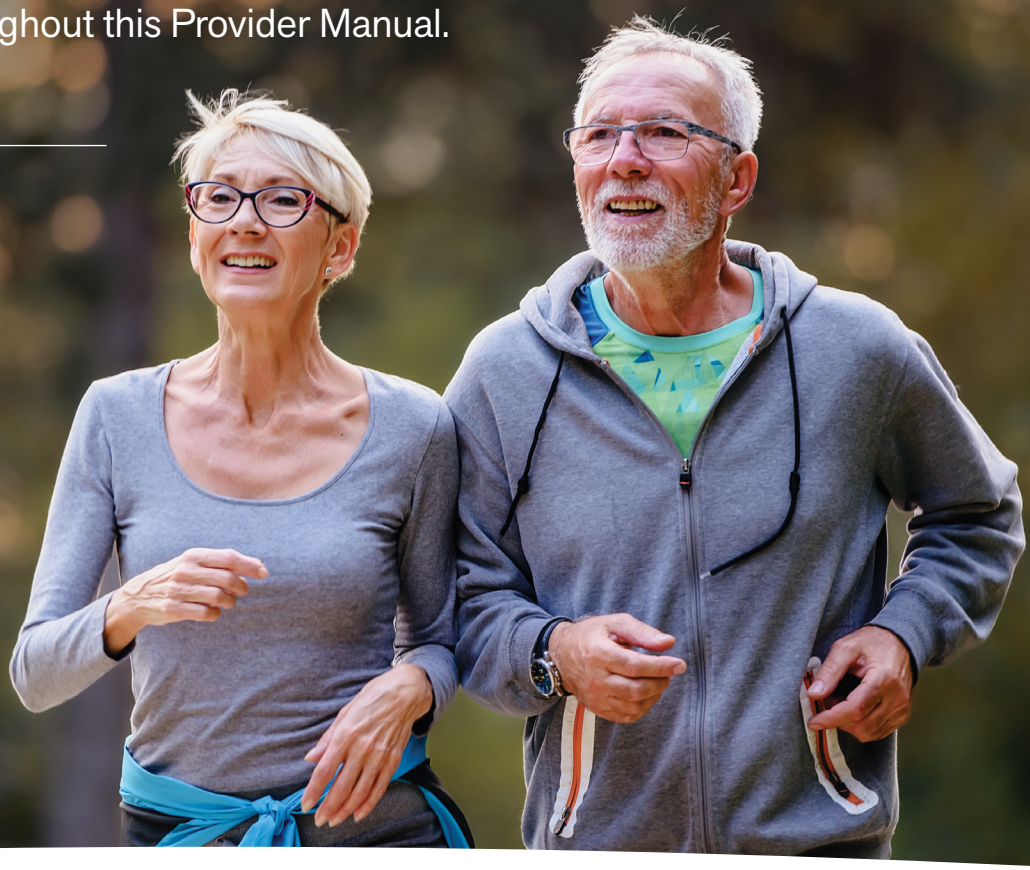
MyAdvocate Medicare Advantage Provider Manual

BESHP, Inc., is DBA MyAdvocate, and the names are used interchangeably throughout this Provider Manual.



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MEDICARE ADVANTAGE

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Product Overview HMO

Discussion of Disenrollment from Medicare Advantage

With regard to our affiliated providers, MyAdvocate Medicare Advantage considers it inappropriate for medical personnel to initiate or to promote discussion of disenrollment in Medicare Advantage (MA) plans except in the rare circumstance in which the MyAdvocate Medicare Advantage plans cannot or does not provide the covered medical items or services needed by a patient. MyAdvocate Medicare Advantage staff are prohibited from disenrolling, or requesting or encouraging an individual to disenroll, from any plan offered by MyAdvocate Medicare Advantage. There are exceptions to this rule such as disenrollment due to failure to pay premium and disruptive behavior.

Encounter Data Policy

MyAdvocate Medicare Advantage shall comply with the reporting requirements in §422.516 and the requirements in §422.310 for submitting data to CMS as set forth below. 42 CFR §422.504(a)(8).

Certification of data that determine payment requirements — As a condition for receiving a related monthly payment from CMS, MyAdvocate Medicare Advantage agrees that its chief executive officer (CEO), chief financial officer (CFO), or a designee who reports directly to such officer, must request payment under the contract on a document that attests to (based on best knowledge, information, and belief, as of the date specified on the certification form) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment/disenrollment information, changes in benefit packages, and other information that CMS may specify.

The CEO, CFO, or a designee who reports directly to such officer, must attest to the fact that each enrollee for whom MyAdvocate Medicare Advantage is requesting payment is validly enrolled in a Medicare Advantage plan offered by MyAdvocate Medicare Advantage, and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief, as of the date specified on the attestation form) is accurate, complete, and truthful.

The CEO, CFO, or a designee who reports directly to such officer, must attest (based on best knowledge, information and belief, as of the date specified on the attestation form) that the data he/she submits is accurate, complete, and truthful. If such data are generated by a related entity, contractor, or subcontractor of MyAdvocate Medicare Advantage, such entity, contractor, or subcontractor must similarly attest (based on best knowledge, information, and, belief, as of the date specified on the attestation form) the accuracy, completeness, and truthfulness of the data.

The CEO, CFO, or a designee who reports directly to such officer, must attest (based on best knowledge, information and belief, as of the date specified on the attestation form) that the information in the bid submission is accurate, complete, and truthful and fully conforms to the bid proposal requirements.

This attestation requirement is applicable to all MyAdvocate Medicare Advantage contractors, including those that are nonrenewing or terminating their contracts.

Encounter data

Data collection basic rule — MyAdvocate Medicare Advantage must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of MyAdvocate Medicare Advantage.

Sources and extent of data

- To the extent required by CMS, risk adjustment data must account for services covered under the original Medicare program; for Medicare covered services for which Medicare is not the primary payer; or for other additional or supplemental benefits that the MA organization may provide.
- The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

Other data requirements

- MyAdvocate Medicare Advantage must submit data that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards. Alternatively, MyAdvocate Medicare Advantage may submit data according to an abbreviated format, as specified by CMS.
- The data must be submitted electronically to the appropriate CMS contractor.
- MyAdvocate Medicare Advantage must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the services.
- MyAdvocate Medicare Advantage may include in its contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

Validation of risk adjustment data — MyAdvocate Medicare Advantage and its providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.

Use of data — CMS uses the data obtained under this section to determine the risk adjustment factor used to adjust payments, as required under §422.304(a)(1), (a)(2), and (a)(3). CMS may also use the data for other purposes except for medical records data.

Deadlines for submission of risk adjustment data — Risk adjustment factors for each payment year are based on risk adjustment data submitted for services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate.

The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

CMS allows a reconciliation process to account for late data submissions. CMS continues to accept risk adjustment data submitted after the March deadline until December 31 of the payment year. After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary. Risk adjustment data that is received after the annual December 31 late data submission deadline will not be accepted for the purposes of reconciliation.

Medicare Advantage Part D Data Submission

Prescription drug event data — As a Medicare Advantage Part D plan, MyAdvocate Medicare Advantage Plan is required to submit Part D drug claims data to CMS. For each Part D dispensing event, MyAdvocate Medicare Advantage Plan shall submit a summary record called the prescription drug event (PDE) record to CMS. The PDE record contains prescription drug cost and payment data that will enable CMS to make payment to plans and otherwise administer the Part D benefit. Specifically, the PDE record will include covered drug costs above and below the out-of-pocket threshold; distinguish enhanced alternative costs from the costs of drugs provided under the standard benefit; and will record payments made by Part D plan sponsors, other payers, and by or on behalf of beneficiaries. MyAdvocate Medicare Advantage shall also identify costs that contribute towards a beneficiary's true-out-of-pocket or Troop limit, separated into three categories: low-income cost-sharing subsidy amounts paid by the plan at the point of sale; beneficiary payments; and all Troop-eligible payments made by qualified entities on behalf of a beneficiary.

Medicare Advantage Part D Reporting Requirements

Part D reporting requirements — As a Medicare Advantage Part D Plan, MyAdvocate Medicare Advantage is required to report to CMS data elements that CMS will use to monitor the prescription drug benefit provided to Medicare beneficiaries. MyAdvocate Medicare Advantage shall submit Part D drug data in the following areas: Access to Extended Day Supplies at Retail Pharmacies; Appeals; Drug Benefit Analyses; Exceptions; Generic Drug Utilization; Grievances; Licensure and Solvency; Medication Therapy Management Program; Pharmacy and Therapeutics Committees/Provision of Part D Functions; Retail Pharmacy Access; Transition; Vaccines; Discounts

and Other Price Concessions; Home Infusion Pharmacy Access; LTC Pharmacy Access; and Pharmaceutical Manufacturer Rebates.

Medicare Advantage Reporting Requirements

Required information — MyAdvocate Medicare Advantage shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires. At the same time, MyAdvocate Medicare Advantage safeguards the confidentiality of the doctor patient relationship, statistics, and other information with respect to the following:

- Cost of operations.
- Patterns of utilization of services.
- Availability, accessibility, and acceptability of services.
- To the extent practical, developments in the health status of its enrollees.
- Information demonstrating that MyAdvocate Medicare Advantage has a fiscally sound operation.
- Other matters that CMS may require.

Fiscal soundness — MyAdvocate Medicare Advantage shall submit to CMS electronically through the Health Plan Management System (HPMS) an independently audited financial statement, using Statutory Accounting Principles (SAP). In addition, MyAdvocate Medicare Advantage shall enter 13 financial data elements from the corresponding statements into HPMS. These independently audited financial statements must be submitted to CMS no later than April 30 of the following year.

Significant business transactions — MyAdvocate Medicare Advantage shall report to CMS annually within 120 days of the end of its fiscal year (unless for good cause shown, CMS authorizes an extension), the following:

- A description of significant business transactions (as defined in §422.500) between MyAdvocate Medicare Advantage and a party in interest.
- With respect to business transactions, Medicare Advantage organizations must provide either a showing that the costs of the transactions listed do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or if they do exceed a limit of $25,000 or 5 percent of the Medicare Advantage organization's total operating expenses, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.
- A combined financial statement for MyAdvocate Medicare Advantage and a party in interest if either of the following conditions are met: 35 percent or more of the costs of operation of MyAdvocate Medicare Advantage go to a party in interest; or 35 percent or more of the revenue of a party in interest is from MyAdvocate Medicare Advantage.

Requirements for combined financial statements:

- The required combined financial statements must display in separate columns the financial information for MyAdvocate Medicare Advantage and each of the interested parties.
- Inter-entity transactions must be eliminated in the consolidated column.
- Statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

Upon written request from MyAdvocate Medicare Advantage showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph with respect to a particular entity.

Reporting and disclosure under ERISA:

- For any employees' health benefits plan that includes a Medicare Advantage organization in its offerings, MyAdvocate Medicare Advantage shall furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to MyAdvocate Medicare Advantage) under the Employee Retirement Income Security Act of 1974 (ERISA).

