Provider Manual CY2027

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Introducing Provider Partners Health Plans (HMO I-SNP)

Provider Partners Health Plans will also be referred to as Provider Partners throughout this document.

We are delighted to have you on board as a participating provider in our Special Needs Plans (SNP). Provider Partners Health Plans takes a different approach to caring for residents of nursing homes, skilled nursing facilities, assisted living facilities, and other long-term care facilities. Our team includes a group of experienced clinicians, physicians, hospitals, and other providers to improve care and outcomes for our members.

Provider Partners Health Plans offers the following Medicare Advantage plans designed to improve care for Medicare beneficiaries:

- **Institutional Special Needs Plan** (I-SNP): individuals with Medicare living in contracted long-term care facilities.
- **Institutional Equivalent Special Needs Plan** (IE-SNP): individuals with Medicare who reside at home, Assisted Living Facilities, or personal care homes, and the state in which they reside has certified that they need the type of care that is usually provided in a nursing home.

Provider Partners is currently offering plans in the service areas below for 2027.

Our service area includes the following counties in **Illinois (IL)**: Cook, DuPage, Kane, Lake, McHenry, Ogle, Will, and Winnebago.

Our service area includes the following counties in **Indiana (IN)**: Allen, Bartholomew, Boone, Brown, Carroll, Cass, Clark, Crawford, Daviess, DeKalb, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Fulton, Gibson, Grant, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jefferson, Johnson, Knox, Kosciusko, La Porte, Lake, Lawrence, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Noble, Orange, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Scott, Shelby, Spencer, St. Joseph, Starke, Switzerland, Tippecanoe, Tipton, Vanderburgh, Vermillion, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, and Whitley.

Our service area includes the following counties in **Missouri (MO)**: Audrain, Barry, Boone, Butler, Caldwell, Callaway, Camden, Carroll, Cedar, Chariton, Christian, Clay, Cole, Crawford, Dade, Dallas, DeKalb, Douglas, Franklin, Greene, Henry, Hickory, Howard, Iron, Jackson, Jasper, Jefferson, Laclede, Lafayette, Lawrence, Lincoln, Livingston, Madison, Maries, McDonald, Miller, Moniteau, Montgomery, New Madrid, Phelps, Platte, Polk, Ray, Reynolds, Ripley, Saline, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Stoddard, Stone, Taney, Warren, Washington, Webster, and Wright.

Our service area includes the following counties in **North Carolina (NC)**: Cabarrus, Catawba, Davidson, Davie, Forsyth, Gaston, Guilford, Lincoln, Mecklenburg, Mitchell, New Hanover, Pender, Union, and Wilkes.

Our service area includes the following counties in **Pennsylvania (PA)**: Allegheny, Armstrong, Beaver, Bucks, Butler, Cambria, Chester, Crawford, Delaware, Fayette, Greene, Lancaster, Lawrence, Mercer, Montgomery, Philadelphia, Somerset, and Westmoreland.

Our service area includes the following counties in **Texas (TX)**: Anderson, Angelina, Bandera, Bexar, Brazos, Brown, Burleson, Burnet, Caldwell, Chambers, Cherokee, Collin, Collingsworth, Colorado, Comanche, Concho, Cooke, Dallas, DeWitt, Delta, Denton, Ector, El Paso, Falls, Fannin, Fort Bend,

Freestone, Garza, Goliad, Gray, Gregg, Grimes, Guadalupe, Hall, Hardin, Harris, Harrison, Henderson, Hood, Hopkins, Howard, Hutchinson, Jackson, Jasper, Jefferson, Jim Wells, Karnes, Kaufman, Lampasas, Limestone, Lubbock, Madison, Matagorda, Maverick, McLennan, Medina, Milam, Moore, Nacogdoches, Navarro, Orange, Palo Pinto, Parker, Potter, Randall, Refugio, Robertson, Rockwall, Runnels, San Saba, Smith, Somervell, Tarrant, Titus, Tom Green, Travis, Trinity, Tyler, Upshur, Uvalde, Van Zandt, Victoria, Washington, Williamson, Wise, and Young.

Model of Care

The Centers for Medicare & Medicaid Services (CMS) mandates that all Medicare Advantage Special Needs Plans (SNPs) create and execute a Model of Care (MOC). This model outlines the approach the plan will take in delivering specialized care to its enrollees.

- MOCs are narrative documents developed by the plan that must be submitted for CMS approval.
- SNPs will undergo audits based on the processes and commitments specified in their MOCs filed with CMS.

Our MOC ensures early diagnosis and intervention by the Nurse Practitioner (NP) and/or Primary Care Physician (PCP). It encourages improved communication between providers, members, their families, if desired, and facility staff. Enhanced communication will guarantee that each member receives the appropriate services they need. Care coordination is essential to our Model of Care (MOC). This strategy is founded on the belief that a personalized, closely monitored, and well-coordinated level of care can minimize fragmentation and improve overall well-being.

As a result, Provider Partners MOC is built upon the following essential principles:

- Nurse Practitioners (NPs) orchestrate and deliver care to members residing in-network residential care facilities, focusing on the psychosocial well-being, and maintaining optimal functioning of each member.
- Clinicians assess the complete spectrum of a member’s physical, social, and psychological needs.
- Plan providers possess experience or advanced education in geriatric medicine, specifically aimed at caring for frail elderly and disabled individuals.
- The MOC reduces unnecessary transfers of members by providing care directly at their place of residence, facilitated by NPs, Primary Care Providers (PCPs), or other in-house providers.
- Clinicians place a strong emphasis on preventive care by working closely with facility staff and providers. This collaboration ensures regular assessments and the early identification of members’ needs and concerns.
- Care teams advocate for patients and assist in maximizing the available benefits for them.
- Families and responsible parties are encouraged to participate in the care of members.

In accordance with CMS and MOC requirements, all Special Needs Plan (SNP) members are mandated to have had a comprehensive Health Risk Assessment (HRA) within 90 days of enrolling in the plan, with subsequent assessments required at least annually. Based on the individual needs identified in the HRA, a personalized care plan will be developed and implemented for each member. The HRA identifies members’ risk levels (high or low), which dictates their visit schedule with Provider Partners' clinical staff. In the I-SNP Advantage plan, high-risk members are visited bi-monthly, while all members

receive monthly assessments. In the IE-SNP Community and Essential plans, high-risk members are seen monthly, and all members are assessed at least quarterly. In the event the member has a change of care (transition to hospital), they will also be seen, and their care plan will be updated.

Each member will have an Interdisciplinary Care Team (ICT) to oversee their care plan. The composition of the ICT is based on member needs, but at a minimum, each member's ICT includes the NP, Registered Nurse Care Coordinator (RNCC), member or responsible party, facility staff, and the PCP.

The NP and RNCC coordinate communication among ICT members and may identify and communicate with additional participants to support the member's care plan.

Provider Partners supports members through care transitions (e.g., hospitalizations, transitions from facility to facility, etc.), including providing a single point of contact (the NP) to maintain continuity of care. If needed, the Provider Partners care team can contact the member's family/responsible party when these transitions occur.

When the member returns to the facility after hospitalization, the NP will conduct a post-discharge assessment and medication reconciliation within two business days, update the care plan, and make the ICT aware.

Provider Partners MOC is evaluated on an ongoing basis as part of Provider Partners' overall Quality Improvement (QI) Program. Multiple metrics are collected and analyzed to determine how the MOC is performing, which include, but are not limited to, care coordination and compliance-related process measures (e.g., annual HRA completion, timely post-hospitalization NP visits, etc.), HEDIS® measures, and utilization measures such as admissions and readmissions. Results are reported to the Quality Improvement Committee (QIC), to which the Board of Directors delegates oversight of the QI Program and the MOC. The MOC is formally evaluated on at least an annual basis.

The MOC's care coordination and quality improvement processes are supported by Provider Partners operations, administrative, IT, analytics, compliance, customer service, and provider network infrastructure.

Provider Partners is required to offer MOC training to network providers upon initial contracting and at least annually thereafter. Provider Partners must also offer training to non-contracted providers who see Provider Partners members routinely. Provider MOC training can be found at the following link for all plans: https://www.pphealthplan.com/model-of-care-provider-training/.

The Role of the Primary Care Physician

The following specialties are considered (but not limited to) PCPs:

- Family practice
- General practice
- Geriatrics
- Internal medicine

All Provider Partners members may select a PCP. If the member does not select a PCP, one will be assigned based on the member's geographic area and/or nursing facility of residence.

The scope of services to be provided by the PCP may include, but is not limited to, the following:

- Diagnostic testing and treatment

- Injections and injectable substances
- Office or nursing facility visits for illness, injury, and prevention

The PCP has the primary responsibility for coordinating the members' overall healthcare among the members' various healthcare providers. The PCP works closely with the Provider Partners Nurse Practitioner to reduce fragmented, redundant, or unnecessary services and provide the most cost-effective care. Provider Partners monitors referrals to promote the use of network providers, analyze referral patterns, and assess medical necessity.

PCPs, as well as all other providers, are expected to:

- Maintain high quality
- Provide the appropriate level of care
- Use healthcare resources efficiently
- Be active participants in members' ICTs as requested by the NP or RNCC

The Role of the Nurse Practitioner

The Nurse Practitioner (NP) is responsible for providing clinical care to members, conducting Health Risk Assessments (HRAs) and interim evaluations alongside Registered Nurse Care Coordinators (RNCCs). In collaboration with physicians, nursing facility administrators, staff, members, their families, and/or responsible parties, NPs focus on treating the "whole person" through their care plan rather than solely addressing the member's disease or illness.

Regular Facility Visits and Care Coordination

During NP visits, they monitor any changes in the member's health status, emphasize early diagnosis and intervention, and coordinate communication among all relevant practitioners and family members.

Personalized Care Plans

NPs assess, develop, and manage individualized care plans for Provider Partners members. They collaborate closely with nursing facility staff, primary care providers, the members, and their family or responsible party to create a responsive care plan based on the initial HRA. This assessment is conducted upon enrollment and at least annually, unless prompted by a change in the member's health status or condition.

Oversight and Education

The RNCC or NPs complete the HRA and oversee diagnostic services and treatments to ensure parity in medical and mental health care. They guarantee access to comprehensive benefits as needed and provide education on health risks and care to members and their families or responsible parties. NPs coordinate diverse services, facilitate better communication within ICT, and ensure the effective integration of treatments.

The Role of the RN Care Coordinator

The RN Care Coordinator (RNCC) serves as the primary contact for a member's care and acts as the hub for the Integrated Care Team (ICT), fostering collaboration among internal ICT participants, such as the Nurse Practitioner (NP), and external participants, including facility staff and the Primary Care Provider (PCP). Each member is paired with an RNCC, who plays a crucial role in managing the member's medical, cognitive, psychosocial, and functional needs while communicating effectively to coordinate the care plan with the NP, facility staff, PCP, member, and/or family or responsible party, as necessary.

An RNCC from Provider Partners is designated to advocate for members and assist with healthcare-related needs within each nursing facility, serving as an extension of the NP in supporting and coordinating the member's care.

The RNCC is responsible for ensuring the timely and appropriate delivery of services, facilitating smooth transitions, and coordinating prompt follow-up to prevent any lapses in service or care during transitions between settings or providers. Additionally, they conduct chart audits and/or pharmacy reviews to enhance care quality.

The Role of the Specialist

Members can visit in-network specialists with or without a referral from their Primary Care Provider (PCP) or Nurse Practitioner (NP). Additionally, female members have the option to see in-network gynecologists or their PCP for a well-woman exam without needing prior authorization or a referral.

To fully benefit and minimize out-of-pocket expenses, members are encouraged to consult with in-network specialists. If members opt for an out-of-network provider, those services may not be covered. Prior authorization must be obtained before any services are rendered. For inquiries regarding participating network providers, please call the number located on the back of your Member ID card or visit our website www.pphealthplan.com.

Authorizations

Provider Partners requires authorization for certain services and procedures. Providers should fill out the authorization request form provided on the plan website and fax it directly to our Utilization Management (UM) team at 1-844-593-6221. Providers are encouraged to speak with the members' PCP or NP to ensure an appropriate care plan.

CMS Processing Timeframes (Part C):

Type	Processing Period	With Extension
Pre-Service	7 calendar days	21 calendar days
Part B Drug	72 hours	N/A
Expedited: Pre-Service	72 hours	17 calendar days
Expedited: Part B Drug	24 hours	N/A

CMS Processing Timeframes (Part D)

Type	Standard	Expedited
Coverage Determination	72 hours	24 hours

For pre-service authorization requests, Provider Partners is required to deliver an expedited determination when a member or the member's physician indicates that adhering to the standard period may significantly jeopardize the member's life, health, or ability to achieve maximum function. (The physician is not obligated to use the exact wording.)

Medicare Coverage Determination Guidelines, as well as nationally recognized healthcare guidelines (InterQual) and relevant plan policy, are used when reviewing authorization requests. These coverage guidelines are available on the plan's website (https://www.pphealthplan.com/policies/). The plan's Medical Director makes all clinical and out-of-network denial decisions and is available for consultation

with both in-network and out-of-network practitioners. The Medical Director may contact network specialists to assist with the medical necessity determination process.

