

GROUP BENEFITS SERVICES AGREEMENT NON-RISK PARTICIPATING

This Agreement is between the Employer named in the Schedule and the TML MultiState Intergovernmental Employee Benefits Pool (IEBP), 1821 Rutherford Lane, Suite 300, Austin, Texas 78754

SCHEDULE

- | | |
|--|--|
| 1. Employer: | <u>City of Carrollton</u> |
| 2. Effective Date: | <u>January 1, 2015</u> |
| 3. Monthly Service Charge per employee per month: | |
| Claims Administration per received claim: | 10/01/15 01/01/16 |
| Claim Adjudication | \$13.25 \$13.25 |
| Medical Management | \$4.00 \$4.00 |
| | Third year will not be in excess of a 5% increase of administrative fees |
| 4. Optional Services (PEPM = per employee per month; PPPM = per participant per month) | |

<input checked="" type="checkbox"/> United Choice Plus PPO Network Access Fee using direct contracts: Choice Plus Network access requires benefit plan designs that incentivize network provider utilization. These requirements are as follows: <ol style="list-style-type: none"> 1. Equal to or greater than a \$250 Network and Non Network deductible variance 2. Equal to or greater than a \$500 Network and Non Network out-of-pocket maximum variance 3. Benefit Steerage of 20% 4. Network and Non Network out-of-pockets may not accumulate 	\$14.20 PEPM	\$14.20 PEPM
<input checked="" type="checkbox"/> International Centers of Excellence Network	PEBA Agreement	PEBA Agreement
<input type="checkbox"/> Online Enrollment System	\$0.85 PEPM	\$0.85 PEPM
<input type="checkbox"/> IEBP Online Enrollment Implementation Fee	\$1,500.00 (one time investment) \$175.00 Per hour for custom programming within IEBP specifications	
<input type="checkbox"/> Online Enrollment Payroll File	Custom Programming Charge	
<input checked="" type="checkbox"/> ACH	No Charge	No Charge
<input checked="" type="checkbox"/> Virtual Card		
<input type="checkbox"/> Notification Dollar Amount \$ <u>NONE</u>		
<input checked="" type="checkbox"/> Wet Signature Requirement \$ <u>20,000.00+</u>		
<input checked="" type="checkbox"/> Positive Pay Bank Account		
<input checked="" type="checkbox"/> Control Disbursement Bank Account		
<input type="checkbox"/> Manual Disbursement Bank Account		
<input checked="" type="checkbox"/> Payment Date/Frequency <u>DAILY</u>		
<input checked="" type="checkbox"/> Executed ACH Authorization Form		
<input checked="" type="checkbox"/> Health Plan Identification Number	No Charge	No Charge
<input checked="" type="checkbox"/> Current Telemedicine Services – <u>640.00 per call</u> \$30.00/\$10.00, \$0.99 admin fee PEPM	Teladoc fee schedule	
<input checked="" type="checkbox"/> Continuation of Coverage/Group Set up \$50.00	\$0.50 PPPM	\$0.50 PPPM
<input type="checkbox"/> Onsite Wellness	PEBA Options/Direct Cost	
<input checked="" type="checkbox"/> Flex Debit Card Group Set up \$50.00	\$3.70 PEPM	\$3.70 PEPM

TML MultiState Intergovernmental Employee Benefits Pool

<input type="checkbox"/>	Flex Paper Card Group Set up \$50.00	\$5.00 PEPM	\$5.00 PEPM
<input checked="" type="checkbox"/>	Disease Management	\$1.50 PEPM	\$1.50 PEPM
<input checked="" type="checkbox"/>	Dental	\$1.15 PEPM	\$1.15 PEPM
<input type="checkbox"/>	Vision	\$0.00 PEPM	\$0.00 PEPM
<input checked="" type="checkbox"/>	Retiree Direct Billing	\$1.00 PRPM	\$1.00 PRPM
<input checked="" type="checkbox"/>	External Vendor Reporting	Programming Charge of \$150.00/hour	
<input type="checkbox"/>	Alternate Plan	\$1.25 PEPM	\$1.25 PEPM
<input checked="" type="checkbox"/>	iCES/AutoAudit	No Charge per Addendum A attached	
<input checked="" type="checkbox"/>	Covered Individual Claim Look-Up	No Charge	
<input checked="" type="checkbox"/>	Custom Claims Reports	\$150/programming hour	
<input checked="" type="checkbox"/>	Pharmacy Benefit Management Interface	<u>OptumRx PBM Retail Vendor</u> Wells Fargo .75 claim repricing data analytics <input checked="" type="checkbox"/> OptumRx <input checked="" type="checkbox"/> Broad Network <u>Mail Service</u> <input checked="" type="checkbox"/> OptumRx <u>Biotech Specialty RX</u> <input checked="" type="checkbox"/> OptumRx Specialty Pharmacy <u>Clinical/PA Services</u> <input checked="" type="checkbox"/> RxResults <input type="checkbox"/> OptumRx <u>Formulary Management</u> <input type="checkbox"/> OptumRx <input checked="" type="checkbox"/> Political Subdivision	<u>Restat/Catamaran PBM Retail Vendor</u> <input type="checkbox"/> Restat/Catamaran <input type="checkbox"/> Align Network <input type="checkbox"/> Align and Broad Network <u>Mail Service</u> <input type="checkbox"/> Catamaran Home Delivery <u>Biotech Specialty RX</u> <input type="checkbox"/> Restat/Catamaran <u>Clinical Services</u> <input type="checkbox"/> Restat/Catamaran <input type="checkbox"/> RxResults <u>Formulary Management</u> <input type="checkbox"/> Restat: \$0.58 per claim <input type="checkbox"/> Political Subdivision: \$0.58 per claim
<input checked="" type="checkbox"/>	HIPAA Certificates	Included in Medical Admin Fee	
<input checked="" type="checkbox"/>	Benefit Booklets (every 2 years)	Included for Number of EE Plus 10%	
<input checked="" type="checkbox"/>	PPN Directories	Included For Number of EE Plus 10%	
<input checked="" type="checkbox"/>	ID Card Distribution <input checked="" type="checkbox"/> Costs for more frequent ID card distribution will be submitted to employer <input checked="" type="checkbox"/> Mailings to covered individual addresses will be direct cost to employer <input checked="" type="checkbox"/> Educational Insert \$0.229/envelope + postage <input checked="" type="checkbox"/> Mailings of ID cards for new members or member changes will be direct cost to employer ID Card Sort <input checked="" type="checkbox"/> Alpha <input type="checkbox"/> Alpha by Plan <input type="checkbox"/> Alpha by Location <input type="checkbox"/> Alpha by Location by Plan	One Card Average Cost \$0.99 Two-Card Set Average Cost \$1.08 plus (includes materials, fees and distribution to group) Actual cost of the ID cards will be billed to the group monthly as a pass through of the cost from the ID card vendor's invoice; Mailing Costs and Overnight delivery request will be billed at cost to the employer	
<input checked="" type="checkbox"/>	Network Claim Audit	\$250 per claim – External Vendor	
<input checked="" type="checkbox"/>	TML MultiState IEBP Subrogation	20% of savings	