- MyAdvocate Medicare Advantage shall furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

Loan information — MyAdvocate Medicare Advantage shall notify CMS of any loans or other special financial arrangements it makes with contractors, subcontractors, and related entities.

Enrollee's access to information — MyAdvocate Medicare Advantage shall make the information reported to CMS under §422.504(f)(1) available to its enrollees upon reasonable request.

Recipient of Federal Funds Policy

Affiliated providers acknowledge that payments received from MyAdvocate Medicare Advantage to provide services to Medicare Advantage members are, in whole or part, from federal funds. Therefore, affiliated providers and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds. These laws include but are not limited to, Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans With Disabilities Act; the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance"); and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104-191; Standards for Privacy of Individually Identifiable Health Information (Unofficial Version) (45 CFR Parts 160, 162 and 164); Regulation Text December 28, 2000, as amended, Part 160 (May 31, 2002) and Parts 160, 164 (August 14, 2002).

Benefit Information

General Plan Information

In general, MyAdvocate Medicare Advantage offers coverage of Part A and Part B services in accordance with Medicare guidelines. Services that are not covered by Medicare may not be covered by our plans, except as specifically set forth in the Evidence of Coverage. Services must be provided by a Medicare certified provider who has not opted out of Medicare.

Some services may require prior authorization.

- Network providers are responsible for obtaining prior authorization on behalf of the member.

Covered services may apply to member cost-share.

- Unless specifically stated, members must use an in-network provider to receive the in-network cost sharing.
- To view a member's eligibility and benefits, log in to the Provider Portal.
- For plan specific documents such as the Explanation of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Acupuncture for Chronic Low Pain

MyAdvocate Medicare Advantage plans cover acupuncture in accordance with NCD 30.3.3. If a member does not meet the coverage criteria outlined in NCD 30.3.3 then affiliated providers must submit an organization determination to deny non-covered services to the member. Non-affiliated providers may have the member sign an Advanced Beneficiary Notice (ABN) and bill with appropriate modifier on the claim for services to deny to the member.

MyAdvocate Medicare Advantage covered services include up to 12 acupuncture visits in 90 days for Medicare beneficiaries with a diagnosis of chronic low back pain. An additional 8 sessions may be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. For the purpose of this benefit, chronic low back pain is defined as:

- Lasting 12 weeks or longer.
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic disease, inflammatory disease, infectious disease, etc.).
- Not associated with surgery.
- Not associated with pregnancy.

In addition to member coverage requirements, for acupuncture to be covered the following provider requirements must be met:

- Physicians (as defined in 1861(r) (1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.
- Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:
  - A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM).
  - A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.
- Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.

There could be cost share associated with this benefit. To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan specific documents such as the EOC, see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Continuity and Coordination of Care

MyAdvocate Medicare Advantage believes its members should receive seamless, continuous, and appropriate care through communication between behavioral health providers and primary care providers. The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations support MyAdvocate Medicare Advantage with our interest in patient safety and coordination of care.

When patients are present for behavioral health care, they need to be informed about how their records will be handled and, in certain circumstances, to give consent or authorization regarding what information can be shared and with whom. Coordination of care reduces the risk of problems when patients see multiple providers in different settings and when providers lack access to the patient's complete medical record. Important mental health information to be shared would include patient diagnosis, medication, and/or treatment plan.

In an effort to provide high-quality health care, affiliated behavioral health providers are required to communicate with primary care providers. MyAdvocate Medicare Advantage monitors this activity through an annual provider survey sent to both behavioral health providers and primary care providers. Providers indicate if they believe it is important to share this information as well as if the sharing of this information occurs.

MyAdvocate Medicare Advantage appreciates your help and cooperation in this matter to improve communication between providers through continuity and coordination of care.

MyAdvocate Medicare Advantage monitors the timely, effective, and confidential exchange of information between behavioral health (BH) providers and primary care providers (PCP), medical/surgical specialists, and other relevant medical delivery systems.

MyAdvocate Medicare Advantage collects, analyzes, and acts on data on the exchange of information regarding continuity of care. Examples of monitoring activities may include:

- Surveys of BH providers regarding the exchange of health care information between BH providers and other providers.
- Surveys of PCPs regarding information provided to and from BH providers.
- Review of PCP medical records to determine if PCPs receive BH specialist feedback, such as BH hospitalization discharge summaries.
- Health Effectiveness Data and Information Set (HEDIS) — a standardized set of healthcare quality measures used to measure and compare performance.

Coverage Inquiry for Organization Determinations

Per CMS regulations, Medicare Advantage plans and their contracted providers may not issue a financial waiver or an Advanced Beneficiary Notice of Non-Coverage (ABN) to any Medicare Advantage member as an appropriate notification of non-coverage. This rule can be found in the Medicare Managed Care Manual, Chapter 4, Section 160: Beneficiary Protections Related to Plan-Directed Care.

MyAdvocate Medicare Advantage contracted providers are required to submit a Medicare Advantage Coverage Inquiry on behalf of a member. MyAdvocate Medicare Advantage will make coverage decision and send appropriate member and provider notification. If a Coverage Inquiry is not submitted and the services do not meet Medicare criteria, the claim will be denied as provider responsibility and services cannot be billed to the member. If the service does not require an Organization Determination, we will respond to the provider stating that an Organization Determination is not required for this service.

Non-contracted providers are not required to follow this process and may continue to issue ABNs or submit a Coverage Inquiry, if preferred. If an ABN is utilized the GA modifier must be submitted on the claim to indicate the ABN was issued and is on file. Providers do not need to submit a copy of the ABN but must have it available upon request. If a Coverage Inquiry is on file or the service is submitted with the GA modifier, not covered items or services will be denied member responsibility.

Providers can submit a Coverage Inquiry using one of the following:

1. Email: um@myadvocatema.com
2. Mail:

   MyAdvocate Medicare Advantage
   Attn: Health Services UM
   1515 St. Joseph's Ave
   PO BOX 8000
   Marshfield, WI 54449

Frequently asked questions

When is an organization determination needed?

An Organization Determination is needed only when the service being requested is sometimes covered by Medicare based on medical necessity requirements and you do not feel the member will meet criteria. Obtaining an organization determination via the Coverage Inquiry prior to the services being performed will allow MyAdvocate Medicare Advantage to deny the claim to the patient and you to bill the member for services. If you do not obtain an organization determination and the services provided do not meet the established criteria for coverage, MyAdvocate Medicare Advantage the claim will deny as provider responsibility.

When is an organization determination not needed?

1. If the service is sometimes covered depending on criteria and the member meets the criteria to have the service covered.
2. If the service requested is a Medicare Statutory Exclusion.
3. If the service is always covered by Medicare.
4. If the service is excluded as outlined in the MyAdvocate Medicare Advantage Evidence of Coverage.

When should an organization determination be expedited?

An organization determination should only be expedited if waiting for the decision under standard response time could place the member's life, health, or ability to retain maximum function in serious jeopardy. In these instances, an organization determination can be requested after a member has received the service.

What if the member wants a service that is not covered?

If a service is never covered by Medicare (a Medicare Statutory Exclusion) and the member still wants the service, you can notify the member that service is not covered, provide the service, and bill the member directly for the service. It is in the best interest of all to notify the member of the non-coverage in writing and keep that documentation on file in the provider's business office.

Can we still utilize the GA modifier?

MyAdvocate Medicare Advantage will follow CMS guidelines and claims submitted with a GA modifier by contracted providers will be denied as a contractual obligation for invalid modifier.

What if the service requires prior authorization from MyAdvocate Medicare Advantage?

If the service you are providing requires prior authorization from MyAdvocate Medicare Advantage, you do not need to submit a Coverage Inquiry for an Organization Determination in addition to the prior authorization request. Only the prior authorization request is required and will provide appropriate provider and member notification.

Dental services

Non-Medicare covered dental benefits:

- MyAdvocate Medicare Advantage partners with Delta Dental to provide preventive and comprehensive dental benefits.
- Questions about benefits, limitations, covered services, provider network, or claims should be directed to Delta Dental Customer Service at 1-866-406-2172.

- Hours are Monday — Friday 8 AM to 8 PM CST

- This plan covers the following preventive and comprehensive dental services every calendar year. All covered services are subject to the maximum benefit for the plan.
  - Up to 2 oral exams every year
  - Up to 3 cleanings every year
  - 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years
- Comprehensive dental services:
  - Restorative
  - Endodontics
  - Periodontics (periodontal cleanings included in preventive; limits apply)
  - Prosthodontics, removable
  - Implant services
  - Prosthodontics, fixed
  - Oral and maxillofacial surgery
  - Adjunctive general services
- There may be member costs associated with these services. To view a member's eligibility and benefits log in to the Provider Portal. For plan specific information see: Medicare Resources and Forms | MyAdvocate Medicare Advantage.
- The maximum this plan pays for services, under this benefit:
  - MyAdvocate Medicare Advantage Silver: $1,000
  - MyAdvocate Medicare Advantage Gold: $1,250
- Claims for services covered under this dental benefit should be submitted to Delta Dental.
- Members who use a Delta Dental network dentist will have lower costs. Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in member out-of-pocket costs being higher. To find a Delta Dental network provider:
  - Go to www.DeltaDentalNE.org/MyAdvocate-dentists
  - Call Delta Dental Customer Service at 1-866-406-2172 (TTY 711)
  - Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in member out-of-pocket costs being higher.

Medicare-covered dental benefits:

- MyAdvocate Medicare Advantage follows guidelines on coverage for dental services covered under the medical benefit. For information on dental services that Medicare covers see the CMS.gov website.
- Medicare-covered dental services include:
  - Surgical repair of the jaw after a fracture or injury
  - Reconstruction of the jaw following a facial tumor
  - Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease
  - Oral examination prior to kidney transplantation or heart valve replacement (does not include coverage for any dental treatments)
  - There is no Medicare coverage for services such as extraction of teeth or tissue to prepare for dentures or to make dentures fit appropriately, or for follow-up dental care after the underlying health condition was treated
- Medicare covered dental services must be completed by a Medicare-certified provider to qualify for coverage.

- Claims for dental services covered under the medical benefit must be submitted to MyAdvocate Medicare Advantage on a CMS 1500 claim form and be submitted using CPT/HCPCS codes.
  - Claims submitted with dental codes (D codes) or on a dental claim form will be denied
- To view a member's eligibility and benefits log, in to the MyAdvocate Medicare Advantage Provider Portal.
- For plan specific documents such as the Evidence of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Emergency and Non-Emergency Transportation

MyAdvocate Medicare Advantage covers emergency ambulance services, including fixed wing, rotary wing, and ground ambulance to the nearest facility that can treat the member at the appropriate level of care.

