



*Medicare Advantage HMO&PPO*

*Provider Manual*

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# Medicare Overview

## *Medicare Program*

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans. Medicare is a Health Insurance Program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

### *Part A*

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in a Medicare-covered employment, is age 65, and a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other Durable Medical Equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

### *Part B*

Medicare Part B pays for many medical services and supplies, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by The Centers for Medicare and Medicaid Services. Part B also covers:

- Outpatient hospital services
- X-rays and laboratory tests
- Certain ambulance services
- Durable Medical Equipment
- Services of certain specially qualified practitioners who are not physicians
- Physical and Occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and Pap smears

- Home Health care if a beneficiary does not have Part A.

## **Medicare Advantage Plans**

The Balanced Budget Act of 1997 (BBA) established Medicare Part C also referred to as Medicare Advantage (MA). Prior to Jan. 1, 1999, Medicare HMO's existed as Medicare Risk or Medicare Cost plans. The Balanced Budget Act of 1997 was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

### ***Medicare HMO***

Blue Cross and Blue Shield of Georgia (BCBSGA) contracts with a network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. BCBSGA Medicare Advantage HMO members should select a primary care physician from those that are part of the plan's network. The Primary Care Physician (PCP) is responsible for managing the member's medical care, including admissions to a hospital

Medicare HMOs have "lock-in" requirements. This means that in order to access benefits, a member is locked into receiving all covered care from doctors, hospitals and other health care providers who are contracted with the plan. In most cases, if a member goes outside the plan for services, neither the plan nor original Medicare will pay. The member will be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which a member may receive anywhere in the world; for urgently needed care, which you may receive while temporarily away from the plan's service area; for out-of-area renal dialysis services; and if the service is prior authorized by the plan. Urgent care is also covered inside the service area if the Plan's delivery system is temporarily unavailable or inaccessible. A Medicare Advantage organization must provide coverage and payment for all services that are covered under Part A and Part B of Medicare.

### ***Medicare Local PPO***

BCBSGA's local PPO plan is a managed care plan in which you pay less out-of-pocket costs when you use providers who are part of the BCBSGA Medicare Advantage PPO network. Local PPOs are available in select counties within a state. CMS allows the Medicare Advantage plan to select the counties that they want to participate in. BCBSGA has a contract with the Federal government that allows BCBSGA to administer all Medicare benefits. Medicare Advantage PPO members are not required to select a primary care physician or obtain a referral for specialty care. Members are encouraged to coordinate their care through a primary care physician. BCBSGA Medicare Advantage PPO members can utilize providers both in and out of the network. Precertification is required for some services.

### ***Medicare Regional PPO***

CMS requires BCBSGA to offer a Regional PPO in all counties within the designate CMS defined region. A Regional PPO is also a managed care plan in which you pay less out-of-pocket costs when you use providers who are part of the BCBSGA Regional PPO network. It is not an insurance policy that pays our member's Medicare deductible and coinsurance charges. Instead, BCBSGA has a contract with the Federal government that allows BCBSGA to administer all Medicare benefits. BCBSGA Regional PPO members are not required to select a primary care physician or obtain a referral for specialty care. Members are encouraged to coordinate their care

through a primary care physician. BCBSGA Medicare Advantage PPO members can utilize providers both in and out of the network. Precertification is required for some services.

Beginning January 1, 2010, BCBSGA Medicare PPO plans will participate in the Reciprocal Network Sharing program. The Network Sharing program will allow all Blue Medicare Advantage (MA) PPO members to obtain in network benefits when traveling in the service area of any other participating Blue MA PPO plan as long as the member receives services from a contracted MA PPO provider. The abbreviation "MA" enclosed within a suitcase symbol on the member ID card will help to identify MA PPO members participating in the Reciprocal Network Sharing program.

### ***Managed Care Plan Enrollment***

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A & B and continue paying Part B premiums
- Live in the plan's service area
- Not have permanent kidney failure at the time of enrollment unless they are currently enrolled in the Plan's commercial product.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from November 15<sup>th</sup> through December 31<sup>st</sup> each year, with a 01/01/ plan effective date.

### ***Effective/Termination Date Coincides with a Hospital Stay***

If a member's effective date occurs during an inpatient stay in a hospital, BCBSGA is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility (SNF)).

BCBSGA is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A are covered by the Medicare Advantage plan beginning on the effective date of enrollment.

If the member's Medicare Advantage coverage terminates while the members is hospitalized, BCBSGA is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

# **Provider Participation in BCBSGA's MA Plans**

## ***Participation Procedures for Physicians and Physician Group(s)***

BCBSGA's MA plans must provide for the participation of individual health care professionals through reasonable procedures that include:

- (a) Written notice of rules of participation
- (b) Written notice of material changes in participation rules before they become effective
- (c) Written notice of adverse participation changes, and
- (d) Process for appealing adverse physician participation decisions.

(These requirements also apply to physicians that are part of a subcontracted network.)

In addition, PROVIDER agrees that in no event, including but not limited to non-payment by Plan, insolvency of the Plan or breach of their Agreement, shall the PROVIDER bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Individual or persons other than the Plan acting on their behalf for Covered Services provided pursuant to their Agreement. This provision does not prohibit the collection of supplemental charges or Cost Shares on the Plan's behalf made in accordance with the terms of the Covered Individual's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-Covered service, subject to medical coverage criteria, with appropriate disclosure to the Covered Individual of their financial obligation. This advance notice does not apply to services not covered due to a statutory exclusion from the Medicare Advantage Program.

PROVIDER further agrees that for Covered Individuals who are dual eligible enrollees for Medicare and Medicaid, that PROVIDER will ensure they will not bill the Covered Individual for Cost Sharing that is not the Covered Individual's responsibility and such Covered Individuals will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, PROVIDER agrees to accept the Plan payment as payment in full or by billing the appropriate State source.

## ***Terminating Participation with BCBSGA's Medicare Advantage Plans***

In the event a provider wishes to terminate his/her participation in either of BCBSGA's Medicare Advantage networks or BCBSGA terminates a provider for reasons other than cause, a mandatory 60-day notification is required for the termination by either party. Please refer to your contract for specific termination requirements.

Any provider requesting termination of his/her participation should send written notification to the BCBSGA Network Management Department in his/her region. Upon receipt of the termination request, BCBSGA will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

## ***Termination of a Provider Contract with Cause***

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A Medicare Advantage organization that suspends or terminates an agreement under which the health care professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- Reason for the action
- Standards and the profiling data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable
- Affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

### ***Termination of a Provider Contract without Cause***

Any provider requesting termination of his/her participation should send a written notification to the BCBSGA Network Management Department in his/her region. Upon receipt of the termination request, BCBSGA will send a written CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination.

### ***Provider Anti-discrimination Rules***

Plans are prohibited from discriminating with respect to reimbursement, participation or indemnification solely on the basis of a provider's licensure or certification as long as the provider is acting within the scope of such licensure or certification. This prohibition does not preclude any of the following:

- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of enrollees; a Medicare Advantage (MA) plan may choose to contract with a doctor of medicine that meets the needs of enrollees and does not need to contract with another practitioner who can provide only a discrete subset of physician services.
- Use of different reimbursement amounts for different specialties or within the same specialty
- Implementation of measures designed to maintain quality and control costs consistent with the MA organization's responsibilities.

### ***Confidentiality and Accuracy of Enrollee Records***

Medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a particular enrollee, BCBSGA including its participating providers, is obligated to abide by all Federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and enrollee information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years;

### ***Encounter Data for Risk Adjustment Purposes***

Each MA organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

Physician services must be submitted by the MA organization for all the services provided by network and non-network physicians and non-physician practitioners.