TML MultiState Intergovernmental Employee Benefits Pool

<input checked="" type="checkbox"/> External Medical Specialty Review	<p style="text-align: center;">Direct Cost of Review</p> Regular Review \$340.00 Expedited 24 hour review \$515.00 Expedited 48-72 hour review \$442.00 Oncology Review \$975.00
<input checked="" type="checkbox"/> External Claim Usual and Customary	<p style="text-align: center;">15% of savings – External Vendor</p>
<input checked="" type="checkbox"/> Internal Claim Usual and Customary	<p style="text-align: center;">No Charge</p>
<input checked="" type="checkbox"/> Secondary Network and/or Out of Network Professional Negotiations	<p style="text-align: center;">15% External Vendor First Health/Logo, MultiPlan, TC³, Ethicare</p>
<input checked="" type="checkbox"/> Dental Consultant	<p style="text-align: center;">\$23.00 dental, \$50.00 medical, \$75.00 TMJ referral</p>
<input checked="" type="checkbox"/> Run Out	<p style="text-align: center;">Six month Run Out will be provided if ninety-day termination notice is implemented. Cost will be the medical claim administration cost at termination.</p>
<input checked="" type="checkbox"/> Broker/Agent Fee	<p style="text-align: center;">\$0.00</p>
<input checked="" type="checkbox"/> Covered Individual External Appeal Request (<i>Effective 07/01/11 anniversary months thereafter</i>)	<p>AllMedMd \$185 to \$310/case (Depends on number of pages to review and whether it is a non-expedited, expedited, or Rush case review.)</p> <p>Medical Review Institute of America (MRIoA) Allied Health Services (Speech, Ancillary Services, Physical Therapy, Chiro, Acupuncture, Message Therapy, Occupational Therapy, Podiatry, Dentistry) \$119/case \$169/hr for Phone Consultations Standard Physician Specialist review \$175 for Short review (20 pages or less) \$340 for Standard Physician Specialist review Expedited Reviews = + 50% for 24 hr TAT, +30% for 72 hr TAT; Max of \$250/case</p> <p>Managing Care Managing Claims (MCMC) Standard Physician Specialist review \$210 - \$375/hr (depends on specialty and TAT requested) Allied Health Services(OT, ST, PT, Psychologist, Podiatry, Respiratory Therapist, Optometry, Chiro, Dentistry) \$85 - \$185/case (effected by requested TAT) Cases with >100 pages: \$150/hr - \$210/hr (effected by requested TAT)</p> <p>MCN (Medical Consultants Network) <u>Internal Review:</u> Standard Review = \$350.00 (Standard pricing for files up to 100 pages. Additional charge of \$25.00 for each additional 50 pages). Expedited Review = \$500.00 Reconsideration = \$50.00</p> <p><u>External Review:</u> Standard Review = \$400.00 (Standard pricing for files up to 100 pages. Additional charge of \$25.00 for each additional 50 pages). Expedited Review = \$550.00 Cancellation = \$50.00</p>

- **DEFINITIONS:** The following terms where used in this Agreement, have these meanings:
- **We, us, or our** - The TML MultiState Intergovernmental Employee Benefits Pool, known as the "Group Benefits Administrator" herein, or any subcontractor which it designates to perform the functions and meet the obligations to which it agrees in this Agreement.
 - **You or your** - The Employer named in the Schedule.
 - **The Plan** - The employee benefit plan which the Employer named in the Schedule has adopted to provide medical expense benefits to eligible persons, as defined, and which is attached to this Agreement.
 - **Eligible Persons** - Employees and dependents who are eligible for benefits under the Plan.