- If the member chooses to be transported to a facility farther away, payment for mileage will be based on the distance to the closest appropriate facility. All additional mileage will be denied as patient responsibility.

Services are subject to member benefits. To view a member's eligibility and benefits log, in to the MyAdvocate Medicare Advantage Provider Portal. For plan-specific documents such as the Evidence of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Non-emergency transport

Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically necessary.

Covered services include:

- Hospital-to-hospital ambulance transport when member is being transferred due to needing a higher level of care.
- Transports between a skilled nursing facility, hospital, and home are covered for certain medical conditions.
  - All non-emergency transport requires run notes to be submitted with the claim to justify the transport
  - Additionally, non-emergency transport billed with HCPCS A0428 'Ambulance service, basic life support, non-emergency transport (BLS)' require a Physician Certification Statement (PCS) or Non-Emergency Ambulance Transport (NEAT) form be submitted with the claim

Non-covered services include:

- Hospital-to-hospital transport due to member request.
- Medical van transport.
- First responder/fire department charges.

When in doubt as to whether a non-emergency transport (scheduled or non-scheduled) meets coverage criteria, please MyAdvocate Medicare Advantage complete a Coverage Determination prior to transport.

Services are subject to member benefits. To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan-specific documents such as the Evidence of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Emergency and Urgently Needed Care Coverage

Emergency care

A MyAdvocate Medicare Advantage emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.

- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

"Emergency services" are inpatient or outpatient covered services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition. In the event of an emergency, the member should be instructed to go to the nearest emergency room or call 911 or the emergency access number for the member's area for assistance. MyAdvocate Medicare Advantage

Emergency services are covered with the same member cost sharing from an in- or out-of-network provider.

- Providers should contact MyAdvocate Medicare Advantage if an emergency inpatient admission occurs.
- Members are encouraged to contact MyAdvocate Medicare Advantage as soon as possible after an out-of-area emergency room visit.

Once the member has stabilized, services are no longer considered emergent. If out-of-network, members can continue to receive Medicare-covered services which will apply to their out-of-network cost-sharing.

Urgent care

Urgently needed services are defined as a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Urgent care services are covered with the same member cost sharing from an in- or out-of-network provider.

- Members are encouraged to contact MyAdvocate Medicare Advantage as soon as possible after an urgent care visit.

Worldwide emergency and urgently needed care

MyAdvocate Medicare Advantage covers up to $250 annually for worldwide emergency care, urgently needed care, and emergency transportation. Once the $250 annual maximum is reached, the member is responsible for 100% of costs.

Hearing Services and Hearing Aids

Medicare covered hearing services

MyAdvocate Medicare Advantage follows Medicare criteria for coverage of Part B hearing services.

To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan specific documents such as the Evidence of Coverage, see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Additional hearing benefits

One routine hearing exam is covered every calendar year.

Up to two hearing aids (limit 1 per ear) will be covered each year.

- Hearing aids must be dispensed by a TruHearing Network provider. If you wish to provide hearing aids to our members using the TruHearing Network, please contact TruHearing at 1-844-330-4421. If you would like more information on becoming a TruHearing network provider, contact TruHearing at 1-855-286-0550. More information about TruHearing can be found online at www.TruHearing.com.
- Member cost-sharing will apply. To view a member's eligibility and benefits, log in to the Provider Portal. For plan specific documents such as the Evidence of Coverage, see Medicare Resources and Forms | MyAdvocate Medicare Advantage.
- If members use any other hearing aid provider, there is no coverage and claims will be denied as member responsibility. MyAdvocate Medicare Advantage

The following items are not covered and claims will be denied as member responsibility.

- Ear molds
- Hearing aid accessories

- Extra batteries
- Hearing aid return fees
- Loss and damage warranty claims
- Repairs
- Over-the-Counter (OTC-H) hearing aids
- Additional provider visits

Home Health Care and Home Infusion Services

MyAdvocate Medicare Advantage follows Medicare criteria for coverage of Part B home health and home infusion therapy services. To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan specific documents such as the Explanation of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Services require prior authorization.

- MyAdvocate Medicare Advantage Home Health agencies must contact MyAdvocate Medicare Advantage to initiate prior authorization within two business days of the initial assessment. Member must be evaluated by the member's primary care provider to recertify the plan of care every 60 days.

Billing guidelines for home infusion chemotherapy that initiated in the provider's office and completed in the patient's home indicate that external infusion pumps or other supplies dispensed in the provider's office are not separately billable or reimbursable as durable medical equipment.

Part B Drugs, Including Macular Degeneration Eye Injections

MyAdvocate Medicare Advantage covers Part B drugs administered in an office or outpatient setting. To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan specific documents such as the Explanation of Coverage (EOC), see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

- The Part B drug will apply applicable member cost-share.
- If an office visit is billed, members may have an office visit co-pay, depending on plan benefits.
- Administration fees for Part B drugs do not apply any member cost-share.

Providers are required to buy the Part B drugs and bill the drug on a medical claim.

Prior authorization is required for some Part B drugs. We do not require a referral for Part B drugs.

Step therapy may be required for certain Part B injections. For detailed information see: https://www.myadvocatema.com/help.

The following information is available when you log into the Provider Portal:

- Member eligibility and termination dates
- Group numbers
- Type of policy (HMO, POS, indemnity, etc.)
- Coordination of benefits (COB) information
- Out-of-pocket amounts (deductible, coinsurance, copayments)
- Prior authorization submission and status

MyAdvocate Medicare Advantage plans renew on a calendar year basis. These plans:

- Are not COBRA plans
- Are fully funded
- Cannot exclude for pre-existing conditions
- Do not have a lifetime maximum

- Do not have annual benefit caps on Part B drugs

MyAdvocate Medicare Advantage Preventive Care Services

MyAdvocate Medicare Advantage covers Medicare covered preventive services with no member cost share whether they are received from an in- or out-of-network Medicare certified provider. For a list of covered preventive services, go to www.medicare.gov/coverage/preventive-screening-services.

If a diagnostic visit or test is performed in addition to the preventive service, applicable member cost-sharing will be applied to those services.

To view a member's eligibility and benefits, log in to the MyAdvocate Medicare Advantage Provider Portal. For plan specific documents such as the EOC, see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Renal Dialysis and Service to Treat Kidney Disease

Inpatient or outpatient renal dialysis treatments for End-Stage Renal Disease (ESRD) are covered when received from an in- or out-of-network Medicare certified provider.

Other covered services include:

- Kidney disease education
- Self-dialysis training for you or anyone helping you with home dialysis treatment
- Home dialysis equipment and supplies
- Certain home support services
- Telehealth or in-person office services
- Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B
- Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar®
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics
- Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta).

Services are subject to applicable member cost share. To view a member's eligibility and benefits, log in to the Provider Portal. For plan specific documents such as the EOC, see Medicare Resources and Forms | MyAdvocate Medicare Advantage

Sleep Apnea Treatment — Oral Appliances

MyAdvocate Medicare Advantage follows Centers for Medicare and Medicaid Services (CMS) standards of coverage for services relating to oral appliances for the treatment of obstructive sleep apnea and for a custom-fabricated oral appliance to treat obstructive sleep apnea (OSA) to be covered by Medicare, it must be provided and billed for by a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) certified supplier.

Per confirmation with CMS, coverage guidelines dictate payment for all care associated with the oral appliance dispensed for obstructive sleep apnea is included in the reimbursement for the device. Specifically, "all care" is defined as the initial visit, fitting, adjustments, modifications, home sleep studies, and all other professional services. Claims for these professional services will be denied as not payable separately.

- MyAdvocate Medicare Advantage will deny all care prior to, the same day as, or within 90 days after delivery of the oral appliance as provider responsibility.
- MyAdvocate Medicare Advantage will deny any follow-up services related to an oral appliance and be billed by a dentist or oral surgeon that are greater than 90 days after the delivery of an oral appliance as member responsibility.

CMS standards of coverage for services relating to oral appliances can be found in CMS Local Coverage Article

A52512 'Oral Appliances for Obstructive Sleep Apnea'.

Skilled Nursing Facility (SNF)

For information related to claim processing, reimbursement, and consolidated billing, see the Claim Processing Policies and Procedures "Skilled Nursing Facility" section of the Provider Manual.

MyAdvocate Medicare Advantage follows Medicare coverage for skilled nursing facility (SNF) services with the exception that we do not require a hospital stay prior to a SNF admission. Care must occur at a Medicare certified facility.

Part A:

- All Part A SNF stays require prior authorization. All post-acute facilities (skilled nursing facility, inpatient rehab, or long-term acute care facility) must notify MyAdvocate Medicare Advantage of an admission within 24 hours or the next business day of admission after receiving the approved authorization.
- If the member in transitioned to the post-acute facility without prior authorization, the health plan will not guarantee reimbursement.
- MyAdvocate Medicare Advantage covers up to 100 days of SNF care each benefit period
  - A new benefit period begins when a member is not admitted to a hospital, SNF or swing bed for 60 consecutive days.
- Copay days start over with each new admission.
- Members pay 100% of costs after the 100-day benefit period is exhausted and for stays that do not meet Medicare criteria including custodial care.
- Once a Part A stay's benefit period has been exhausted Part B services may still qualify for coverage. See "Part B" information below for details.
- Services are subject to applicable member cost share. To view a member's eligibility and benefits, log in to the Provider Portal. For plan specific documents such as the EOC, see https://www.myadvocatema.com/help
- MyAdvocate Medicare Advantage members pay 100% after the 100-day benefit period is exhausted

Part B:

- Services are subject to applicable member cost share. To view a member's eligibility and benefits, log in to the Provider Portal. For plan specific documents such as the EOC, Medicare Resources and Forms | MyAdvocate Medicare Advantage.

Comprehensive Medication Review (CMR): For purposes of the Medicare Advantage plan, MyAdvocate Medicare Advantage must offer a comprehensive medication review to all members enrolled in a mediation therapy management (MTM) program, including those receiving care in a long-term care (LTC) setting.

Vision Services and Hardware Coverage

Medicare covered vision services

MyAdvocate Medicare Advantage follows Medicare criteria for coverage of Part B vision services, including glasses after cataract surgery. Claims for glasses must be billed with an appropriate cataract surgery related diagnosis for the eyeglasses or contact lenses to be covered. If the member chooses deluxe frames or lenses (i.e., scratch resistant, tint, progressive, transitions, etc.), they may apply to the additional vision benefits listed below.

To view a member's eligibility and benefits log in to the Provider Portal. For plan specific documents such as the Evidence of Coverage, see Medicare Resources and Forms | MyAdvocate Medicare Advantage.