The extent of the data must account for:

- Services covered under the original Medicare program
- Medicare covered services for which Medicare is not the primary payor
- Other additional or supplemental benefits that an MA organization may provide.

The data must account separately for each provider, supplier, physician or other health care practitioner that would be permitted to bill separately under the Medicare fee-for-service program, even if they participate jointly in the same encounter.

Data requirements must also:

- Conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards
- Be submitted electronically by the Plan to the appropriate CMS contractor.

MA organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data as prescribed by CMS. CMS will use the data obtained under this section to determine the risk adjustment factor that it applies to annual capitation rates and any other purposes. Please refer to your BCBSGA Medicare Advantage Participation agreement.

### **Data Reporting Submissions**

- Provider agrees to provide all information necessary to meet its data reporting and submission obligations to CMS including, but not limited to, data necessary to characterize the context and purpose of each encounter between a Medicare Advantage enrollee and the provider, and data necessary for the plan to meet its reporting obligations under 42 CFR Section 422.516.

### **Encounter Data**

- Encounter data shall include all information necessary for the plan to submit data to CMS as set forth in 42 CFR Section 422.257. If the provider fails to submit encounter data accurately, completely and truthfully, in the format described in 42 CFR Section 422.257, then this will result in denials and/or delays in payment of the provider's claims.

### **Accuracy of Encounter Data**

- Provider has contractually agreed to certify the accuracy, completeness, and truthfulness of the provider's generated encounter data that the plan is obligated to submit to CMS. No later than 30 days after the beginning of every fiscal year while the Medicare Advantage participation is in effect, the provider agrees, upon request, to give the plan a certification in writing, in a format that the plan specifies, that certifies to the accuracy, completeness, and truthfulness of the provider's encounter data submitted to the plan during the specific period.

### ***Federal Funds***

BCBSGA has a contract with CMS to perform activities as a Medicare Advantage (MA) organization. In performing its duties as an MA, BCBSGA receives Federal payments and, as such, BCBSGA agrees to comply, and must ensure that all related entities, contractors, and subcontractors paid by BCBSGA to fulfill BCBSGA's obligations under its MA contract with CMS agree to comply, with all Federal laws applicable to those entities receiving Federal funds. The payments you receive from BCBSGA under this agreement for services rendered to BCBSGA's Medicare Advantage covered individuals are, in whole or in part, from Federal funds. Thus, you, as a recipient of said Federal funds, agree to comply with the following:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Americans with Disabilities Act
- Rehabilitation Act of 1973
- Other laws applicable to recipients to Federal funds, and
- All other applicable laws and rules.

### ***Prompt Payment by MA Organization***

Receipt of claims by non-contracted providers will be considered a "clean claim" if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The MA organization is bound to adhere to the following prompt payment provisions for non-contracted providers:

- Pay 95 percent of clean claims within 30 days of receipt
- Pay interest on clean claims not paid within 30 days
- All other claims must be approved or denied with 60 calendar days from date of receipt.

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider.

Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified timeframe, the claim will be closed and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a physician or other practitioner who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at [www.cms.gov](http://www.cms.gov). You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

### ***Use of Georgia Blue Cross and Blue Shield (GABCBS) trademark within communications***

GABCBS welcomes you to use our name and logo along with other information, such as how a person may contact us, when you send out communications to you patients. In order to use the GABCBS name or logo within a communication, a provider must first obtain permission from the GABCBS as noted within your provider contract. Our provider contracts stipulate that any printed materials, including but not limited to letters to Plan Covered Persons, brochures, advertisements, telemarketing scripts, packaging prepared or produced by PROVIDER or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Plan to assure compliance with Federal, State, and Blue Cross/Blue Shield Association guidelines. GABCBS agrees its approval will not be unreasonably withheld or delayed. In order to make this easier on you the provider, we have simplified the submission of the document(s) to GABCBS for review.

To submit a document for review, please send the copy to your local Provider Relations Consultant. Once the copy is submitted it will be the responsibility of your local Provider Relations Consultant to insure that the internal GABCBS legal review is completed in a timely manor. Although GABCBS's legal team will be reviewing the copy, it is your responsibility to comply, and to require any of your subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and marketing activities under this Agreement, including but not limited to, the National Marketing Guide for Medicare Managed Care Plans, and any requirements for CMS prior approval of materials. We again welcome you to use our name and logo when you send out communications to you patients in an effort to provide information to your patients.

## **SUMMARY OF PROVIDER CREDENTIALING PROGRAM**

**Please note that the term 'The Company' refers to Blue Cross and Blue Shield of Georgia throughout this section of the manual.**

### ***Credentialing Scope***

The Company credentials the following contracted health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing

services covered under the medical benefits plan and Doctors of Dentistry providing services covered under the medical benefits plan including oral maxillofacial surgeons.

The Company also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master's-level clinical social workers who are state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, other individual health care providers listed in the Company's network directory will be credentialed.

The Company credentials the following contracted Health Delivery Organizations (HDOs): Hospitals; Home Health Agencies; Skilled Nursing Facilities; (Nursing Homes); Free-Standing Surgical Centers; Lithotripsy Centers treating kidney stones and free standing Cardiac Catheterization labs if applicable to certain regions; as well as Behavioral Health Facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

### ***Credentials Committee***

The decision to accept, retain, deny or terminate a practitioner's participation in the Company programs or networks is conducted by a peer review body, known as the Company Credentials Committee (CC).

*The CC will meet at least once every forty-five (45) days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to Company members and who falls within the scope of the credentialing program, having no other role in Company network management. The Chair of the CC may appoint additional participating practitioners of such specialty type, as deemed appropriate for the efficient functioning of the Company Credentials Committee.*

*The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the provider; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner or HDO from participation in one or more of the Company programs or networks, require a majority vote of the voting members of the CC in attendance, the majority of whom are participating providers.*

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and professional practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner within 30 calendar days of identification of the issue. This communication will specifically notify the practitioner of his or her right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The provider will be given no less than 14 calendar days in which to provide additional information.

The Company may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

### ***Nondiscrimination Policy***

The Company will not discriminate against any applicant for participation in its programs or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, the Company will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence as outlined in Company Credentialing Program Standards. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

### ***Initial Credentialing***

Each Practitioner or HDO must complete a standard application form when applying for initial participation in one or more of the Company programs or networks. This application may be a state mandated form or a standard form created by or deemed acceptable by the Company. For practitioners, the Council for Affordable Quality Healthcare (CAQH) a Universal Credentialing Datasource is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and providers. To learn more about CAQH, visit their web site at [www.CAQH.org](http://www.CAQH.org).

The Company will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180 day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, the Company will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

<b>Verification Element</b>
License to practice
Hospital admitting privileges at a hospital participating in each of the Company's programs or networks in which the practitioner participates or applies for participation, if applicable.
DEA, CDS and state controlled substance certificates The DEA/ CDS must be valid in the state(s) in which the practitioner will be seeing the Company's members. Practitioners who see members in more than one state must have a DEA/CDS for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
Verification of eligibility for participation with Medicare and Medicaid, Review quarterly Opt-Out Report,
National Practitioner Data Bank report

B. HDOs

<b>Verification Element</b>
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

***Recredentialing***

The recredentialing process incorporates re-verification and the identification of changes in the provider's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the provider's professional conduct and competence. This information is reviewed in

order to assess whether network practitioners and HDOs continue to meet Company credentialing standards.

During the recredentialing process, the Company will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the network within the scope of the Company Credentialing Program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

### ***Health Delivery Organizations***

New HDO applicants will submit a standardized application to the Company for review. If the candidate meets Company screening criteria, the credentialing process will commence. To assess whether participating Company network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in the Company Credentialing Program Standards, all participating HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, the Company may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO

Recredentialing of HDOs occurs every 3 years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Company programs or networks must complete and submit the applicable recredentialing application, along with all required supporting documentation.