Authorization requests, including the authorization form and clinical information that supports the request, must be faxed to 1-844-593-6221. Provider Partners will review all requests, and if additional information is needed, clinical UM staff will contact the requesting provider to obtain such documentation.

An approved authorization remains valid for the duration specified in the authorization letter. The provider making the request must utilize the Provider Partners authorization number, as noted on the approval letter, in the designated field of the CMS-1500 claim form.

When there is a denial, the provider will receive a copy of the member's denial letter, which includes clinical criteria utilized by the UM department, next steps, and appeal rights. Authorization requirements may change annually and are posted to the plan's website (https://www.pphealthplan.com/provider-resources/) and notated in the member's Evidence of Coverage. Failure to comply with the plan's prior authorization requirements may result in administrative denial.

Preventive Screenings and Disease Management

The NP visits each member either monthly or quarterly, based on the type of plan they are enrolled in. In addition, Provider Partners requests that each member visit their PCP at least annually and perform a complete medical evaluation addressing the member's specific needs and conducting appropriate preventive screenings.

Preventive guidelines to be addressed include, but are not limited to:

- Screening for colorectal cancer
- Mammography
- Influenza vaccine administration
- Pneumonia vaccine administration

Gaps in member compliance require appropriate intervention to improve and meet recommended goals. Either Provider Partners staff or the members' PCP may provide this intervention.

The following charts list suggested guidelines for providers to follow when ordering preventive tests and treatments for members with chronic conditions.

Prevention Measurements Table

General Preventive Care	
Pneumonia Vaccine	Once per lifetime (age 65 years or older)
Influenza Vaccine	Once every 12 months
Breast Cancer Screening	Once every 12 months
Body Mass Index (BMI)	Once every 12 months
Prostate Cancer Screening	Once every 12 months
Colorectal Cancer Screening: Fecal Occult	Once every 12 months

Chronic Conditions Measurements Table

Diabetes/Obesity:	
Eye Exam	Once every 12 months
HgbA1C	Once every 6 months
Microalbumin	Once every 12 months
CHF:	
Ejection Fraction measurement	Once per lifetime
CAD:	
LDL levels	Once every 12 months

I. Provider Standards and Procedures

Provider Credentialing

Credentialing of providers may be conducted internally by Provider Partners staff or delegated to an external entity. If delegated, Provider Partners will conduct both pre-delegation and annual audits to ensure credentialing standards are maintained throughout the network. The standards below outline the overall approach to credentialing by Provider Partners. The delegated entity's standards may differ slightly. If there are any questions, please contact Network Operations at 1-855-969-5907.

The provider credentialing process involves several steps: application, primary source verification, notification, and a Credentialing Committee review.

Providers who would like to participate in the Provider Partners network should request a Participation Agreement from Network Operations at 1-855-969-5907.

Pursuant to CMS Medicare Advantage provider credentialing requirements under **42 CFR § 422.204**, providers who wish to participate in the Provider Partners network must have a fully executed provider agreement and be successfully credentialed, and/or have completed all applicable delegated credentialing audit and oversight requirements. Providers will not be considered participating or in-network with Provider Partners until all applicable contracting, credentialing, and delegated audit requirements have been completed and approved by Provider Partners.

Once contracted, the provider may submit the CAQH (Council for Affordable Quality Healthcare) provider identification number via email to: pphpprovidernetwork@pphealthplan.com.

Provider Partners follows NCQA (National Committee for Quality Assurance) standards involving credentialing and re-credentialing of providers. Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information to the primary source data. If Provider Partners notes any discrepancies, it

notifies the provider in writing and gives the provider two weeks to forward the correct information to Network Operations.

In addition, a physician has the right to review the information submitted in support of the application. If the physician discovers erroneous information on the application, he or she has an opportunity to correct this information before the Provider Partners Credentialing Committee, or the external vendor reviews it. The physician must update their CAQH profile to reflect the correct information.

Credentialing Committee Review

Completed credentialing files are presented to the Provider Partners Credentialing Committee for review and final decision. Files that do not require committee approval can be reviewed by the Chair of the Credentialing Committee, who may also approve the discussion.

Provider Partners' credentialing staff will send notification letters to providers within 60 days of the credentialing decision.

If a provider is denied credentialing and wishes to appeal the decision, the provider must submit a request in writing to the Manager of Credentialing.

Re-credentialing Process

All physicians must be re-credentialed within three years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except that physicians are also evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but are not limited to, the following:

- Compliance with Provider Partners policies and procedures
- Provider Partners sanctioning related to UM, administrative issues, or quality of care
- Member’s complaints
- Member satisfaction surveys
- Participation in quality improvement activities
- Quality-of-care concerns.

Provider Partners or its designee will query CAQH for a current application for the purposes of re-credentialing six months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to obtain a current CAQH application by the deadline may result in termination from the network.

Malpractice Insurance

Provider Partners requires providers to carry the minimum professional liability insurance. Please refer to your Participation Agreement to verify those amounts.

CMS Preclusion List

The CMS Preclusion List identifies providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished to Medicare Beneficiaries. The Preclusion List was created to ensure patient protection, safety, and to protect Medicare Trust Funds from prescribers and providers identified as bad actors.

Claims with a date of service on or after April 1, 2019, that are submitted by providers and prescribers who are on the CMS Preclusion List will be denied. Precluded providers and prescribers must hold

Provider Partners members harmless from financial liability for services provided on or after the claim denial date. Providers are required to work directly with CMS for any errors or updates to the Preclusion List. There is no opportunity for providers to appeal their precluded status with Provider Partners.

If a provider appears on the Preclusion List, Provider Partners will send the following notifications:

- A letter to the provider notifying them that claims 60 days from the date of service will not be paid, and members are to be held harmless.
- A letter to any member seen by the provider (or assigned to in the event of a PCP) that appeared on the list. The letter indicates that the members must change doctors, and that services will no longer be paid for by the provider on the Preclusion List.
- Providers will also receive notification of the members impacted.

Credentialing Denials and Appeals

Provider Partners will send a letter to providers who have been denied credentialing that includes the following:

- The specific reason for the denial.
- The provider's right to request a hearing.
- A summary of the provider's rights in the hearing.
- The deadline for requesting a hearing.
- The provider has a timeline of 30 days following receipt of the notice in which to submit a request for a hearing.
- Failure to request a hearing within 30 days shall constitute a waiver of the right to a hearing.
- A request for consent to disclose the specifics of the provider's application and all credentialing documentation to be discussed.
- Appropriate requirements specific to the state in which the practice is located.

Upon receipt of the provider's request for a hearing, Provider Partners will notify the provider of the date, time, and place of the hearing.

The provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause of denial. The provider may be represented by legal counsel or another person of the provider's choosing if Provider Partners is informed of such representation at least seven days before the hearing.

There is no appeal process if a provider is denied credentialing based on administrative reasons, such as:

- Network need
- Failure to cooperate with the credentialing or re-credentialing process
- Failure to meet the terms of minimum requirements (e.g., licensure)

Provider Termination

The relationship between a provider and Provider Partners may be severed for several reasons, which may include any of the following:

- Provider is non-compliant with the contractual coverage requirements.

- Provider's license, certification, or registration to provide services in the provider's home state is suspended or revoked.
- Provider makes a misrepresentation with respect to the warranties outlined in the Provider Service Agreement.
- The Office of Inspector General (OIG), Medicare, or Medicaid has sanctioned the provider.

Either Provider Partners or the provider may initiate termination. If a provider began treating a member prior to termination, the provider must continue treatment until the member can be safely transferred to another participating provider without negatively affecting the member's well-being.

The terminating provider will be compensated for this treatment according to the rates agreed to in the provider's contract.

Should the terminating provider note special circumstances involving a member – such as treatment for an acute condition, life-threatening illness, or disability – the provider should ask Provider Partners for permission to continue treating that member. In such cases, Provider Partners will continue to reimburse the provider at the contracted rates.

The provider may not seek payment from the member for any amount for which the member would not be responsible if the provider were still in the Provider Partners network. The provider is to abide by the determination of the applicable grievance and appeals procedures and other relevant terms of the provider's contractual agreement.

When the Credentialing Committee decides to terminate a provider's agreement or impose a corrective action that will result in a report to the National Practitioner Data Bank and/or applicable state licensing agency, the Credentialing Department shall promptly notify the affected provider.

Such notice shall:

- State the specific reason for the termination or corrective action.
- Inform the provider that he/she has the right to request a hearing.
- Contain a summary of the provider's right in the hearing under this policy.
- Inform the provider that he/she has 30 days following receipt of the notice within which to submit a request for a hearing.
- State that failure to request a hearing within the specified time shall constitute a waiver of the right to a hearing.
- State that upon receipt of the hearing request, the provider will be notified of the date, time, and place of the hearing.
- Allow the provider to be represented by an attorney or another person of his/her choice.

A provider shall have 30 days following receipt of notice to file a written request for a hearing. Requests shall be hand-delivered or sent by certified mail, return receipt requested, to the chairperson of the Credentialing Committee. If such a hearing is requested, the Credentialing Committee shall follow the steps as defined by the Credentialing Department's policies and procedures. Copies of such policies and procedures are available upon request.

A provider who fails to request a hearing within the time and in the manner specified in this policy waives any right to a hearing. Such a waiver shall constitute acceptance of the action, which then becomes the final decision of the Credentialing Committee and is not subject to appeal.

As indicated in their contracts, providers must give written notice to Provider Partners before voluntarily leaving the network. Providers also must supply copies of medical records and facilitate a member's transfer of care upon request by Provider Partners or the member.

For terminations initiated by PCPs, Provider Partners will notify affected members in writing and ask them to select a new PCP. If a member does not select a PCP, Provider Partners will assign a PCP before the provider's effective date of termination. PCPs must continue to provide care for 90 days following termination.

For terminations by specialists, Provider Partners will notify all members who have visited the specialist in the past 90 days. This notification will alert the members of the provider's forthcoming termination and allow for transition of care to another in-network provider.

Practice Information

At the time of credentialing, re-credentialing, and directory printing, Provider Partners will verify important demographic details about a provider's practice to help ensure the accuracy of information such as claims payments and provider directories. Provider Partners will also verify if providers are accepting new members to comply with all CMS requirements.

Providers should notify Provider Partners of any changes in practice information 60 days before the effective date of the change to avoid improper claims payment and incorrect directory information.

All in-network providers must have the hours of operation clearly posted in their offices.

Office Requirements

Providers are to bill Provider Partners for all services performed in their offices or at the nursing facilities for assigned members. The services should be within the standard practices of the provider's license, education, and board certification. However, reimbursement for such services will vary by Provider. Providers should refer to their participation agreement for reimbursement rates and terms.

Provider Partners wants to make sure that all members—including those with limited English proficiency, diverse cultural backgrounds, the homeless, and individuals with physical and mental disabilities—receive healthcare services and assistance with their health plan in a culturally competent manner. Each member is entitled to receive healthcare in a manner that is respectful and consistent with the member's cultural perspective. The goal of this policy is to enhance patient care compliance.

Once cultural expectations and health service needs are determined, providers may be required to supply interpreters to overcome barriers of language and/or understanding. To further promote understanding and support, providers also may be required to supply the members with appropriate educational materials and information about community resources.

For assistance with members requiring culturally competent services, providers may call Provider Services at 1-855-969-5907.

While on vacation or a leave of less than 30 days, a network provider must arrange for coverage by another Provider Partners provider. If a provider goes on leave of 30 days or longer, the provider must notify Provider Services at 1-855-969-5907.

If a network provider arranges with either a participating or non-participating physician to cover for his/her patients during an absence, the network provider is responsible for making sure the covering physician will:

- Accept compensation from Provider Partners as full payment for covered services.
- Do not bill the member, except for applicable copayments.
- Obtain approval from the Health Services Department (fax number 1-844-593-6221), as outlined in this manual, before all non-emergency hospitalizations and non-emergency referrals.
- Comply with the rules, protocols, policies, procedures, and programs outlined in this manual.

All network providers are required to provide 24-hour on-call coverage. If a provider delegates this responsibility, the provider covering must participate in the Provider Partners network and be available 24 hours a day, seven days a week.

Accessibility Standards

Provider Partners follows accessibility requirements set forth by applicable regulatory and accrediting agencies. The purpose of these standards is to make sure services are available and accessible to members in a timely fashion. Provider Partners monitors compliance with these standards annually.