MyAdvocate Medicare Advantage additional vision benefits

MyAdvocate Medicare Advantage partners with VSP to offer the following additional vision benefits:

- Routine eye exams: 1 exam every year
- Refraction and diagnostic eye exam services: 1 exam every year
- Eyeglass lenses: single vision, lined bifocal, lined trifocal, and lenticular: 1 pair every year
- Contact lenses: The eyewear benefit allowance for contacts is in lieu of glasses. The contact lens allowance applies to contact lens fitting/evaluation and contact lenses.
- $300 annual hardware allowance towards: eyeglass frames or contact lenses (in lieu of eyeglasses)

Members must use a VSP provider to receive these benefits. Members are responsible for 100% of the costs for services received from a provider who does not participate in VSP and for all services received above the frequency allowances.

Care Management

MyAdvocate Medicare Advantage has programs available that are above and beyond the normal Medicare benefit to help improve member health. MyAdvocate Medicare Advantage uses established criteria and assessment tools to identify members who may benefit from these programs. Not all members are eligible for these programs. If a member is selected to participate, they must also be willing to participate in MyAdvocate Medicare Advantage's Case Management program. These programs are available at no extra charge to the member.

Referring Members: As a provider, you may refer a member you think would benefit from MyAdvocate Medicare Advantage by participating in care management. Referrals, which are at Plan's discretion, may result from, but are not limited to, members receiving hospital inpatient, skilled nursing facility, or chronic care services or health risk assessment results. Please call our provider services line (PAL) at 888-298-4650 and ask to speak to a care manager.

Chronic Care Management

MyAdvocate Medicare Advantage assists members over the age of 18 who have a diagnosis of asthma, diabetes, coronary artery disease, heart failure, chronic lung disease and/or hypertension, or other potential chronic conditions identified. The care management program focuses on promoting member self-management of their condition(s) and coordinating needed health care services.

Members participating in the care management team are assessed for their needs regarding their condition and may receive educational mailings that address how to care for their condition and pertinent gaps in care. High-risk members may be outreached by a care manager. Care managers offer the following services to members who enroll in the program to optimize their self-management skills:

- Regular contact with a care manager — per member agreement
- Clinical assessments of health status and comorbidities
- Support of providers' plan of care
- Regular updates to provider(s) as needed
- Referrals to social workers, health coaches, and community resources
- Medication reconciliation
- Identifying gaps in care and follow up needs

End Stage Renal Disease (ESRD) Care Coordination

ESRD definition

ESRD is defined as a stage of kidney impairment that is irreversible and permanent. ESRD requires a regular course of dialysis or a kidney transplant to maintain life. An individual who has received a kidney transplant that restores kidney function and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD. Therefore, the individual may be eligible to elect a Medicare Advantage plan.

ESRD guidelines

Members already enrolled in MyAdvocate Medicare Advantage who subsequently become eligible for Medicare because of ESRD, and aging Medicare members who subsequently develop ESRD, cannot be disenrolled from the HMO as a result of the development of ESRD.

Process for submitting ESRD Annotation to CMS for Medicare Advantage is the same as that for original Medicare.

Health Assessment

All newly enrolled MyAdvocate Medicare Advantage members are encouraged to complete a Health Assessment within 90 days of enrollment.

By completing the health assessment, we are able to learn more about a member's health needs and goals. This allows us to identify members who may have health care needs and connect them with care management programs and other resources from which they may benefit.

Request a paper copy of the HRA by calling Customer Service at 1-888-298-4650, TTY 711.

Hospice Care Coordination

Overview

MyAdvocate Medicare Advantage members who are appropriate for end of life palliative medical and support services will be referred to a Medicare-certified hospice program for hospice care. Original Medicare, not MyAdvocate Medicare Advantage, in accordance with Medicare's guidelines, will provide coverage for hospice care for MyAdvocate Medicare Advantage members.

Hospice patient definition

A member is eligible for hospice care only after the attending physician and the hospice medical director concur that the member is terminally ill and has a life expectancy of 6 months or less.

Hospice guidelines

A member must sign a statement choosing hospice care instead of MyAdvocate Medicare Advantage coverage for his/her terminal illness.

Care must be provided by a Medicare-approved hospice. MyAdvocate Medicare Advantage members will be provided with information on all Medicare-approved hospice programs in the area. The member selects a Medicare certified hospice of choice.

Coverage guidelines

Medicare Advantage plan members may receive care from any Medicare certified hospice program. Original Medicare (rather than MyAdvocate Medicare Advantage) will pay the hospice provider for the services they receive.

The hospice doctor can be a network provider or an out-of-network provider. They will still be a plan member and MyAdvocate Medicare Advantage will pick up the cost share for the member that original Medicare applies, minus any cost share the member would have as a Medicare Advantage plan member.

Example: Member is on MyAdvocate Medicare Advantage plan and has an office visit. The claim should be submitted to original Medicare to have Medicare cost-share apply. Medicare will assign the member 20% coinsurance. The claim should then be crossed over to MyAdvocate Medicare Advantage who will process the claim according to plan benefits.

The claim must first go to original Medicare and then must be submitted to MyAdvocate Medicare Advantage as secondary with the Medicare EOMB attached showing what Medicare paid. If there is no EOMB attached, the claim will be denied ANSI B9.

- A member can elect to be enrolled in hospice for an unlimited number of election periods of hospice care. The period consists of two 90-day benefit periods followed by an unlimited number of 60-day periods. Benefit periods can be used concurrently or at intervals; however, the member must be certified as terminally ill at the beginning of each benefit period.
- A member has the right to discontinue hospice care at any time; however, any days remaining in that benefit period are forfeited.
- A member has the right to change hospice programs one time per benefit period.
- A MyAdvocate Medicare Advantage case manager may monitor members involved in hospice care, as indicated.

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving the quality of health care. The organization's primary activities are assessing and reporting on the quality of the nation's managed care plans.

MyAdvocate Medicare Advantage Maintaining NCQA accreditation is integral to our commitment to quality and excellence.

NCQA began accrediting managed care organizations in 1991 in response to the need for standardized, objective information about the quality of these organizations. NCQA Health Plan Accreditation builds upon more than 25 years of experience to provide a current, rigorous, and comprehensive framework for essential quality improvement and measurement. It is the only program in the industry that bases results on clinical performance and consumer experience (HEDIS® and CAHPS®).

NCQA standards are a roadmap for improvement—organizations use them to perform a gap analysis and align improvement activities with areas that are most important to patients across the U.S., such as network adequacy and consumer protection. Standards evaluate plans on:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Members' Rights and Responsibilities
- Member Connections
- Medicaid Benefits and Services

The use of HEDIS® data allows the Health Plan Accreditation to effectively measure care and service performance. This focuses attention on activities that keep members healthy.

Notice of Medicare Non-Coverage

Information taken from the CMS Web site https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html.

As of January 1, 2004, enrollees of Medicare Advantage (MA) plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that state and the enrollee's MA plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review. The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties: 1) The MA organization, 2) The provider, 3) The patient/MA enrollee or authorized representative, and 4) the QIO.

Further information

- The Notice of Medicare Noncoverage (NOMNC) form fulfills the CMS requirement 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the MA Manual for Medicare Advantage organizations effective January 1, 2004.

Reminder

- MyAdvocate Medicare Advantage's care managers will attempt to work collaboratively with each provider to facilitate the advance notice process. However, it remains the agency/facility's responsibility to issue the NOMNC in a valid manner. This is a federal requirement and is not an optional procedure.

Outpatient Observation Frequently Asked Questions

What is outpatient observation?

Observation is a special service or status that allows physicians to place a patient in an acute care setting within the hospital for a limited amount of time to determine the need for inpatient admission. The patient will receive periodic monitoring by the hospital's nursing staff while in observation.

What is the difference in billing?

Observation stay is billed as an outpatient service (Part B under Medicare).

What kind of medical problems do patients have that would make observation appropriate?

There are many types of medical problems that would support the need for observation, for example symptoms that can usually be resolved within 24 to 48 hours or where the need for admission is unclear. It is the intent of the Medicare program to allow a physician more time to evaluate/treat a patient and make a decision to admit or discharge. Observation generally does not exceed 24 hours and only in extreme conditions exceeds 48 hours.

What are some examples of these problems?

Nausea, vomiting, stomach pain, headache, fever, and some types of shortness of breath and chest pain.

What is meant by a "limited amount of time?"

Observation is only appropriate for short time periods. Medicare currently allows 24 to 48 hours.

What happens at the end of the "specified amount of time?"

Typically the physician will decide whether to discharge the patient to home or admit him/her as an inpatient.

What if a physician decides the condition requires acute inpatient care?

When that determination is made, the physician must then write an order to convert the outpatient observation stay to an inpatient admission and notify the health plan of the change of status.

What if the patient is admitted as an inpatient but it is determined subsequent to the admission that the patient should have been in outpatient observation?

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon reviewing the case later, the hospital's utilization review committee determines that an inpatient level of care does not meet the hospital's admission criteria.

Centers for Medicare and Medicaid Services (CMS) has a new condition code from the National Uniform Billing Committee (NUBC), since 2004:

- Policy — In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:
- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital,
  - The hospital has not submitted a claim to Medicare for the inpatient admission,
  - A physician concurs with the utilization review committee's decision,
  - The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.
- Condition Code 44 — Inpatient admission changed to outpatient — For use on outpatient claims only, when the physician ordered inpatient services but upon internal review performed before the claim was initially submitted, the hospital determines the service did not meet its inpatient criteria.

For additional information: CMS Manual Transmittal 299 — September 10, 2004.

After an observation admission, what if a physician decides that the patient does not require acute inpatient care?

The physician will discharge the patient and follow up with care on an outpatient basis.

Can a patient be placed into outpatient observation after undergoing an outpatient surgical procedure?

Procedures have a routine 4 to 6 hours of recovery associated with them. However, if the patient experiences a postoperative/post-procedure complication, then the physician may place the patient into observation to monitor or admit as an in-patient.

What type of post-surgical conditions may warrant further evaluation in "outpatient observation?"

- Inability to urinate
- Inability to keep liquids down, thus requiring IV hydration
- Inability to control pain
- Unexpected surgical bleeding
- Unstable vital signs
- Inability to safely ambulate after spinal anesthesia
- Unusual reaction to the surgical procedure or anesthesia (such as difficulty awakening from anesthesia, drug reaction, or other post-surgical complication)

Can a physician order observation services before the procedure is performed?

No. Routine preparation before a test or procedure is not considered to be an observation service. Observation services should only be ordered after the procedure and only after a routine recovery period has revealed a complication that would require additional time for monitoring and treatment.

If a physician places a patient in observation, how does this affect the patient's copays?

Since observation is an outpatient service, any outpatient copays will apply. Medicare beneficiaries will be responsible for any "self-administrable" medications.

Preventive Service Guidelines

Preventive service guidelines for patients

MyAdvocate Medicare Advantage follows the U.S. Preventive Services Task Force (USPSTF) Preventive Health Guidelines. USPSTF

A list of the major recommended preventive services can be found on the U.S. Preventive Services Task Force website. The Plan recommends members speak with their health care provider to determine what preventive services are recommended.