You have adopted the Plan and asked us to administer the benefits provided by the Plan. Therefore, in consideration of the mutual promises contained in this Agreement, it is agreed as follows.

I. OUR DUTIES

- a. **We agree** to process all claims presented on behalf of eligible persons for the payment of benefits according to the terms of the Plan. We will administer benefits per your plan document unless authorized by you, in writing, to pay outside the plan guidelines. We will not process any claim which was incurred prior to the Effective Date shown in the Schedule, unless authorized by you in writing prior to determination.
- b. **We agree** to provide, at monthly intervals, a listing of all Plan benefits paid. One custom and one free programming change of two hours or less per year is provided, at your request, at no cost per plan year. Subsequent custom reports will be billed as shown in the schedule.
- c. **We agree** to design, review and print standard forms to explain benefits to employees, standard enrollment cards, standard ID cards and one (1) standard benefit book every two (2) years.
- d. **We agree** to provide underwriting services including (i) annual cost projections, (ii) cost projections for Plan modifications; and estimates of reserve amounts required to fund the Plan on a current basis.
- e. **We agree** to provide assistance to you in designing your Plan benefits based on coverage adequacy, cost control effectiveness, and medical or economic developments. We will not provide legal review or advice regarding your plan document or otherwise.
- f. **We agree** to provide an annual report of tax reportable claim payments to medical care providers.
- g. **We agree** to allow you to obtain a third party to conduct an onsite claims audit at our offices. Such claims audit will be limited to once per agreement year and the date(s) will be mutually agreed upon. We agree to not unnecessarily delay the claims audit by not mutually agreeing to a date.
- h. **We agree** to administer all provisions contained in the Plan booklet/document adopted by the Employer.
- i. **We agree** to use care and diligence in the exercise of our powers and the performance of our duties as Group Benefits Administrator hereunder but shall not be liable for any mistake or judgment or other action taken in good faith or for any loss unless resulting from our gross negligence.
- j. **We agree** to process any written requests, issues or comments received from Eligible Persons on appeals of denied benefits and forward the information to the Employer for review and decision.
- k. **We agree** upon receipt of the Employer's written decision of benefit appeals, to calculate any amount due and payable, or issue a denial notice, all in accordance with written instructions of the Employer.

- i. **We agree** to notify stop loss carriers of potential claims and provide all reporting required by stop loss carriers when requested to do so in writing. The Group Benefits Administrator shall have no responsibility for the accuracy of any data or reports sent to or accessed by the stop-loss carrier, through a consultant or otherwise, unless the Group Benefits Administrator has first reviewed and approved such data or reports. The Employer shall promptly notify the Group Benefits Administrator if and when the Employer agrees to an stop-loss "lock-in" date.
- m. **We agree** to provide coordination of benefit services and pursue subrogation on behalf of the employer, when applicable. Subrogation is handled by in house counsel. Should a subrogation matter proceed to litigation, all attorney fees, court costs, and other expenses shall be paid by you. Should we be joined as a party to any subrogation or claim related litigation, you will reimburse TML MultiState IEBP for its attorney fees, court costs, and other expenses, including TML MultiState IEBP's legal expenses incurred for counsel retained separate and apart from you. TML MultiState IEBP will pursue subrogation on claims paid through the claim adjudication run timeframe, unless you provide TML MultiState IEBP written notice that subrogation services should terminate immediately. We will continue to be entitled to the 20% fee listed above, regardless of whether the collection is made through you or TML MultiState IEBP, as long as the recovery was based on claims paid through TML MultiState IEBP.
- n. **We agree** to refund all amounts paid over the specific stop loss limit within ten (10) days of approval by the stop loss carrier. We do not assume responsibility for the payment of any stop loss claim.
- o. **We agree** to refund all amounts paid over the aggregate stop loss attachment point within ten (10) days of approval by the stop loss carrier.
- p. **We agree** to provide notification, continued stay review, discharge planning and large care management as needed.
- q. **We agree** to use iCES and/or Auto Audit claim screening software to review your claims at no additional cost, as directed by you on Addendum A to this Agreement.
- r. **We agree** to receive claims electronically for your eligible persons to the extent providers are capable of electronic submission.
- s. **We agree** to maintain claims processing data electronically on microfilm, optical disk, or other appropriate media for six (6) years and provide you with copies of this data for individual requests within two (2) business days following receipt.
- t. **We agree** to provide your bank with a daily 'positive pay' file, which documents which claims were paid each business day.

II. YOUR DUTIES

- a. **You agree** to establish a checking account at your bank, which will be used to pay all of your claims per Addendum A. You will be the custodian of this account and will be responsible for depositing all funds necessary to pay said claims. This account must utilize the 'positive pay' feature of the banking process. Through this process, TML MultiState IEBP will be responsible for transmitting a daily file, which gives an electronic listing of all checks written the night before. TML MultiState IEBP will be a signer on the account for check writing purposes only. We will use the facsimile signature of the Chairman of our Board of Trustees to sign your checks. You agree to have your own personnel listed as authorized signers, for the purpose of inquiries, research or reconciliation of the account.

Any fees associated with the establishment or daily process and operation of this account will be your responsibility.