On request, HDO's will be provided with the status of their credentialing application. The Company may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

### ***Ongoing Sanction Monitoring***

To support certain credentialing standards between the recredentialing cycles, the Company has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management
4. State licensing Boards/Agencies
5. Member/Customer Services Departments.
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Company Departments
8. Any other verified information received from appropriate sources

When a participating practitioner or HDO has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of the Company CC, review by the Company Medical Director, referral to the CC, or termination. The Company credentialing departments will report practitioners to the appropriate authorities as required by law.

### ***Appeals Process***

The Company has established policies for monitoring and re-credentialing participating providers inclusive of HDO's who seek continued participation in one or more of the Company's networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and the Company may wish to terminate providers. The Company also seeks to treat participating and applying providers fairly, and thus provides participating providers with a process to appeal determinations terminating participation in the Company's networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, the Company will permit providers (including HDO's) who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (Informal/Reconsideration only). It is the intent of the Company to give practitioners the opportunity to contest a termination of the practitioner's participation in one or more of the Company's networks or programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's suspension or loss of licensure, criminal conviction, or the Company's determination that the practitioner's continued participation poses an imminent risk of harm to the Company's members. A practitioner whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal.

### ***Reporting Requirements***

When the Company takes a Professional Review Action with respect to a professional provider's participation in one or more Company networks, Company may have an obligation to report such to the NPDB and/or HIPDB. Once Company receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook and the Healthcare Integrity and Protection Data Bank (HIPDB) Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

## ***COMPANY CREDENTIALING PROGRAM STANDARDS***

### **A. Eligibility Criteria**

#### ***Health Care Practitioners***

Initial applicants must meet the following criteria in order to be considered for participation:

1. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to the Company's members;
2. Possess a current, valid, and unrestricted DEA and/or CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat the Company's members; the DEA/CDS must be valid in the states(s) in

- which the practitioner will be seeing the company's members. Practitioner's who see members in more than one state much have a DEA/CDS for each state; and
3. Must not be currently debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP.
  4. For MDs, DOs, DPMs and Oral & Maxillofacial Surgeons, the applicant must have current, in force board certification (as defined by the ABMS, AOA, RCPS, CFPC, ABPS, ABPOPPM or ABOMS) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.
    - a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
      - i Previous board certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice. OR
      - ii Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of Board Certifications in that clinical specialty or subspecialty. OR
      - iii Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a Faculty Appointment of Assistant Professor or higher at an Academic Medical Center and Teaching Facility in the Company Network AND the applicant's professional activities are spent at that institution at least 50% of the time.
    - b. Providers meeting one of these 3 alternative criteria (i, ii, iii) will be viewed as meeting all Company education, training and certification criteria and will not be required to undergo additional review or individual presentation to the Credentials Committee. These alternatives are subject to Company review and approval. Reports submitted by Delegate to Company must contain sufficient documentation to support the above alternatives, as determined by the Company.
  5. For MDs and DOs, the applicant must have unrestricted hospital privileges at TJC (The Joint Commission) or an AOA accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the Company Credentials Committee may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The Company Credentials Committee will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there was an appropriate referral arrangement with a network physician providing inpatient care that exists.

#### **Criteria for Selecting Practitioners**

##### **A. New Applicants (Credentialing)**

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed date within 180 days of the date of submission to the Credentials Committee for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission

to the Credentials Committee for a vote, as deemed by appropriate accrediting agencies;

4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Company members;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA and CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat the Company's members. The DEA/ CDS must be valid in the state(s) in which the practitioner will be seeing the Company's members.

Practitioners who see members in more than one state must have a DEA/CDS for each state. Initial applicants who have NO DEA/CDS certificate the applicant will be viewed as not meeting criteria and the credentialing process will not proceed.

However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if **all** of the following are met:

- a. It can be verified that this application is pending
  - b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA certificate is obtained,
  - c. The applicant agrees to notify the Company upon receipt of the required DEA
  - d. The Company will verify the appropriate DEA/CDS via standard sources
  - e. The applicant agrees that failure to provide the appropriate DEA within a 90 day timeframe will result in termination from the network.
- ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing the Company's members will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if **ALL** the following criteria are met:
    - a. It can be verified that this application is pending and
    - b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA certificate is obtained,
    - c. The applicant agrees to notify the Company upon receipt of the required DEA
    - d. The Company will verify the appropriate DEA/CDS via standard sources applicant agrees that failure to provide the appropriate DEA within a 90 day timeframe will result in termination from the network.

**AND**

    - e. Must not be currently debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater then 6 months in the past 5 years with the exception of those gaps related to parental leave or immigration where 12 month gaps will be acceptable. Other gaps in work history of 6 to 24 months will be reviewed by the

- Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.
14. No history of criminal/felony convictions or a plea of no contest;
  15. A minimum of the past ten (10) years of malpractice case history is reviewed.
  16. Meets Credentialing Standards for education/training for specialty(ies) in which practitioner wants to be listed in a Company network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and Oral & Maxillofacial Surgeons;
  17. No involuntary terminations from an HMO or PPO;
  18. No “yes” answers to attestation/disclosure questions on the application form with the exception of the following:
    - a. investment or business interest in ancillary services, equipment or supplies;
    - b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    - c. voluntary surrender of state license related to relocation or nonuse of said license;
    - d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet threshold criteria
    - e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
    - f. previous failure of a certification exam by a provider who is currently board certified or who remains in the five (5) year post residency training window.
    - g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
    - h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

***Note: the Credentials Committee will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.***

*Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, Practitioner’s name and specialty.*

- B. Currently Participating Applicants (Recredentialing)
  1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
  2. Re-credentialing Application signed date within 180 days of the date of submission to the Credentials Committee for a vote;
  3. Primary source verifications within acceptable timeframes of the date of submission to the Credentials Committee for a vote, as deemed by appropriate accrediting agencies;
  4. No evidence of potential material omission(s) on re-credentialing application;
  5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Company members;
  6. \*No current license probation;
  7. \*License is unencumbered;
  8. No new history of licensing board reprimand since prior credentialing review;

9. \*No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);
10. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
11. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a participating provider of similar specialty at a participating hospital who provides inpatient care to members needing hospitalization;
12. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
15. Malpractice case history reviewed since the last Credentials Committee review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
17. No new (since previous credentialing review) “yes” answers on attestation/disclosure questions with exceptions of the following:
  - a. investment or business interest in ancillary services, equipment or supplies;
  - b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
  - c. voluntary surrender of state license related to relocation or nonuse of said license;
  - d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria listed in II.A.15 of Attachment A;
  - e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
  - f. previous failure of a certification exam by a provider who is currently board certified or who remains in the five (5) year post residency training window.
  - g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
  - h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
18. No QI data or other performance data including complaints above the set threshold.
19. Recredentialed at least every three (3) years to assess the provider’s continued compliance with Company standards.

\*It is expected that these findings will be discovered for currently participating practitioners through ongoing sanction monitoring. Practitioners with such findings will be individually reviewed and considered by the Credentials Committee at the time the findings are identified.

***Note: the Credentials Committee will individually review any practitioner that does not meet one or more of the criteria for recredentialing.***

## **II. Additional Participation Criteria and Exceptions for Behavioral Health Providers (Non Physician) Credentialing.**

Providers must have a minimum of two (2) years experience post-licensure in the field in which they are applying beyond the training program or practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two (2) years of post licensure experience.