MyAdvocate Medicare Advantage care management features

- Convenient — We deliver assistance via telephonic, electronic contact, and/or mailed information. The care manager works with the member to coordinate an outreach schedule.
- Comprehensive — We focus on all the ways a member's condition affects their life.
- Collaborative — We promote a collaborative relationship with the member, provider(s), care manager, and other professionals.
- Coaching — We use a motivational approach to promote behavior change for optimal health.
- Individualized — We customize our approach based on an individual's health needs and goals.

Program goals

- Improve member health

- Ensure high-quality health care
- Change behavior and increase self-management skills
- Empower members to effectively manage their condition
- Prevent health complications
- Contain health care costs
- MyAdvocate Medicare Advantage

Contact information

- All programs: 888-298-4650

Quality Improvement — Utilization Management Program Overview

The goal of the Quality Improvement/Utilization Management (QI/UM) program is to support the Plan in providing accessible, high-quality, cost-effective patient care using appropriate resources. QI/UM program initiatives assess the quality of clinical care provided by affiliated providers and customer service provided by the Plan. QI/UM initiatives focus on interventions needed to continually improve the quality of care and service delivered to members.

MyAdvocate Medicare Advantage QI/UM program objectives are to:

- Monitor and evaluate the quality and appropriateness of health care provided to MyAdvocate Medicare Advantage members.
- Monitor and evaluate the performance of affiliated providers on an ongoing basis.
- Promote patient safety through QI/UM activities such as education materials, health management systems, credentialing, and pharmacy management.
- Define expectations for each indicator through the use of acceptable standards of care, routinely evaluate opportunities to improve the delivery of care and services, and organize data for trend analysis and pattern assessment.
- Pursue opportunities to improve care provided to members by monitoring member satisfaction, ensuring access, availability, and service delivery against standards and implementing corrective actions as needed.
- Promote and monitor continuity and coordination of care among medical and behavioral health providers participating in member care.
- Maintain MyAdvocate Medicare Advantage network provider involvement in and awareness of QI/UM and credentialing activities.
- Conduct ad hoc primary care physician and behavioral health site visits and medical record reviews to ensure provider compliance with MyAdvocate Medicare Advantage standards.
- Conduct ongoing evaluation, monitoring and documentation of the effectiveness of interventions and recommendations of QI/UM activities.
- Promote and enhance education aimed at members and providers to facilitate high-quality care; provide a systematic complaint procedure to ensure all complaints are reviewed and resolved in a consistent and timely manner.
- Provide a systematic grievance/appeals process to ensure all grievances/appeals are reviewed and resolved in a consistent and timely manner.
- Promote health education and use of preventive health care services; annually monitor results through HEDIS®.
- Protect the confidentiality of data, medical records, and other member, provider, vendor, and/or employer sensitive information.
- Monitor timeliness standards on a quarterly basis; assess provider satisfaction with the UM process on an annual basis.

- Regularly communicate to members, providers and staff the findings of the QI program to ensure its effectiveness and support.
- Orient new staff to the QI/UM program.
- Evaluate, no less than annually, the effectiveness of the QI/UM program and recommended areas for improvement.

To see the annual QI evaluation, call MyAdvocate Medicare Advantage Customer Service to request a paper copy.

HEDIS is registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

MyAdvocate Medicare Advantage Protocols

To obtain a copy of a specific MyAdvocate Medicare Advantage protocol, call 888-298-4650 or sending an email to MemberServices@MyAdvocateMA.com .

Precertification of hospital admissions

Based on medical diagnosis or proposed surgery and medical information, MyAdvocate Medicare Advantage will:

- Authorize coverage for a length of stay based on InterQual Level of Care Criteria. (Remember that the InterQual Level of Care Criteria is a minimum length of stay consistent with quality care, not an average or maximum. Actual length of coverage for a stay is based on medical necessity and intensity of service.)
- Notify the provider of the number of days for which coverage is authorized for elective admissions by fax (affiliate) or by letter (non-affiliate).
- Upon request, send a copy of the appropriate InterQual Level of Care Criteria available by contacting the MyAdvocate Medicare Advantage Utilization Review Coordinator.
- Follow the admission with the hospital Utilization Review Department if the member is not discharged within the pre-certified time frame. The admission will be reviewed for medical necessity and intensity of service.
- Contact the provider for additional information (if not available through the hospital utilization review department) to determine whether additional days will be covered or denied based on medical necessity for an acute care setting. Alternate settings and appropriate home health services will be explored for those who do not meet criteria for continued coverage of acute care.

Note: The provider, not the member, is responsible to pre-certify an admission to the hospital for medical and/or surgical treatment.

Contact the MyAdvocate Medicare Advantage Utilization Review Coordinator at 888-298-4650.

Transplants Organ and stem cell/bone marrow transplantation is a medical procedure in which an organ or cells are removed from one body (or own body) and placed in the body of a recipient, to replace a damaged or missing organ or stem cells/marrow.

MyAdvocate Medicare Advantage requires prior authorization for pre-transplant, transplant, post-transplant, and precertification for admission.

- Fax: 715-221-6616
- Call for more information: 888-298-4650

Two Midnight Rule

In line with the recent Centers for Medicare and Medicaid Services suspension of the Two Midnight Rule, the health plan will continue to review for level of care appropriateness. MyAdvocate Medicare Advantage. Please follow the updated process below when submitting clinical information for both inpatient admissions and observation admissions:

Inpatient admissions and concurrent review

Notify MyAdvocate Medicare Advantage within 24 hours or the next business day of the admission. Failure to pre-certify an inpatient admission may result in decreased or denied coverage. Fax the following within 24 hours of notification of admission to MyAdvocate Medicare Advantage Health Services at 888-298-4650 **or use the**

portal to enter an new inpatient admission.

- Clinical information
- Inpatient order

1. After all information is received, MyAdvocate Medicare Advantage will review the case and make the determination.
2. If no clinical information is received after the second attempt from the health plan's staff to retrieve information, associated claims will be denied to the provider as a provider contract requirement.
3. The frequency of concurrent review is determined by the member's condition and severity of illness.
4. The facility/provider is responsible for providing the requested clinical information timely for concurrent review to prevent a penalty for late notification.
5. Notify MyAdvocate Medicare Advantage at 715-221-6616 (fax) of all maternity admissions (mom and baby) that are longer than the mandated time frames: 48 hours for vaginal delivery and 96 hours for C-section delivery. By sending an email to the shared UM: UM@MyAdvocateMA.com.
6. Provide timely concurrent review activities by fax (715-221-9980) to prevent an adverse determination or late notification. A timely review is defined as providing clinical information within 24 hours of the last covered day.
7. Failure to provide this information means MyAdvocate Medicare Advantage will not be able to perform timely initial or concurrent review of the admission. MyAdvocate Medicare Advantage will therefore not reimburse the facility for covered services incurred prior to the performance of the initial or concurrent review of the admission. The facility shall not bill, charge, collect a deposit from, seek remuneration or compensation from the MyAdvocate Medicare Advantage member, or any person acting on the member's behalf, for covered services incurred prior to the performance of the initial or concurrent review.

Observation admissions

1. The Health Plan does not need notification of observation stay unless the stay is getting close to the 48 hours in observation status. MyAdvocate Medicare Advantage Fax the following within 24 hours of notification of admission to MyAdvocate Medicare Advantage Health Services at **715-221-9980**.
2. Clinical information.
3. After all information is received, MyAdvocate Medicare Advantage will review the case and make the determination.
4. If no clinical information is after the second attempt from the health plan's staff to receive information, associated claims will be denied to the provider as a provider contract requirement.

All Inpatient Facilities reviews must be completed on both inpatient and observation patients greater than 48 hours; MyAdvocate Medicare Advantage will provide you with the number of days certified. In the event you require more days than originally certified, you must submit an additional request 24 hours prior to the member's authorization expiration date.

- For inpatient-only admissions, the provider needs to provide the inpatient order as well as clinical information to MyAdvocate Medicare Advantage within 24 hours of admission to certify the patient's inpatient admission .
- If the provider fails to provide the needed clinical information within 24 hours of the admission, MyAdvocate Medicare Advantage will deny for provider contract requirement. Each day will be denied to the provider until MyAdvocate Medicare Advantage receives required clinical information.

If you have any questions about this information, please call our provider customer service line at 1-888-298-4650, Monday through Friday from 8 a.m. to 5 p.m.

Claims Processing Policies and Procedures

General Claim Submission Information

In general, MyAdvocate Medicare Advantage requires providers to bill claims according to Medicare guidelines. Services that are not covered by Medicare may not covered by our plans, except as specifically set forth in the Evidence of Coverage.

Services must be provided by a Medicare certified provider who has not opted out of Medicare.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Claim submission

The standard CMS 1500 or UB-04 claim form or their electronic equivalent are required for claim submissions. Providers must use universal CPT codes, HCPCS codes and/or revenue codes. Include all claim information as required by Original Medicare.

- Electronic Payer ID: 39045
- Paper claims:

  MyAdvocate Medicare Advantage
  Attn: Claims
  P.O. Box 8000
  Marshfield, WI 54449-8000

Paper claim specifics

We use optical character recognition (OCR) software to assist in processing paper claims. OCR software processes claim forms by reading text within fields on the claim form utilizing scanners to create an image. This software speeds paper claim processing if claim forms are completed correctly. Tips for submitting error-free paper claim submission:

- Use only a CMS 1500 (02-12) red and white claim form — claim forms that are black and white may darken upon scanning resulting in certain fields to be unreadable, resulting in claim denials.
- Use black ink only.
- Required information must be filled in completely, accurately, and legibly.
- Accurately align text within the individual fields on the claim form.
- Do not highlight data on the claim form; this shows as black on the scanned image.
- Do not staple, clip, or tape anything to the claim form.
- All attachments should be one sided; do not print double sided.
- If submitting an attachment intended for several claim forms, please put a copy of the attachment behind each claim form.
- Place all necessary documentation in the envelope behind the claim form on an 8 x 11 sheet of paper; do not submit additional notes on Post-it® notes or paper size smaller than 8x11.

Electronic claim specifics

Electronic claim submission is our preferred option. We accept electronic transactions following standard HIPAA 5010 transaction guidelines and code sets. Below is a list of Clearinghouses which transmit directly to MyAdvocate Medicare Advantage:

- Apex EDI
- Availity

- Claim Lynx
- Cvikota Company
- Experian
- Gateway EDI Inc — TriZetto
- Health Care Data Systems
- Healthcare IP
- MCPS
- MultiPlan
- OptumInsight (aka Relay Health)
- Optum
- OutSource Inc
- PNC Healthcare
- Quadax
- Rycan Technologies Inc
- Smart Data Solutions
- SSI Group
- Waystar

When MyAdvocate Medicare Advantage receives a file transmission from a Clearinghouse, a standard 999 response file will be sent.

Providers are responsible for fees associated with utilizing a Clearinghouse.

