KeyCare ADVANTAGE

2027 Provider Manual

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GENERAL INFORMATION

Welcome!

Welcome to the KeyCare Advantage Provider Manual, a comprehensive guide to delivering exceptional care and service to your valued patients. This manual serves as a dedicated resource, carefully crafted to empower you in providing the highest standard of care within the KeyCare Advantage network.

At KeyCare Advantage, we understand that delivering exceptional healthcare goes beyond the exam room. It encompasses understanding the intricacies of the plan, aligning with established policies and procedures, and ensuring a seamless process for claim payment and prior authorizations.

Within these pages, you will find a wealth of information designed to support your practice. Whether you are seeking insights into the finer details of our plan's coverage, need clarification on reimbursement procedures, or require guidance on obtaining prior authorizations, this manual has you covered. It serves as a bridge between your expertise and our shared commitment to exceptional patient care.

It is important to note that this manual is explicitly incorporated as part of your contract with KeyCare Advantage and forms the foundation of our collaboration. In the event of a conflict between your contract and this manual, the obligations, terms, and conditions your contract contains shall take precedence. Just as our partnership relies on mutual understanding and cooperation, this manual reflects our dedication to equipping you with the tools you need to succeed within our network

We encourage you to explore these pages thoroughly, to familiarize yourself with the intricacies of our offerings, policies, and procedures.

Thank you for choosing to partner with KeyCare Advantage. Together, we will continue to elevate the standards of care and make a meaningful impact on the lives we touch.

Terms and Definitions

Term /Acronym	Definition
CMS	Centers for Medicare and Medicaid Services
COVERED SERVICES	Those services provided by the health plan in accordance with the health plan's Medicare contract
DUAL ELIGIBLE	A member who is eligible for both Medicaid and Medicare programs.
EXPLANATION OF PAYMENT (EOP)/REMITTANCE ADVICE (RA)	The EOP/RA statement is sent to the provider after our plan has determined coverage and payment. The statement provides a detailed description of how the claim was processed.
GRIEVANCE	Any oral or written expression of dissatisfaction by a member submitted to the health plan or to a state agency
MEMBER	A covered beneficiary enrolled in the plan. The terms member, patient, covered person and customer are used interchangeably to refer to the recipient of healthcare services.
NETWORK	All participating Providers, offering services to the Plan beneficiaries.
PROVIDER	A health care entity or health care professional contracted to provide services to Plan members. This term is inclusive of physicians, mid-level practitioners, facility, and ancillary provider types.

Plan Overview

ISNP Ventures, LLC d/b/a KeyCare Advantage is a Medicare Advantage Special Needs Plan in Maryland designed for senior living residents. Members receive a dedicated care team to coordinate care, schedule appointments, etc. In addition to Original Medicare benefits, they get enhanced coverage and extra support to bolster overall health and well-being. KeyCare Advantage's mission is to provide better outcomes, greater satisfaction and contained health care costs by re-orienting the provision of healthcare services to preventive lifestyle and chronic care management in a residential care.

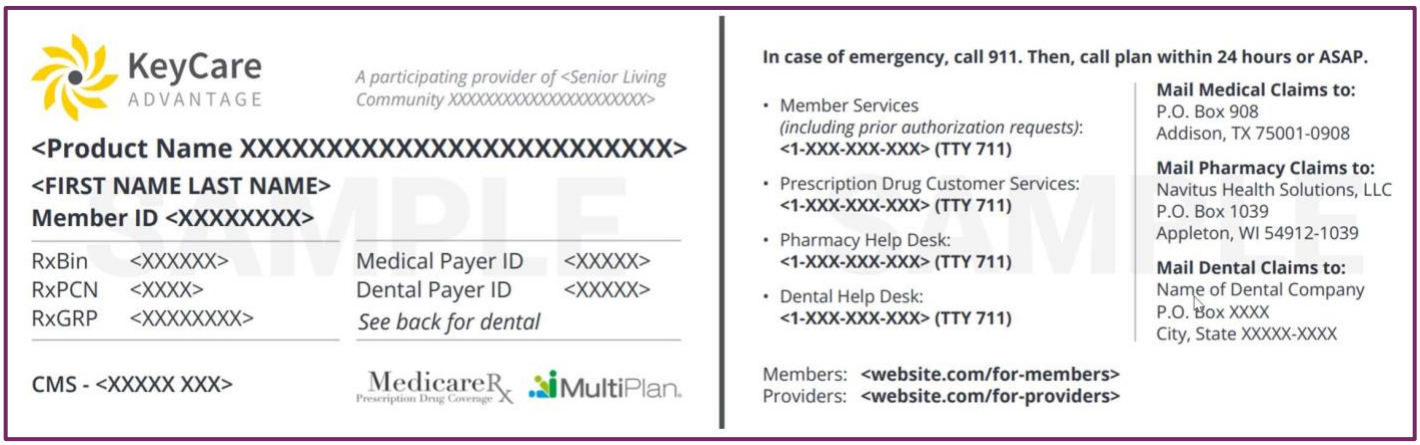
In this comprehensive provider manual, whenever the term **"plan"** is referenced, it pertains specifically to the KeyCare Advantage plan. This distinction ensures clarity and precision as you navigate the various aspects of care delivery and administration within our network.

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility during each visit, or before the appointment. You can verify member eligibility through the following ways:

- Member ID Card: Note that changes do occur, and the card alone does not guarantee member eligibility.
- Provider Web Portal: the web portal allows providers to verify eligibility online 24/7.
- Provider Services Department

Member ID cards are issued yearly. If a member has lost their ID card, they can contact Customer Service.



NOTE: Membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) may retroactively terminate members and recoup payments it made to the plan. When this occurs, the plan claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question. Typically, the beneficiary is disenrolled to Medicare fee-for- service. If the Medicare timely filing period has passed, Federal law gives providers an extra six months after the plan's recoupment to file a claim.

Model of Care for Special Needs Plans (SNP)

For members with special needs, we offer a Special Needs Plan (SNP) that includes a Model of Care (MOC) that is patient-centered, primary care driven healthcare care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, our Model of Care improves the quality of life for members while providing access to same services covered by Original Medicare. Supplemental benefits offer additional services and support for the plan's specialized population.

Model of Care Goals

- Improve access to medical, mental health, and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services; and • Improve member health outcomes.