### **1. Licensed Clinical Social Workers (LCSW) or other Master Level Social Work License Type:**

- a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE).
- b. Program must have been accredited within 3 years of the time the practitioner graduated.
- c. Full accreditation is required, candidacy programs will not be considered.
- d. If Masters level degree does not meet criteria and provider obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet this criteria, this doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education (CHEA). In addition, a Doctor of Social Work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

### **2. Licensed Professional Counselor (LPC) and Marriage and Family Therapist (MFT) or Other Master Level License Type:**

- a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or Doctoral degrees in Education are acceptable with one of the fields of study above.
- b. Master or Doctoral Degrees in Divinity **do not** meet criteria as a related field of study.
- c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post Secondary Education, APA, CACREP, or COAMFTE listings. The institution must have been accredited within 3 years of the time the practitioner graduated.
- d. If Masters level degree does not meet criteria and provider obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a Doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

### **3. Clinical Nurse Specialist/Psychiatric and Mental Health Nurse Practitioner:**

- a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within 3 years of the time of the practitioner's graduation.
- b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State Board of Registered Nursing, if applicable.
- c. Certification by the American Nurses Association (ANA) in psychiatric nursing.

This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

- d. Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable with appropriate supervision/consultation by a participating psychiatrist as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate State Controlled Substance (CDS) Certificate if required. The DEA/CDS must be valid in the state(s) in which the practitioner will be seeing the Company's members. Practitioners who see members in more than one state must have a DEA/CDS for each state.

**4. Clinical Psychologists:**

- a. Valid state clinical psychologist license.
- b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within 3 years of the time of the practitioner's graduation.
- c. Education/Training considered as eligible for an exception is a provider whose Doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
- d. Master's level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.

**5. Clinical Neuropsychologist:**

- a. Must meet all the criteria for a clinical psychologist listed in 4.c above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
- b. A provider credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
- c. Clinical neuropsychologists who are not board certified nor listed in the National Register will require Credentials Committee review. These providers must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
  - i. Transcript of applicable pre-doctoral training OR
  - ii. Documentation of applicable formal 1 year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
  - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
  - iv. Minimum of 5 years experience practicing neuropsychology at least 10 hours per week

**III. Health Delivery Organization (HDO) Eligibility Criteria**

All Health Delivery Organizations must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, the Company may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the Credentials Committee and will be considered for member access need only when the credentials Committee review indicates compliance with Company standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality of care or patient safety. HDOs are recertified at least every three (3) years to assess the HDO's

continued compliance with Company standards.

**A. General Criteria for Health Delivery Organizations:**

1. Valid, current and unrestricted license to operate in the state in which it will provide services to the Company's members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded for participation in any of the following programs; Medicare, Medicaid or FEHBP
4. Liability insurance acceptable to Company.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the Credentials Committee to determine if the Company's quality and certification criteria standards have been met.

**B. Additional Participation Criteria for Health Delivery Organizations by Provider Type:**

1. **Hospital:**
  - a. Must be accredited by the TJC or HFAP (formerly referred to as AOA Hospital Accreditation Program), NIAHO
2. **Ambulatory Surgery Center:**
  - a. Must be accredited by TJC, HFAP, AAPSF, AAAHC, AAAASF, or IMQ.
3. **Home Health Care Agency:**
  - a. Must be accredited by the TJC, , CHAP or ACHC.
4. **Skilled Nursing Facility:**
  - a. Must be accredited by the TJC, or CARF.
5. **Nursing Home:**
  - a. Must be accredited by the TJC.
6. **Free Standing Cardiac Catheterization Facilities:**
  - a. Must be accredited by the TJC or HFAP (may be covered under parent institution).
7. **Lithotripsy Centers (Kidney Stones):**
  - a. Must be accredited by the TJC.
8. **Behavioral Health Facility:**
  - a. The following behavioral health facilities must be accredited by the TJC, HFAP, NIAHO or CARF as indicated.
    - i Acute Care Hospital – Psychiatric Disorders (TJC), HFAP, NIAHO
    - ii Residential Care – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF)
    - iii Partial Hospitalization/Day Treatment – Psychiatric Disorders (TJC, HFAP NIAHO or CARF for programs associated with an acute care facility or Residential Treatment Facilities.)
    - iv Intensive Structure Outpatient Program – Psychiatric Disorders (TJC, HFAP, NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents or CARF if program is a residential treatment center providing psychiatric services)

- v Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation (TJC, HFAP, NIAHO)
- vi Acute Inpatient Hospital – Detoxification Only Facilities (TJC, HFAP, NIAHO)
- vii Residential Care – Chemical Dependency (TJC, HFAP, NIAHO or CARF)
- viii Partial Hospitalization/Day Treatment – Chemical Dependency (TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)
- ix Intensive Structure Outpatient Program – Chemical Dependency (TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)

#### A. MEDICAL FACILITIES

<b>Facility Type (MEDICAL CARE)</b>	<b>Acceptable Accrediting Agencies</b>
Acute Care Hospital	TJC, HFAP, NIAHO
Ambulatory Surgical Centers	TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ
Free Standing Cardiac Catheterization Facilities	TJC, HFAP (may be covered under parent institution)
Lithotripsy Centers (Kidney stones)	TJC
Home Health Care Agencies	TJC, CHAP, ACHC
Skilled Nursing Facilities	TJC, CARF
Nursing Homes	TJC

#### B. BEHAVIORAL HEALTH

<b>Facility Type (BEHAVIORAL HEALTH CARE)</b>	
Acute Care Hospital—Psychiatric Disorders	TJC, HFAP NIAHO,
Residential Care—Psychiatric Disorders	TJC, HFAP, NIAHO CARF
Partial Hospitalization/Day Treatment—Psychiatric Disorders	TJC, HFAP, NIAHO CARF for programs associated with an acute care facility or Residential Treatment Facilities.
Intensive Structured Outpatient Program—Psychiatric Disorders	TJC, HFAP NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents  CARF if program is a residential treatment center providing psychiatric services

Acute Inpatient Hospital—Chemical Dependency/Detoxification and Rehabilitation	TJC, HFAP, NIAHO
Acute Inpatient Hospital—Detoxification Only Facilities	TJC, HFAP, NIAHO
Residential Care—Chemical Dependency	TJC, HFAP, NIAHO, CARF
Partial Hospitalization/Day Treatment—Chemical Dependency	TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents;  CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents
Intensive Structured Outpatient Program—Chemical Dependency	TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents;  CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

## Utilization Management Medicare Advantage Plans

Components of utilization management for BCBSGA Medicare Advantage plans:

- Application of Clinical Criteria Guidelines
- Referral Management
- Access to Care and Services
- Precertification
- Concurrent Review
- Denials
- Emergency Care/ Urgent Care
- Case Management
- Under and Over Utilization

### *Application of Clinical Criteria Guidelines*

BCBSGA uses Medicare coverage guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the criteria. Medical necessity decision making includes assessing the needs of the individual patient and characteristics of the local delivery system.

BCBSGA uses the following Utilization Management criteria for their MA Plans:

- **Medicare Coverage Directives** are the primary criteria used in making decisions regarding coverage for BCBSGA's Medicare Advantage plans. Medicare Advantage plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers.
- **BCBSGA Medical Policy** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request.
- **Milliman** (Inpatient and Surgical Care, Case Management, and Primary and Pharmaceutical Care) is used to determine medical necessity and appropriateness of site review, assign initial length of stay for inpatient services, and review catastrophic admissions.
- **BCBSGA UM Guidelines** are used in addition to Milliman criteria. BCBSGA-developed guidelines are either topics that are not part of Milliman criteria or are modifications of those guidelines. Guidelines are also developed for Disease Management and Preventive Services. These guidelines are available upon request.

### ***Referral Management***

Although Medicare Advantage HMO members are not required to select a primary care physician, the Primary Care Physician (PCP) can serve as the coordinator of care to ensure access to medically necessary specialty care. The PCP may oversee all of the medical care and services provided to the member. Out-of-network referrals require plan notification and authorization.

