiated referrals. If either the NPI or TIN is missing, the member's cost share reduction will not apply, resulting in higher out-of-pocket costs for your patient.

Members who follow the Harbor Health referral model may save money through lower cost sharing and improved care coordination. Cost share reduction is a benefit feature in most, but not all, Harbor Health plans.

Providers are strongly encouraged to verify referral completeness at the time of submission to avoid claim denials or member cost share reduction ineligibility for members.

Notification of changes

Providers must notify Harbor Health of changes to the following information no less than 30 calendar days prior to the effective date of the change:

- TIN changes (include copy of W-9 Form)
- Address additions, changes, or deletions
- Phone number or fax number changes
- Office hours
- Hospital affiliations
- Specialty
- State license number
- NPI number
- Additions or departures of providers or locations from a group practice or ancillary/facility group

Providers must notify Harbor of any changes in ownership, TIN, Federal Employer Identification Number (FEIN) or business entity name no fewer than 10 business days prior to the effective date of the change. Any changes to a provider's ownership, TIN/FEIN, or W-9 will suspend provider's network participation status until approved in writing by Harbor.

The network participation status of any new providers to a group practice or new locations for ancillary/facility providers will be effective upon approval from Harbor Health and as of the date of successful completion of credentialing.

Failure to notify Harbor Health of any of the above changes may result in payment denials.

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Provider demographic changes and data submission requirements

All participating providers and provider groups—whether under delegated or non-delegated credentialing agreements—are required to maintain accurate and current demographic and operational information. This supports accurate claims processing, network directory compliance, and regulatory obligations.

Provider groups must submit a monthly report of all additions, changes, and terminations to their provider rosters, regardless of whether a change occurred that month.

Providers must report changes at least 30 calendar days in advance, or as soon as known, to avoid potential delays in claims processing, inaccurate directory listings, and compliance risks.

To report a change, providers will reach out to ***ProviderRelations@HarborHealth.com*** and request their latest dataset for updating.

Step-by-step instructions:

STEP 01 Email ***ProviderRelations@HarborHealth.com*** and request an updated roster for the group to make changes

STEP 02 Harbor Health Support will email you a full updated review of your data to verify the change you requested to be made.

STEP 03 Once verified, Harbor Health will process the change.

Failure to submit required data

Failure to provide accurate or updated demographic information may result in:

- **Delays in claims payment** due to incorrect or missing provider-level data
- **Incorrect listing in the provider directory,** impacting member access and regulatory compliance
- **Credentialing disruption** or administrative hold on referrals, authorizations, or payment

All claims must include **complete and accurate provider data elements** to allow for proper adjudication. Harbor Health reserves the right to request any additional information needed to validate the provider or process the claim.

A monthly submission is still required even if no changes occurred.

Questions?

For help with demographic updates or questions about required data fields, contact: ***ProviderRelations@HarborHealth.com*** or call **1 (855) 481-0525**

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Provider termination or network departure

The following section applies to groups who are directly contracted with Harbor Health. If your group is part of one of Harbor's national partner wrap networks, please refer to that network's resources to ensure the appropriate process is followed.

Participating providers and provider groups have the right to voluntarily terminate their participation with Harbor Health. To ensure a smooth transition and maintain continuity of care for members, providers must follow the procedures outlined below.

Notification requirements

Providers must notify Harbor Health in writing at least 90 calendar days in advance of their intended termination date. The notice must be submitted by an authorized representative and include:

- Provider/group name and TIN/NPI
- Effective date of termination
- Reason for termination (e.g., retirement, relocation, contract decision)
- Location(s) affected
- Contact information for follow-up
- Any members in active treatment (e.g., oncology, OB, post-op care)

How to submit a termination notice

Notices must be submitted in writing:

- **Email (preferred):** *ProviderRelations@HarborHealth.com*

Responsibilities before termination

To avoid disruption to member care, terminating providers are expected to:

1. Complete active courses of treatment or cooperate in transfer of care
2. Assist with continuity of care for members eligible for transition periods under TDI rules or applicable law
3. Return or destroy confidential plan materials, as directed
4. Continue claims submission for dates of service prior to termination per contract guidelines
5. Complete any open appeals, credentialing audits, or quality reviews

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Termination confirmation

Harbor Health will send a written acknowledgment confirming receipt of the termination request and the effective date of termination. Providers may be contacted to discuss transition of care for high-risk or special-needs members.

Failure to follow process

Questions?