If this account is not maintained and properly funded, we may at our option, take any of the following actions:

- (i) suspend the processing and payment of your claims;
- (ii) terminate this Agreement immediately by written notice to you.

- b. **You agree** to provide us in a timely fashion all information and assistance we may need to properly administer the Plan.
- c. **You agree** to verify according to your plan document, the eligibility of any persons who request coverage under your plan. Your verification of eligibility will be indicated on the enrollment record in the space provided for "Employer Acceptance". Once accepted by you and the enrollment record received by us, those persons will be considered eligible persons.
- d. **You agree** to remit any premium for stop loss, life or other insured contracts by the twentieth (20th) of each month and understand we do not advance premiums in your behalf.
- e. **You agree** that if we or any of our agents or employees are subject to any fine, penalty, loss, damage, cost, expense or legal fee because of our administration of the Plan in good faith according to the terms of the Plan document, you will pay or reimburse us for any such fine, penalty, loss, damage, cost, expense or legal fee. In the event current revenues are inadequate to fund the obligation at the time it is determined, you agree to take the appropriate budgetary action sufficient to pay the obligation.
- f. **You agree** to pay us a monthly service charge determined by multiplying the Monthly Service Charge shown in the Schedule of this Agreement by the number of employees covered under the Plan as of the first day of each calendar month commencing on the Effective Date of this Agreement. Payment shall be due as of the first day of each calendar month and shall be payable no later than the thirtieth (30th) of the month or the last day of the month.
- g. **You agree** to act on all benefit appeals in accordance with the provisions outlined by the Plan.
- h. **You agree** that if a payment is made to or on behalf of an ineligible person or if an overpayment is made to a covered person, the Group Benefits Administrator shall attempt, with full cooperation and assistance of the Employer, to recover such payment through reimbursement or from future benefits that become due to such person or entity. The Group Benefits Administrator shall not be responsible for any such payment or overpayment unless it was due to gross negligence of the Group Benefits Administrator.
- i. **You agree** to become a member of the TML MultiState Intergovernmental Employee Benefits Pool and to be bound by the terms of the TML MultiState Intergovernmental Employee Benefits Pool Interlocal Agreement.
- j. **You agree** to assume responsibility for providing to each employee the proper information required for the employee's federal income tax return, including but not limited to any W-2 or 1099 forms.

III. DURATION OF AGREEMENT

This agreement shall take effect on the effective date and shall automatically be renewed for a successive twelve (12) month period unless terminated by either party as set forth in Section IV. Modification of the agreement is acceptable as outlined in Section V.

IV. TERMINATION OF AGREEMENT

- a. **You can terminate** this Agreement by giving us written notice of your intent to do so, at least 31 days prior to the termination date.
- b. **We can terminate this Agreement:**
 - (i) immediately, by written notice to you, if you fail to maintain the bank account required by the Plan, fail to pay our charges when due, or in any other way fail to perform your duties under the Agreement;
 - (ii) 31 days after giving you written notice of our intent to do so.
- c. **You agree** to pay us for any outstanding charges by the last day of the month of your receipt of our bill. If you do not pay such charges by the end of the month, you will also pay us for any attorney's fees or other collection fees we incur, plus the maximum interest allowed by law.
- d. **We will have no further obligation** to process claims after the date this Agreement terminates.

V. MODIFICATION OF AGREEMENT

- a. If you and we agree on the terms of the modifications, this Agreement can be modified at any time.
 - (i) We can change any of the charges shown in the Schedule 31 days after giving you written notice of our intent to do so. Such written notice shall supersede the applicable items(s) in the schedule and any prior such notice(s). However, no such change shall take effect sooner than the first anniversary of the Effective Date shown in the schedule.

VI. DISCLAIMER

We act only as a provider of services to your Plan. We do not insure your Plan in any way. We are not a fiduciary.

This Agreement is made binding by the signature of your and our representatives who are duly authorized to enter into such agreements.

TML MultiState IEBP

Susan L. Smith

Print name


Signature

Executive Director

Title

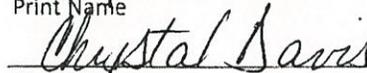
12.15.14

Date

City of Carrollton

Crystal Davis

Print Name


Signature

Workforce Services Director

Title

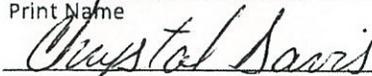
11/20/14

Date

Please Identify the Person that Maintains Plan Document Administrative exception Authority

Crystal Davis

Print Name


Signature

Workforce Services Director

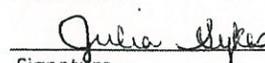
Title

11/26/14

Date

Julia Sykes

Print Name


Signature

Benefit Coordinator

Title

11/26/14

Date

EMPLOYER: City of Carrollton
EFFECTIVE DATE: January 1, 2015

Pursuant to Section 252.021 of the Local Government Code. The TML MultiState Intergovernmental Employee Benefits Pool will procure the coverage indicated below on behalf of said employer.

- | Yes | No | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Stop Loss Coverage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Life & Accidental Death and Dismemberment Coverage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Long Term Disability |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Short Term Disability |

NEWSPAPER OF RECORD: _____

AUTHORIZED OFFICIAL: Crystal Davis
TITLE: Workforce Services Director
DATE: 11/26/14

ADDENDUM A

REASONABLE AND CUSTOMARY

EMPLOYER: City of Carrollton

EFFECTIVE DATE: January 1, 2015

The undersigned employer has chosen the following percentile/RBRVS to be used for determining Reasonable and Customary charges.