Provider Partners sets standards to be met for services within providers' offices. The next table describes sample types of services and the respective standards to be followed:

Primary Care Physician	
Chest pain	Same day
Mild respiratory symptoms >3 days	Next day
Routine physical examination	Within 30 calendar days
Obstetricians-Gynecologists	
Urgent referral	Next day
Non-urgent referral	Within 2 calendar weeks
Well-woman examination	Within 10 calendar weeks
Specialists	
Emergency	Same day
Urgent referral	Next day
Routine referral	Within 30 calendar days

Provider, Member, and Member's Family Satisfaction Surveys

Satisfaction surveys may provide Provider Partners with feedback on performance-related areas, including, but not limited to:

- Access to care and/or services

- Overall satisfaction with Provider Partners
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Member Administration

Contacting Provider Partners Health Plans: 1-800-405-9681
Website: www.pphealthplan.com

Provider Services:

- Phone: 1-855-969-5907 (TTY 711)
- Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M., Monday-Friday from April 1 through September 30.
- Roster updates or contract questions: pphpprovidernetwork@pphealthplan.com

Authorization Department:

- Phone: 1-855-969-5907
- Authorizations Fax: 1-844-593-6221
- Appeals Fax: 1-888-918-2989

Medical Claims submissions:

Mailing Address:

Provider Partners Health Plans
P.O. Box 21063
Eagan, MN 55121

Credentialing:

To request a hearing:

Provider Partners Health Plans
Attn: Provider Relations C/O Provider Partners Health Plans
8820 Columbia 100 Parkway, Suite 430
Columbia, MD 21045

Pharmacy:

Pharmacy Management Department
Email: pharmacysupport@pphealthplan.com

Coverage Determination and Appeals

- Phone: 1-844-368-8732
- Fax: 1-844-403-1028
- Web: https://www.pphealthplan.com/pharmacy-resources/

Fraud Waste & Abuse Hotline:

- Medicare Fraud Hotline: 1-800-447-8477
- Report online: https://tips.oig.hhs.gov/

Member ID Cards

All Provider Partners members are provided with a member ID Card which should be presented at the time of medical services. Refer to the Provider Partners website at www.pphealthplan.com for information about specific benefits, member cost-sharing, and product logos. A copy of each plan's member ID card is shown below.

COPIES OF EACH PLAN'S ID CARDS

Provider Partners Missouri Essential Plan (HMO I- SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: MO3008109
MEMBER: Test10 A Test9
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H9191 005
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners Health Plans
PO Box 21063, Eagan, MN 55121
EDI# 31404
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners North Carolina Advantage Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: NC000005
MEMBER: Test8 Test7
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4439 001
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners
Health Plans
PO Box 21063
Eagan, MN 55121
EDI# 31406
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners North Carolina Community Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: NC000007
MEMBER: Test10 Test9
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4439 002
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners
Health Plans
PO Box 21063
Eagan, MN 55121
EDI# 31406
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners North Carolina Community Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: NC000007
MEMBER: Test10 Test9
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4439 002
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners
Health Plans
PO Box 21063
Eagan, MN 55121
EDI# 31406
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners North Carolina Essential Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: NC000007
MEMBER: Test12 Test11
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4439 003
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners
Health Plans
PO Box 21063
Eagan, MN 55121
EDI# 31406
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners Pennsylvania Advantage Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: PA300007
MEMBER: Test6 S Test5
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4093 001
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners Health Plans
PO Box 21063, Eagan, MN 55121
EDI# 31400
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners Pennsylvania Community Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: PA300008
MEMBER: Test7 J Test6
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4093 004
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners Health Plans
PO Box 21063, Eagan, MN 55121
EDI# 31400
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners Pennsylvania Community Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: PA300008
MEMBER: Test7 J Test6
RxBIN: 610011
RxPCN: CTRXMEDD
RxGRP: PVHMEDD
SAMPLE
Provider Partners. Health Plans
MedicareRx
CMS H4093 004
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners Health Plans
PO Box 21063, Eagan, MN 55121
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Optum Rx
PO Box 650287
Dallas, TX 75265

Provider Partners Pennsylvania Community Plan (HMO I-SNP)
TOLL-FREE 1-800-405-9681 (TTY 711)
HEALTH PLAN (80840)
MEMBER ID: PA300008
MEMBER: Test7 J Test6
RxBIN: 610011
RxPCN: CTRXMEDD
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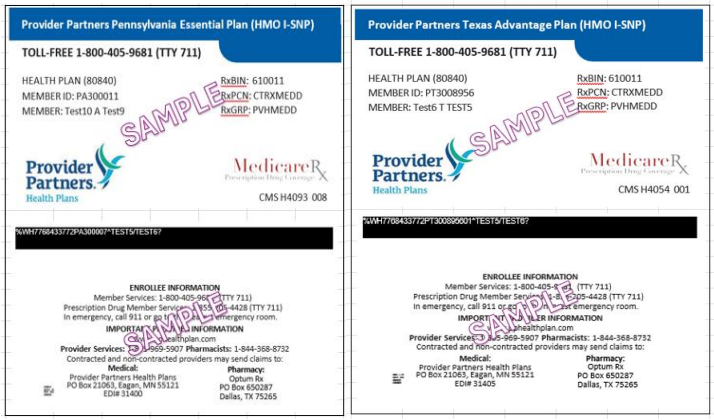
ENROLLEE INFORMATION
Member Services: 1-800-405-9681 (TTY 711)
Prescription Drug Member Services: 1-855-205-4428 (TTY 711)
In emergency, call 911 or go to the nearest emergency room.
IMPORTANT PROVIDER INFORMATION
Provider Services: 1-855-969-5907 Pharmacists: 1-844-368-8732
Contracted and non-contracted providers may send claims to:
Medical:
Provider Partners Health Plans
PO Box 21063, Eagan, MN 55121
EDI# 31400
Pharmacy:
Optum Rx
PO Box 650287
Dallas, TX 75265



Selecting a Primary Care Physician

All Provider Partners members may select a PCP from the list of participating primary care physicians in the Provider Partners Provider Directory. If a member does not select a PCP, Provider Partners will assign a PCP based on geographic access. A PCP is not permitted to refuse services to an eligible member.

Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month.

Verifying Member Eligibility

Possession of an ID card is not a guarantee of eligibility. Providers should photocopy the card and check it for any change of information. Providers should verify members' eligibility before each office visit using the telephone number listed on the back of the member's health plan ID card. This number is 1-855-969-5907.

Member Copayments and Coinsurance

Provider Partners covers the same benefits as Original Medicare, as well as some enhanced services.

For a list of benefits and their respective cost-sharing amounts, go to www.pphealthplan.com for the most recent Summary of Benefits and Evidence of Coverage (EOC).

As an Institutional SNP, some members may be eligible for the cost-sharing benefits each state's Medicaid provides. Generally, this will provide the members with no cost-sharing for covered services provided by in-network providers. Other plan members will have the same cost-sharing expenses as with Original Medicare Part A and Part B, with applicable deductibles, copayments, and coinsurance costs.

Providers are not allowed to charge copayments, coinsurance, or deductible charges that are the responsibility of Provider Partners or each state's Medicaid.

Benefit Exclusions

The following list indicates some, but not all, of the services not covered by Medicare or Provider Partners. Some of these services may be covered by the State Medicaid program. Provider Partners staff will help coordinate benefits and services.

Dental services per plan design	Please refer to the yearly Evidence of Coverage that can be found on our website at www.pphealthplan.com

Foot care, routine	Please refer to the yearly Evidence of Coverage that can be found on our website at www.pphealthplan.com
Durable medical equipment (DME) and medical supplies that do not meet Medicare coverage criteria	Not a covered service
Experimental or investigative procedures	Not a covered service
Eye surgery for refractive defects	Exception: Veterans Affairs hospitals and military treatment facilities are considered for payment according to current legislation.
Government treatment	Exception: Veterans Affairs hospitals and military treatment facilities are considered for payment according to current legislation.
Homemaker services	Not a covered service
Naturopath services	Not a covered service
Obesity treatment	Exception: This exclusion does not apply to surgical obesity treatment if treatment is necessary to treat another life-threatening condition involving obesity, or if providers document that non-surgical obesity treatments have failed.
Orthodontia	Not a covered service
Orthopedic shoes, unless part of a leg brace	Not a covered service unless provided in the treatment of a diabetes-related condition(s) or unless an integral component of a leg brace.
Personal comfort items	Not a covered service
Private duty nursing	Exception: If Provider Partners Health Plans determines that such services are medically necessary before service is rendered
Sex transformation	Not a covered service
Work-related conditions	Not a covered service

Quality Improvement (QI)

Provider Partners QI Program provides oversight, direction, and support as well as implements structures and processes to measure and improve quality of care and services throughout the organization.

Provider Partners' approach to QI is built on a model that involves the entire organization and related operational processes. The QI program incorporates performance results from all clinical and member

services related to Provider Partners departments and encourages providers to participate in QI initiatives.

The QI Program promotes improved member health and satisfaction outcomes and cost-effective care by instilling a discipline of rigorous data collection, goal setting, analysis, intervention implementation, reporting, and accountability, stakeholder communication, and dissemination of best practices related to Provider Partners' clinical and member services functions.

The QI model employs a cycle of continuous improvement and a “Plan-Do-Study-Act” (PDSA) methodology involving identification of key metrics and benchmarks, data collection and analysis, comparison of results against established goals/benchmarks, and implementation of remediation/action plans. Opportunities for improvement are identified through qualitative and quantitative reviews of clinical care and services.

QI is a shared responsibility between Provider Partners, its contracted networks, and other delegated entities. The QI department oversees and assists with many of the activities that support continuous QI, including:

- Reviewing processes to identify QI needs
- Organizing work groups and committees, such as the QIC
- Identifying best practices
- Developing and implementing improvement initiatives
- Collecting data to evaluate the results of the activities and initiatives

HEDIS® results and other department/function-specific metrics as identified in the QI Work Plan serve as ongoing indicators for the QI Program. Examples of these metrics include, but are not limited to, medication adherence measures, preventive screening rates, positive member satisfaction survey responses, vaccination rates, customer service call center average time-to-answer, and network adequacy against CMS time and distance standards.

Participation in the collection, review, and submission of performance data is one means by which Provider Partners evaluate the quality of Member Services, care, and satisfaction.

In addition, Provider Partners is a full participant in CMS-required activities, including, but not limited to, the Chronic Care Improvement Program (CCIP) that targets the improvement of care for members with chronic conditions.

Advance Directives

All healthcare providers who participate in the MA program must offer members written information about their right to make their own healthcare decisions, including the right to accept or refuse medical treatment and the right to execute Advance Directives.

An Advance Directive is a written statement that an individual has established – in advance of serious illness – regarding a medical decision. The Advance Directive must be in accordance with the member’s state regulatory guidelines for it to be considered valid. All adults have the right to create and initiate an Advance Directive.

The two most common forms of advance directives are a living will and a healthcare durable power of attorney.

Living Will – A Living Will goes into effect when your physician decides that you can no longer express your own healthcare decisions and certifies this in writing. It is a written document concerning the kind of medical care a person wants or does not want if he or she is physically or mentally unable to decide.

Healthcare Durable Power of Attorney – A healthcare durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is physically or mentally unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Neither document becomes effective unless the individual is unable to make decisions (as certified by a treating physician). The individual can make changes or revoke the living will or healthcare durable power of attorney at any time. Otherwise, it should remain effective throughout the person's life.

A member who decides to execute a living will or a healthcare durable power of attorney is encouraged to notify their PCP, or treating provider, of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCP or treating provider. If a member is under the care of a provider who is unable to honor the member's Advance Directive, the member may transfer to the care of a provider willing to do so.

Member Appeals

A Level 1 appeal consists of a review of an adverse initial determination, the evidence, and findings upon which it was based, and any other evidence that the parties submit or that is obtained by the plan. The Evidence of Coverage (EOC) is provided to each member and provides detailed instructions on how to file an appeal with the plan related to adverse organization determinations, service (authorization), or payment (claims).

When the plan renders a decision to deny a service or claim, the member and/or provider receive notification and any appeal rights available. Subsequently, if the denial is upheld on appeal, the member's appeal will be forwarded to the Independent Review Entity (IRE) contracted by CMS to conduct Level II appeals.

As defined by CMS, "the parties to an organization determination (Part C) for purposes of an appeal include:

- The enrollee (including his or her representative*).
- An assignee of the enrollee (i.e., a physician or other provider who has provided a service to the enrollee and formerly agrees to waive any right to payment from the enrollee for that service).
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.

*A member may appoint an authorized representative to act on their behalf. To be appointed, both the member and the proposed representative (including attorneys) must sign, date, and complete the Appointment of Representative (AOR) form (CMS1696 form) or an equivalent written notice. The AOR form is available on the CMS website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf. For pre-service authorization requests, a member's treating physician or non-physician provider may file an appeal on the member's behalf without representation documentation. However, Medicare regulations require that the physician notify the member that the appeal is being filed.

A Level 1 appeal must be submitted in writing for a standard request but may be verbally for an expedited request. Member appeal requests must be filed within 65 days from the date of the notice of the initial determination unless good cause can be established.

Level 1 Appeal Adjudication Timeframes:

Plans must authorize or provide the service or benefit as expeditiously as the member's health condition requires, but no later than the time limits listed below (based on when the request was received).

Type	Part C	Part C with Extension	Part D
Standard Request for Item, Service, or Part D Drug	30 days	44 days	7 days*
Standard Part B Drug	7 days	N/A**	N/A
Expedited Reconsideration or Redetermination	72 hours	17 days**	72 hours*
Payment	60 days	N/A	14 days

*Note: Part D redetermination exception requests cannot be tolled for receipt of the prescribing physician's supporting statement.

** Part B drug timeframes cannot be extended.

For pre-service authorization appeal requests, Provider Partners must provide an expedited determination if a member or the member's physician indicates (the physician does not have to use the exact words) that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If a member has already received a service, and the authorization process was not followed, a contracted provider must utilize the "Provider Payment Dispute Resolution Process."

Standard appeals requests must be submitted in writing to:

Provider Partners Health Plans
Attn: Member Appeals
P.O. Box 21063
Eagan, MN 55121

Expedited appeal requests should be faxed to 1-888-918-2989. The CMS member appeals (reconsideration) process includes up to five (5) levels of review.