BCBSGA Medicare Advantage HMO members are allowed to have direct access to women's health specialists within the network for routine and preventive women's health care without a PCP referral or prior authorization. BCBSGA Medicare Advantage PPO members also have direct access to women's health specialists and do not need prior authorization. However, they will have less out-of-pocket expense if they select a provider in the network.

For BCBSGA's Medicare Advantage PPO plans, members are not required to select a PCP or obtain a referral for specialty care. Members are encouraged to coordinate their care through a family physician. BCBSGA Medicare Advantage PPO members can utilize providers both in and out of the network. Precertification is required for some services.

CMS considers plan-directed care to be the financial responsibility of the health plan and/or its contracted network but in either case, not the responsibility of the MA member. Plan-directed care is care the member believes they were instructed to obtain, or authorized to receive and such

instruction and/or authorization was provided by a health plan representative. A representative of the health plan includes plan-contracted physicians.

For services that require prior authorization, it becomes extremely important that BCBSGA authorization procedures are followed. If a member proceeds to receive care at the direction of his/her primary care physician or network specialist, believing that such care was verbally or otherwise authorized by the physician, the member cannot be held financially responsible. In such cases when the referring network physician fails to follow BCBSGA authorization protocols, BCBSGA may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

### ***Access to Care and Services***

BCBSGA may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability, except as it relates to End Stage Renal Disease. BCBSGA's MA Plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare. The Medicare Advantage organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24 hours a day, seven days a week.

BCBSGA has established performance measures to assist in developing and maintaining adequate providers and practitioners in all our Medicare Advantage networks. Performance is monitored at least annually and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for BCBSGA HMO members when providers and practitioners are not available or accessible in the members' geographic locations. There are also instances where an in-network provider is not available for members in our Local and Regional PPO's. In those instances, the provider should collaborate with our Utilization Management area to obtain authorization. In certain circumstances, the member may only be responsible for the in-network cost sharing.

Providers and suppliers must be located throughout the service area. Services are generally considered accessible if they reflect usual practice and travel patterns in the local area. Generally, hospital and primary care physician services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care services exceed 30 minutes as in some rural areas.

#### **Appointment access standards for primary care services are:**

##### **Emergency:**

- Immediate 24 hours a day/seven days a week access available – for emergent diagnoses. Behavioral Health providers must be available to assess a patient experiencing an emergent situation within 6 hours.

##### **Urgent:**

- Within 48 hours – including Behavioral Health urgent services.

**Routine:**

- Within 10 business days – including Behavioral Health routine services.

Organizations and providers who contract with BCBSGA’s MA network are required to establish and implement appropriate treatment plans for a member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty providers. Treatment plans must be time-specific and updated by the PCP.

The BCBSGA medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a referral to another participating provider of that like specialty.

Plans may select the providers through whom services are provided as long as:

- The plan makes services available and accessible within the service area with reasonable promptness and in a manner, which assures continuity.
- The plan provides access to appropriate providers, including credentialed specialists, for medically necessary care; and if a network provider is unavailable or inaccessible then the MA organization must arrange for services outside of the network.
- Coverage is provided for emergency services; without regard to prior authorization or whether the provider was a participating provider.
- The plan maintains and monitors a network of appropriate providers.
- The plan gives women enrollees direct access to women’s health specialists within the network for women’s routine and preventive health care services.
- The plan establishes written standards for timeliness of access to care and Customer Service that meet or exceed standards established by CMS and continuously monitors to assure continuous compliance with standards.
- The plan ensures services are provided in a culturally competent manner.
- The plan ensures services are available 24 hours a day, seven days a week, when medically necessary.
- The MA organization ensures continuity of care and integration of services and makes a “best effort” attempt to conduct an initial assessment of an enrollee’s health care needs within 90 days of enrollment.

*\*Not all contracting providers have to be located within the service area but CMS must determine that all services covered under the plan are accessible from the service area.*

***Direct Access to Preventive/Routine Gynecological and Mammography Services***

Women enrollees may choose direct access to a women’s health specialist within the network for routine and preventive health care services provided under the plan as basic benefits. These

services include annual Pap testing and mammography exams. No referrals are required for routine gynecological exams or mammography services provided by a network provider for the Medicare HMO. Members in the Medicare Advantage PPO may choose either a network or a non-network provider. Please refer to the most recent Medicare Advantage provider directory for the Mammography center and OB/GYN specialty provider listings. Our provider directories are also available on-line at BCBSGA.com.

### ***Direct Access to Influenza and Pneumococcal Immunizations with NO Cost Sharing***

BCBSGA strongly encourages all members to receive influenza and pneumococcal immunizations. No referral or copayment for the immunization is required.

### ***Precertification***

The BCBSGA Precertification Department is notified of all inpatient admissions, including hospital, skilled nursing facility, rehabilitation, and selected outpatient procedures. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results and attempts at conservative treatment (when appropriate) in order to complete the precertification process.

An BCBSGA Medical Management Nurse will review each request for admission, procedures or services. If evidence-based criteria are met, the review nurse will document clinical data and authorize the requested service. Approval letters are mailed to the member, the PCP, the hospital and the attending physician within one business day of the decision. If the review nurse determines that the criteria are not met, or there is insufficient information to complete a review, the request for service is referred to a medical director for review. Only physicians are able to render denials. If a denial decision is indicated, the notification includes information regarding the appeal process, availability of a physician to discuss the case, and the reason for the denial including the specific clinical criteria or benefits provision.

Appropriately, licensed and trained professionals make UM decisions according to established criteria. Non-clinical associates, under the supervision of a licensed professional, may collect non-clinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Only physicians are able to render denials. Practitioners from appropriate specialty areas are utilized as needed for medical necessity reviews and appeals.

Please contact your local provider relations department to obtain the most current copy of the MA Precertification list.

### ***How to Precertify***

Physician Online Services – You may access our website and submit a precertification request as well as search the status of your precertifications. Log on at BCBSGA.com to use this service.

Fax Notification – You may fax your request to 1-(866) 959-1537. After Medical Management reviews your precertification request, BCBSGA will respond with an authorization or a request for additional information. **NOTE:** It is essential that you provide

your fax number on the request form. Medical Management will accept notification of timely precertification requests.

Telephone – the BCBSGA Senior Medical Management Program can be reached at **866-797-9884**, 8:00a.m. to 8:00 p.m. Eastern Time., Monday-Friday. Select the option for pre-certification on the telephone menu selections. During non-business hours you will have an option to leave a voicemail message, or for an emergency admission, your call will be handled by our 24-hour Nurse Call Center.

### ***Inpatient Acute Concurrent Review***

BCBSGA performs concurrent review for Medicare Advantage members at contracted in-area hospitals. The review's purpose is to continuously improve medical care by:

- Determining the need for continued stay
- Initiating discharge planning and case management.

### ***Denials***

**Denials for emergent inpatient admissions, discontinuation of coverage, and lack of information** may not be issued to BCBSGA Medicare Advantage (MA) members. CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested service requiring Utilization Management review, further attempts must be made to collect the missing information.

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. Physician review decisions are made within one working day. Plan providers are also entitled to a physician-to-physician review.

Hospitals must notify Medicare Beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to:

[http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp)

### ***Pre-service denials***

When a contracted provider is denied a pre-service request for a member, Federal regulations [CFR §422.568(c) and (d)] grant an MA member the right to receive a Notice of Denial of Medical Coverage (NDMC) from the MA organization regarding his/her appeal rights. Therefore, a physician or practitioner is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan. BCBSGA's Network Management department will provide the required notification language along with guidance on delivery methods acceptable to CMS.