Important Information About our Special Needs Plan

1. All members are required to choose or designate a Primary Care Physician (PCP) at enrollment. The staffing model, which could include care provided by a Nurse Practitioner (NP) or Physician Assistant (PA), is described in our Model of Care.
2. Our plan has received permission from CMS to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from the member's PCP, to treat members in the nursing home when appropriate and reserves acute hospital beds for members requiring more intensive services.
3. Our plan is "provider friendly" and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, prior authorization, and referral processes outlined in this manual

KEY CONTACT INFORMATION

PROVIDER AND MEMBER CUSTOMER SERVICE

- Email: CustomerService@keycareadvantage.com
- Phone: 1-844-206-1205 (TTY 711)

APPEALS & GRIEVANCES

- Email: Appeals@CuranaHealth.com
- Email: Grievances@CuranaHealth.com
- Fax: 1-833-610-2380

CLAIMS

Electronic Medical Claims

- Availity is the clearing house
- Payer ID: KCMD1

Medical Paper Claims:

- ISNP VENTURES, LLC d/b/a KEYCARE ADVANTAGE | PO Box 607, Glen Burnie, MD 21060-0607

Dental Claims:

- Liberty Dental | PO Box 401086 Las Vegas, NV 89140
- Dental Payer ID: CX083

CREDENTIALING

- Email: CredentialingOperations@curanahealth.com
- Practitioner Credentialing: Use CAQH application at https://proview.caqh.org/
- Organization credentialing application (for facilities and ancillaries): https://form.jotform.com/232605673353052

COMPLIANCE

- Phone: 1-844-317-9059, TTY 711
- Fax: 1-833-572-2372
- Email: Compliance@keycareadvantage.com
- 8028 Ritchie Highway Suite 210, Pasadena, MD 21122

ONLINE PROVIDER DIRECTORY

- Search our Network

SNP MODEL OF CARE

- Attest to the Model of Care Training

PRIVACY

- Email: PrivacyNotice@keycareadvantage.com

NETWORK SUPPORT

- To update provider demographic and billing information, email:
- KeyCare@allyalign.com

PROVIDER FEEDBACK SURVEY

- Share your feedback

PROVIDER PORTAL

- Login

QUALITY DEPARTMENT

- Email: QualityTeam@curanahealth.com
- Fax: 1-833-610-2386

UTILIZATION MANAGEMENT

- Fax: 1-833-610-2399
- Phone: 1-844-206-1205 (TTY 711)> Select #2 Providers> Select #3 for Prior Authorizations

BENEFITS AND SERVICES

All plan members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and services are subject to change on January 1st of each year. Providers may contact the Provider Services' line for information on covered services and verification of applicable member copayments and/or cost sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost sharing as defined under the plan policy or CMS regulations. Participating providers of our plan are, however, prohibited from balance-billing members copayments and/or cost sharing when members are determined qualified and eligible for benefits under the state Medicaid program.

Emergent and Urgent Services

Our plan follows the Medicare definitions of "emergency medical condition," "emergency services," and "urgently needed services" as defined in the Medicare Managed Care Manual Chapter 4 Section 20.2C:

Emergency medical condition: "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."

Emergency services: "Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

Urgently needed services: "Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required because of an unforeseen illness, injury, or condition.
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan's network of providers."

Our plan network includes hospitals, emergency rooms, and providers able to treat the emergent conditions of plan members twenty-four (24) hours a day, seven (7) days a week. Emergency services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues

occurring onsite in the member's nursing home or in the service area, the PCP is responsible for providing, directing, or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCP or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergency issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCP, working with the Plan's PCP, is responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the member.

While most members remain in the service area, plan members may receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside the plan's authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved for only continuity of care.

Our plan network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost sharing.

Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by the plan:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for members with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for members with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, and eyeglasses (which are only covered after cataract surgery) unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogamy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures and non-prescription contraceptive supplies.

- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the plan, the plan will reimburse veterans for the difference. Members are still responsible for the plan cost sharing amount.

Non-Covered Services

Providers may only collect fees from members for non-covered services when the service is clearly listed as a non-covered service in the members EOC, or the member has been provided with a standardized written Organization Determination (OD) denial notice from the plan prior to the item or service being rendered to the member.

In circumstances where there is a question whether the Plan will cover an item or service, providers should inform Members that they have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, plan provides the Member with a standardized written OD denial notice which states the specific reasons for the denial and informs the Member of his or her appeal rights.

Providers may not hold the members financially responsible or issue any form or notice that advises the customer they will be responsible for the costs associated with non-covered services unless the customer has already received the appropriate pre-service OD denial notice from the plan or the service or item is explicitly stated as a non-covered service in the EOC.

Continuity of Care

It is our policy to provide continuity and coordination of care with medical practitioners treating the same members, and coordination between medical and behavioral health services. As such, participating providers must notify the plan when they are terming or wish to term their participation with our plan network in accordance with the terms and condition of their participation agreement. This will ensure we are able to provide members with at least 30-calendar day advance notice of a provider termination where possible. If advance notice is not possible, please notify us as soon as possible. Any timeframes outlined herein are subject to the terms and conditions of the provider's participation agreement.

When a practitioner leaves the plan network and a member is on an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period as outlined in the provider's participation agreement.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of ninety calendar days, whichever is shorter.

If the plan terminates a participating provider, our plan representatives will work to transition a member into care with a Participating Physician or other provider within the plan network. The plan is

not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

We recognize that new members join our health plan and may have already begun treatment with a provider who is not in our provider network. Under these circumstances, we will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to ninety calendar days to complete the current course of treatment.

Our plan will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member's enrollment for a period of up to ninety calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Provider Services team.

MEDICAL MANAGEMENT

To ensure services are delivered timely to members, the guidelines below should be followed.

Notification of Inpatient and Observation Admissions

The preferred method for providing notification of inpatient and observation admissions is through the Plan's utilization management portal. You can request access by signing up through our plan website.

For timely care coordination, our plan requires notification within five (5) calendar days for the following services:

- Elective Admissions
- ER and Urgent-Direct Admissions
- Observation Status
- Admissions following outpatient procedures or Observation status.
- Transfers to Acute Rehabilitation, Skilled Nursing, and Long-term Acute Care (LTAC) facilities

Emergent admission notification must be received within three (3) calendar days of admission. For observation stays, our plan expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though our plan will waive the three-day stay requirement.

Prior Authorization

The preferred method for requesting prior authorization is through our plan utilization management portal. You can request access by signing up through our website.

Requests for prior authorization of services should be made at least fifteen (15) days in advance of any elective admission, procedure or services requiring Prior Authorization. The PCP and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures, and outpatient services ordered by the PCP.

For prior authorizations, providers should contact Provider Services or submit through our portal.

Services Requiring Prior Authorization

Providers should refer to the provider section of our plan website for a list of services typically requiring referral or authorization.

Documentation for Prior Authorizations

The Utilization Management Department evaluates requests utilizing CMS guidelines as well as nationally accepted criteria. Once the requests are processed the provider and member are notified of the determination. Examples of information required for an organization determination include but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- Servicing/Attending physician name.
- Service Date(s)
- Number of visits, if applicable
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code • Clinical information supports the need for the service.