CMS Timeliness Standards Regarding Member Appeals

CMS regulations require that Provider Partners respond to pre-service standard appeals within 30 calendar days and 60 calendar days for post-service appeals. Therefore, providers must respond to requests for information from Provider Partners within five calendar days so that Provider Partners can obtain all appropriate and complete information to make a timely and fully informed decision. The

deadline for pre-service standard appeals may be extended by 14 calendar days if doing so is in the interest of the members.

Provider Partners must decide on expedited appeal requests within 72 hours of receipt. Providers must respond to Provider Partners requests for information regarding expedited pre-service appeals within 24 hours to ensure timely resolution. The deadline for pre-service expedited appeals may be extended by 14 calendar days if doing so is in the interest of the members.

Expedited appeals should be faxed to 1-888-918-2989.

Post-service (payment) appeals cannot be processed as expedited or extended.

Member Grievances

CMS defines a grievance as "an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken." The member's Evidence of Coverage (EOC) provides details on how to file a grievance with the plan, including those involving a potential quality of care concern expressed by the member. CMS defines a quality-of-care grievance as "related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings."

Members may file a grievance with the plan either orally or in writing, typically no later than 60 days after the incident that precipitates the grievance. The plan will investigate as expeditiously as the case requires, but no later than 30 days unless an extension is made upon receipt of the request, or within 24 hours for expedited grievances.

If a member expresses dissatisfaction to you or your staff, please refer them to their Evidence of Coverage or suggest they call Member Services at 1-800-405-9681.

II. Hospitalization Guidelines

Overview

Provider Partners strives to deliver a coordinated approach to providing care for our members. This coordination is led by the Nurse Practitioner (NP) working in conjunction with the PCP and the member's Interdisciplinary Care Team (ICT). The members' ICT may include community and facility-based providers, as well as the facility staff where the member may reside. It is through this coordinated approach that services are delivered in the most effective and efficient manner. Provider Partners has incorporated certain prior authorization processes, as described in Section I, "Authorizations." Network facilities must be utilized, except for extenuating circumstances. The plan's Model of Care (MOC) emphasizes care in the most clinically appropriate setting to minimize member disruption and the risk of adverse events, such as infections and falls.

Transition Liaison

The NP is the central resource in coordinating transitions of care and ensuring that members are appropriately and successfully transferred from one care setting to another. Most transitions are from the nursing facility to the hospital and back again to the nursing facility.

If a member must be hospitalized and is admitted via the ER, the NP will contact hospital staff to offer an assessment and discuss the member's typical functioning level within two business days. This communication can assist in avoiding unnecessary therapy or care, preventing redundant X-ray or lab tests, and reducing the length of stay.

Provider Partners' goal is to help reduce re-hospitalizations and avoid adverse events during the period of transition. Provider Partners NPs and RNCCs work closely with facility staff and ask to be notified immediately when a transition of care is underway. Furthermore, upon arrival at their assigned facilities, RNCCs conduct rounds and attempt to "lay eyes on" each member, which further enables the identification of hospitalized members, members who have returned to the facility, and members who are at-risk for transition due to a change in condition.

Facility staff are responsible for transferring necessary member information to the hospital, including face sheet, medication list, and Advance Directives including Medical Orders for Life-Sustaining Treatment (MOLST) and Physician Orders for Life-Sustaining Treatment (POLST).

The NP and/or the RNCC follow up regularly with the hospital while the member is admitted.

Elective Admissions

To admit a member for an elective admission, the admitting provider must receive prior authorization from Provider Partners as outlined in Section I, "Authorizations." The admitting provider must work with the plan's Nurse Practitioner and/or the RNCC and the hospital to schedule the admission and any pre-admission testing.

Pre-Admission Diagnostic Testing

Pre-admission diagnostic testing includes:

- Laboratory diagnostic tests
- Radiological diagnostic tests
- Other diagnostic tests, including electrocardiograms, pulmonary function, and neurological function

All pre-admission diagnostic testing conducted before a member's medically necessary surgery or admission to the hospital is covered when performed at an approved facility. Certain procedures require prior authorization.

Emergency Admissions

Provider Partners will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Upon admitting a member from the emergency department, the hospital should collect the following information:

- Member name and Provider Partners ID number

- The name of the member's referring provider (PCP, NP, or the nursing facility), if applicable
- The name of the admitting provider if different from the referring provider or PCP
- Clinical documentation that supports the emergent admission and treatment plan

The hospital must notify the Provider Partners UM Intake department via fax at 1-844-593-6221 within one (1) business day of the emergency admission. The facility staff should notify the Provider Partners Nurse Practitioner (NP) or RNCC immediately when a member experiences a transition of any kind.

Observation Status

Observation status applies to members for whom inpatient hospital admission is being considered but is not certain. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether the member will require further inpatient treatment or if he/she can be discharged from the hospital.

Observation services are commonly ordered for members who present to the emergency department and who then require a significant period of treatment or monitoring **to determine whether the member should be admitted or discharged**. Observation status should be used when:

- The member's condition is expected to be evaluated and/or treated within 24 hours, with follow-up care provided on an outpatient basis, such as in their respective nursing facility.
- The member's condition or diagnosis is not sufficiently clear to allow the member to leave the hospital.

As an Institutional Special Needs Plan (I-SNP), most plan members reside in a facility. The member's care needs, and subsequent care that may be provided at the facility where the member resides should be discussed with the plan's Nurse Practitioner (NP) or RNCC to determine whether continued hospital level of care is required.

The hospital is required to comply with all CMS requirements related to the provision of the "Medicare Outpatient Observation Notice" (MOON).

If a physician decides to admit a member who is in observation status, the facility should notify the Provider Partners UM Intake department via fax at 1-844-593-6221 within one business day of the admission decision.

Admission Review

A request for inpatient authorization will be sent to the Medical Director for review if:

- The request does not appear to meet clinical guidelines and/or
- A member's condition no longer meets the criteria for an extended length of stay/level of care.

Notices of Non-Coverage/Denial

Per CMS requirements, the plan must provide notice when it issues adverse determination. Copies of the forms below are provided to the members, and are housed by Provider Partners:

- Integrated Denial Notice (IDN): Notice of Denial of Medical Coverage/Notice of Denial of Payment (CMS 100003–NDMCP) – Used when the plan denies a request for medical service (such as an authorization request), in whole or in part, or when denying a

member's request for payment of a service already received. The IDN informs the member of the plan's decision rationale and provides relevant appeal rights that may be pursued. If an IDN is issued to a member, the rendering provider also receives a copy for transparency purposes.

- Notice of Medicare Non-Coverage (CMS 10095-NOMNC) – Used when informing members receiving skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services of the termination of services. For providers that offer these services, please refer to your contract, which specifies responsibilities surrounding NOMNC generation and delivery. For providers who are responsible for the process, NOMNCs must meet CMS requirements, and copies must be maintained within the member's file and provided to the plan upon request. The plan maintains the right to audit a provider's NOMNC compliance.

Concurrent Review

Concurrent review is performed to assess the appropriateness of continued inpatient care in a hospital (medical or psychiatric), rehabilitation center, LTAC, or skilled nursing facility.

Concurrent review includes:

- Review of medical necessity and whether care could be provided at a lower level of care, such as a skilled nursing facility or home health.
- Determination of the next review date
- Discharge planning needs

The facility must provide relevant clinical records and the plan of care to the UM Department, as requested, to avoid any unnecessary delays in discharge to the appropriate level of care.

Medicare Coverage Determinations, as well as InterQual® Healthcare Guidelines, are used when coordinating inpatient care. Provider Partners obtains clinical information on inpatient members by coordinating with the utilization review staff at the facility. This may involve reviewing the medical record and/or interviewing attending physicians. Provider Partners will follow the same process as described above for inpatient stays if the services are not approved to facilitate discharge planning. If the services are approved to continue, the UM Intake team will notify the provider by fax or phone.

Transfers

The members' Nurse Practitioner (NP) and/or RNCC will help coordinate the transfer of any Provider Partners member from an in-network hospital to another facility. Every effort should be made to maintain the use of in-network facilities. This helps to ensure a coordinated approach to the management of the members and minimizes member disruption.

Administrative Denials

An administrative denial is issued for those services for which the provider has not followed requirements set forth in their contract or the plan's provider manual. An administrative denial may be issued for failure to follow prior authorization of an elective service, procedure, or admission. It may also be issued for failure to notify the UM Department within one business day of an emergency service, procedure, or admission.

Situations that may result in an administrative denial include:

- Failure to obtain authorization pre-service for an elective service.

- Failure to request authorization within one business day of determining the member has Provider Partners coverage, and extenuating circumstances do not exist.
- Failure to follow the plan's requests for clinical updates related to continuing care, such as SNF services.

In these circumstances, the members have begun or completed service, so they are not involved in an administrative denial, as it is between the plan and a contracted provider. Therefore, any denial notice, including appeal rights, follows the policies as outlined in the Provider Manual and provider dispute (appeal) policy.

Members must be held harmless and cannot be billed for any service except for relevant copayments and/or coinsurances as required by CMS and the provider's contract.

Discharge Planning

The Provider Partners Nurse Practitioner (NP) and/or RNCC works with the hospital staff, the long-term care facility where the member may reside, and internal UM staff to coordinate discharge planning services. Additionally, the plan NP conducts a post-discharge clinical visit, which may include:

- Assessing clinical stability and ordering any new services that may be needed to avoid a readmission
- Medication reconciliation
- Confirmation that follow-up appointments are scheduled
- Care Plan revisions that may be required

Contact the UM department for members who may benefit from discharge planning services, as well as confirming the member's actual discharge date.

Transplant Management

The Provider Partners' care management team helps providers interpret transplant benefits for members and choose a facility from the national transplant network. Each transplant facility is selected based on its level of expertise and standards of care using an established set of criteria.

Transplant coverage includes pre-transplant, transplant, and post-discharge services, as well as the treatment of complications after transplantation. Providers should contact the Provider Partners' UM Intake department via fax at 1-844-593-6221 as soon as they feel transplant services may be necessary and before evaluation for transplant services.

A claim for a transplant may be reviewed for medical necessity to ensure coverage for qualified Medicare benefits.

III. Claims and Reimbursements - Billing Guidelines

Provider Partners Health Plans covers the cost of medically necessary services. Medically necessary services are "health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine," according to the Centers for Medicare & Medicaid Services, or CMS. Provider Partners Health Plans' decisions about medical necessity happen at three levels, based on Medicare guidelines. From most general to most specific:

1. Laws. Federal and state laws can set requirements for what is covered.

2. National coverage determinations, or NCDs. Using a public, evidence-based process, Medicare provides instructions on whether and how a certain item or service is covered for the whole country.
3. Local coverage determinations, or LCDs. If a particular item or service is not included in relevant laws or NCDs, Medicare contracts with local companies that make coverage decisions. LCDs do not apply nationally — they are geographically limited to certain areas according to Medicare's contracts.

Provider Partners Health Plans does not pay for "medically unreasonable and unnecessary services and supplies to diagnose and treat a Medicare patient's condition."

Providers should bill Provider Partners rather than Medicare or a Medicare Supplement carrier. Providers should bill all Medicare-covered services in accordance with Medicare and CMS rules, standards, and guidelines applicable to Parts A and B. In addition, providers should use applicable CMS billing forms (i.e., UB-04/CMS1450, CMS1500, or such successor forms) and follow the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes, and defined modifiers.

Diagnosis codes should be billed to the highest level of specificity. The following information should be included in the claims:

- National Provider Identifier
- The Member's identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.)

Providers who are paid based on interim rates should include with the claim a copy of the current interim rate letter if the interim rate has changed since the previous claim submission.

Billing questions and/or problems should be directed to Provider Services at 1-855-969-5907.

Filing a Claim for Payment

Electronic Submissions

Provider Partners is contracted with HealthAxis for claims adjudication. Provider Partners is contracted with SSI Healthcare Revenue Cycle Solutions for the Electronic Data Interchange (EDI) claims clearinghouse. They can forward claims to Provider Partners. The Provider Partners EDI Submitter Payer IDs:

State	EDI Number
Illinois	31401
Indiana	31407
Missouri	31404

North Carolina	31406
Pennsylvania	31400
Texas	31405

Filing claims electronically reduces administrative costs, speeds claims payment, and improves payment accuracy. To begin submitting claims electronically or for questions regarding electronic claims (EDI) contact HealthAxis at 1-855-969-5907.

Facility Implementations Specific to the Provider Partners EDI Submission SSI:

1. Providers should contact their clearinghouse and request the setup of EDI Submitter Payer IDs to route to SSI.
2. Providers can submit claims by uploading an ANSI X12 837 file directly to the SSI client portal. This method requires completion of an enrollment process. To begin the registration process, please visit https://thessigroup.com/ and select the "Claimsnet Registration" in the menu. Need assistance? Contact the support team at 1-800-820-4774.