For questions regarding network participation or termination, contact: ***ProviderRelations@HarborHealth.com*** or call 1 (855) 481-0525.

If a provider exits the network without proper notice or cooperation, Harbor Health may:

- Notify regulatory bodies, per contractual or legal requirements
- Flag the provider's status in credentialing or payment systems
- Withhold final payments until obligations (e.g., continuity of care) are fulfilled

For providers ceasing practice (e.g., retirement, closure)

In addition to the above, providers who are retiring, closing a practice, or leaving the state must provide:

- A closure plan outlining patient transition strategy
- Final date of availability for services
- A record retention statement, as required by law

General provider expectations

Harbor expects providers to provide care to members in a culturally competent manner, being sensitive to language, culture, and reading comprehension capabilities. They should freely communicate with members regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations. Additional expectations include but are not limited to:

- Providers must not discriminate on the basis of race, age, religion, sex, national origin, marital status, source of payment, or disability of any member.
- Providers must agree to provide continuing care to participating members.
- Responsiveness and Harbor Health Medical Group coordination.
- Providers must use participating providers when services are available and can meet the member's needs. Based on the member's plan benefits, prior approval may be required when referring members to providers who are outside the network of participating providers (out-of-network providers).

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- Providers must abide by Harbor quality improvement, utilization management, credentialing, peer review, appeals, grievance, and other policies and procedures. This includes participation in evidence-based patient safety programs, investigations into potential fraud, waste, or abuse, and coordination of member care with the Harbor care coordination team.
- Providers may not balance bill members for services that are covered by their benefit plan. A provider may not bill for charges that exceed contractually allowed reimbursement rates.
- The provider agrees to prepare complete medical and other related records in a timely fashion for all members in their care and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment and the outcome at completion or discontinuation of treatment.
- Medical records for members must be maintained for a minimum of 10 years from the last date on which the service was provided.
- Providers agree to allow access to medical records for review by appropriate committees of Harbor and, upon request, must provide the medical records to representatives of Harbor, governmental entities and/or their contracted agencies.
- The provider agrees to inform Harbor, in writing, within 24 hours of any revocation or suspension of their Drug Enforcement Administration (DEA) number, certification or other legal credential authorizing him/her to practice in the state of Texas or any other state. Failure to comply with the above could result in termination from the plan.
- Providers agree to inform Harbor immediately, in writing, of any changes in licensure status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance, change in eligibility for payment under Medicare and any other change that would affect their status with Harbor.
- Providers agree to provide or assist Harbor in obtaining Coordination of Benefits/Third party Liability information.
- Confirm member eligibility and benefits prior to rendering services.

Specialist expectations

Specialists must work closely with the referring physician regarding the treatment the patient is to receive. Specialists must also provide continuous 24/7 access to care for members.

Specialists may be required to obtain any required authorizations prior to rendering services. Specialists are required to coordinate referrals and authorizations with Harbor. They must provide ongoing consultation report(s) to the appropriate PCP within thirty (30) days of the consultation.

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Network adequacy requirements

Harbor Health complies with state and federal network adequacy requirements for primary care and all other provider types. Additionally, network providers are expected to comply with the Centers of Medicare and Medicaid Services' (CMS) appointment wait time standards for members with an ACA individual and family (IFP) plan. Specifically, providers must offer appointments within the following timeframes for a member with an IFP plan:

- **Primary care (routine visit):** 15 business days
- **Specialty (non-urgent visit):** 30 business days
- **Behavioral health:** 10 business days

Providers who cannot meet these timeframes are required to notify Harbor Health.

Network adequacy after-hours coverage

Providers must ensure members have 24/7 access to clinical guidance through an on-call clinician or nurse triage line. Recorded messages that direct members to seek emergency care are acceptable only if they also provide a way to reach a clinician for urgent needs.

After-hours emergency care obligations

Providers must treat any condition that a prudent layperson would view as an emergency. Emergency services must be provided without prior authorization. Stabilization is required before transfer or discharge, and medically necessary post-stabilization care must be coordinated with Harbor.

Member complaint process

Complaint definition: Any expression of dissatisfaction about care, service, or plan operations.

Members must initiate and file a complaint with Harbor Health, but providers may be asked to support members with the complaint process by supplying any necessary information related to the complaint.