Decisions and Time Frames

Expedited	Determinations made within 72 hours
Standard	Determination made within 7 calendar days
Part B Medication - Standard	Determinations made within 72 hours
Part B Medication - Expedited	Determinations made within 24 hours

Expedited: When you as a provider believe waiting for a decision under the standard time frame could place the member's life, limb, or ability to regain maximum function in serious jeopardy, you may request an expedited request.

Standard: If all required information is submitted at the time of the request, CMS mandates a health plan determination within seven (7) calendar days.

Once the Utilization Management Department receives the request for authorization, we will review the request for the following information, criteria, and hierarchy to make medical necessity approval determinations:

1. Health Plan (Administrative - eligibility and plan benefits)
    a. Evidence of Coverage (EOC)
    b. The Plan Benefit Package (PBP)
2. UM Clinical System Software (Administrative - eligibility and plan benefits)
3. CMS
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD)
    c. LCDs outside of applicable plan service area
    d. Medicare Benefit Policy Manuals, Transmittals and Publications
4. AAH Medical Coverage Policies (AAH-MCP)
5. Evidence Based Criteria

a. MCG
b. Medicare Drug Compendia
6. Other Approved Evidence Based Resources and Medical Literature

Criteria are approved annually by the Utilization Management Committee. Appropriate, actively practicing physicians and other Providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on the development or adoption of UM criteria and on instructions for applying the criteria.

The authorization number assigned to the request is only used for reference; it does not signify approval. Claims for services requiring prior authorization must be submitted with the assigned authorization numbers. This authorization number can be used to reference the admission, service, or procedure.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, skilled nursing facility (SNF), or other inpatient setting. Services which continue after the initial admission approval are reviewed to ensure:

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility/vendor contract, our Utilization Management department and Medical Directors utilize CMS guidelines and Millman Care Guidelines (MCG) to conduct medical necessity reviews. Our plan is responsible for final authorization.

If clinical information is not received within 24 hours of admission or prior to the last covered day, a medical necessity determination will be made using the existing clinical documentation and may result in denial for lack of information. Facilities may fax the members' clinical information within one business day from start of care. Refer to Key Contacts List for phone and fax information.

The plan Medical Director reviews all acute rehab, long-term acute care (LTAC), and SNF stays that do not meet medical necessity criteria. If the Medical Director (MD) deems the inpatient or SNF request does not meet medical necessity criteria, the MD will issue an adverse determination (a denial). A review of continued services for Acute Inpatient Rehabilitation can result in a denial if the MD determines no further treatment is required at that level of care. The Utilization Management clinician notifies the provider(s), e.g., facility, attending/ordering provider verbally and in writing, and notifies the member as required by law. The criteria used for the determination is available to the practitioner/facility and member. This information is available on our Plan website.

A written Integrated Denial Notice (IDN) is issued to both provider and member. This document includes information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

We issue written Notice of Medicare Non-Coverage (NOMNC) letters to facilities providing care to our members, according to CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA). The form requires the member or the authorized representative/POA to sign the notice within the written time frame listed. The facility is expected to fax a copy of the signed NOMNC back to our Utilization Management Department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal. Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. The Plan will not generate these NOMNCs.

Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, non-covered or exhausted benefits, or eligibility. Late notification will result in an administrative adverse determination and does not allow the provider to appeal.

Only a plan Medical Director, or delegated advanced practice practitioner, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When deciding based on medical necessity, the plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director decides to deny or limit an admission, procedure, service, or extension of stay, we notify the facility or provider's office of the denial of service. Denial notices are issued to the provider, the member or the member's authorized representative, documenting the denied request and the process for appeal, according to CMS guidelines.

Plan employees are not compensated for denial of services. The provider may request a peer-to-peer conversation with the Medical Director by telephone to discuss decisions only before an adverse determination is rendered.

After the adverse determination is rendered and per CMS guidance, the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with the pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification, and sent to the provider and/or member as applicable. Written notifications are sent to the members and requesting providers as follows:

- For non-urgent pre-service decisions-within seven calendar days of the request.
- For urgent medical service decisions–*within 72 hours of the request.
- For urgent Part B drug services decisions–*within 24 hours of the request.
- For concurrent decisions–*within 72 hours of the request.

*Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than three calendar days after the oral notification.

Our plan complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

Member Medical Records

Providers are required to maintain patient medical records current and in accordance with HIPAA privacy and document retention regulations. Member information must be kept confidential and stored in a secure location where only authorized personnel can access. Patients have the right to approve or refuse the disclosure of their medical records when required by law. Providers must maintain a clinical record system that supports the capacity to properly process, store, retrieve and distribute medical records. Medical record requirements apply to both paper and electronic record systems.

Documentation must demonstrate consistency in entries to ensure that diagnosis and treatment align with initial assessment and impressions, treatment, therapies, referrals, consultations, and continuity of follow-up care. The following must be included in medical records:

- Identifying information of the member
- Identification of all providers participating in the member's care and information on services furnished by these providers.
- Significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions, including over-the-counter products and dietary supplements.
- Information on allergies and adverse reactions
- Past medical history, physical exams, courses of treatment and risk factors.
- Immunization records
- Labs, X-ray, and all studies
- Member's preference for a Power of Attorney
- A copy of member's advance directive if one is available.
- Health education and wellness promotion services accessed by members.
- Provision of significant medical advice given by telephone, including medical advice provided by after-hours information or triage services.

Unless otherwise stated in the provider agreement, the Plan has the right to request and access medical records for the purposes of claim payment, quality of care and other quality activity, coordinating treatment plans, utilization management reviews or as part of a regulatory audit, CMS, state, or federal audit.

Records and Confidentiality

Providers shall maintain the medical, financial, and administrative records concerning all services provided to plan members that Provider would maintain in the ordinary course of business. Such records shall be retained by Provider for the period required by all applicable laws or regulations, but in no event less than ten (10) years from the date the service was rendered. During the term of their agreement and for ten (10) years thereafter, the Plan, as well as state and Federal agencies, have the right to review records related to services rendered to plan members, upon reasonable notice, during regular business hours. In accordance with State and federal regulations regarding Medicare members, Providers are required to maintain medical records in such format as necessary for the

evaluation of the quality, appropriateness, and timeliness of services performed under their Provider Agreement.

Providers must supply the Plan and the state and Federal agencies at an agreed upon fee schedule, with copies of Plan member medical records upon reasonable request. Member medical records shall be treated as confidential to comply with all state and Federal laws and regulations regarding the confidentiality of patient records. Providers should participate in any system established by the Plan to facilitate the sharing of records, subject to applicable confidentiality requirements.