   Please note:
   - The client portal is intended solely for claim submission and does not support eligibility inquiries or claim status requests.
   - Claims must include the appropriate SSI Payer ID and SubID in the 2010BB NM1 09 segment of the 837 files.
   - If a provider's practice management system cannot generate a compliant 837 file, SSI will be unable to process the registration.
3. Providers may submit claims through their designated clearinghouse. Once notification has been made to the clearinghouse, if the provider is unable to transmit claims within a 5 to 10-day period, they should escalate the issue to Provider Partners. Provider Partners will then notify SSI's VPS Management Team, which can provide additional outreach to the clearinghouse on behalf of Provider Partners.
4. Once SSI receives the info requested above, it will contact the clearinghouse to request the setup on behalf of the provider. The SSI group will try its best to assist in the process; however, it cannot guarantee that the clearinghouse will ultimately set up these payer IDs.
   *This process can take approximately 2-4 weeks based on the clearinghouse/facility participation.

Paper Submissions

Providers who prefer to submit claims by mail should send them to the following address:

Provider Partners Health Plans
Attn: Claims
P.O. Box 21063
Eagan, MN 55121

Filing Deadlines

Timely filing requirements are specified within the applicable Provider Participation Agreement. For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, or the patient is admitted for care.

Failure to comply with timely filing requirements will result in claim denial unless documented extenuating circumstances exist.

Key Points

Here are some key points to consider when filing claims:

- Do not bill the Medicare carrier or fiscal intermediary. Doing so will delay payment, and Medicare will not process the claim.
- Providers must include their NPI number on all claims.
- Durable medical equipment suppliers must use a 10-digit DME Medicare supplier number.
- Laboratories must use their 10-digit CLIA number.
- Providers should submit claims to Provider Partners as soon as possible after the service is rendered.
- Submit claims using the same coding rules as Original Medicare and use only Medicare-approved CPT codes and defined modifiers.
- Bill diagnosis codes to the highest specificity.
- Ensure that the correct place of service (POS) is on the claim.
    - **Place of Service Code 31 (Skilled Nursing Facility - SNF):**
        - This code is used when services are provided in a Skilled Nursing Facility.
        - An SNF is a facility that provides skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but do not require the level of care provided by a hospital.
        - Use POS 31 when the patient is in a Skilled Nursing Facility and receiving care that requires the level of services provided by an SNF, such as post-hospitalization rehabilitation or long-term care involving skilled nursing services. This would indicate the member is in a Part A stay.
    - **Place of Service Code 32 (Nursing Facility - NF):**
        - This code is used when services are provided in a Nursing Facility.
        - A Nursing Facility provides continuous nursing care and related services to patients who need nursing care or rehabilitative services but do not require the level of care provided by a hospital or skilled nursing facility.
        - Use POS 32 when the patient is in a Nursing Facility, typically for custodial care or intermediate care that does not meet the criteria for skilled nursing services (Part A). This would indicate the member is in a Part B stay.
    - **Place of Service Code 13 (Assisted Living Facility - ALF):**
        - An Assisted Living Facility is a residential setting that aids with daily living activities for individuals who need some level of support but do not require

full nursing care. It bridges the gap between independent living and skilled nursing care.

- Assisted living facilities offer services such as meal preparation, medication management, housekeeping, transportation, and social activities. Residents typically have their own apartments or rooms within a communal setting.
- When healthcare services are provided in an assisted living facility, providers use POS 13 on professional claims. It helps determine the appropriate reimbursement rate for services rendered in this setting.

Clean vs. Unclean Claims

Provider Partners processes and pays all error-free claims, known as clean claims, for covered services provided to a member within 30 calendar days of receipt by the plan, or as required by applicable federal law. If a clean claim is not paid within the 30-day period, Provider Partners will pay interest on the claim according to Medicare guidelines.

Under CMS guidelines, a "clean" claim is a claim with no defects or improprieties. An "unclean" claim may include:

- Lack of required substantiating documentation.
- A particular circumstance requires special treatment that prevents timely payment from being made on the claim.
- Any required field where information is missing or incomplete.
- Invalid, incorrect, or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes).
- A missing Explanation of Benefits (EOB) for a member with another form of coverage.

Provider Partners will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

Type	Processing Timeframe	With Extension*
Payment: Clean Claims	30 days**	N/A
Payment: Other Claims	60 days**	N/A

*14-day extension if the enrollee requests the extension or if the MA plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. MA plan must notify enrollee in writing if extension is going to be taken and explain the reason for the delay. Note: Part B drug and payment timeframes cannot be extended. See 42 CFR §422.568(b)(1) and (2).

**Non-contract providers and enrollees: The MA plan must pay 95 percent of clean claims within 30 calendar days of the request. All other claims submitted by non-contract providers or enrollees must be paid or denied within 60 calendar days from the date of the request. For additional guidance, see 42 CFR §422.520. Contract providers: The timeframe for processing payment requests is based on the contract terms between the MA plan and the provider. For additional guidance, see 42 CFR §422.520.

National Provider Identifier

All healthcare providers should have a National Provider Identifier (NPI). The NPI replaces Legacy identifiers such as the Unique Physician Identification Number or UPIN.

The purpose of the NPI is to uniquely identify a healthcare provider in standard transactions, such as healthcare claims. The NPI may also be used to identify healthcare providers on prescriptions, in internal files to link proprietary provider identification numbers, in coordination of benefits between health plans, inpatient medical record systems, and in program integrity files.

The NPI is the only healthcare provider identifier that can be used for identification purposes in such transactions.

Reimbursements

Provider Partners complies with Medicare's prompt payment of claims requirements for all clean claims. Claims must be submitted within the time limit specified in the provider's contracts. Provider Partners processes all error-free claims (known as clean claims) for covered services provided to a member within 30 calendar days of receipt by the plan.

Special Circumstances

For certain Medicare-approved providers, Provider Partners pays as follows:

- Eligible hospitals are reimbursed according to CMS Inpatient Prospective Payment System (IPPS) Diagnosis-Related Group (DRG) reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under Original Medicare based on rates published on the CMS website (www.cms.gov). The payment is added to the IPPS. However, because Fiscal Intermediaries are responsible for operating IME and Direct Graduate Medical Education (DGME), Provider Partners does not reimburse those components of the DRG.
- Provider Partners reimburses qualifying Disproportionate Share Hospitals (DSH) with the same capital exception payments and add-on payments for operating DSH that they would have received under Original Medicare. The payment is added to the PPS rate. Provider Partners reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.
- Provider Partners does not reimburse facilities for bad debt incurred because of members not paying their cost-sharing amounts (if any) unless specified in a provider's contract.
- Provider Partners does not enter the annual cost settlement process with providers, contracted or non-contracted. Providers who have treated Provider Partners members should contact Medicare or their Fiscal Intermediary about their cost settlements.

Billing for Non-Covered Services

Providers may not bill a member if Provider Partners denies payment because the service was not covered, unless:

- The provider has informed the member in advance that the services may not be covered by providing an Advance Beneficiary Notice (ABN).
- The members have agreed, in writing, to pay for the services.

For those members who are dually eligible, providers should bill Medicaid for relevant services that may be covered. Please also refer to the section on "Balance Billing Provisions."

Balance Billing Provisions

A provider may collect only applicable plan cost-sharing amounts from Provider Partners members and may not otherwise charge or bill members. Balance billing is prohibited by providers who offer plan-covered services to Provider Partners members.

Per CMS guidance, Billing Prohibition for Qualified Medicare Beneficiaries (QMBs):

All Original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – cannot charge QMBs for Medicare cost-sharing for Covered Parts A and B Services. (Note: QMBs cannot elect to pay Medicare deductibles, coinsurance, and copayments, but may have a small Medicaid copayment.)

- Medicare Remittance Advice notices clearly indicate if a beneficiary is a QMB and show that the beneficiary's deductible, copayment, and coinsurance cost-sharing is zero.
- If a provider bills a QMB for Medicare cost-sharing or turns a bill over to collections, the provider must recall it. If the provider collects any cost-sharing money from a QMB, the provider must refund it.
- A provider may be subject to sanctions if it bills a QMB for amounts above the total of all Medicare and Medicaid payments (even though Medicaid does not fully pay the Medicare cost-sharing).

For more information, see the Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program MLN Matters® article.

Additional Billing Requirements for Dually Eligible Beneficiaries

Special instructions apply when a provider issues an Advance Beneficiary Notice (ABN) to a dually eligible beneficiary, based on the expectation that the plan will deny the item or service because it is not medically reasonable and necessary or constitutes custodial care.

- The provider cannot bill the dually eligible beneficiary when the ABN is furnished.
- Once both Medicare and Medicaid adjudicate the claim, providers may only charge the patient in the following circumstances:
    - If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.
    - If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any State laws that limit beneficiary liability.

For more information, see the ABN Form and Instructions available on the Medicare website.

Provider Remittance Advice Form

Provider Partners sends providers a Provider Remittance Advice Form (PRAF) once it has received and paid a claim.

Questions regarding the PRAF may be addressed to Provider Partners at 1-855-969-5907 from 8 AM to 5 PM (local time zone), Monday-Friday.

When calling, providers should have the following information available for the representative:

- National Provider Identifier (NPI)

- Claim number in question
- Member's name
- Date of service
- Member's date of birth
- Issue requiring review
- Member's ID number
- Copy of claim (if available)

Coordination of Benefits

If a member has primary coverage with another plan, providers should submit a claim for payment to that plan first. The amount payable by Provider Partners will be governed by the amount paid by the primary plan and the coordination of benefits policies.

To bill the correct payer, the provider must obtain all the information that determines whether the member is covered. The provider must include all this information on the claim form to facilitate the correct adjudication.

For a provider who accepts Medicaid and who treats a Provider Partners member who is a Medicaid patient, Provider Partners will pay the Medicare portion of the claim. The provider must then submit the claim to the appropriate state Medicaid entity for the Medicaid portion of the claim.

The following types of situations, not an exhaustive list, will prevent payment by Provider Partners as the primary payer:

- Employer Group Health Plan (EGHP): These members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse's age is not material to the determination of primary coverage, only the qualification of the EGHP.
- Disabled Beneficiaries Employer Group Health Plans: These members are eligible for Medicare based on disability, are under the age of 65 years, and are covered by a Large Group Health Plan (LGHP) through their own or a family member's employment. LGHP is defined by at least one of the employers having at least 100 employees.
- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either respiratory or pulmonary diseases. Provider Partners is the primary payer for all other care and service needs.
- Workers' Compensation: The Workers' Compensation carrier handles all injuries and illnesses that result from employment. Provider Partners pays only when the Workers' Compensation benefits are exhausted, or the services/care were not covered by the Workers' Compensation carrier but are Medicare benefits.
- Veterans Administration (VA) Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. Provider Partners may supplement VA payment when the member files a claim for Part B services that were not fully reimbursable by the VA.

Provider Payment (Claim) Dispute (Appeal) Resolution Process

If a contracted provider believes a clean claim should have been paid differently, they have the right to dispute the payment. Initially, the provider may contact the Provider Services Call Center to discuss the claim with a specialist. If the specialist cannot reprocess the claim (i.e., they believe the claim was processed correctly under plan rules), providers must address disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments, or the amount of the claim) in writing. Providers may direct any questions to Provider Services at 1-855-969-5907.

To file a payment dispute, providers should submit a written request for dispute resolution along with any supporting documentation. Providers are encouraged to include a cover sheet outlining the reason for the requested review along with the claim. Provider Partners will respond to all written disputes regarding claims within 60 calendar days. If Provider Partners agrees with the reason for the payment dispute, Provider Partners will issue a new Explanation of Payment (EOP) and pay any additional amount that is owed, including interest due.

Claims that are denied related to medical necessity must be reviewed by the UM department before making any payment. Should an administrative denial be overturned, the case is reviewed for medical necessity before a decision is communicated.

Provider Partners will inform providers in writing if the decision is unfavorable, and no additional payment is allowed.

Claims must be disputed within 120 days from the date payment/denial is initially received by the provider. In cases where Provider Partners re-adjudicates a claim, providers have an additional 120 days from the notification date in which to dispute the adjustment.

IV. Medicare Risk Adjustment

What is Risk Adjustment?

Risk adjustment is the process by which CMS reimburses MA plans based on the member's age, gender, and health status throughout the plan year.

Provider Partners contracts with CMS to offer MA plans. The risk of the member is determined by the ICD-10 diagnosis code included in the encounters; claims submitted to Provider Partners and passed to CMS.

Physician/Provider Roles

The physician's role in this process is to submit encounter records and supporting documentation that are clear, concise, consistent, complete, and legible. All ICD-10 diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. Provider Partners places an increased emphasis on physician/provider education and recommendations related to Hierarchical Condition Categories (HCC), ICD-10 diagnoses, and documentation regulations. The CMS-HCC model relies on ICD-10-CM coding specificity.

- To follow risk adjustment guidelines, specific International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes are required.
- Medical records must support all diagnosis conditions coded on the claims and encounters you submit using clear, complete, and specific language.
- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment, or management.

- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results, and/or other reasons for the visit.
- Specify if conditions are chronic or acute in the medical record and coding. Only choose diagnosis code(s) that fully describe the member's condition and pertinent history at the time of the visit. Do not code conditions that no longer exist.
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member's condition.
- Check the diagnosis code against the member's gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted for risk adjustment consideration are subject to federal and/or Provider Partners internal audit. Audits may come from CMS and HHS, or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please give us the requested medical records quickly. Please provide all available medical documentation for the services rendered to the members.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

How Does Risk Adjustment Impact Physicians and Members?