- Medical**
- 90TH
- 85TH
- 80TH
- 70TH
- 60TH
- 50TH

- Dental**
- 90TH
- 85TH
- 80TH
- 70TH
- 60TH
- 50TH

MDR Table: Indemnity MDR Table or PPN/HMP Out of Network MDR Table

OR

Medical
 110% RBRVS

RBRVS Fee Schedule: Indemnity Table or PPN/HMP Out of Network RBRVS Fee Schedule

The Undersigned Employer has given consent to implement the external audit results for the Preferred Provider Network and Non Network claims that are not paid per a Fixed Fee schedule. External audits are implemented for claims that are not repriced under a United Healthcare network contract.

MANAGEMENT PROGRAM	CLAIM THRESHOLD	FEE
Audit – Network Inpatient	≥ \$20,000	1.5 % of Elig charges not to exceed \$5,000
Audit – Non Network Inpatient	≥ \$20,000	1.5 % of Elig charges not to exceed \$5,000
Audit – Network Outpatient	≥ \$15,000	1.5 % of Elig charges not to exceed \$5,000
Audit – Non Network Outpatient	≥ \$15,000	1.5 % of Elig charges not to exceed \$5,000
Facility UCR – Non Network	≥\$500 and ≤ \$15,000	10% of savings not to exceed \$5,000 per patient per treatment episode/per calendar year
Facility UCR – Non Network for End Stage Renal Disease	Any Amount	10% of savings not to exceed \$5,000 per patient per treatment episode/per calendar year

Please list any variance on the above thresholds: NONE

AUTHORIZED OFFICIAL:

Crystal Davis

TITLE:

Workforce Services Director

DATE:

11/26/14

**GROUP BENEFITS SERVICES AGREEMENT
NON-PARTICIPATING**

TML MULTISTATE INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL

CHECK STATUS INQUIRY / STOP PAYMENT

EMPLOYER: City of Carrollton

EFFECTIVE DATE: January 1, 2015

The undersigned employer has chosen the following option in which to charge the \$25 per check inquiry fee.

- No – Does not want to charge
- Yes – All provider and enrollee checks
- Yes – Only provider checks
- Yes – Only enrollee checks

AUTHORIZED OFFICIAL:

Crystal Davis

TITLE:

Workforce Services Director

DATE:

11/26/14



AUTO AUDIT CLAIMS SCREENING RECOMMENDATIONS

The following is a list of Edits the Auto Audit program utilizes for the screening of claims based on designated setup of front end or back end screening:

Front	Back
End	End

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #01 - OBSOLETE CODES</u>
Identifies obsolete procedure codes for the billed date of service. Auto Audit substitutes a more appropriate code for the obsolete code if one is available. All obsolete code effective dates can be customized to meet specific client update needs. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #02 - EXPERIMENTAL PROCEDURES</u>
Identifies procedures that the industry considers to be experimental or investigatory. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #03 - DISCRETIONARY/COSMETIC PROCEDURES</u>
Identifies procedure codes to be cosmetic or discretionary. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #04 - APPROPRIATE USE OF MODIFIERS</u>
Identifies procedure and modifier combinations that are billed inappropriately. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #05 - SEPARATE PROCEDURES</u>
Identifies procedures considered being included in the major procedure. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #06 - ASSISTANT SURGERY</u>
Identifies procedures that do not warrant payment for assistant surgeon involvement. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #07 - OBSTETRICAL GLOBAL FEE</u>
Identifies separately billed visits and services. Any visit not associated with the pregnancy would be allowed. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #08 - SURGICAL GLOBAL FEE</u>
Identifies separately billed office visits, consults or other procedures occurring within a set time period before and/or after a surgical procedure. Visits and procedures unrelated to the surgical procedure are allowed. The client has the ability to select Medicare guidelines or industry standard guidelines. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #09 - NEW PATIENT CODE</u>
Identifies billing of more than one new patient procedure code for the same patient/provider. A more appropriate (established patient) procedure code is recommended. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #10 - INPATIENT IHM/DISCHARGE CODE</u>
Identifies a physician billing for more than one initial IHM code or discharge visit for the same patient for the same hospitalization. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #11 - ICU VISIT FREQUENCY</u>
Identifies a physician billing more than two-hour visits for the same patient on the same date of service. |