Provider must obtain any necessary releases from Covered Persons with respect to their records and the information contained therein to permit the Plan, or state and Federal agencies, access to such records.

RADV (Risk Adjustment Data Validation) Audits

Each year, CMS conducts RADV audits to ensure the integrity of Medicare Advantage risk adjustment programs by verifying that diagnoses submitted by MA plans are supported by appropriate medical record documentation. CMS selects a statistically valid sample of members for audit, and health plans like ours are required to retrieve medical records from providers to validate the diagnoses.

We may contact you to request medical records for one or more of your patients who were selected by CMS for this audit. Record requests may include progress notes, consultation reports, diagnostic results, or any other supporting clinical documentation that substantiates diagnoses submitted for risk adjustment during the audit period.

All information collected will be handled securely and in compliance with HIPAA and CMS confidentiality standards.

Utilization Reporting and Monitoring

Under- and over-utilization may indicate inadequate coordination of care or inappropriate provision of services. Both under- and over-utilization may be harmful to the member. Utilizing data from provider and practitioner sites, individual product lines, our plan monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. We implement appropriate interventions when potential problems are identified and will further monitor the effect of these interventions. We carefully ensure that financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. Our plan unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

Transplant Network

Our plan partners with Optum to provide plan members with access to quality transplant providers. Optum’s Centers of Excellence (COE) deliver broad access, choice, and exceptional value. Our goal is to partner with Optum and network providers to reduce unnecessary procedures, improve the quality of transplant procedures and improve the overall transplant customer experience. If you are interested in joining Optum’s COE network of providers, visit their website at www.optum.com

CLAIMS AND ENCOUNTER SUBMISSIONS

Claim Format Standards

While our plan prefers electronic transmission of claims via the HIPAA compliant 837I (Institutional) and 837P (Professional) formats, paper claims submitted on the CMS-1450 (aka UB04) and the CMS-1500, or successor forms are accepted. If interested in submitting claims electronically, contact Provider Services.

Our plan also offers the ability to submit claims through the provider portal. Instructions on how to gain access to the portal can be found on the plan website.

Timely Filing

As a participating provider in our network, you are required to submit all claims in accordance with the timely filing requirements specified in your provider agreement. If not contracted or stated, CMS timely filing is followed.

Claim Requirements

Participating providers must submit a claim and/or encounter for services rendered regardless of any copayments, deductibles, or coinsurance collected from plan members. Our plan pays ‘clean’ claims according to contractual requirements. A ‘clean’ claim is a claim that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by the plan, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim.

Our plan can only pay ‘clean’ claims. Providers are responsible for accurate claims submission. While we will make our best effort to inform you of claims errors, claim accuracy rests solely with the provider.

Standard CMS required data elements must be present for a claim to be considered a ‘clean’ claim and can be found in the CMS Claims Processing Manuals.

Pricing

Original Medicare typically has market adjusted prices by code (i.e., CPT or HCPCS) for the services traditional Medicare covers. However, there are occasions where our plan offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, we will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Our plan requests you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement is incorrect.

We will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. We will also follow guidelines put forth by the AMA CPT, and CMS HCPCS coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by our plan is subject to the appeals/payment dispute, and clinical review policies and procedures outlined in this manual.

New or Unlisted Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when new codes are added by CMS for new and newly approved services or procedures, or if existing codes are changed. Providers should not bill with terminated or deleted CPT or HCPCS codes.

Our plan follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, we will load the new code as made available.

In the event a provider submits a code, and our plan claims system does not recognize it as a payable code or does not have a contracted allowance, the following process applies:

- The plan maintains the right to review and/or deny any claim with CPT/HCPCS codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. Examples include but are not limited to new CPT/HCPCS codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS.
- The provider may dispute the denial as outlined in their contract, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and
- The plan will pay for any services that include proof of payment by Original Medicare within the past six (6) months at the provider's contract rate or, if not addressed, 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing for which the provider furnishes proof.
- Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re- adjudication process.
- All codes/services submitted for payment but not recognized by the claims system will be subject to verification of medical necessity. Providers should always call for prior authorization of any procedure/service/or code for which they have concerns about coverage.

Model of Care and Chronic Care Management Reimbursement Policy

Consistent with the established Model of Care for our members, the Plan will not issue separate reimbursement for chronic care management services. These services are fully integrated into the comprehensive care provided by the member's designated Advanced Practice Provider (APP) and/or Care Ally.

The following chronic care management codes are excluded from separate reimbursement:

Code	Care Type	Staff Type	Time
99490	Chronic care management	Clinical staff	First 20 minutes
99439	Chronic care management	Clinical staff	Each additional 20 minutes
99491	Chronic care management	Physician or other qualified	First 30 minutes
		health care professional	
99437	Chronic care management	Physician or other qualified health care professional	Each additional 30 minutes
99487	Complex chronic care management	Clinical staff	First 60 minutes
99489	Complex chronic care management	Clinical staff	Each additional 30 minutes
G3002	Chronic pain management and treatment	Physician or other qualified health care professional	First 30 minutes (Must meet or exceed 30 minutes)
G3003	Chronic pain management	Physician or other qualified health care professional	Each additional 15 minutes (Must meet or exceed 15 minutes)
99453	Initial device supply with daily recording or programmed alert transmission, and patient education. This code is billed once per patient per episode of care.	Physician or other qualified health care professional	Initial
99454	Monthly supply of the device(s) used for daily recording of physiologic data and transmission to a practitioner. Requires at least 16 separate	Physician or other qualified health care professional	Monthly

	days of readings in a 30-day period to be billable.		
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff time in a calendar month that includes interactive communication with the patient or caregiver. This code is billed once per calendar month.	Physician or other qualified health care professional	20 minutes
99458	An add-on code for each additional 20 minutes of RPM services beyond the initial 20 minutes covered by 99457.	Add-on code	After the first 20 minutes

HEDIS® Coding Tips

CPT Category II codes, when added to a claim, help identify additional information about our members' care. This method of reporting simplifies and improves accuracy of reporting select quality measures for HEDIS®, CMS Star Ratings reporting and incentive programs. Category II codes are for informational purposes only and this communication is not intended to suggest or guide reimbursement. Reach out to Provider Services if you would like additional information.

Additional coding tips can be found on the Plan's website in the For Providers section, Provider Documents, Quality Resource Guide.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by our plan are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your contract, the member may not be billed for services denied by our plan unless the member received the denial before the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed the plan procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the members or the services are not covered, the EOP/RA will alert you to this. Obtaining pre-services review will reduce denials.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice, the financial responsibility for that member shifts from our plan to Original Fee for Service Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services the plan is financially responsible for during this time include any supplemental benefits our plan offers in addition to Fee for Service Original Medicare benefits.