### ***Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care, and Ambulance Services***

BCBSGA's MA plans are financially responsible for emergency services provided by contracted and non-contracted providers where services are immediately required because of an emergency medical condition. The Plan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

A Medicare Advantage organization is required to cover emergency services for its MA members regardless of whether the services were pre-authorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

***Emergency medical condition*** means a medical condition manifesting itself by acute symptoms of sufficient severity 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
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

***Urgently needed services*** are not emergency services as defined above, but are covered services which are medically necessary and immediately required as a result of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- An enrollee is temporarily absent from the MA plan's service area.
- When the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

***Post-Stabilization Care*** is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and under specific circumstances includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the purposes of this requirement, post-stabilization care and maintenance care are used synonymously. The plan's financial responsibility for post-stabilization care services includes:

- Any service administered, even though not pre-approved by the plan or its representative, during the one-hour period following the request to the MA organization for pre-approval of further post-stabilization care.
- Services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for pre-approval within one hour.
- The MA organization's representative and the treating physician cannot reach an agreement concerning care decisions and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes care through transfer.
- The MA organization's representative and the treating physician reach an agreement on the member's care.
- The member is discharged.

### ***Case Management***

Case Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes.

Members who might benefit from case management are identified through a referral process. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, and sales staff.
- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other health care providers, members or their families.

In addition, case referrals can be generated prospectively from the UM system during the precertification process and retrospectively from the claims system through claims data analysis and data review activities. Case referrals may also be triggered by the results of Senior Health Risk Assessment surveys and/or internal disease management registries, as appropriate. The Senior Health Risk Assessment is a risk appraisal, which evaluates health and wellness factors such as member's self-perception of health, presence of chronic or serious conditions, functional limitations, prior health care utilization and availability of social support. These factors are potentially predictive of future health care needs and we make a best-effort attempt to conduct this initial assessment of each enrollee's health benefit needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment. Essential functions of an BCBSGA Case Manager include the following:

**Assessment:** The case manager collects and analyzes data about actual and potential member needs. This may involve gathering data in relation to the member's medical issues, cognitive status, and functional status. After the data is analyzed, there is the planning, implementing and evaluation of the case management plan.

**Planning:** The case manager develops a member centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best way possible. This means identifying both short and long-term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

**Linking/Coordination:** The case manager helps ensure continuity of care and integration of benefits across a variety of settings. Coordination is achieved through communication with the member, family and providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual member to help promote continuity of care.

**Monitoring/Evaluation:** Case management will monitor interventions, based upon benefits, to help make sure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met then the case manager should work with the member to modify the plan for the member.

**Advocacy:** The case manager should incorporate the member's needs and goals in the plan. Case managers should gather input from all relevant parties to help ensure continuity of benefits so that the member will achieve optimal results. Case managers are required to help protect the privacy and confidentiality of members at all times. Case managers should also present their limitations due to potential conflicts of interest between the member and BCBSGA.

### ***Skilled Nursing Facility***

BCBSGA will coordinate Skilled Nursing Facility (SNF) benefits for our Medicare Advantage members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. BCBSGA Medicare Advantage plans waive the Original Medicare requirement for the 3-day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a member into a SNF from various sites, including the office, home or from an observation stay. Care in a SNF is covered if **ALL** of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis.
- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained and members will be assessed the applicable copays. A benefit period is used to determine coverage under BCBSGA's Medicare Advantage plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

Inpatient stays solely to provide custodial care are not covered under BCBSGA Medicare Advantage plans. Custodial care is defined as care furnished for the purpose of meeting non-medically necessary personal needs that could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. BCBSGA Medicare Advantage plans or Original Medicare does not cover custodial care unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

The obligation on the provider to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare, SNF

and inpatient hospital services to enrollees of Medicare Advantage organizations. This obligation applies to all SNFs and applies to both teaching and non-teaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code, 04). It is also the provider's obligation to keep an audit trail on these claims.

### ***Home Health Services***

For a member to qualify for home health benefits, the member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service. Under BCBSGA's Medicare Advantage plans, the member does not have to be bedridden to be considered confined to home. The condition of the member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the member leaves the home, the member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration or to receive medical treatment. Home Care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- Durable Medical Equipment
- Portable x-rays and EKGs
- Laboratory tests.

### ***Under and Over Utilization***

BCBSGA has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

BCBSGA does not compensate, reward or give incentives, financially or otherwise, its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision-making for BCBSGA's MA plans is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

## **BCBSGA Medicare Advantage Member Appeals and Grievances**

### ***Distinguishing Between Member Appeals and Member Grievances***

There are two procedures for resolving MA member concerns: the member **appeals** process and member **grievance** process. All member concerns are resolved through one of these mechanisms.

The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

### **MA member appeals**

Member disputes or concerns about initial determinations are considered appeals and are resolved only through the appeals process. These are primarily concerns related to denial of services or payment for services. Examples of appeals include:

- Denials of services or supplies that the member believes should be covered.
- Denials of payment for emergency or out-of-area urgently needed services.
- Discontinuation or reduction of services in a SNF, HHA, or CORF. (Follows Fast Track Appeal Process)

### **MA member grievances**

All other member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process (see "MA Member Grievances" section of this manual). Examples of grievances include complaints or issues raised about:

- Accessibility/timeliness of appointments
- Quality of services
- BCBSGA MA staff
- BCBSGA Medicare Advantage physicians and their staff
- The Plan's decision not to expedite an appeal

### ***MA Member Appeals***

As Medicare Advantage enrollees, they all have the right to obtain a prompt resolution of issues raised, including complaints or grievances and concerns related to authorization, coverage, or payment of services. Essential components of the MA Member Appeals process include:

- Distinguishing between provider appeals and member appeals
- Notification of appeal rights
- Appeal timeframes
- Filing a member appeal
- Processing standard member appeals
- Expedited member appeals
- Types of decisions subject to expedited/ 72-hour review
- How an expedited member appeal is processed

- Hospital discharge appeals and QIO review process.

## **Distinguishing between provider appeals and MA member appeals**

BCBSGA's Complaint and Appeal Procedures apply to provider appeals for BCBSGA's Medicare Advantage plans. **It is critical to note that there are separate and distinct policies and processes for MA member appeals.** Thus, MA member appeals are considered separate and distinct from provider appeals.

Our members have the right to appeal any decision about our payment for, or failure to arrange or continue to arrange for, what they believe to be covered services (including non-Medicare-covered benefits). Coverage decisions that are commonly appealed include decisions with respect to:

- Payment for emergency services, post-stabilization care, or urgently needed services
- Payment for any other health services furnished by a non-contracting medical provider or facility that the enrollee believes should have been arranged for, furnished, or reimbursed by BCBSGA
- services the enrollee has not received, but which the enrollee feels BCBSGA is responsible to pay for or arrange
- Discontinuation of services that the enrollee believes is medically necessary covered services.

**The physician should always treat an appeal as an MA member appeal rather than a provider appeal when the issue involves:**

- Denial of services covered by Medicare that are arranged for by BCBSGA's MA plans.
- Reimbursement for emergency or urgently needed services.
- Any other health services furnished by a provider or supplier, that the member believes are covered under Medicare and should have been arranged for or reimbursed by BCBSGA Medicare Advantage.
- BCBSGA Medicare Advantage plan refusal to arrange for services that the member believes should be arranged for by the plan.
- Termination of services the member believes are medically necessary covered services or services he/she is still entitled to receive.

### ***Provider Payment Disputes***

The physician may submit a written provider payment dispute concerning any case in which he or she disagrees with a Medicare Advantage payment. This essentially involves issues after a service has been rendered and a payment dispute exists between the plan and the physician.