- | | | |
|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #12 - IHM VISIT FREQUENCY</u>
Identifies when more than one physician bills for the same date of service for the same patient, and each is billing for a condition with the same body system. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>RULE #13 - PHYSICIAN VISIT FREQUENCY</u>
Occurs when a physician bills for multiple visits for the same patient for the same date of service with a related diagnosis. (This rule is turned off) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #14 - REPEAT PROCEDURES</u>
Identifies repeat procedures occurring within 3 days, or the time period customized by the client. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE# 15-PROFESSIONAL COMPONENT ALLOWANCE</u>
Identifies records whenever modifier-26 is used designating that the physician is billing for the professional component of a procedure only. The corresponding technical component is then reduced, so the total does not exceed the maximum allowed. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #17 - MUTUALLY EXCLUSIVE PROCEDURES</u>
Identifies procedures that are "mutually exclusive" (cannot be performed together on the same day of service), and denies the procedure of lesser value. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>RULE #18 - POST-OP CARE, RULE #19 - PRE-OP CARE</u>
Identifies visits billed by a non-operative physician within the global period of surgery. Visits unrelated to the surgical procedure are allowed. (This rule is turned off) |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #20 - MEDICAL PROTOCOL</u>
Identifies unjustified, frequently billed procedures and reflected by industry standard. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #21 - FRAGMENTED PROCEDURES</u>
Occurs when a physician bills for multiple procedures on the same date of service that are components of a major procedure for which there is a unique procedure code. The fragmented procedures are rebundled into the appropriate major procedure code. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #22 - SECONDARY PROCEDURE MANAGEMENT</u>
Identifies multiple procedures that qualify for payment. The procedures of highest value are paid in full, and up to four additional procedures are allowed at 50 percent, for customized by the client. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <u>RULE #23 - BILATERAL PROCEDURE MANAGEMENT</u>
Allows up to 150 per cent of the fee schedule for that procedure or as customized by the client. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #24 - UTILIZATION REVIEW</u>
Identifies procedures associated with upcoding, questionable appropriateness, not warranted by the patient's condition, or that are inherently vague. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>RULE #25 - CASE MANAGEMENT</u>
<u>Identifies specific procedures or diagnosis that may have a potential catastrophic impact.</u>
(This rule is turned off) |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>RULE 26-ASSISTANT SURGERY ALLOWANCE</u>
Payment is reduced to not exceed 25 percent of the fee schedule allowed for that procedure, or as customized by the client. (This rule is turned off) |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RULE #27 - CHEMISTRY LAB UNBUNDLED</u>
Identifies billing for more than one chemistry procedure code, and bundles them into the appropriate chemistry panel. |

- | | | |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE 28-MAXIMUM FEE ALLOWANCE</u>
Reduces payment to the maximum allowed for that procedure. (This rule is turned off) |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> X | <u>RULE #32 - NON-COVERED BENEFITS OR INVALID CODES</u>
Identifies procedures that are not a covered benefit. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> X | <u>RULE #33 - MULTIPLE DISALLOWED PROCEDURES</u>
Identifies duplicate procedure codes for the same patient on the same date of service, billed by the same physician. |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE #34 - DUPLICATE PROCEDURES</u>
Identifies duplicate procedure codes for the same patient on the same date of service, billed by the same physician. (This rule is turned off) |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE #35-MANDATORY OUTPATIENT PROCEDURES</u>
Identifies procedures bulled with an inpatient location that should have been per formed in the ambulatory setting. (This rule is turned off) |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE #36 - POTENTIAL COORDINATION OF BENEFITS</u>
Identifies claims with diagnosis codes, potentially indicative of motor vehicle accidents or workers compensation. (This rule is turned off) |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> X | <u>RULE #37 - OFFICE VISIT UPCODING</u>
Occurs when a physician bills for an extensive or comprehensive office visit that is in excess of the expected frequency for that diagnosis. |
| <input checked="" type="checkbox"/> X | <input type="checkbox"/> | <u>RULE #38 - INAPPROPRIATE CODES</u>
Identifies procedure codes that are not appropriate for a patient’s gender or age and diagnosis codes that are not appropriate for a patient’s gender. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> X | <u>RULE #39 - SENTINEL EVENTS</u>
Identifies events indicative of a possible quality of care issue. |
| <input checked="" type="checkbox"/> X | <input type="checkbox"/> | <u>RULE #40 - PROVIDER CUSTOMIZATION</u>
Allows the client to identify specific providers or specialties billing targeted procedures and/or diagnosis. |
| <input checked="" type="checkbox"/> X | <input type="checkbox"/> | <u>RULE #41 - PROCEDURE AND DIAGNOSIS CODE COMPATIBILITY</u>
Identifies inappropriate diagnosis/procedure code combinations. |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE #42 - PRE-EXISTING CONDITIONS</u>
Identifies records with “targeted” diagnosis codes that may be indicative of chronic conditions. (This edit is turned off) |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <u>RULE #43 - SECOND SURGICAL OPINION</u>
Identifies a procedure that has not had a required second surgical opinion. (This rule is turned off) |



ICES CLAIMS SCREENING PROCESSING RULES

POLICY

Claims Edit System is an automated, clinically derived editing and repricing tool that automatically reviews claims for coding accuracy and appropriateness prior to a claim being paid. iCES KnowledgeBase edit tables interact to deliver 3.5+ million rules and relationships between different codes and other parameters.

The following is a summary of policies established from edits the iCES program utilizes for the screening of claims:

Add-on: This edit identifies reimbursement for physician claims submitted with add-on codes when billed in conjunction with primary procedures.

After Hours and Weekend Care: This edit identifies reimbursement for services provided outside of, (or which are disruptive of) normal posted office hours with scheduled staff.

Anesthesia: This edit identifies reimbursable anesthesia services outlined in three categories: anesthesia delivery, pain management and labor/delivery services.

Assistant Surgeon: This edit identifies services provided by assistant surgeons that are reimbursable services and the method for determining reimbursement amounts for assistant surgeon services.

B Bundle Codes: This edit identifies reimbursement of status "B" codes found on the National Physician Fee Schedule (NPFSS).

Bilateral Procedures: This edit identifies bilateral procedures and the application of multiple procedure reductions.