Members can revoke hospice elections at any time. If so revoked and once notified by CMS, the plan will resume coverage for the member on the first day of the following month in which Hospice was revoked. These rules apply for both professional and facility charges.

Our plan may be notified of a hospice election by CMS after claims have been paid for dates of service during the hospice election period. In this instance, the Plan will notify the provider that a refund is due to the Plan. The provider must remit the refund to us and submit a claim for these services to Fee for Service Original Medicare, consistent with CMS policies.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e., property and casualty insurer, an automobile insurer, or worker's compensation carrier), not two health insurers.

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by the Claims Department.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to us with any information regarding the third-party carrier. All claims are processed per the usual claims' procedures.

For claims related questions, please contact the plan Provider Services Department.

Appeals and Payment Disputes

Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow this process. Payment dispute procedures are separate and distinct from appeal procedures. A formal payment dispute request is required from the provider to contest the amount paid on a claim which does not include a medical necessity or administrative denial.

All Payment Disputes must be:

- Submitted in writing within 60 days from the original payment.
- Include a cover letter with:
    - Claim identifiable information.
    - The specific rationale as to why the payment made is not appropriate or needs adjustment.
- Include necessary attachments:
    - Copy of the original Remittance Advice (RA)
    - Applicable medical records or other documents supporting your request for additional payment.

Providing the above information enables our Payment Dispute Unit to review the request properly and promptly. Payment disputes with missing information may delay our review and resolution. We will not request additional information and expect the provider to submit the necessary information to substantiate their request for additional payment.

The payment dispute must be in writing and mailed or faxed to the Payment Dispute Department. Providers will be notified of the final decision.

Participating Provider Administrative Plea/Appeals Responsibility

Providers may submit a formal request to review a previous decision where a determination was made stating the Participating Provider failed to follow administrative rules, assigning liability to the Provider (see original decision letter) where the services were rendered.

All requests must be:

- Submitted in writing.
- Submitted within 65 days of the decision letter date.
- Include a cover letter with:
- Member identifiable information
- Date(s) of service in question
- The specific rationale as to why the administrative rules were not followed, requiring an exception to be made or extenuating circumstance warranting a rereview of the request for provision of payment.
- Include necessary attachments:
    - Copy of the original decision
    - All applicable medical records

The appeal must be in writing and mailed or fax to the Appeals Department. If our plan waives the administrative requirement, and the request requires a medical review, we will not request additional records to support the provider's argument. The provider is expected to submit the necessary information to substantiate the request for payment. Providers will be notified of the final decision.

MEMBER GRIEVANCES, APPEALS, AND COMPLAINTS

Appeals

A plan member has the right to appeal against any decision about the plans' failure to provide or pay for what they contend are covered services.

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide.
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by the plan.
- Services they have not received, but believe are the responsibility of the plan to pay; and/or
- A reduction in or termination of service a member feels is medically necessary.

Also, a member may appeal any decision on a hospital discharge. In this case, a notice will be given to our members with information about how to appeal, and our members will remain in the hospital while the decision is reviewed. Our members will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to the Evidence of Coverage (EOC) for additional information.

For pre-service determinations, our members treating provider acting on behalf of our members or staff of the provider's office acting on said provider's behalf (e.g., request is on said provider's letterhead); or any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding may file an appeal.

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 60 days of the original decision. Appeal requests should include a copy of Remittance Advice (RA) reflecting the denial, and any medical records supporting why the service was needed.

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing.

Our member or treating provider may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Providers contracted with our plan may not use the member appeal process to file an appeal for post service payment disputes. Contracted providers should use the process outlined in the “Billing and Claims” section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances we should consider.

Member Grievances & Complaints

Plan members have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan us or their treating provider. Situations for which a grievance may be filed include but are not limited to:

- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns.
- Involuntary disenrollment situations; and/or
- Complaints concerning the quality of services a member receives.

Complaints may be received by the Plan’s PCP, Contracted Facilities, Plan Customer Service representatives, and through Member Services. All complaints are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with us in investigating grievances related to the provider or providers services.

PROVIDER PARTICIPATION

Credentialing

Our plan does not discriminate in terms of participation, reimbursement, or based on the population of beneficiaries serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. All practitioners and organizational applicants to the plan must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

No provider can be assigned an effective date with the plan, be included in the Plan Provider Directory, or have plan Members assigned to them without successfully completing the credentialing process.

Practitioner Credentialing Requirements

To participate in the plan network, credentialing is required for:

- All physicians who provide services to plan members, including members of physician groups; and
- All other types of health care professionals that provide services to plan members, and who are permitted to practice independently under state law.

Credentialing is not required for:

- Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.
- Hospital-based health care professionals that provide services to plan members incident to hospital services unless those health care professionals are separately identified in member literature as available to members for services.
- Students, residents, or fellows.

Practitioners must submit a complete application to begin the credentialing process. The application can be a State Mandated Credentialing application or the CAQH Universal Credentialing Application form. If the CAQH form is used, practitioners must provide their CAQH ID.

The application must include an attestation, consent and release form that is less than 90 days old. Any questions answered unfavorably in the application must include an explanation. The information included in the providers submitted application will be reviewed and utilized in the assessment of the provider for plan participation.

When assessing practitioners, the following criteria are used:

- Has a current license to practice in the plan's service area where the services will be provided.
- Is Board Certified in practicing specialty (as applicable). Note that some specialties require board certification for plan participation, questions for specific specialties may be directed to Credentialing.

- Maintains current professional liability insurance as that meets state and contractual requirements.
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare, Medicaid, or any other government health-related program.
- Education, training, and work history must show ability to meet contractual requirements.
- Has a completed application that includes explanations for:
    - Gaps in work history over 6 months
    - Disclosure of questions that were answered unfavorably.

Organizational Provider Credentialing Requirements

To participate in the plan network, credentialing is required for all contracted organizational provider types that provide routine services to plan members and have a registered organization NPI number. Organizational providers must fill out a plan or state mandated organizational credentialing application for review. An application is required for each NPI that the organization will bill the plan under. The plans online organization credentialing application is used for evaluating organizations (link in Key Contact Information and Sites).

When assessing organizational providers, the following criteria is used:

- Has a current license to practice (as applicable depending on state requirements and services) in the plan's service area where the services will be provided.
- Maintains current professional and general liability insurance as that meets state and contractual requirements.
- Is enrolled to participate with Medicare/ Medicare Certified
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare, Medicaid, or any other government health-related program.
- Has been reviewed and approved by an accrediting body (if applicable).
- If not accredited, has a CMS or state licensing survey completed within the past 36 months, or a letter of good standing from the appropriate licensing agency.
- Has a completed application that includes:
    - Copies of all current support documents listed on the application according to services provided.
    - Has been attested to within the past 120 calendar days.
    - Includes an explanation for all disclosure questions answered unfavorably.
    - Ensure all documents are within 45 days of expiration.