Anatomical Modifier Requirement Policy

The policy applies to MyAdvocate Medicare Advantage products and to all network and non-network physicians and other qualified health care professionals. It applies to services reported using:

- 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.
- UB-04 (CMS-1450) or its electronic equivalent or its successor form.

According to the American Medical Association (AMA) CPT (Current Procedural Terminology) Manual and the HCPCS (Healthcare Common Procedure Coding System) Level II Manual, anatomic-specific modifiers designate the area or part of the body on which a procedure is performed. Use of laterality and/or anatomical modifiers add more information to the code to provide the highest specificity for the procedure being performed. In addition, they help to eliminate the appearance of duplicate billing and unbundling.

Based on AMA policy, anatomical modifiers are required whenever appropriate. If a procedure code in the list below is billed without a required anatomical modifier, it will be denied ANSI 16 " Claim/service lacks information or has submission/billing error(s)." and Remark N822 "Missing procedure modifier(s)."

- Procedure codes in the range of 10000-69999 are assigned a bilateral indicator of "1" on the National Physician Fee Schedule
- Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, includes stent placement, atherectomy, and balloon angioplasty. There are five major coronary arteries (left main, left anterior descending, left circumflex, right, and ramus intermedius), each having a corresponding descriptive anatomical modifier. PCI codes are required to be reported with one of the five anatomical PCI modifiers to be considered for reimbursement.

Anatomical/laterality modifiers include:

- E1-E4 (Eyelids)

- FA, F1-F9 (Fingers)
- TA, T1-T9 (Toes)
- LC (Left circumflex, coronary artery)
- LD (Left anterior descending coronary artery)
- LM (Left main coronary artery)
- RC (Right coronary artery)
- RI (Ramus intermedius)
- LT (Left side)
- RT (Right side)
- 50 (Bilateral)

Claims Coding Resources

The MyAdvocate Medicare Advantage claim processing system utilizes industry standard claim editing software, including Optum Claims Edit System (CES) for primary editing and Cotiviti as a second pass editing vendor. Our clinical editing processes promote correct coding and implement to the extent possible, claim payment policies that are broad in scope, simple to understand, and that come from regulatory guidance.

As a payor, under federal fraud and abuse guidelines, MyAdvocate Medicare Advantage we are restricted from instructing providers on how to bill.

When editing claims, we take into consideration historical claims experience as well as policy guidelines from the following sources:

- AMA CPT coding guidelines
- National and regional Medicare policies
- National specialty academy guidelines

Payment policies focus on areas such as, but not limited to:

- AMA CPT Procedure Code Definition and Guidelines
- National Correct Coding Initiative (CCI)
- Modifier usage
- ICD Diagnosis Code Guideline
- Global Surgery period
- Evaluation and Management Guidelines
- Add On code usage
- Professional, technical, global policy
- Diagnosis to Procedure
- Place of Service
- Age appropriateness
- CMS' National and Local Coverage Determinations
- Revenue Code Validation

Resources

Below are the resources MyAdvocate Medicare Advantage suggests as guidance for proper coding:

- American Medical Association CPT Manual
- National and regional CMS policies (Medicare guidelines regarding payment for specific services)

- Medicare Claim Processing Manual
- National Specialty Academy guidelines
- The American Academy of Professional Coders
- EncoderPro.com (can be purchased from Optum 360 Coding)
- ICD-10_CM Expert (can be purchased from AAPC)
- Medicare Physician Fee Schedule

Claims Payment Calendar

Claims finalize for payment on the following days each month:

- 5th business day
- 10th business day
- 15th business day
- Last calendar day (includes weekends and holidays)

Clean Claim and Interest Policy

Clean claim definition

A claim is considered "clean" when it is HIPAA compliant and on an accurate claim form. It must include all provider and member information as well as records, additional information, or documents MyAdvocate Medicare Advantage requires to process the claim.

A claim that does not meet the definition of a clean claim and requires investigation or additional documentation constitutes an "unclean claim."

The Health Plan will update the clean claim date to the date at which all necessary information to process the claim was received.

Interest

MyAdvocate Medicare Advantage pays interest to providers on "clean claims" that are not paid within contracted guidelines indicated below. Interest is calculated using the CMS interest rate, calculated MyAdvocate Medicare Advantage at the time of claim payment and paid on a per-claim basis. The amount paid per claim/claim line will be identified on the provider statement with ANSI code 225 'Penalty or Interest Payment by Payer'.

- Non-contracted/NonPAR Providers: Interest paid at day 31.
- Contacted/PAR Providers: Interest paid at day 61.

CMS 1500 Claim Form Instructions

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To access the sample claim form, click the link below:
CMS 1500 Sample Claim Form

General information

Our claim processing system is designed to process standard health insurance claim forms (CMS 1500) using CPT-4 Procedure Codes or Health Care Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-10-CM Diagnosis Codes.

Refer to the following resources for guidelines on completing the CMS 1500:

- Medicare Claims Processing Manual, Chapter 26 — Completing and Processing Form CMS-1500 Data Set
- 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by NUCC

At MyAdvocate Medicare Advantage a claim is considered complete when the following data elements are submitted (numbered as shown on the paper claim form):

1. Type of health insurance coverage applicable to this claim — check appropriate box
1a. Insured's Identification Number
2. Patient's name
3. Patient's birth date/sex
4. Insured's name (writing "same" or leaving blank is not acceptable.)
5. Patient's address
6. Patient's relationship to insured
7. Insured's address (street, city, state, zip)
8. Not required
9. Other insured's name — If item number 11d is checked, complete 9, 9a, and 9d, otherwise leave blank
10. Check appropriate box if patient's condition is related to:
10a. Employment
10b. Auto accident (box 15 required)
10c. Other accident (box 15 required)
10d. Not required
11. Insured's policy group or FECA number
11a. Insured's date of birth (MM/DD/YY) and sex
11b. Not required
11c. Insurance plan name or program name
11d. Enter an 'x' in the correct box
12. Patient's or authorized person's signature ("signature on file" is acceptable)
13. Insured's or authorized person's signature
14. Date of current illness, injury, pregnancy (LMP)
15. Other date — enter applicable qualifier and accident date when box 10b or 10c is checked
16. Not required
17. Name of referring provider or other source (if referring provider name is entered, box 17b required)
17a. Not required
17b. NPI of referring provider from 17
18. Hospitalization dates related to current services
19. Additional claim information
20. Outside lab — enter an 'x' in the correct box and if yes, enter the purchase price
21. Diagnosis or nature of illness or injury (ICD-10-CM)
22. Resubmission code and/or original reference number
23. Prior authorization number
24a. Red shaded area: Qualifier N4 followed by the 11 digit NDC code, the quantity qualifier and the quantity.
24a. White area: Date(s) of service (MM/DD/YY)
24b. Place of service
24c. EMG: Emergency Indicator
24d. Procedures, services or supplies (CPT/HCPCS and modifier)
24e. Diagnosis pointer
24f. Charge amount
24g. Days or units
24h. Not required
24i. Only required if entering a provider ID in 24j
24j. Rendering Provider NPI (in the white area) — Required if rendering provider is different than billing provider. Note: Claims for physical, occupational and speech therapy billed on a CMS 1500 form should include the rendering provider's National Provider ID (NPI). This will ensure proper processing and payment for services.
24j: Not required for Medicare Advantage claims

25. Federal Tax ID Number (TIN) and check appropriate box
26. Patient's account number — identified and assigned by provider
27. Accept assignment — check appropriate box if provider agrees to accept Medicare assignment
28. Total charge — sum of all charges in 24f
29. Amount paid — payment received from other payer or patient (do not include discounts)
30. Not required
31. Signature of physician or supplier including degrees or credentials
32. Service facility location– name and address of facility where services were rendered
32a. Service facility location NPI– NPI for the service facility location in 32 (only report a service facility location NPI when the NPI is different from the billing provider NPI)
32b. Not required
33. Billing provider information and phone number — name, address and phone number of provider requesting to be paid for services rendered. Billing provider address must be a physical location; not a PO Box.
33a. Billing provider NPI — NPI of the billing provider listed in box 33
33b. Billing provider taxonomy — Not required for Medicare Advantage claims

MyAdvocate Medicare Advantage Coordination of Benefits

- If a member carries insurance through more than one insurer, MyAdvocate Medicare Advantage will coordinate the benefits to ensure maximum coverage without duplication of payments.
  - Order of Benefit Determination
    - If covered expenses are incurred by a member who is eligible to apply for Medicare and for whom Medicare is primary, MyAdvocate Medicare Advantage will determine the benefits payable, if any, using the rules and regulations of Medicare in determining whether Medicare or MyAdvocate Medicare Advantage is primary.
    - If Medicare is primary for a Medicare eligible member, the member is considered enrolled in and covered under Medicare Parts A and B, whether or not a member is actually enrolled in one or both parts of Medicare.
    - To learn more about coordination of benefits and secondary payer, please visit https://www.cms.gov/Medicare/Medicare.html
- The provider must submit claims to the primary carrier before submitting them to MyAdvocate Medicare Advantage. After a claim is processed by the primary carrier, a claim should be submitted to MyAdvocate Medicare Advantage along with either the primary carrier's Explanation of Benefits (EOB) or their electronic payment/denial information. The affiliated provider must submit the claim within 365 days from the date of service or within 60 days of the primary payer's statement, whichever is later.
- When a patient has a VA authorization, any services related to that authorization should not be billed to the member's personal health insurance. The provider is responsible for billing the related services to the appropriate Third-Party Administrator documented in the referral.
- If the provider fails to comply or is unaware of the primary insurance carrier, claims for which MyAdvocate Medicare Advantage is secondary will be denied using ANSI code 22. This denial reason will print on the provider's reimbursement statement.
- If a primary insurance is discovered after charges have been processed by MyAdvocate Medicare Advantage, and the primary insurance makes payment, the provider may have an overpayment. The provider is required to submit a copy of the original claim and a copy of the EOB from the primary insurance. Claims will be reprocessed based on the primary insurance payment. The adjustment will be reflected on the provider's reimbursement statement.
- If MyAdvocate Medicare Advantage discovers a primary insurance after charges have been processed, MyAdvocate Medicare Advantage will reverse its original payment. The adjustment will be reflected on the provider's statement using ANSI 22.

- If the primary insurance denies a claim because of lack of information, MyAdvocate Medicare Advantage will also deny.
- If the primary insurance denies a claim with Claim Adjustment Group Code "CO" (financial responsibility for the unpaid charge is assigned to the provider as a contractual obligation), as a secondary or tertiary payer, MyAdvocate Medicare Advantage will also deny these charges using Claim Adjustment Reason Code (CARC) 276 (services denied by the prior payer are not covered by this payer). Affiliated providers may not balance bill members for CARC 276 denials.
- If the provider has any questions regarding coordination of benefits, call 888-298-4650 Monday through Friday, between 8:00 a.m. and 5 p.m. or email COB@myadvocatema.com.