Increased coding accuracy helps Provider Partners identify patients who may benefit from disease and medical management programs. More accurate health status information can be used to match health care needs with the appropriate level of care. Risk adjustment helps meet the CMS physician responsibilities when reporting ICD-10-CM codes, including:

- Primary diagnoses, to the highest level of specificity
- Secondary diagnoses, to the highest level of specificity
- Maintaining accurate and complete medical records (ICD-10-CM codes must be submitted with proper documentation)
- Reporting claims and encounter data in a timely manner

With your help in providing accurate and timely coding for risk adjustment, we can avoid unnecessary and costly administrative revisions and provide your patients and our members with superior customer service.

Why is Medical Record Documentation Important for Risk Adjustment?

- Accurate risk-adjusted payment relies on complete medical record documentation and diagnosis coding.
- CMS conducts risk adjustment data validation by medical record review.
- Specificity of the ICD-10-CM diagnosis coding is substantiated by the medical record.
- Documentation should be clear, concise, consistent, complete, and legible.
- Document coexisting conditions at least annually.
- Use standard abbreviations.
- Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-10-CM code on the date of service, and are signed and dated by the physician or physician extender).
- Identify the patient and date on each page of the record.

- Authenticate the record with signature and credentials.

It is important for the physician's office(s) to fully code each encounter; the claim should report the ICD-10-CM code of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed. Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses that were addressed were reported.

Requests for Medical Records

Provider Partners continually conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding. In addition, if CMS conducts an annual Data Validation Audit on the Medicare Advantage Health Plan, you will be required to assist us by providing medical record documentation for members included in the audit. If this occurs, medical records can be mailed or faxed to:

Provider Partners
Attn: Med Records Request
P.O. Box 21063
Eagan, MN 55121
Fax #: 1-888-918-2989

The collection of risk adjustment data and request for medical records to validate payment made to Medicare Advantage organizations is considered a healthcare operation and does not violate the privacy provisions of HIPAA (CFR 164.502).

CMS Data Validation: Data validation helps ensure the integrity and accuracy of risk-adjusted payments. It is the process of verifying that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member. Medicare Advantage Plans are selected for data validation audits annually. It is important for physicians and their office staff to be aware of risk adjustment data validation activities because medical record documentation may be requested. As previously stressed, accurate risk-adjusted payment relies on the diagnosis coding derived from the member's medical record.

Data Process for Risk Adjustment

1. The physician documents the member's visit in the medical record; the office codes the claim from the medical record.
2. Provider Partners submits diagnosis data from claims to CMS for risk adjustment calculation and payment.
3. CMS conducts annual data validation audits on selected plans.

Hierarchical Condition Category (HCC) Model

CMS implemented the Hierarchical Condition Categories (HCC) model in 2004 to adjust capitation payments to Medicare Advantage plans for the health expenditure risk of their enrollees. Effective Calendar Year 2024, Medicare updated the risk adjustment model to Version 28 to be fully implemented in 2026.

In the U.S. Department of Health & Human Services Hierarchical Condition Category (HHS- HCC) risk adjustment model, a value is assigned to each diagnosis code that falls into the payment model. The

ICD-10-CM codes are then grouped into an HCC. Unlike hospital diagnosis-related groups (DRGs), HCCs are cumulative: Each additional HCC in an unrelated disease category is factored into the risk profile.

Under the risk adjustment model, physicians/providers should document, and coders should report all present, relevant diagnoses. ICD-10 guidelines instruct us to choose a primary diagnosis (to describe the main reason for the member's visit on the encounter), and to "list additional codes that describe any coexisting conditions."

Providers should code for all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. Co-existing conditions include chronic, ongoing conditions, such as diabetes, congestive heart failure, atrial fibrillation, COPD, etc. These diseases are managed by ongoing medication and have the potential for acute exacerbation if not treated properly, particularly if the patient is experiencing other acute conditions. These diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor medical encounters. Co-existing conditions also include ongoing conditions such as multiple sclerosis, hemiplegia, rheumatoid arthritis, and Parkinson's disease.

HCCs are given a severity ranking, the higher the medical risk to the patient, the higher the ranking. It is important to follow normal coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a visit must be documented. The medical record documentation must support that the diagnosis was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the CMS instructions for Risk Adjustment implementation. In addition, the diagnosis must be coded according to ICD-10-CM Guidelines for Coding and Reporting. Codes with a higher HCC ranking result in more "credit."

Helpful CMS Webpages

- Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
- Medicare Billing: 837P and Form CMS-1500: https://www.cms.gov/files/document/837p-cms-1500pdf
- Medicare Billing: 837I and Form CMS-1450: https://www.cms.gov/files/document/837i-form-cms-1450-mln006926.pdf

Frequently Asked Questions

These are a few of the most frequently asked questions regarding Medicare Risk Adjustment:

Q: How often does the diagnosis have to appear to be counted for risk adjustment?

A: The diagnosis must appear at least once a calendar year.

Q: Is a "typed" signature on a report acceptable for office consultation notes, a discharge summary, and hospital consultations?

A: No. The provider who dictated the report must sign it, regardless of the record type, and add his/her credentials. Electronic signatures are acceptable but must be accompanied by such words as "electronically signed by," "authenticated by," or "signed by."

Q: Are medical records containing dictated progress notes that are dated but not signed acceptable for medical review?

A: No. Medical record documentation should be signed and dated by the physician.

Q: If providers submit an unsigned medical record, will Provider Partners return the record to the provider for a signature?

A: Yes, if it is within 30 days. Otherwise, providers must submit a new medical record with the provider's signature to substantiate the HCC.

Q: Can a pathology report alone substantiate a risk adjustment assignment?

A: No. Pathology and other laboratory reports simply present the actual results and generally do not have a documented diagnosis and the physician's signature. However, if such a report is signed by an M.D., it has a final diagnosis, and can be tied back to the actual visit, then it can be used as a coding source.

Q: Can a radiology report alone substantiate a risk adjustment assignment?

A: Radiology is not an acceptable source to report diagnoses for risk adjustment because it generally does not have a documented diagnosis but instead provides an impression of the findings.

Q: How often should providers document chronic conditions, such as an old myocardial infarction (MI)?

A: Yearly, or as often as the diagnosis factors into the medical decision-making.

V. Pharmacy – Part D Services

Overview

The Provider Partners Pharmacy Department manages the administration of pharmacy benefits. They are available to answer formulary and/or medication-related questions. You can contact the Provider Partners pharmacy team at pharmacysupport@pphealthplan.com.

Provider Partners Health Plans partners with a Prescription Benefits Manager (PBM), to administer the prescription programs for the Provider Partners members.

The Provider Partners formulary may be viewed by going online to https://www.pphealthplan.com/pharmacy-resources/:

- Select, "2027 Comprehensive Formulary (Prescription Drugs)"
- You can search the formulary online and download and print the comprehensive formulary.

Pharmacy Policies

Generics

All formularies include both brand-name and generic medications. The formulary does not include preferred use medication.

Formulary

Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for Provider Partners. Some covered drugs may have additional requirements or limits on coverage. These requirements and limits include prior authorizations, quantity limits, and/or step therapy. To request coverage for a drug that has additional requirements, call: 1-844-368-8732.

Excluded Medications

Medicare has excluded certain medication classes from coverage by Part D Medicare programs. These classes include all drugs (brand and generic) and combination drugs that contain a medication within these classes:

- Medications used for erectile dysfunction.
- Medications used for anorexia, weight loss, or weight gain, with the caveat of Part D drugs used for AIDS wasting and cachexia due to chronic disease.
- Medications used for cosmetic purposes or hair growth.
- Medications used to promote fertility.
- Medications used for symptomatic relief of cough or colds.
- Nonprescription medications – Medications that, by federal law, do not require a prescription.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

Alert – No Appeal for Excluded Medications

Medications falling into the categories listed above cannot be covered even for medical necessity. The decision of non-coverage cannot be appealed, nor can exceptions be made to allow for coverage.

Discontinuing, Changing, or Reducing Coverage

Generally, if a Provider Partners member is taking a formulary drug that was covered at the beginning of the year, Provider Partners will continue coverage of the drug during the coverage year, except when a new, less expensive generic drug becomes available or when adverse information about the safety or effectiveness of a drug is released.

Other types of formulary changes, such as removing a drug from the formulary, will not affect members currently taking the drug and will remain available at the same cost share for the remainder of the coverage year.

Notification of Formulary Changes

If Provider Partners removes drugs from the formulary, adds coverage determinations, such as prior authorizations, quantity limits, and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier, Provider Partners must notify affected members and providers of the change at least 60 days before it becomes effective.

If the Food and Drug Administration deems a formulary drug to be unsafe or if the drug's manufacturer removes it from the market, Provider Partners will immediately remove the drug from the formulary and notify members who take the drug.

Transition Policy

Provider Partners may provide temporary coverage of medications for new members who are taking non-formulary drugs or drugs that require coverage determination. Provider Partners may grant a

temporary 30-day supply within the enrollee's first 90 days of membership, during which time the provider should initiate the same "coverage determination" process outlined previously. Transition coverage is available for residents of long-term care facilities or members whose medications are affected by a level-of-care change (e.g., discharge from an acute setting or admission to/discharge from a long-term care facility).

Pharmacy Network

Members must fill all medications at in-network pharmacies for coverage at the lowest out-of-pocket cost. Members who use out-of-network pharmacies may pay higher out-of-pocket costs and must submit receipts for reimbursement. In-network pharmacies include community-based pharmacies, pharmacies that serve long-term care facilities, specialty pharmacies (home infusion pharmacies), and pharmacies owned by Indian tribal councils.

Mail-order Services

Provider Partners now offers mail-order services to our members. Some of the benefits to the members include:

- Personal service: 24-hour access to a pharmacist.
- Online convenience: save time and set up automatic refills or order any time of day or night at https://www.optumrx.com/member-resources/refills-and-requests.html

*Please note: Members who used our "Automatic Refill" service in the past automatically received drug refills when our records indicated that they were about to run out. As of January 2014, members need to provide permission to have their drugs refilled by mail. To get mail-order forms and information about ordering prescriptions for your patients through mail order, email pharmacysupport@pphealthplan.com or call 1-855-205-4428.

VI. Pharmacy – Part B Services

Definition of Part B Coverage

Medicare Part B was designed to help people with Medicare pay for their medical costs, but not for their medications.

Over the years, though, Congress added benefits to treat specific diseases, including medications used to treat those diseases. The Part B benefit does not apply to specific medications (Exceptions may apply for IPPB solutions and some diabetic supplies) but rather to the treatment of certain diseases.

Medicare Part B covers a limited number of prescription drugs. These Part B drugs fall into three categories:

- Drugs furnished incident to a physician's service.
- Drugs used in conjunction with durable medical equipment (DME).
- Certain statutorily covered drugs, including:
    - Immunosuppressive drugs for beneficiaries with a Medicare-covered organ transplant
    - Hemophilia blood clotting factor
    - Certain oral anti-cancer drugs
    - Oral anti-emetic drugs
    - Pneumococcal, influenza, and hepatitis vaccines (for intermediate to high-risk individuals)

- Antigens
- Erythropoietin for trained home dialysis patients
- Certain other drugs separately billed by End-Stage Renal Disease (ESRD) facilities (e.g., iron dextran, vitamin D injections)
- Home infusion of intravenous immune globulin for primary immune deficiency

Medicare Part B drug coverage has not been changed by the implementation of the new Medicare Part D drug program. Drugs that were covered by Medicare Part B before the Part D prescription drug program became operational continue to be covered under Medicare Part B.

Copayments for each category are as follows:

- Part A – Generally no copayment (part of the hospital payment)
- Part B – Generally no coinsurance (varies by plan and/or product)
- Part D – Generally no member copayment (varies by plan and/or product and/or by tier level)

Part B Medication Authorizations and Claims

Drugs furnished incident to a physician's services follow the same authorization and claim procedures as other physician services. For prescription medications dispensed by a pharmacy, the Provider Partners' pharmacy claims system can adjudicate Part B claims. Some prescription medications may require a Part B vs. D coverage determination review.

Part B vs. D Coverage Determination for Prescription Medications Dispensed by Pharmacy

While the use of some medications is assumed to fall under Part B coverage, others require additional clinical information before coverage can be determined. Therefore, certain prescription medications are subject to prior authorization for Part B vs. Part D coverage determination. The intent is not to establish clinical grounds for approval, but to determine the circumstances of the claim for payment purposes.

Provider Partners will allow payment as a Part D benefit only when they can establish appropriate coverage. Otherwise, coverage is redirected as a Medicare Part B claim.

In addition:

- Some medications could be covered under Part B (medical) or Part D (prescription), depending on several issues, including the diagnosis, residential status of the member, or route of administration.
- Part B and D drugs have different copayments, and Part B drugs do not apply to True Out-of-Pocket costs (TrOOP).
- The process to determine if the drug is to be covered as Part B or Part D is the same process outlined previously for "coverage determination."

VII. Physician Rights, Responsibilities, and Roles

Provider Partners is committed to offering its members access to physicians and healthcare services and facilities that provide quality care in a manner that preserves a member's dignity, privacy, and autonomy.

As such, Provider Partners employees and in-network providers shall:

- Treat all members with respect and courtesy.