After completing the BCBSGA provider dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by The Centers for Medicare and

Medicaid Services (CMS). To file a request for review of a payment dispute with an independent entity, you may contact First Coast Service Options, Inc. using one of the following options:

1. **Email** – if the submission and associated documents do not contain any personally identifiable health information (PHI) (or any PHI has been redacted), the payment dispute decision request can be submitted to a dedicated email box at: [PDRC@fcsso.com](mailto:PDRC@fcsso.com)

Otherwise, First Coast can receive payment dispute decision request (including associated documents, such as claims forms that may contain PHI) via the following:

2. **Fax** – A fax number, (904) 361-0551, has been established to receive electronic request for payment dispute decisions.
3. **Mail** – Providers can also mail hard copy request for payment dispute adjudication to the following address:

**First Coast Service Options, Inc.  
Payment Dispute Resolution Contractor  
P.O. Box 44017  
Jacksonville, Florida 32231-4017**

MA organizations and providers with questions regarding the adjudication process or individual disputes being reviewed by the IRE can contact FCSO at (904) 791-6430. Providers and Medicare Advantage organizations will be able to leave messages and should expect a return call within 48 hours of receipt. The payment dispute decision request form can be found on the Provider section of the plan website within the Additional Information section of any Medicare Advantage Product Page.

**Physician appeals follow the standard BCBSGA process for provider appeals** (i.e., no separate policies and procedures exist for provider appeals under BCBSGA Medicare Advantage). BCBSGA participating providers may initiate provider appeals under the Provider Complaint and Appeal Procedures. The processing of a particular provider appeal may vary depending on whether or not it involves a review of medical necessity. The Provider Complaint and Appeals Procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit BCBSGA to examine issues fully and fairly before completion of BCBSGA's internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. BCBSGA typically determines provider appeals within 30 calendar days (for utilization review cases) or 30 business days (for other cases) when sufficient information is received to make a decision. Separate and distinct requirements regarding UM decisions and appeals have been established by CMS for contracting MA plans and must be followed for these members.

#### **Notification of appeal rights**

Medicare Advantage members are notified of their appeal rights and how to file an appeal through a number of ways:

- In the new member enrollment kit
- In their Evidence of Coverage and member handbook

- On all claim and utilization management-issued denial letters
- From Customer Service if the member calls with questions

### **Appeal timeframes**

Members have 60 days from the date of the denial of service to file either a standard or an expedited appeal. The 60-day filing deadline may be extended where good cause can be shown. All standard appeal requests must be in writing. Requests for expedited appeals may be oral or in writing.

For standard appeals, we must resolve service issues within 30 calendar days and payment issues within 60 calendar days from the date the request was received.

An expedited appeal may be requested in cases when the time required to process a standard appeal could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The resolution time for all expedited appeals is 72 hours from the time the request is received.

### **Filing a member appeal**

Any Medicare Advantage member may file an appeal for any decision made by us regarding service or payment with which he/she disagrees. The member may also authorize someone to file an appeal on his/her behalf, including an BCBSGA Medicare Advantage network physician and non-network physician. Note: Effective 03/13/2009, Medicare Advantage Part C standard pre-service appeals no longer require an Appointment of Representative form when a **written** request for reconsideration is made by a treating physician.

An Appointment of Representative (AOR) form may be used for the member to authorize someone to represent them. This form may be obtained by contacting the plan customer service department using the telephone number located on the members ID card or on The Centers for Medicare and Medicaid Services (CMS) website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.

If a member wants to authorize a representative without using this form, the statement submitted by the member must contain at least the applicable elements included in the AOR form, including:

- Provide his/her name, health record number, and a statement, which appoints an individual as his/her representative.
- Sign and date the statement
- Have the member's representative sign and date the statement
- Include the member's representative's signed statement with his/her written appeal request.

The member may appoint any physician to act as his/her representative in requesting an appeal from us regarding denial or discontinuation of medical services. A court-appointed guardian or an agent under a health care durable power of medical attorney may also file a standard or expedited appeal.

Members or their authorized representatives may contact customer service at the telephone number listed on the members ID card to learn how to send a letter of appeal.

Appeals can also be filed with an office of the Social Security Administration. Requests for expedited appeals are accepted orally or in writing. To file an expedited appeal request in writing, the member or their authorized representative may follow the procedure indicated above. To file an expedited appeal request orally, the member or the authorized representative should contact the plan customer service department using the telephone number located on the member's ID card.

### **Processing standard member appeals**

If the member decides to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

- The enrollee must submit a written request for an appeal to BCBSGA within 60 calendar days of the date of the notice of the initial decision. The 60-day limit may be extended for good cause.
- The MA Member Appeals and Grievance Department will process the appeal and notify the enrollee in writing of the decision, using the following timeframes:
- Standard Appeal for Service-Related Request: If the appeal is for a denied service, BCBSGA must notify the enrollee of the appeal decision as expeditiously as the enrollee's health requires, but no later than 30 days from receipt of the enrollee's request. BCBSGA may extend this timeframe by up to 14 days if the enrollee requests the extension or if additional information is needed, and the extension of time benefits the enrollee, such as the need to obtain additional medical records from non-contracting providers that could change a denial decision. As stated above, effective 03/13/2009, Medicare Advantage Part C standard pre-service appeals no longer require an Appointment of Representative form when a treating physician makes a written request for reconsideration.
- Standard Appeal for Payment-Related Request: If the appeal is for a denied claim, BCBSGA must notify the enrollee of the reconsideration determination no later than 60 days after receiving the enrollee's request for an appeal.
- BCBSGA's appeal decision will be made by a person(s) not involved in the initial decision. All appeals of adverse organization determinations based on "lack of medical necessity" must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue. The enrollee or the enrollee's authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing to BCBSGA.
- If BCBSGA decides fully in the enrollee's favor on a request for a service, the service must be provided or authorized within 30 days of the date the enrollee's appeal request was received. If BCBSGA decides fully in the enrollee's favor on a request for payment, the requested payment must be made within 60 days of the date the enrollee's appeal request was received.

If BCBSGA decides to uphold the original adverse decision, either in whole or in part, the entire case file will be automatically forwarded to MAXIMUS Federal Services, Inc. (MAXIMUS), for a new and impartial review. MAXIMUS is CMS' independent contractor for appeal reviews

involving MA plans. BCBSGA must send MAXIUS the file within 30 days of a request for services and within 60 days of a request for payment. MAXIMUS will either uphold the MA organization's decision or issue a new decision. The enrollee will receive written notification if BCBSGA forwards the case to MAXIMUS. MAXIMUS, at their sole discretion, may re-open a decision if they find that an error was made, identify evidence of fraud, or new information is introduced that would have a material impact on the review of the case.

- For cases submitted for review, MAXIMUS will make an appeal decision and notify the enrollee in writing of their decision and the reasons for the decision. If MAXIMUS upholds BCBSGA's decision, its notice will inform the enrollee of his/her right to a hearing before an administrative law judge of the Social Security Administration. If MAXIMUS (or a higher appeal level) decides in the enrollee's favor, BCBSGA must pay for, provide or authorize the service as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date BCBSGA receives the notice reversing our decision.

### **Expedited member appeals**

For member appeals, there are distinct requirements mandated by CMS that Medicare Advantage organizations must follow.

### **MA-expedited determinations and appeals**

MA members have the right to request and receive expedited decisions affecting the member's medical treatment in "time-sensitive" situations. This includes situations where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize the member's life or health, or the member's ability to regain maximum function. If BCBSGA decides, based on medical criteria, that the member's situation is time-sensitive or if any physician makes the request for the member or calls or writes in support of the member's request for an expedited review, BCBSGA will issue a decision as expeditiously as the member's health requires, but no later than 72 hours after receiving the request. BCBSGA may extend this timeframe by up to 14 days if the member requests the extension or if additional information is needed, and the extension of time benefits the member; such as when additional information is needed from the non-contracting provider that could change a denial decision.