If a MyAdvocate Medicare Advantage member has another insurance, follow these instructions to ensure a claim will be processed correctly and in a timely manner:

- Complete information must be on the CMS 1500 claim or UB-04 claim or must be included with the electronic claim.
- On the CMS 1500 claim, box 11d should be checked "Yes" if there is any other insurance information. If box 11d is checked "Yes," boxes 9a — 9d on the CMS 1500 claim must be completed with the other insurance information.
- On the UB-04 claim, field 50 should be completed if there is any other insurance information.
- On electronic CMS 1500 or UB-04 claims, loop 2320 should include other insurance information.
- EOBs or electronic payment/denial information must accompany each CMS 1500 claim and UB-04 claim if other primary insurance is indicated on the claim.

Correction, Adjustment, and Void Requests

For information on timely filing for corrected claims, see the "Timely Filing for Claims Submission" section.

Corrected claim requirements

For purposes of claims payment, MyAdvocate Medicare Advantage will not accept an addendum, amendment, correction or late entry to a medical record dated after a claim denial date. If an addendum, amendment, correction or late entry to a medical record is legally dated prior to a claim denial, it may be considered for claim payment.

Corrected claims are required when facilities have found incorrect information was submitted on a claim or when charges need to be added or corrected.

Here are some examples of when to submit a corrected claim:

- Incorrect patient
- Incorrect date of service
- Incorrect provider
- Incorrect billed amount
- CPT/modifier changes
- Electronic claim originally submitted with COB credits and there has been a change to the COB credits and the provider submits an electronic claim with the new COB credits in the appropriate loops and segments of an 837 file. (Example: Primary coverage initially paid, then reversed and denied, and provider submits a claim with that denial in the 837. The claim must be marked as corrected. If a provider submits the corrected primary EOB via paper, see the section "Corrected Claim is not needed" below).

A corrected claim is not needed in the following scenarios

- Original claim was denied in full.
- Medical records, primary payer information, change in primary EOB credits where a new paper EOB is provided or other documentation needed, but no changes were made to the actual claim.

If payment has been made on previous claims and the corrected claim filing rules below are not followed, claims will be denied as duplicate service.

CMS 1500 corrections

- Electronic claims need to be submitted with a frequency code of "7".
- Paper claims can be marked with "correction/resubmission" in box 19 or frequency code "7" entered in box 22, resubmission code, and the original claim number in "Original Ref No" box.
- *NOTE:* If a claim number is entered in the payer claim control number field when submitting a corrected claim, MyAdvocate Medicare Advantage will automatically reverse the claim number in that field.

UB-04 corrections

- Electronic claims need to be submitted with a type of bill of XX7.
- Paper claims form with type of bill XX7 in box 4.
- *NOTES:*
  - Corrected UB claim forms require the appropriate claim change reason code to be submitted in the Condition Code fields per the Medicare Claims Processing Manual Chapter 1 — General Billing Requirements.
  - All late charges for UB claims must be consolidated into one claim for submission. If the late charges are received separately, they will be denied as a billing error.

Deletions, reporting a duplicate payment, or providing a refund

When a refund needs to be made to MyAdvocate Medicare Advantage due to the deletion of a service or duplicate payment, a void request needs to be completed.

CMS 1500 voids

- Electronic claims need to be submitted with a frequency code of "8".
- Paper claims should be submitted with an "8" in box 22, resubmission code, and the original claim number in "Original Ref No" box.

UB-04 voids

- Electronic claims need to be submitted with a type of bill of XX8.
- Paper claims must be submitted with type of bill XX8 in box 4.
- *NOTES*:
  - Void UB claim forms require the appropriate claim change reason code to be submitted in the Condition Code fields per the Medicare Claims Processing Manual Chapter 1 — General Billing Requirements.

Drug Wastage Policies

The primary aim of the drug wastage policy is to mitigate potential waste and/or abuse by offering guidance on proper billing and reporting practices for discarded drugs and biologicals.

This reimbursement policy applies to all single-use/dose vial (SDV) or other single-use/dose package drugs reported using the 1500 Health Insurance Claim Form (CMS-1500), UB04 claim form or their electronic equivalent. This policy applies to all network and non-network physicians and other qualified health care professionals. All services covered by this policy may also be subject to additional reimbursement policies/claim editing, including the NCCI Editing Policy and Maximum Frequency per Day, prior authorization requirements, National Drug Code (NDC) billing requirements, etc. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy.

When a physician, hospital, or other provider/supplier discards the balance of a single use/dose vial or other single use/dose package after administration of a drug or biological, reimbursement may be made for the amount of drug or biological discarded as well as the dose administered. Reimbursement will not be made for the wastage in

situations where the drug is not separately reimbursable. Payment for the discarded drug will only be made if the smallest vial, or combination of vials, was used to provide the patient the necessary dosage.

First policy

The first policy requires the use of the JW/JZ modifiers. When a SDV or other single-use/dose package drugs are administered, one of the drug wastage modifiers must be present on the claim:

- JW: Drug amount discarded/not administered to any patient
  - Claims with JW should be billed with two service lines. One line with no JW modifier and the number of units administered in the units field. The second line should contain the JW modifier and the number of units discarded in the units field.
- JZ : Zero drug amount discarded/not administered to any patient
  - Claims with JZ are billed on a single line with the JZ modifier and the number of units administered in the units field.

In situations where a drug is billed without modifier JZ or JW, the applicable drug line and associated administration fees, will be denied. In addition, if a claim with the JW is billed but is missing the claim line for the same medication without the JW modifier, the drug line and associated administration fees, will be denied.

It is inappropriate to append the JW/JZ modifiers to a multi-dose vial (MDV) drug. Claims will be denied if the JW or JZ modifier is appended to MDV drugs.

In addition, suppliers and providers must document the amount of the discarded drug in the member's medical records.
For more information on the use of JW and JZ modifiers see Medicare's discarded drugs and biologicals — JW modifier and JZ modifier policy: frequency asked questions (PDF).

Second policy

The second policy requires providers to use the smallest vial size, or combination of vials, that would have provided the appropriate dosage for the member and produced the smallest amount of waste. If a larger vial was used unnecessarily the entire drug wastage line will be denied.

As a reminder, if a drug requires an authorization, the authorization includes vial size in the calculation of the dosage approved. This means that the units approved, for the appropriate dosage, already include any potential drug waste for each administration. Therefore, if a larger than necessary vial size is used we will also deny the waste line as exceeding authorized units.

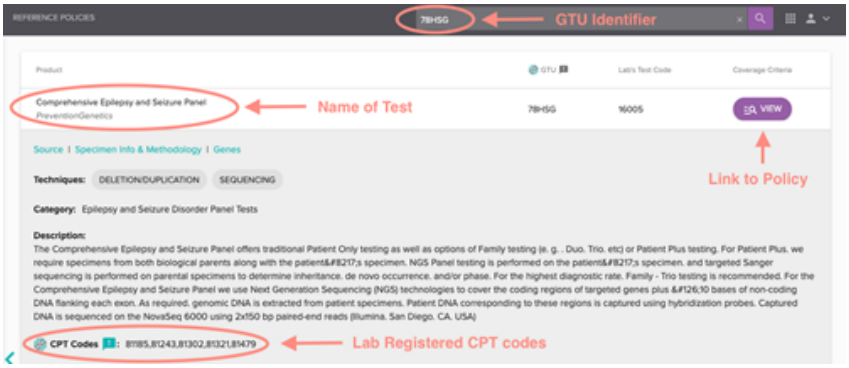
Genetic and Molecular Lab Testing

MyAdvocate Medicare Advantage is committed to improving the sustainability of care by ensuring high-quality, appropriate care is delivered at a fair price. Please review the Genetic and Molecular policy for additional information related to billing.

All providers billing for unlisted genetic and molecular testing services are required to add the appropriate Concert Genetics GTU descriptor to all prior authorization requests (refer to genetic medical policies for prior authorization requirements) and to include on claim submissions. MyAdvocate Medicare Advantage.

In order to identify the genetic or molecular test being performed, the provider must submit the unique Genetic Testing Unit (GTU) descriptor provided through the Concert Genetics portal for all unlisted genetic and molecular tests. The GTU unique test descriptor should be submitted in field:

- CMS 1500 — Loop 2400 SV101-07 on the electronic claim form or in the shaded of the service line in box 19 on a paper claim form (example: 2M6LG).
- UB04 — Loop 2400, SV202-7 on the electronic claim form or in the shaded area of the service line in block 80 (example: 2M6LG).



APPENDIX: Using the GTU on Healthcare Claims

Given the different claim forms and transactions, see below on where to put the GTU on each respective form/transaction.

Claim type	Field or Segment	GTU Format
837P Transaction (Professional Claims)	Loop 2400 segment SV101-7	Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G
HCFA/CMS 1500 Form (Professional Claims)	Item/box 19	
837I Transaction (Institutional Claims)	Loop 2400 segment SV202-7	
UB-04 Form (Institutional Claims)	Item/block 80	

Genetic and molecular testing reimbursement policy

This policy addresses genetic and molecular testing services and applies to reimbursement for codes billed from the following sections in the CPT/HCPCS Manual:

- Molecular Pathology
- Genomic Sequencing Procedures and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses
- Proprietary Lab Analysis (PLA) codes

Refer to MyAdvocate Medicare Advantage Genetic Testing Medical Policies for clinical criteria requirements, e.g., prior authorization.

Billing requirements

All providers billing for genetic and molecular testing services must bill according to the following requirements; if not billed appropriately, claims may be denied:

- Tests qualifying for panel code(s) must be billed with the appropriate panel code(s). Per the NCCI Manual, Chapter 10, section F-8, if one laboratory procedure evaluates multiple genes using a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure.
- Providers must bill for the test performed as indicated on the test requisition form and delivered on the test report.
- If a panel code is not appropriate (or when medical policy exclusively covers components of panels), a limited number of individual components from multi-gene tests may be billed.
- Codes are determined based on the attributes of the testing performed, not based on the clinical indication of the member.

- Coding must be consistent with AMA coding guidelines, as interpreted by the Concert Genetics coding engine (link to concert genetics website).
- Include ordering provider information on all claim transactions.
- Include Concert Genetic assigned unique test ID (GTU descriptor) when billing unlisted genetic and molecular test.
  - *NOTE:* MyAdvocate Medicare Advantage highly recommends including the GTU descriptor when billing any genetic and molecular service as this will become a requirement in 2023.

All laboratories billing for genetic and molecular testing services must register using the Concert Genetics portal. Please visit the Concert Genetics website to:

- Verify accuracy of test catalog and review coding engine standards for each test covered by this policy.
- Complete a brief quality profile.

MyAdvocate Medicare Advantage currently allows pass-through billing for laboratory services, but clinics/facilities are strongly encouraged to only bill for laboratory services they provide. If a clinic/facility bills for a genetic or molecular test performed by an independent laboratory, they should bill in accordance with Concert Genetics' coding recommendation for the performing laboratory and append the 90 modifier.