Credentialing and Recredentialing Process

The Credentialing Department conducts primary source verification of all applicants, including practitioners and organizational providers. This includes licensure, accreditation or certification status, Medicare enrollment (as applicable), liability insurance, sanctions, exclusions, CMS preclusion, education, board certification, and privileges, as appropriate by provider type.

The credentialing process can take up to 90 days to complete. When credentialing is complete, and the credentialing decision is made, the provider is notified in writing of their participation effective date.

All providers are required to recredential at least every three years to maintain an active participating status with the plan. Information obtained during the initial credentialing process is updated and reverified as required. Providers are notified of the need to submit re-credentialing information at least four months in advance of their three-year anniversary date. Three separate attempts are made to obtain the required information via mail, fax, email, or telephonic request. Providers that fail to return recredentialing information before their re-credentialing due date are subject to termination of network participation.

Provider Rights

Providers have the right to be informed of the status of their credentialing application and may request the status of the application either telephonically, in writing or by logging into their HUB account at: https://hub.veritystream.cloud/app/39401HP/userlogin. The online application HUB account is available to all providers and their application credentialing administrators as listed on their credentialing application. The HUB account information is shared with providers upon application submission and allows them to view their status on demand.

Our plan will respond within ten (10) business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations, or other peer-review protected information, also known as primary source recommendation. Providers may submit a written request to review his/her file information at least thirty days in advance. Our plan will establish a time for the provider to view the information.

Providers have the right to correct erroneous information when information obtained during the credentialing process varies from what was submitted by the provider. In instances where there is a substantial discrepancy in the information, our plan will notify the provider in writing of the discrepancy. Providers must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within 30 days of notification.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers (organizational and practitioner) are subject to a review process before approval or reapproval as a participating provider. The Credentialing Committee is composed of plan providers of different specialties and professional backgrounds. Each plan selects a Medical Director to represent the plan. The Plan Medical Director may approve providers who meet all acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All providers must be credentialed and approved before participating in the plan's network.

Non-Discrimination in the Decision-Making Process

Our Credentialing Program is compliant with all CMS and State regulations. Through the universal application of specific assessment criteria, our plan ensures fair and impartial decision-making in the credentialing process. No provider is participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their credentialing approval date. Providers (facility and practitioners) are advised not to see plan members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee are notified in writing within thirty (30) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

In the event a provider's participation is limited, suspended, or terminated due to no longer meeting credentialing criteria, the provider is notified in writing within 30 days of the decision date. Notification includes:

- the reason(s) for the action
- the appeals process or options available to the provider
- a statement of the practitioner's right to an in-person hearing
- a statement of the practitioner's right to be represented by legal counsel
- reference to the evidence or documentation for the proposed adverse action (as applicable) and
- time limits for submitting an appeal

A panel of peers reviews all appeals. The hearing panel includes an actively practicing clinical peer of the practitioner who is not involved in network management. Written notification is provided to the appealing provider at least 60 calendar days prior to the date of the hearing. Written notification of the hearing panel decision is sent to the appealing provider within 60 calendar days after hearing closure.

When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential, managed, and stored confidentially and securely as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information is not disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

Our plan conducts routine, ongoing monitoring of the preclusion list, license sanctions, Office of

Inspector General (OIG) exclusions, CMS Preclusion, Medicare/Medicaid sanctions and the CMS Opt-Out list between credentialing cycles. Any provider whose license has been revoked or has been precluded, excluded, suspended, and disqualified from participating in any Medicare, Medicaid, or any other government health-related program or who has opted out of Medicare will be automatically terminated from the Plan.

Site Evaluations

Site evaluations may be required when it is deemed necessary because of a customer complaint, quality of care issue and/or as otherwise mandated by State or Federal regulations. Office site evaluations will review the following:

- Physical appearance and accessibility.
- Customer safety and risk management.
- Medical record management and security of information.
- Appointment availability.
- Cleanliness & Adequacy of Equipment
- Policies and Procedures

Providers who fail to pass the area of the site visit specific to the complaint or who do not meet the site evaluation standards will be required to submit a corrective action plan and make corrections to meet the requirements. Follow-up reviews may be conducted to ensure compliance.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved and must be credentialed under a specialty or capability required for Online Provider Directory display by CMS. Directory specialty designations commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process.

Plan Notification Requirements for Providers

The following list of changes must be reported to our plan at least thirty (30) days in advance (or longer as stated in the provider agreement) by emailing the provider network support email.

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence.
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)

- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations
- Panel status changes (closed or open panel)
- Office Hour updates
- Telehealth capabilities

To update any of the information listed on the online directory for your practice, navigate to the online provider directory, open your directory listing, and click on 'Report Incorrect Information.' By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory.

Closing Patient Panels

When a participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against plan members by closing their patient panels for our members only. Providers who decide they will no longer accept any new patients must notify us at least 30 days prior to the change effective date.

Access and Availability Standards for Providers

Our plan has established written standards to ensure timeliness of access to care that meets or exceeds the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. Our plan also requires all providers to offer standard hours of operation that (1) do not discriminate against Medicare members, and (2) are convenient for plan members, the facilities where members reside, and facility staff who aid in member care. PCPs are NOT to provide routine visits at times that coincide with regular facility mealtimes or interfere with expected member sleep patterns by occurring before 8 am or after 8 pm or occur during nursing staff shift changes.

Access and Availability Survey

Our plan conducts monitoring of provider access and availability to ensure compliance with CMS standards. The Access and Availability yearly survey is used to review provider compliance with access standards.
The Access and Availability survey is an online survey sent to providers as a link for completion. The survey includes multiple choice questions depending on the provider's specialty type.

Providers must obtain at least an 80% score to pass the survey. Providers that fail the survey are sent a corrective action notice which allows them the opportunity to identify the corrections needed and include remediation actions with due date. A survey is conducted after the due date.

Provider Responsibility

Plan members have access to care 24 hours a day, 7 days a week as medically necessary. We have additional policies in place to make sure members have timely access to regular and routine care services, urgent care services, preventative care, network providers, women's health services, or

after-hours care. The Plan adopts certain clinical and preventive health guidelines and lists them on the Plan website (Provider – Clinical Practice Guidelines and Medical Necessity section) to assist providers in locating the most up to date, evidence-based guidelines to support you in caring for our members.

PCPs are required to provide routine, preventive care, and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as a moderate or high risk.