Care Plan Oversight: This edit identifies appropriate reimbursement for care plan oversight services reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services determined by complexity and approximate time spent by the physician or other health care professional within a 30 day period.

CCI Editing: This policy describes how United Healthcare applies National Correct Coding Initiative (NCCI) edits not otherwise addressed in other iCES reimbursement policies.

Contrast and Radiopharmaceuticals Materials Policy: This policy describes reimbursement for high and low osmolar contrast and radiopharmaceutical materials.

Co-surgeon/Team Surgeon: This edit identifies the method of reimbursement for co-surgeons (-62 modifier) and team surgeons (-66 modifier), and describes the circumstances under which assistant surgeon services are reimbursable services in conjunction with services provided by a co-surgeon.

Discontinued Procedure Policy: This edit discusses reimbursement for claims submitted with modifier 53.

Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy: This edit describes the appropriate billing guidelines for reporting HCPCS codes with modifiers to indicate rental, purchase and maintenance and service of equipment. In addition, it addresses the frequency limitations concerning the rental, rental to purchase and maintenance and service of this equipment.

From and To Days: This edit provides appropriate procedure for reporting identical services performed on consecutive days.

Global Days: This edit identifies the global period of a procedure, and the reimbursement for Evaluation and Management (E/M) or other related services performed by a physician. (Effective Feb 2008, UHO claims are held to the Auto Audit Surgical Global Edit – 08 in place of iCES edits)

Increased Procedure Services (formerly Unusual Services): This edit identifies appropriate reimbursement for claims submitted with a –22 modifier (unusual procedural services) or a –63 modifier (procedure performed on infants less than 4kg), but does not describe reimbursement for use of the –22 modifier in connection with anesthesia delivery services (see instead, the Anesthesia Policy).

Injection and Infusion Services (formerly Therapeutic and Diagnostic Injection Policy): This edit identifies appropriate reimbursement for therapeutic and diagnostic injection services other than chemotherapy, allergy and clinical immunology, and immunizations, which are not addressed by this policy. This policy does not apply to DME and home health care/home health agencies.

Initial Inpatient Consultation: This edit identifies appropriate reimbursement for initial inpatient consultation services.

Interventional Radiology: This edit identifies reimbursement for interventional radiology procedures. This policy does not apply to anesthesiologists or CRNAs.

Laboratory Rebundling: This edit identifies appropriate reimbursement of laboratory panel and component codes.

Maximum Frequency Per Day: This edit identifies appropriate reimbursement for physician claims submitted with multiple units for the same CPT or HCPCS code on the same date of service.

Microsurgery: This edit identifies the code ranges allowed for separate reimbursement for microsurgical technique.

Moderate Sedation: This edit identifies appropriate reimbursement for moderate (conscious) sedation procedures.

Modifier Reference: This edit provides reference to the modifiers in United Healthcare (UHC) reimbursement policies.

Multiple Procedures: This edit identifies appropriate reimbursement related to multiple procedure reduction percentages, which CPT and HCPCS codes are subject to multiple procedure reductions, and the methods by which procedures are determined to be primary versus secondary or subsequent.

New Patient Visit: This edit identifies the appropriate use of new office/outpatient Evaluation and Management (E/M) CPT codes. Home Health Care/Home Health Agencies are excluded from this policy.

Observation Care Evaluation and Management Codes: This policy discusses appropriate coding of Observation care related procedures

Obstetrical: This edit identifies appropriate reimbursement for global and non-global obstetric services. (Effective Feb 2008, UHO claims are held to the Auto Audit Surgical OB Edit – 07 in place of iCES edits)

Once in a Lifetime Procedures: This policy identifies procedures that because of the procedure code description can be performed once in a patient's lifetime.

Physical Medicine & Rehabilitation Maximum Combined Frequency Per Day: This edit identifies appropriate reimbursement for certain timed therapy services provided in an office or outpatient setting.

Physical Medicine & Rehabilitation PT, OT and Evaluation & Management Services: This edit identifies appropriate reimbursement for physical and occupational evaluations.

Physical Medicine & Rehabilitation Speech Therapy: This edit identifies eligible and non-eligible speech therapy related procedures.

Preventive Medicine and Screening: This edit identifies appropriate reimbursement for Preventive Medicine Services performed on the same day as an Evaluation and Management (E/M) service.

Professional/Technical Component: This edit identifies the professional and technical components of a global procedure code.

Prolonged Services: This edit identifies appropriate reimbursement of prolonged physician services involving direct (face-to-face) patient contact that are beyond the usual service in either the inpatient or outpatient setting.

Radiology Multiple Imaging Reduction: This policy describes reimbursement related to multiple imaging reduction percentages, which CPT and HCPCS codes are subject to multiple imaging reductions, and the method by which procedures are determined to be primary versus secondary or subsequent. This policy will only apply to claims submitted on CMS-1500 claim forms or its electronic equivalent.

Rebundling: This edit identifies appropriate coding relationships through rebundling.

Reduced Service: This edit identifies appropriate reimbursement for claims submitted with a -52 modifier (reduced services).

Registered Dietitians and Home Health Specialties Billing Evaluation and Management Codes: This edit describes the correct coding methodology for reporting of services performed by Registered Dietitians and Home Health Specialties.

Robotic Assisted Surgery: This policy described reimbursement for physician claims submitted for surgical techniques requiring the use of a robotic surgical system.