- Not discriminate against members in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment or other protected class.
- Respond promptly to members' questions and document communications with members as appropriate.
- Protect members' rights by publicizing such rights to members, employees, and network providers.
- Comply with all the legal and professional standards of care, ethics, conduct, and behavior applicable to health maintenance organizations, their employees, and their network providers.
- Provide members with information concerning the benefits available to them so they may avail themselves of such benefits as appropriate.
- Make sure members have reasonable access to the services to which they are entitled under their plans.
- Give members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including information about withholding resuscitative service, forgoing, or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Healthcare providers shall obtain informed consent as required by law.
- Inform members of their rights to an appeal if a provider chooses not to supply a service or treatment requested by the member.
- Preserve the integrity and independence of clinical decisions made by in-network providers. In making such decisions concerning a member's medical care, in-network providers shall not allow themselves to be influenced by financial compensation to the provider, or provider network that results from such decisions, or by coverage of a particular treatment, or course of care by the member's plan.
- Follow the guidance of Provider Marketing Training as required by the Medicare Improvements for Patients and Providers Act (MIPPA).

Provider Role in HIPAA Privacy Regulations

Like Provider Partners, participating providers are covered entities under HIPAA and are required to keep Protected Health Information (PHI) confidential. A major goal of the Privacy Rule is to ensure that an individual's PHI is properly protected, while still allowing the flow of health information needed to provide and promote high-quality care, as well as to protect the public's health and well-being.

Provider Partners policies and procedures include regulatory information to ensure Provider Partners complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act. Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations, as is the staff at Provider Partners.

Throughout its business areas, Provider Partners has incorporated measures to make sure potential, current, and former members' Protected Health Information (PHI), individually identifiable health information, and personally identifiable financial information are maintained confidentially, whether that information is in oral, written, or electronic format. Provider Partners employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and healthcare operations), by the member's written request, or if required to be disclosed by law, regulation, or court order.

Provider Partners developed its referral/authorization request form per the core elements and required statements contained in the HIPAA privacy rules. To determine pre-service medical necessity, providers should complete, sign, and return the referral/authorization form to Provider Partners.

All members receive Provider Partners Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Members also receive a copy of the privacy information with their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). These documents clearly explain the members' rights concerning the privacy of their individual information, including the processes established to provide them with access to their PHI and procedures to request to amend, restrict use, and have an accounting of disclosures. The documents further inform members of Provider Partners precautions to conceal individual health information from employers.

Provider Partners Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices that providers are required to give to their patients under HIPAA. To view the Privacy Statement and Notice of Privacy Practices, contact Provider Services at 1-855-969-5907.

This information regarding HIPAA privacy compliance is provided as a courtesy to plan providers and is designed for educational purposes only. It should not be used as a substitute for legal or other professional advice. For more detailed information regarding the confidentiality and accuracy of enrollee records please see regulations under 42 CFR §422.118.

Complying with the Americans with Disabilities Act

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines and any of its amendments, Section 504 of the Rehabilitation Act of 1973 (Section 504), and other applicable state or federal laws.

Provider Partners requires that in-network providers' offices or facilities comply with these statutes/laws.

The ADA and Section 504 require that providers' offices have the following modifications:

(i) The office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs.
(ii) Patient restrooms should be equipped with grab bars.
(iii) Handicapped parking must be available near the provider's office and be clearly marked.

These requirements are not an exhaustive list of the standards or access requirements mandated by the ADA, Section 504, or any other applicable state or federal law.

Anti-Kickback Statute

Provider Partners is committed to conducting their business activities in full compliance with applicable Federal and State laws. In support of this commitment, Provider Partners must ensure that all providers adhere to the Federal Anti-Kickback Statute and state equivalents (the "Anti-Kickback Policy"), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive, or bribe) directly or indirectly, overtly, or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties, such as being barred from participation in federal programs.

Discounts, rebates, or other reductions in price may violate the anti-kickback statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

To be permissible, an activity that implies the anti-kickback statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

VIII. Medicare Advantage and Part D Fraud, Waste, and Abuse

The Scope of Fraud, Waste, and Abuse on the Healthcare System

During Fiscal Year (FY) 2012, the Federal government won or negotiated over $3 billion in healthcare fraud judgments and settlements. The National Health Care Anti-Fraud Association (NHCAA) website reports that healthcare loss due to fraud, waste, and abuse has an impact on patients, taxpayers, and the government because it leads to higher healthcare costs, insurance premiums, and taxes. Healthcare fraud often hurts patients who may receive unnecessary or unsafe healthcare procedures or who may be the victims of identity theft.

Healthcare fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (through false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any healthcare benefit program.

Healthcare waste is the overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions, but rather by the misuse of resources.

Healthcare abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care or medically unnecessary services.

Medical Identity Theft

Medical identity thieves may use a person's name and personal information, such as their health insurance number, to make doctor's appointments, obtain prescription drugs, and file claims with MA Plans. This may affect the person's health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

To limit the number of alleged incidents of medical identity theft involving members, provider claim personnel should verify member account numbers when filing medical claims for processing.

The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2019 can be found online under the US Department of Justice website.

Reporting Fraud, Waste, and Abuse

Suspected incidents of fraud, waste, and abuse (FWA) may be reported anonymously to the Compliance Department by contacting 1-833-213-0636, 24 hours a day, seven days a week. Suspected or detected

non-compliance or FWA concerns can also be reported to the Provider Partners' Compliance mailbox: compliance@pphealthplan.com.

You may also report suspected fraud, waste, and abuse by regular mail by writing to:

Provider Partners Health Plans
8820 Columbia 100 Parkway, Suite 430
Columbia, MD 21045

All reports are fully treated in a confidential manner. Results of investigations may be shared with law enforcement or regulatory authorities in certain instances.

Additional Information is available at the following websites:

- www.insurancefraud.org
- https://www.stopmedicarefraud.org
- www.ssa.gov/oig
- www.nhcaa.org

IX. Medicare Improvements for Patients and Providers Act (MIPPA)

Rules Related to Marketing Medicare Advantage Plans

Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Providers may:

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" from https://www.medicare.gov, including in areas where care is delivered.
- Providing the names of MA organizations with which they contract or participate or both.
- Answering questions or discussing the merits of an MA plan or plans, including cost sharing and benefits information, in areas where care is delivered.
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at https://www.medicare.gov, or 1–800–MEDICARE.
- Referring patients to the MA plan marketing materials available in common areas.
- Providing information and assistance in applying for the Low-Income Subsidy (LIS).
- Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

Plan-Initiated Provider Activities

Providers may:

- Make available, distribute, and display communications materials, including in areas where care is being delivered.

- Provide or make available marketing materials and enrollment forms in common areas.

Providers should not:

- Accept or collect Scope of Appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the MA organization.
- Offer inducements to persuade patients to enroll in a particular MA plan or organization.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials or enrollment forms in areas where care is being delivered.
- Offer anything of value to induce enrollees to select the provider.
- Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

Plan Benefits

Providers should not compare plan benefits against other health plans unless the materials were written, or approved by CMS (for example, information generated through CMS' Plan Finder via a computer terminal for access by beneficiaries) or provided by the health Plan. All plan benefits are available on the Provider Partners Health Plans website at www.pphealthplan.com.

Contact Information

When requested, providers may provide the plan's contact information to a beneficiary so that the beneficiary may contact the plan directly regarding an expressed interest in enrolling in a plan in which the provider participates.

However, for marketing purposes, providers shall not release a beneficiary's contact information to a plan or an agent unless the beneficiary requests that the plan contact him or her.

X. Legal and Compliance

Overview

A sound MA Corporate Governance program requires adherence to legislation, regulation, and general good practice. Compliance itself is the demonstrable evidence that an entity meets prescribed standards and can maintain a history of meeting those standards, which form the requirements of an established compliance structure.

The Compliance Program provides a framework from which the organization can assess its compliance with applicable State and Federal regulations and its established organizational policies and procedures.

In this section, Legal and Compliance refers to State and Federal regulations as well as Federal laws governing HIPAA, the protection and security of a member's PHI, and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Provider Partners' Compliance & Ethics Program

Provider Partners has established a comprehensive Compliance & Ethics Program that focuses on initiative-taking monitoring, training, evaluation, detection, and prevention of violations of CMS

Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Program regulations, guidelines, and applicable federal and state laws. Provider Partners works collaboratively with State and Federal regulatory agencies and contracted business partners to ensure business practices are conducted lawfully, ethically, and in a manner conducive to achieving mutual goals and delivering quality services and health care to our members.

Our Compliance Plan, Codes of Conduct, and compliance policies and procedures promote a culture of compliance by establishing guidelines, requirements, and expectations for all employees, Board Members, and contracted business partners, including our First Tier, Downstream, and Related Entities (FDRs).

As a Medicare Advantage plan sponsor, Provider Partners must ensure that FDRs performing delegated administrative or healthcare service functions related to its Medicare Advantage program are familiar with and comply with the General Medicare Compliance Program and Fraud, Waste, and Abuse (FWA) requirements described in the Provider Partners' Compliance Plan and Code of Conduct. To fulfill General Medicare Compliance Program requirements, our contracted FDRs must:

- Adopt and comply with Provider Partners' Code of Conduct and Compliance Policies and Procedures (P&Ps) or have their own materially similar versions.
- Ensure that the Provider Partners' Code of Conduct and Medicare Compliance Program documents or their own materially similar versions are distributed to all personnel involved with Provider Partners Medicare Advantage business (including downstream entity personnel when applicable) within 90 days of contracting, upon revision, and annually after that.
- Ensure all personnel assigned to perform Provider Partners' Medicare Advantage services know how the compliance program operates and how to identify and report issues of non-compliance and FWA concerns.
- Ensure all personnel receive general compliance training and FWA training within 90 days of hire, and annually thereafter.
- Complete and submit Provider Partners' FDR Compliance Attestation annually.
- Provide evidence of distribution of a Code of Conduct and Compliance P&Ps to Provider Partners upon request.
- Provider Partners maintains ultimate responsibility for fulfilling the terms and conditions of its contract with CMS. CMS may hold Provider Partners accountable for the failure of its FDRs to comply with Medicare Part C and Medicare Part D program requirements.

Regulatory Compliance

Regulatory compliance is not an option; it is a requirement. The Provider Partners' Compliance Program is led by the Chief Compliance Officer (CCO), and addresses all aspects of regulatory compliance, including, but not limited to:

- Utilization Management
- Coverage Determinations
- Formulary Administration
- Appeals and Grievances
- Claims Processing
- Enrollment/Disenrollment
- Credentialing/Recredentialing
- Marketing and Sales
- Compliance Education and Training

- FDR Monitoring and Oversight
- Compliance Risk Assessments
- Exclusion and Debarment Screenings
- Conflicts of Interest
- Compliance Investigations

Every operational area at Provider Partners is responsible for the compliance of its functions. The Provider Partners' Corporate Compliance and Regulatory Committee (CCRC) supports the Chief Compliance Officer in developing, monitoring, and assessing the Compliance Plan. The Compliance Plan operates under the authority and oversight of the Boards of Directors for Provider Partners.

The following documents can be accessed through the Provider Partners Compliance and Ethics Program webpage at: www.pphealthplan.com/pphp-compliance-ethics-program/.

- Provider Partners Compliance Plan
- Provider Partners Code of Conduct
- Provider Partners FDR Code of Conduct & Compliance Guide (FDR Code)
- Compliance Reporting Poster
- Provider Partners FDR Annual Attestation Form
- Provider Partners Offshore Services Attestation Form

XI. Federal & State Regulations

Overview

There are several Federal Regulations that affect Provider Partners' day-to-day operations. These regulations set benchmarks by which the compliance department reviews all internal operational processes as well as external business initiatives and relationships.

These regulations include, but are not limited to:

- The Health Insurance Portability and Accountability Act (HIPAA)
- The Medicare Improvements for Patients and Providers Act (MIPPA)
- The False Claims Act and Fraud Enforcement Recovery Act
- Physician Self-Referral Law (Stark Law)
- Anti-Kickback Statute
- Exclusion Law and Civil Monetary Penalties (CMP) Law
- Fraud, Waste, and Abuse
- The HITECH Act

Health Insurance Portability and Accountability Act (HIPAA)

Congress introduced this act in 1996 to protect health insurance coverage for workers and their families when they change or lose their jobs. It also requires establishing national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans, and employers; it helps people keep their information private.

A major goal of the Privacy Rule is to ensure that individual health information is properly protected while allowing the flow of health information needed to provide and promote high-quality healthcare and to protect the public's health and well-being.

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities").

Information in connection with certain transactions is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards. Using electronic technology, such as email, does not mean a healthcare provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider, whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Healthcare providers include all "providers of services" (e.g., institutional providers such as hospitals) and "providers of medical or health services" (e.g., non-institutional providers such as physicians, dentists, and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Medicare Improvements for Patients and Providers Act (MIPPA)

Congress introduced MIPPA in 2008 to enhance the quality of healthcare, expand access to care, and provide coverage for certain preventative services. MIPPA is addressed in more detail in a prior section of this manual.