### **Types of decisions subject to expedited/ 72-hour review**

- **Expedited Determinations:** If the member believes he/she needs a service, or continues to need a service, and he/she believes it is a time-sensitive situation, the member or any physician (including a physician with no connection to BCBSGA) may request that the decision be expedited. If BCBSGA decides that it is a time-sensitive situation, or if any physician states that it is one, BCBSGA will make a decision on the member's request for a service on an expedited/72-hour basis (subject to an extension as discussed above).
- **Expedited Appeals.** If the member wants to request an appeal of a decision by BCBSGA to deny a service the member requested or to discontinue a service the member is receiving that the member believes is a medically necessary covered service and the member believes it is a time-sensitive situation, the member may request that the appeal be expedited. If BCBSGA decides that it is a time-sensitive situation, or if any physician states that it is one, BCBSGA will make a decision on the member's appeal on an expedited/72-hour basis. This timeframe may be extended by up to 14 days if the member requests the extension or additional information is needed, and the extension of time benefits the member.

**Examples of service decisions which the member may appeal on an expedited basis, when the member believes it is a time-sensitive situation, include the following:**

- If the member received a denial of a service the member requested;
- If the member believes services are being discontinued too soon, such as inpatient services.

### **How an expedited member appeal is processed**

- To request an expedited/72-hour reconsideration, the member or the member's authorized representative may call, write, fax or visit BCBSGA.
- Upon receiving the member's request for an expedited appeal, BCBSGA will determine if the member's request meets the definition of time-sensitive.
  - If the member's request does not meet the definition, it is handled within the standard review process. The member is informed by telephone or in person whether the member's request will be processed through the expedited 72-hour reconsideration or the standard appeal process. The member is also sent a written confirmation within two working days of the phone call or personal contact. If the member disagrees with BCBSGA's decision to process the request within the standard timeframe, the member may file a grievance with BCBSGA. The written confirmation letter will include instructions on how to file a grievance. If the member's request is time-sensitive, the member will be notified of the decision as expeditiously as the member's health requires but no later than 72 hours after we receive the request.
  - An extension up to 14 calendar days is permitted for a 72-hour request for determination/appeal, if the member asks for the extension, or if more information is needed and the extension of time benefits the member.
- The member's request must be processed within 72 hours if any physician calls or writes in support of the member's request for an expedited/72-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize the member's life or health or the member's ability to regain maximum function.
- The MA organization will make a decision on the member's request for determination/appeal and notify the member of the decision within 72 hours of receipt of the member's request. If BCBSGA decides to uphold the original adverse decision, either in whole or in part, the entire file will be forwarded by the MA organization to MAXIMUS for review as expeditiously as the member's health requires, but no later than 24 hours after BCBSGA's decision. MAXIMUS will send the member a letter with its decision within 72 hours of receipt of the member's case from BCBSGA.

When the member requests an expedited determination/appeal, and the member does not hear from BCBSGA within 72 hours of the request, the member can assume that the request has been denied. BCBSGA's failure to notify the member in a timely manner within 72 hours constitutes a denial, which the member may appeal. If the plan fails to notify the member in a timely manner (within 72 hours), the case is automatically forwarded to MAXIMUS.

### **Hospital discharge appeals and QIO review process**

*Hospital discharges are subject to the expedited member appeal process.* The Centers for Medicare Medicaid Services (CMS) has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate

Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than noon of the first working day after the member receives the Notice of Discharge and Medicare Appeal Rights.

The QIO will make a decision within one full working day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, BCBSGA continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.

If an MA member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

### ***Fast Track Appeal Process***

In April 2003, The Centers for Medicare and Medicaid Services (CMS) published final regulations in the Federal Register (commonly known as the Grijalva Regulation) which made improvements to the Medicare Advantage appeals and grievances procedures. It established new notice requirements and appeal procedures for MA members when coverage for provider services (specifically SNF, HHA and CORF service) is terminated or discontinued. This rule was published as a result of an agreement entered into between the parties in *Grijalva vs Shalala*, civ. 93-711 (USDC AZ.) to settle a class action lawsuit.

Effective January 2004, all Medicare Advantage beneficiaries whose services are being discontinued from a Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility (CORF), or are being discharged from a Skilled Nursing Facility (SNF), when services and /or admission was prior authorized are required to be notified via a two-notice process. Notice I – The first notice to be issued: “Notice of Medicare Non-Coverage” (NOMNC). This notice is required to be issued to all Medicare Advantage members when services are terminated or discontinued.

Notice II – The second notice to be issued: “Detailed Explanation of Non-Coverage” (DENC). This notice is only issued if the member disagrees with Notice I and requests an appeal.

### ***MA Member Grievances***

As Medicare Advantage enrollees, all members have the right to obtain a prompt resolution of issues raised, including complaints or grievances and concerns related to authorization, coverage, or payment of services. Essential components of the member grievance process include:

- Notification of grievance rights
- Grievance timeframes

- Who can file a grievance
- How a grievance is filed
- How a grievance is processed
- Grievance outcomes.

### **Notification of grievance rights**

Members are notified of their grievance rights and how to file a grievance through a number of ways:

- In the new member enrollment kit
- In their evidence of coverage and member handbook
- From Customer Service if the member calls with questions.

### **Grievance timeframes**

A written determination of the grievance will be sent to the member within 30 days of receiving the complaint:

### **Who can file a grievance?**

A member or authorized representative can file a grievance if he/she has an issue or concern involving quality of care, the art of caring, personnel (both plan and physician staff), and all other issues that do not involve an initial determination (payment or denial of service issues).

### **How a grievance is filed**

As members of a Medicare Advantage plan, members have the right to file a complaint, also called a grievance, about problems they may observe or experience, including:

- Complaints about the quality of services received
- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar concerns
- Involuntary disenrollment situations
- Disagreement with the decision to process an appeal request under the standard 30-day timeframe rather than the expedited/72-hour timeframe.

A member may call the plan customer service department using the telephone number located on the member's ID card to initiate the grievance process. The Customer service representative gathers the information from the member and forwards the grievance to the MA Appeals/Grievance Department. The Customer service representative may also ask the member to put any verbal complaints in writing. We have a grievance form available for members to complete or the member may write a letter on his/her own. To obtain the address that written grievances should be mailed to, please contact the plan customer service department using the telephone number located on the members ID card. Providers do not have the right to file a formal grievance on their own behalf, as defined by the Medicare program.

## How a grievance is processed

BCBSGA MA member service representatives will attempt the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if the member's complaint cannot be resolved in this manner, the formal member grievance procedure will be followed. BCBSGA MA categorizes some grievances into two classifications for processing and tracking purposes. These two categories are:

- Customer service grievances (complaints about BCBSGA MA staff and/or policies)
- Provider quality grievances (complaints about the MA networks or providers).

The classification of the grievance dictates which specific internal procedure is followed. Grievances classified as *customer service complaints* are routed to managers in the appropriate department (Customer Service or Network Management) by the MA Appeals/Grievance department for review and investigation. These types of grievances are typically non-clinical in nature. A written determination will be sent to the member within the required 30-day timeframe. Grievances classified as *provider quality grievances* are processed by BCBSGA's Quality Improvement department or by the delegated entity if applicable. These types of grievances are typically clinical in nature. Therefore, the MA organization requires the provider to provide any related medical records, answer questions from health plan representatives, or furnish any necessary information to assist in the process of resolving the grievance on behalf of the member. Upon receipt of the grievance, the QI department or delegated entity will send the member an acknowledgement letter. After the investigation is complete, the QI department will send the member a final letter.

*The information contained in this handbook should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for BCBSGA members and enrollees are the responsibility of providers and practitioners. Please encourage the patient to review his/her Policy or Evidence of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment, as this Handbook does not supersede the Policy or Evidence of Coverage and Schedule of Benefits. The information in this Handbook may change from time to time.*

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