- Assigned providers must make routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner.
- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.
- Specialists are required to be available for a consultation or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, the plan, PCP, plan Medical Director and Utilization Management staff, and nursing home facility staff):

    - Emergency care calls, both weekdays and after-hours calls, are to be addressed immediately. Urgent care calls, both weekdays and after-hours calls, are returned within 30 minutes.
    - Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

MEDICARE REQUIRED POLICIES

Non-Discrimination and Cultural Competency

CMS defines health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes”.

Participating providers must provide services to all plan customers, consistent with the benefits covered in their policy, without regard to English proficiency or reading skills, ethnic, cultural, racial or religious background, mental or physical disabilities, sexual orientation, gender identity, socioeconomic or financial background, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

We encourage providers to visit the U.S. Department of Health and Human Services Office of Minority Health website for resources, training, policies, programs and best practices on Cultural and Linguistic Competency: Cultural and Linguistic Competency | Office of Minority Health (hhs.gov)

Dual Eligibles and Cost Sharing

For all members eligible for both Medicare and Medicaid, members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for members enrolled in Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

Member Hold Harmless

Participating Providers are prohibited from balance billing plan members including, but not limited to, situations involving non-payment by the Plan, insolvency of the Plan, or the Plan’s breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than the Plan, acting on behalf of customers for covered services provided pursuant to the Participating Provider’s Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable customer’s Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual. Participating providers should call Provider Services to check on member cost-share responsibility if not listed on the member ID card.

Provider Marketing Guidelines

Below is a general guideline to assist providers in determining what marketing and outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided patient toward a specific plan or limiting to several plans offered either by the Plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions. Please consult the CMS Marketing Guidelines or other published CMS materials for the full list of acceptable and unacceptable provider behaviors.

Providers Can:

- Suggest looking into Plan membership as a matter of course in treatment
- Collect a Permission to Contact if a resident/responsible party voices interest in learning more about the Plan
- Pass a Permission to Contact to a sales agent
- Mail or provide a letter to patients notifying them of their affiliation with the Plan
- Provide objective information to patients on specific Plan attributes and formularies, based on a patient's medications and healthcare needs while treating the member
- Answer questions or discuss the merits of a plan or plans, including cost-sharing and benefit information. These discussions may occur in areas where care is delivered
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the Plan and making a healthcare enrollment decision
- Provide beneficiaries with communication materials furnished by the Plan in a treatment setting
- Refer patients to the Plan marketing materials available in common areas
- Display and distribute in communal areas KeyCare Advantage marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the Plan
- Provide information and assistance in applying for the Low-Income Subsidy (LIS)
- Display promotional items with the Plan logo
- Allow plans to have a room/space in provider offices separate from where members receive healthcare services, to provide Medicare beneficiaries with access to a plan sales representative

Providers Cannot:

- Offer anything of monetary value to induce members to select them as their provider
- Distribute marketing materials/applications in an exam room
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest
- Collect/accept enrollment applications or scope of appointment forms on behalf of the Plan
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Health Screen potential plan members when distributing information to patients. Health screening is prohibited
- Expect compensation directly or indirectly from the Plan for beneficiary enrollment activity

- Call members who are disenrolling from the Plan to encourage re-enrollment in the Plan
- Call patients to invite them to the sales and marketing activities of a health plan
- Advertise using the Plan's name without the Plan's prior consent and potentially CMS approval depending upon the content of the advertisement

Member Assignment to New PCP

PCPs will receive regular updates of member assignments and related services and benefits. Plan PCPs have a limited right to request a member be assigned to a new PCP. A PCP may request a member be moved to the care of another PCP due to the following behaviors:

- Fraudulent use of services or benefits
- The member is disruptive, unruly, threatening, or uncooperative to the extent their membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior mentioned above
- Threats of physical harm to a provider and/or their office staff
- Non-payment of required member cost share for services rendered to members who are not Dual Eligibles (Medicare and Medicaid)
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary
- Repeated refusal to comply with office procedures essential to the functioning of the PCP's practice or to accessing benefits under the Plan

The PCP should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remediated through reasonable efforts, and the PCP feels the relationship is irreparably harmed, the PCP should complete the Patient Transfer Request form and submit it to us. The Patient Transfer Request form can be located on the Plan website in the Provider Resources, Plan Documents, Forms section.

Plan staff will research the concern to determine if the situation warrants requesting a new PCP assignment. If so, the Plan will document all actions taken by the provider and the plan to cure the situation, including member education and counseling. A PCP cannot request disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member may request a change in PCP for any reason. The PCP change requested by the member will be effective the first (1st) of the month following receipt of the request unless circumstances demand an immediate change.

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment. The Plan requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted with the Plan may be informed by the member that the member has executed, changed, or revoked an advance directive. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive for inclusion in their medical record. If the member's PCP and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, the provider must advise the member and the Plan. The Plan and the PCP and/or treating provider will arrange for a transfer of care. To ensure providers maintain the required processes to advance directives, the Plan will conduct periodic medical record reviews.

The Right to Be Treated with Dignity and Respect

Members must be afforded appropriate privacy and treated with respect, consideration, and dignity. The Plan and its contracted providers must obey all laws against discrimination to protect members from unfair treatment. Anti-discrimination laws mandate that the Plan and its contracted providers must not discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. Also, contracted providers may not discriminate against members based on their payment status or refuse to serve members because they receive assistance with Medicare cost-sharing from a State Medicaid program. If Plan members need help with communication, such as a language interpreter, they can call the Plan's Member Services Department. The Member Services Department can also assist members in filing complaints about access to facilities (such as wheelchair access).

The Right to See Participating Providers, Get Covered Services and Prescriptions Filled Promptly

Members will get most or all their healthcare from participating providers—the doctors and other health providers who are contracted with the Plan. Members have the right to choose any participating provider. The Plan will collaborate with members to ensure that they find physicians who are accepting new patients. Members have the right to seek care from a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can secure appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to receive the care and services they need. The EOC also outlines a member's rights to receive care for medical emergencies and urgent needs.

The Right to Know About Treatment Choices and Participate in Decisions About Their Healthcare

Members have the right to obtain complete information from their providers regarding their medical care and to be fully involved in the planning and decision-making processes concerning their treatment. Plan providers must ensure that explanations are given in a manner that members can easily understand. Members must be informed about all recommended treatment options for their condition, including all appropriate and medically necessary choices, regardless of cost or coverage by the Plan. This includes the rights to be informed about the different Medication Management Treatment Programs the Plan offers and those in which members may participate, and the right to informed about any risks associated with their treatment.

Members have the right to a detailed explanation from the Plan if they think the Plan provider has denied or discontinued care they are entitled to receive. In these situations, members should request an initial decision, which is detailed in their EOC.

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave. This includes the right to stop taking their medications. If members refuse treatment, they assume responsibility for any consequences resulting from their decision.