Complaints and complaint appeals will be handled in accordance with Texas required timeframes. Specifically:

- **Acknowledgment of the complaint:** Within 5 business days of receipt of the complaint form
- **Complaint resolution:** Within 30 calendar days of receipt of the complaint form
- **Complaint appeal resolution:** Within 30 calendar days of receipt of the complaint appeal

***Note:** If the complaint appeal is related to an ongoing emergency or a denial of continued hospitalization, a complaint resolution will be made in accordance with the medical or dental immediacy of the case, but not later than 1 business day after Harbor receives the complaint.

Providers must direct members to **HarborHealth.com/Member-Support/Complaints** to file a complaint with the health plan.

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Member Rights and Responsibilities

Harbor Health is committed to treating members in a manner that respects their rights and its expectations of members' responsibilities. Providers should be aware of the following members' rights and responsibilities. Members have:

- A right to receive information about Harbor Health, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about Harbor Health or the care it provides.
- A right to make recommendations regarding the Harbor Health member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that Harbor Health and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

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08 Compliance and quality

Harbor takes compliance with all applicable federal and state laws and the prevention of fraud, waste, and abuse very seriously. It emphasizes the common values for actions and establishes resources to help resolve questions about compliance issues. Please review this section thoroughly. The need for each provider's adherence to its spirit and specific provisions cannot be overemphasized. All providers and their employees and agents have important responsibilities, including a duty to report compliance concerns.

Providers or staff members who have questions regarding anything found in this section or who encounter a situation they believe violates its provisions should notify Harbor immediately.

Providers should take great care to ensure all claims submitted reflect accurate information and conform to applicable federal and state laws and regulations. No provider or their employee or agent should knowingly present, or cause to be presented, claims for payment or approval that are false, fictitious, or fraudulent.

Harbor reserves the right to conduct periodic audits and monitoring of a provider to confirm that compliance goals are being maintained and assist in the reduction of any identified problem areas. Auditing and monitoring activity will include periodic profiling to identify any changes in billing patterns that may indicate improper activities.

Providers should periodically conduct educational programs for their staff so as to ensure continued compliance with all applicable laws. It is imperative that providers require their professional staff and all other employees to attend compliance education programs and they agree to abide by all applicable codes of conduct adopted by the provider. A similar education requirement should be made of all independent contractors and agents providing healthcare-related services to the provider.

Providers, including but not limited to individual practitioners, medical groups, and facilities, must cooperate with Harbor quality improvement activities to improve the quality of care, quality of services, and member experience. Cooperation includes collection of data, evaluation of data, and participation in the Harbor quality improvement programs. Harbor may use provider performance data for quality improvement activities.

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09 Contact information

Provider Relations

Contact:	**Harbor Health**
Phone:	1 (855) 481-0525
Email:	ProviderRelations@HarborHealth.com

Claims Appeals (medical)

Contact:	**Health Axis**
Mailing address:	Harbor Health PO Box 211262 Eagan, MN 55121
Website:	HHProvider.Prod.HealthAxis.net
Fax:	(512) 610-9186

Pharmacy coverage determinations or appeals

Contact:	**Judi Rx (open 24/7)**
Phone:	1 (855) 481-1620
Fax:	(833) 434-0563

Contact:	**Judi Rx prior authorization (open 24/7)**
Phone:	1 (855) 481-1620
Website:	Judi.Health/Judi-Rx-Prescribers

Contact:	**Electronic PA: CoverMyMeds**
Website:	CoverMyMeds.health

Contact:	**Coverage determinations**
Mailing address:	Judi Rx Attn: Claims Department 9450 SW Gemini Dr., #87234 Beaverton, OR 97008

Contact:	**Coverage determinations**
Phone:	1 (855) 481-1620
Mailing address:	Judi Rx Attn: Claims Department: Appeals 9450 SW Gemini Dr., #87234 Beaverton, OR 97008

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Credentialing

Contact:	**OneCred**
Email:	**HHSupport@OneCred.com**

Compliance

Contact:	**Health Care Lighthouse Compliance Hotline**
Toll-free phone:	English-speaking USA & Canada: (833) 352-8868 Habla español USA & Canada: (800) 212-1288
Email:	**Everyday compliance questions:** *Compliance@HarborHealth.com* **Anonymous reports**: *Reports@Lighthouse-Services.com* *(must include "Harbor Health" in the text of report)*
Website:	**Lighthouse-Services.com/HarborHealth**

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We’re in this together

For help with your Harbor Health plan, reach out to your account manager or call Harbor Health at (855) 481-0525.

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