False Claims Act and Fraud Enforcement Recovery Act

The Federal False Claims Act (31 U.S.C. Sections 3729-33) aims at preventing fraud against the government, including fraudulent billing and fraudulent submission of claims or statements to any Federal healthcare program. The False Claims Act (FCA) applies when a false claim for reimbursement is submitted for payment to a government program and the provider knew or should have known that the information or certification of the claims was false. The Federal FCA and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The Federal FCA prohibits retaliation against an employee for investigating, filing, or participating in a whistleblower action.

Congress strengthened and broadened the scope of the False Claims Act by passing the Fraud Enforcement and Recovery Act (FERA) of 2009. FERA extends the liability for False Claims Act violations to claims not directly submitted to the government (e.g., the False Claims Act attaches to false claims presented to MA plans). FERA strengthened whistleblower protection, relaxed the standard for False Claims Act violations, and made retention of overpayments made to a provider a violation of the False Claims Act.

The U.S. Department of Justice press release dated December 20, 2013, titled 'Justice Department Recovers $3.8 Billion in False Claims Act Cases in Fiscal Year 2013,' is available on the DOJ website.

Physician Self-Referral Law (Stark Law)

Congressional concern with the implications of self-referral arrangements led to the inclusion in the Omnibus Budget Reconciliation Act of 1989 ("OBRA 1989") of a provision barring self-referral arrangements for clinical laboratory services under the Medicare program.

The Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"), known as "Stark II," extended the ban, effective January 1, 1995, to an additional list of services and applied it to Medicaid at the same

time. CMS has issued a series of implementing regulations. CMS issued "Phase III" of the final regulations on September 5, 2007.

"Self-referrals" occur when physicians refer patients for services in which they (directly or indirectly) have a financial interest. This interest can be in the form of ownership or investment interest in the entity; it may also be a compensation arrangement between the physician and the entity.

In September 2010, CMS published the Medicare Self-Referral Disclosure Protocol (SDRP") which sets forth a process to enable providers to self-disclose actual or potential violations of the Stark Law. For further information on SDRP, please use the email 1877CallCenter@cms.hhs.gov.

Anti-Kickback Statute

Provider Partners is committed to conducting their business activities in full compliance with applicable Federal and State laws. In support of this commitment, Provider Partners must ensure that all providers adhere to the Federal Anti-Kickback Statute and state equivalents (the "Anti-Kickback Policy"), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive, or bribe) directly or indirectly, overtly, or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties such as being debarred from participation in federal programs.

Discounts, rebates, or other reductions in price may violate the Anti-Kickback Statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

To be permissible, an activity that implies the Anti-Kickback Statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

Exclusion Law and Civil Monetary Penalties (CMP) Law

The Exclusion Law (42 U.S. Code § 1320a–7) excludes individuals or entities convicted of criminal offenses relating to patient abuse or neglect, a felony offense related to health care fraud, or a felony offense related to controlled substances from participation in any Federal health care program for a minimum of five years. If there is one prior conviction, the exclusion will be for 10 years, and the exclusion will be permanent if there are two prior convictions. The Civil Monetary Penalties Law authorizes the Secretary of Health and Human Services Office of Inspector General (OIG) to impose civil monetary penalties for a variety of conduct and different amounts of penalties, and assessments may be imposed on the type of violation at issue. Penalties range from $15,000 to $70,000 per violation. Violators are also subject to three times the amount of remuneration offered, paid, solicited, or received.

Fraud, Waste, and Abuse

Congress enacted Fraud, Waste, and Abuse in 2007 as part of the Deficit Reduction Act (DRA) of 2005. This act requires entities to establish written policies providing detailed information about fraud, waste, and abuse in Federal healthcare programs and to distribute these policies to employees, agents, and contractors.

The HITECH Act

The American Recovery and Reinvestment Act (ARRA) was signed into law on February 17, 2009. Among many other things, the ARRA dedicates substantial resources to health information technology that supports the secure electronic exchange and use of health information.

Title XIII of Division A and Title IV of Division B of the Act are referred to as the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The HITECH Act includes many measures designed to broaden the scope and increase the rigor of HIPAA compliance. The HITECH Act expands the reach of HIPAA data privacy and security requirements to include the Business Associates of those entities (healthcare providers, pharmacies, and the like) that are subject to HIPAA. Business Associates are companies such as accounting firms, billing agencies, law firms, and others that provide services to entities covered under HIPAA.

Under the HITECH Act, companies are now directly subject to HIPAA security and privacy requirements as well as to the same civil and criminal penalties that hospitals, pharmacies, and other HIPAA-covered entities face for violations. Before HITECH came into force, Business Associates that failed to properly protect patient information were liable to the covered entities via their service contracts, but they did not face governmental penalties.

The HITECH Act specifies that Business Associates will be subject to the same civil and criminal penalties previously imposed only on covered entities. As amended by the HITECH Act, civil penalties range from $100 to $50,000 per violation with caps of $25,000 to $1.5 million for all violations of a single requirement in a calendar year. Criminal penalties include fines up to $50,000 and imprisonment for up to one year. In some instances, fines are mandatory.

State Regulations

Many state regulations also have an impact on the plan's day-to-day operations. Many of these regulations relate to Medicaid and/or relationships existing between governmental entities and Provider Partners.

In addition, many states now have enforceable regulations related to HIPAA, the False Claims Act, and Patient Anti-Brokering or Anti-Referral Acts, which mirror the Federal regulations and, rather than being pre-emptive, are in addition to the Federal mandates under which Provider Partners operates.

To include the state regulations would be too voluminous to include in this provider manual. However, the Compliance Department is always available to providers to discuss any concerns or questions regarding the applicability of state regulations to our relationship with providers.

XII. Glossary and Abbreviations

Glossary of Healthcare Terms

Abuse: Incidents inconsistent with accepted medical or business practices, improper or excessive.

Advance Directive: A written document that states how and by whom a member wants medical decisions to be made if that member loses the ability to make such decisions for himself or herself. The two most common forms of Advance Directives are living wills and durable powers of attorney.

Ancillary Services: Healthcare services that are not directly available to members but are provided because of another covered healthcare service, including, but not limited to, radiology, pathology, laboratory, and anesthesiology.

Benefits plan: The schedule of benefits establishes the terms and conditions according to which members enrolled in Provider Partners receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment, coinsurance, deductible, and/or out-of-pocket maximum amounts; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Board-Certified: Term describing a practitioner who has completed residency training in a medical specialty and has passed a written and oral examination established in that specialty by a national board of review.

Care Team: Term describing the group who work together to form the member's care plan, including but not limited to the member's PCP, Plan NP, Plan RNCC, and plan account managers.

Claim: A request by a healthcare provider for payment for services rendered to a member.

Clean Claim: A claim that is free from defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term shall not include a claim from a healthcare provider who is under investigation for fraud and abuse regarding that claim.

Coinsurance: A cost-sharing requirement under a health insurance plan that provides that a member will assume responsibility for payment of a fixed amount or percentage of the cost of a covered service, where the cost is generally the allowed amount under the fee schedule.

Complaint: A dispute or objection regarding a provider or the coverage, operations, or management policies of a managed care plan that has not been resolved by the managed care plan and has been filed with the plan or with the appropriate state Department of Insurance. A complaint is different from a grievance.

Comprehensive Health Record: A document that combines the history and physical (H&P) and the Health Risk Assessment (HRA).

Coordination of Benefits (COB): The process to prevent duplicate payment of medical expenses when two or more insurance plans or government benefits plans provide coverage to the same person. The rules that determine which insurer provides primary or secondary coverage are governed by healthcare industry standards and, in some instances, by applicable regulatory agencies.

Copayment: Cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

Covered Services: Healthcare services for which a health plan is responsible for payment according to the benefit package purchased by the member.

Credentialing: Provider Partners review procedure for potential or existing network. Providers must meet certain standards to begin or continue participation in the network of the plan. The credentialing process may include an examination of a provider's certifications, licensures, training, privileges, and/or professional competence.

Deductible: The amount the member may be required to pay for covered services before Provider Partners begins to pay for such services.

Disenrollment: Process of termination of a member's coverage.

Durable Medical Equipment (DME): Medically necessary equipment designed for specific medical needs and for long-term use at home. *See* **Home** *definition for more information.*

Emergency Services: Any healthcare service provided to a member after a sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the member (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any body organ or part.

Emergency transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition of the member is as described above.

Encounter Data: Data relating to treatment or service rendered by a provider to a member, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

Enrollment: The process by which a health plan signs up groups and individuals for membership.

Explanation of Benefits (EOB): Statement that explains the benefits provided; the allowable reimbursement amounts; any deductibles, coinsurance, or other adjustments taken; and the net amount paid.

Fraud: The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit.

Grievance: A type of complaint you make about us or one of our in-network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Maintenance Organizations (HMO): Sometimes called "managed care organizations," HMOs contract with doctors and hospitals who agree to accept their payments. In an HMO, a member receives care from the doctors, hospitals, and other providers who contract with the HMO. A health maintenance organization (HMO) is a type of health insurance plan that provides comprehensive medical services to a population in a specific geographic area for a fixed, prepaid fee. HMOs are a type of managed care plan that combines financing and care delivery, which is intended to incentivize cost-efficient care.

Health Plan Employer Data Information Set (HEDIS): A core set of performance measures developed and managed by the National Committee for Quality Assurance (NCQA) to assist employers and other purchasers in evaluating health plan performance. HEDIS measures are also used by government agencies to monitor the quality of care provided or arranged by health plans.

Health Insurance Portability and Accountability Act (HIPAA): Regulations regarding the use and disclosure of certain information held by "covered entities" (generally, healthcare clearinghouses, employer-sponsored health plans, health insurers, and medical service providers that engage in certain transactions). Establishes regulations for the use and disclosure of Protected Health Information (PHI), which is any information held by a covered entity concerning health status, provision of healthcare, or payment for healthcare that can be linked to an individual.

Home: For the purposes of rental and purchase of DME, the member's home may be their own home, an apartment, a relative's home, a home for the aged, an Assisted Living Facility, or a Personal Care Home. Medicare rules say that a Skilled Nursing Facility is ***not considered*** a member's home.

Medicare Advantage (MA) Plan: Medicare managed care plans are an optional coverage choice for people with Medicare. They are also known as Medicare Part C or Medicare Advantage plans. Managed care plans take the place of Original Medicare coverage (Part A and Part B). The plans are offered by private companies overseen by Medicare. They are required to cover everything Original Medicare does, and they often cover more.

National Provider Identifier (NPI): The number used to identify healthcare providers in standard transactions, such as healthcare claims. The NPI is the only healthcare provider identifier that can be used for identification purposes in standard transactions by covered entities. It eliminates UPIN numbers – multiple provider numbers assigned by Medicare, Medicaid, and private payers.

Network: Contracted groups of physicians, hospitals, laboratories, and other healthcare providers who participate in a health plan's healthcare delivery system. The providers agree to undergo the Provider Partners credentialing process, follow Provider Partners' policies and procedures, submit to monitoring of their practices, and provide services to members at contracted rates.

Out-of-Area Care: Care for illness or injury that is delivered to members traveling outside the designated service area.

Out-of-Network Care: Care performed by providers who do not participate in the Provider Partners' network.

Out-of-Pocket Expenses: Payments toward eligible expenses that the member funds for himself/herself and/or dependents, including copayments, coinsurance, and deductibles.

Participating or In-Network Provider: Facility, hospital, doctor, or other healthcare provider that has been credentialed by and has a contract with a health plan to provide services.

Primary Care Physician (PCP): A healthcare practitioner who, within the scope of his/her practice, supervises, coordinates, prescribes, or otherwise provides or proposes to provide healthcare services to a member, initiates member referral for specialist care, and maintains continuity of care for enrolled members of an HMO.

Specialist: Provider or practitioner who specializes in a particular branch of medicine, such as cardiology, dermatology, orthopedics, or surgery.

Waste: Acting with gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit.

Abbreviations

ADA—Americans with Disabilities Act

ANOC—Annual Notice of Change

BMI—Body Mass Index

CAD— Coronary Artery Disease

CAHPS—Consumer Assessment of Health Plan Survey

CAQH—Council for Affordable Quality Healthcare

CCIP—Chronic Care Improvement Program

CHF—Congestive Heart Failure

CPT—Current Procedural Terminology

DME—Durable Medical Equipment

EOB—Explanation of Benefits

EOC—Evidence of Coverage

FDR—First Tier, Downstream, and Related Entities

FWA—Fraud, Waste, and Abuse

HCC—Hierarchical Condition Category

HEDIS—Health Plan Employer Data Information Set

HIPAA—Health Insurance Portability and Accountability Act

HITECH—Health Information Technology and Economic and Clinical Health Act

HMO—Health Maintenance Organization

LDL—Low-Density Lipoprotein

LIS—Low-Income Subsidy

MLP—Mid-Level Practitioner

NCQA—National Committee for Quality Assurance

NP—Nurse Practitioner

NPI—National Provider Identifier

OEC—Online Enrollment Center

OIG—Office of Inspector General

PCP—Primary Care Physician

PDSA—Plan-Do-Study-Act

PHI—Protected Health Information

POA—Power of Attorney

PRAF—Provider Remittance Advice Form

QIP—Quality Improvement Project

RNCC—Registered Nurse Care Coordinator

SDRP—Self-Referral Disclosure Protocol

TrOOP—True Out-Of-Pocket

UPIN—Universal Provider Identification Number