The Right to Make Complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. A member or their appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If a member makes a complaint or files an appeal or coverage determination, the Plan must manage their case fairly and without discrimination based on their actions. Plan members should be directed to call the Member Services Department to obtain information related to appeals, grievances, concerns, and/or coverage determinations.

Right to Receive Complete and Accurate Health Information

Members, or legally authorized designees, should receive complete and accurate information concerning their health evaluation, diagnosis, treatment, and prognosis and have the right to participate in health care decisions unless such information is contraindicated for medical reasons.

In addition to the above, members have the following rights:

- The right to maintain confidentiality of their health information
- Right to refuse to participate in research, if applicable
- Right to interpretive services, as necessary
- Right to access information regarding advance directives, as required by state or federal laws and regulations.
- Right to access to provider credentials upon request
- Right to change providers, including Primary Care Providers (PCP) and expedite the request to change
- Right to receive information about a provider’s malpractice insurance upon request • Right to request a second opinion related to health care treatment and services

QUALITY IMPROVEMENT

Quality Improvement Program

The purpose of the Quality Improvement (QI) Program is to ensure that we have the necessary infrastructure to coordinate equitable care, promote quality, performance, and efficiency on an ongoing basis.

The QI Program is designed to monitor and evaluate the quality, appropriateness and outcomes of care and services delivered to Members objectively and systematically. In addition, it is designed to provide mechanisms that continuously pursue opportunities for improvement and problem resolution. The Health Plan's QI Program includes all elements required by Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 5 and 16b.

A formal evaluation of the QI Program is performed annually and provides guidance for changes to the QI Program in the following year. The following information is monitored in various forums during the year and analyzed as part of the annual evaluation:

- Social determinants of health, cultural and linguistic needs of the population and clinical needs of members with complex health needs
- Delegated activities
- Provider accessibility and availability
- Member satisfaction
- Member safety
- Grievances and Appeals
- Customer Service
- Continuity and coordination of care
- SNP model of care
- Chronic Care Improvement Program (CCIP) and Performance Improvement Projects (PIP)
- Medicare Advantage and SNP HEDIS® measures[1]
- CMS Display measures
- CMS Star measures
- Medicare HOS and CAHPS survey results, if required[2]
- Credentialing and recredentialing
- Provider Directory Update Timeliness
- Provider Satisfaction
- Network adequacy
- Utilization management (UM) program
- Under and over utilization
- Quality of Care Issues and Sentinel events
- Part C Reporting Elements
- Part D Medication Management data

PCPs each play an active role in making sure members receive the best care. Each year, we will evaluate past performance and implement improvement activities. Providers and members may request a copy of the Quality Improvement Program or Annual Evaluation at any time.

Member Satisfaction

KeyCare Advantage strives to improve the quality of services, benefits, and health care by collaborating closely with providers to enhance the member experience through the utilization of a member survey. Each year, the survey is conducted beginning in January. The survey includes questions regarding member satisfaction with a variety of topics such as satisfaction with practitioners, Plan services and benefits and access to care.

The survey results are a valuable tool used to identify areas of opportunity to improve the overall Member experience with their health care and Health Plan.

Quality of Care Concerns

We are committed to ensuring members receive quality care according to recognized standards of care. Quality of Care concerns may be identified by providers, staff, members or their designated representatives.

- Potential Quality Issues (PQI) are defined as a potential deviation from expected provider performance, clinical care or outcome of care occurring in any care setting indicative of potential inappropriate or incomplete medical care. PQIs are usually identified by providers and staff.
- Quality of Care Complaints are those concerns reported by members, families, or providers (on members' behalf) indicating a potential problem in the provision of quality care and services. Please refer to section Member Grievances & Complaints above for details on how members report complaints.

The purpose of identifying these concerns is to formulate opportunities to improve clinical care and service. Some examples include:

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- Post-operative complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Avoidable incidences resulting in injury to the member.
- Mortality review (in cases where death was not an expected outcome)

Providers can submit potential quality of care concerns by accessing the Provider Portal or accessing the form on the Plan's website (Provider section, Provider Documents, Potential Quality Issue (PQI) Referral Form). All reported Quality of Care concerns are reviewed and tracked. We may request records from providers and facilities as part of the process. The Quality Improvement Committee reviews trends related to quality-of-care concerns and may recommend actions to prevent future instances. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re- credentialing.

CORPORATE COMPLIANCE PROGRAM

Overview

The purpose of the Corporate Compliance Program is to articulate the plan's commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern plan operations. Further, the Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations.

Our plan and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Noncompliance with regulatory standards undermines plan business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. The plan and its employees are also committed to meeting all contractual obligations outlined in contracts with the CMS. These contracts allow the plan to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program prevents violations of federal and state laws governing plan lines of business, including but not limited to, healthcare fraud, waste, and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

We have a plan in place, policies, and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. We also have policies ensuring we will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designees. If you have compliance concerns or questions, call the Compliance Hotline.

Fraud, Waste, And Abuse

Our plan has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by the plan encompasses all aspects of plan business and its business relationship with third parties, including healthcare providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith.

The Compliance Officer may be contacted in the following manner:

Phone:	1-844-317-9059, TTY 711
Email:	compliance@keycareadvantage.com
Fax:	1-833-572-2372
Address:	8028 Ritchie Highway Suite 210, Pasadena, MD 21122

The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affecting the plan's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.

All communications are kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or another party that reports compliance concerns in good faith can do so without fear of retaliation.

Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, our plan conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows us to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. We will review your coding and may review medical records of providers who continue to show significant variance from their peers.

As a participating provider, you are required to:

Maintain Documentation

- Keep all relevant documentation to support the services billed.
- Ensure records are accurate and complete.

Submit Records

- Provide all requested documentation to KeyCare, governmental agencies, and their representatives upon request.
- Submit records within the specified timeframe and at no charge

Failure to provide the requested records will forfeit your right to an appeal. AAH will recover the paid amount of the associated claims and may send a referral to applicable regulatory agencies.

To ensure you receive important plan correspondence, please ensure your practice contact information is current in the Provider Directory.

To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards. You may request a copy of the plan Compliance Program document by contacting Provider Services.

PROVIDER FEEDBACK

Yearly Provider Survey

We value your feedback. On a yearly basis, the plan will send out a provider survey to all participating physicians who have a business email on file. We encourage you to fill out the survey and provide your feedback. Survey results are reviewed for needed changes of Plan operations.

Click to Begin Survey

PROVIDER NEWSLETTER

Connect with us to stay informed of upcoming changes!

Use the link below to opt-in to the provider newsletter distribution list. The newsletter is emailed throughout the year and includes regulatory and plan changes as well as valuable information to help you continue to serve our members.

https://mailchi.mp/keycareadvantage/0tzus36o59