Same Day/Same Service: This edit identifies appropriate reimbursement for multiple Evaluation and Management (E/M) services performed on the same date of service for the same patient.

Split Surgical Package: This policy describes reimbursement for services constituting components of the global surgical package.

Standby Physician: This edit identifies appropriate reimbursement for physician standby services.

Supply: This edit identifies appropriate reimbursement for supplies and surgical trays used in a physician's office.

T Status Codes: This policy describes reimbursement of code with a status of "T" found on the CMS National Physician Fee Schedule.

Telemedicine: This edit identifies appropriate reimbursement for medical services delivered other than in person (such as over the phone, Internet or other communication devices), but does not include care plan oversight services (see instead, the Care Plan Oversight Policy).

Time Span Codes: This policy describes reimbursement methodology for certain procedure codes specific to a time parameter (e.g. weekly, monthly)

Urgent Care Policy: This policy describes reimbursement for services provided in an urgent care center.

Viral Hepatitis Serology Testing: This edit identifies appropriate reimbursement for physicians and other healthcare professionals for viral hepatitis serology testing.

Wrong Surgical or Other Invasive Procedures: This policy is applicable to both facility and professional services and discusses expectations that a provider would waive all costs associated with the wrong surgical or other invasive procedures.

HIPAA PRIVACY AUTHORIZATION SHEET (Changes)

(ASO Members Only)

MEMBER NAME: City of Carrollton _____

FUND CONTACT NAME: January 1, 2015 _____

BUSINESS ASSOCIATE AGREEMENT

HIPAA requires that you have a written agreement with any business associates who create, receive, maintain or transmit protected health information on your behalf. The agreement must include provisions from HIPAA's Privacy and Security Rules that notify the business associate of its obligation to comply with HIPAA's rules on privacy, security and breach notifications.

Have you executed a HIPAA-compliant business associate agreement with any business associate listed below to whom you are giving access to Protected Health Information? Yes No

ACCESS TO PROTECTED HEALTH INFORMATION

Certain employees and business associates will need access to protected health information to administer your employee health plan. TML MultiState IEBP will release protected health information to employees and business associates only if authorized by the above-listed fund contact. All requests to add or remove access to protected health information must be made by the above-listed fund contact and must be made in writing (letter, fax, e-mail).

TML MultiState IEBP has different levels of access to protected health information. These levels are:

- **Full Access:** Gives the authorized employee or business associate access to both individual and group records. The authorized person may access claims, eligibility and medical management information over the phone. Claims and eligibility information also may be accessed through myTML MultiState IEBP, TML MultiState IEBP's interactive web page. The authorized person will have access to the employer section of TML MultiState IEBP's website (www.tmlmultistateiebp.org), including online enrollment. The authorized person will have access to all month-end reports through myTML MultiState IEBP.
- **Claims & Eligibility Only:** Gives the authorized employee or business associate access to individual records. The authorized person may access an individual's claims, eligibility and medical management information over the phone. Individual claims and eligibility information also may be accessed through myTML MultiState IEBP. The authorized person will have access to the employer section of TML MultiState IEBP's website, including online enrollment.
- **Online Enrollment Only:** Gives the authorized employee or business associate access to the employer section of TML MultiState IEBP's website, including online enrollment.
- **Check Register Only:** Gives the authorized employee or business associate access to month-end check registers through myTML MultiState IEBP. The authorized person also may access check register and check tracer information over the phone.

AUTHORIZED INDIVIDUALS

	Delete the Access Indicated Below (check all that apply):	Add the Access Indicated Below (check all that apply):
Name: _____ Phone: _____ E-mail: _____	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only
Name: _____ Phone: _____ E-mail: _____	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only
Name: _____ Phone: _____ E-mail: _____	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only
Name: _____ Phone: _____ E-mail: _____	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only
Name: _____ Phone: _____ E-mail: _____	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only	<input type="checkbox"/> Full Access <input type="checkbox"/> Claims & Eligibility Only <input type="checkbox"/> Online Enrollment Only <input type="checkbox"/> Check Register Only

SECURE FAX

TML MultiState IEBP will fax protected health information only to a secure fax machine. A secure fax machine is accessible only by employees authorized to receive protected health information.

This fax machine is secure and may be used to receive protected health information: 972-466-4789

Fund Contact's Signature

Date

Please return to:

Marjorie Jane Wilkes, Privacy & Security Officer
 TML MultiState Intergovernmental Employee Benefits Pool
 1821 Rutherford Lane, Suite #300
 Austin, TX 78754-5151
 (800) 348-7879, ext. 6504
 secure fax: (512) 719-6509
 marjorie.wilkes@tmliebp.org

City of Carrollton

PHI Access as of 11/15/2014

FULL ACCESS:

Lesley "Erin" Rinehart (nee Kasal), Assistant City Manager

Chrystal Davis, Director of Workforce Services

Julia Sykes, Benefits Coordinator

Anna Velarde

Brenda Olinger

Jarrad Wills (Holmes & Murphy)

CHECK REGISTER ONLY:

Thinh Nguyen (Check Register Only)

Diana Salas (Check Register Only, diana.salas@cityofcarrollton.com)

BUSINESS ASSOCIATES:

Holmes & Murphy (consultant)

Marathon Health, Inc. "Marathon Clinic"

SECURE FAX:

(972) 466-4789