MyAdvocate Medicare Advantage requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal. Non-compliance with this policy will result in a written notification from MyAdvocate Medicare Advantage. Continued non-compliance may result in a denied reimbursement or termination of the provider's contract.

Limitation of Liability

MyAdvocate Medicare Advantage shall not be liable to trading partner for any indirect, incidental, special, or consequential damages (including lost profits) arising under or out of the performance of this section, whether or not MyAdvocate Medicare Advantage had any knowledge, actual or constructive, that such damages might be incurred based on breach of warranty, contract, negligence, or strict liability.

Miscellaneous

Complete agreement

This section, including those references set forth in the Transaction Terms provision, constitutes the complete agreement of the parties with respect to the use of electronic data interchange, and supersedes all prior representations or agreements, whether oral or written, with respect to electronic data exchange.

Obligation to EDI

No obligation to engage in any electronic data interchange is to be implied from the execution or delivery of this section.

Force majeure

Neither MyAdvocate Medicare Advantage nor the affiliated provider shall be liable for any failure to perform its obligation in connection with any electronic data interchange, including any document, where such failure results from any act of God or other cause beyond such party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any documents.

MyAdvocate Medicare Advantage Drug Code Requirements

National Drug Code (NDC) numbers are unique 11-digit identifiers for drugs; they provide full transparency as to the manufacturer, drug name, dosage, strength, and package size of the drug. The NDC is composed of three segments in a 5-4-2 format. If the NDC on the label does not include 11 digits, a leading zero should be added to the appropriate segment of the NDC to complete the 5-4-2 configuration.

Example:

1111-1111-11 = 01111-1111-11
11111-111-11 = 11111-0111-11
11111-1111-1 = 11111-1111-01

MyAdvocate Medicare Advantage requires NDCs on drug related services for all professional claims and facility claims for outpatient hospital services. This requirement applies to CMS-1500 and UB-04 paper claims and their electronic equivalent when billing for drug-related revenue codes, HCPCS and CPT codes.

The NDC must be submitted with:

- A valid 11-digit NDC number without dashes or spaces.
- Unit of measure qualifier.
- Units (quantity or number of units).

Claims will be denied if:

- An NDC is not indicated on the claim.
- The NDC indicated is invalid, inactive or obsolete.
- The NDC and HCPCS do not match.
- The drug requires prior authorization and no approved prior authorization is on file.

CMS-1500 claim form

NDCs must be indicated in the shaded area of Item Numbers 24A-24G (see example below). To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier N4 followed immediately (no space) by the 11-digit NDC of the drug dispensed with no spaces, hyphens or other characters.
- Enter one space between the NDC and the unit of measurement qualifier.
- Enter the appropriate unit of measure qualifier:
  - F2 [International unit]
  - GR [Gram]
  - ME [Milligram]
  - ML [Milliliter]
  - UN [Unit]
- Immediately following the unit of measure qualifier indicate the NDC unit quantity, with no space in between.
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after.
- 24D Enter the appropriate CPT/HCPCS code.
- Complete all other applicable fields as appropriate.

UB-04 claim form

- Field 42: Include the appropriate revenue code.
- Field 43:
  - Enter NDC qualifier N4 (left-justified) followed by the valid 11-digit NDC of the drug dispensed, with no space in between

- Enter the appropriate unit of measure qualifier, with no space between the NDC and the unit of measure qualifier
  - F2 [International unit]
  - GR [Gram]
  - ME [Milligram]
  - ML [Milliliter]
  - UN [Unit]
- Enter the unit quantity (number of NDC units), with no space between the qualifier and the unit quantity.
- The decimal point is floating and the numbers to the right of the decimal point are restricted to three.

- Field 44: Include the HCPCS code if required.
- Complete all other applicable fields as appropriate.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	XXX	N4XXXXXXXXXXF2/GR/ME/ML/UNX.XX	XXXXX			
2						

Electronic data interface (EDI) transactions 837P and 837I

MyAdvocate Medicare Advantage follows 5010 HIPPA compliant data requirements when exchanging electronic data.

Loop	Segment	Element name	Information
2410	LIN02	Product/Service ID Qualifier	Enter N4 to indicate NDC
2410	LIN03	Product/Service ID	Enter the 11-digit NDC
2410	CTP04	Quantity	Enter the administered NDC quantity
2410	CTP05-1	Unit or Basis for Measurement Code	Enter the unit of measure qualifier (F2, GR, ME, ML, UN)

Multiple NDCs

If multiple NDCs need to be reported due to different drug strengths being administered or when a drug is comprised of more than one ingredient, each NDC should be reported on a separate service line following the below steps. Do not submit multiple NDCs on a single service line.

- Paper claim forms:
  - The CPT/HCPCS code should be repeated on separate service lines for each unique NDC.
  - A KP modifier (first drug of multiple drug unit dose formulation) is required on the first service line and a KQ (second or subsequent drug of a multiple drug unit dose formulation) is required on the second service line.
- Electronic claims:
  - Each NDC will have the 2400 loop repeated as necessary with the NDC information contained in the 2410 loop as indicated in the Electronic Data Interface (EDI) transactions 837P and 837I section above

Provider Appeal and Grievance Policy

All provider appeals must be submitted using the Plan's MyAdvocate Medicare Advantage Formal Provider Appeal form located below. The form must be complete and provide an explanation of why the services should be reviewed. Any supporting documentation should be included at the time of the appeal. The Plan's appeal decision is based on the materials available at the time of formal appeal review. Any appeal that is received without this form, or with an incomplete form, will not be processed as a formal provider appeal.

Formal provider appeal form

Appeal related to post-service claim payments/denials

Providers have the ability to resubmit a claim (within timely filing guidelines), request reconsideration, and/or appeal claim payments/denials.

- Resubmit a claim: Submit a new claim with changed or added information that may result in a different claim determination. This is not a formal appeal. See the "Correction, Adjustment and Void Requests" section for more information on resubmitting a corrected claim.
- Request reconsideration of a claim: An informal verbal or written request for SHP to review a claim that the provider feels were incorrectly processed. This is not considered a formal appeal.
- Appeal: A formal request for review of a claim determination when the provider does not agree with the claim reconsideration decision.

Requesting reconsideration (requests for information regarding a claim payment/denial for services — this is not considered a formal appeal)

- The Plan will accept telephone or written requests.
- The request will be directed to the Provider Customer Service team.
- The Provider Customer Service team will answer the provider's questions, investigate information, and attempt to resolve the issue with the provider.
- If the provider disagrees with the response given to the claim reconsideration, the provider may appeal by following the 'Requesting an appeal' section below.
- If the provider identifies they have an error on the claim they may submit a corrected claim within the timely filing window.
- While a reconsideration request can be submitted at any time, the Plan recommends they be done within appeal and claim resubmission timeframes to avoid missing these deadlines.

Requesting an appeal

No post-service appeals may be submitted until the claim has been received and denied in full or in part. If a finalized claim has not been received, the appeal will be returned to the provider.

Appeals must be submitted within 65 calendar days from the provider's statement on which the charge was denied or reduced.

Appeal process

- Complete the Plan's Formal Provider Appeal form (MA Appeals and Grievance Form). If this form is not used, it will not be considered a formal appeal. Include all relevant information to support why the original denial should be overturned.
- If you are a non-contracted provider appealing a post-service denia,l complete the Waiver of Liability (waiver_of_liability.pdf) form as required by section 50.1.1 of the Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
- Gather all documentation supporting why the claim is being appealed. The Plan will not make any attempts to gather additional information or documentation from providers. Failure to submit complete documentation may lead to upholding of the original denial.
- Completed appeals should be submitted via:
  Fax: 715-221-9650
  Email: ProviderAppeals@MyAdvocateMA.com
  Mail: MyAdvocate Medicare Advantage
  Attn: Provider Appeals
  P.O. Box 8000
  Marshfield, WI 54449-8000
- Appeals will be reviewed by the Plan's Provider Appeals Committee.

- The Plan will respond in writing within 45 calendar days from the receipt (date when it enters our mail center) of a complete appeal. An appeal is considered a complete appeal when all requested information is received.
- The Plan's response to the provider on appeals is final and will be in writing.

Non-contracted provider appeals for Medicare

If the Plan renders a partial or fully adverse decision, we automatically send your appeal to MAXIMUS Federal Services. This is Medicare's Independent Review Entity (IRE). They will review the appeal within 60 calendar days to make sure the correct decision was made. You will receive correspondence by mail regarding their decision. If the IRE renders a favorable decision for you, the Plan must effectuate and comply with the IRE's decision. A new Remittance Advice will be sent to reflect the IRE's decision.

Provider appeals related to adverse determination based on medical necessity

The Plan denies coverage of a service or supply that is determined not medically necessary, not appropriate, or excluded because it is considered to be experimental or investigational. The Plan uses nationally recognized criteria when making coverage determinations. A provider may appeal adverse determinations for prior authorization, pre-certification, referral authorization, or hospital stays in part or in total. When appealing an adverse determination, the request for a reconsideration of the adverse determination must be supported with additional information or written documentation from the medical record that was not previously reviewed by the SHP medical director. The medical director will at their discretion consult with like-specialty physicians.

Appeal process

- Complete the Formal Provider Appeal form (MA Appeals and Grievance Form). If this form is not used or is incomplete, it will not be considered a formal appeal. Include all relevant information to support why the original denial should be overturned.
- Formal appeals must be submitted in writing (with formal appeal form) within 65 days of the adverse determination.
- Appeals must be complete and contain all pertinent information. An appeal decision will be based only on the information submitted by the provider.
- Appeals related to:
  - Prospective review may be conducted via telephone by calling 888-298-4650, or filing a written appeal when the requested service has not occurred.
  - Concurrent review should be directed per the expedited appeal policy. The provider may call the Customer Service Department at 888-298-4650 and request an expedited appeal for concurrent review cases only. The member must currently be an inpatient. A decision will be made as expeditiously as the medical condition requires, but no later than 72 hours after the review commences.
  - Retrospective review must be filed as a formal written appeal.
- Submit pre-service or medical necessity denial appeals by:
  Email: ProviderAppeals@MyAdvocateMA.com
  Mail: MyAdvocate Medicare Advantage
  Attn: Provider Appeals
  P.O. Box 8000
  Marshfield, WI 54449-8000
- Formal appeals will be reviewed by the Plan's Medical Provider Appeals Committee.
- The Plan will respond in writing within 45 calendar days from the date on the provider appeal form. An appeal is considered a complete appeal when all requested information from SHP is received.
- The Plan's response to the provider on appeals is final and will be in writing.

Provider Remittance Advice Statement

MyAdvocate Medicare Advantage uses American National Standards Institute (ANSI) claim adjustment reason

and remark codes. Claim Adjustment Reason Codes (CARC) can be viewed online at https://x12.org/codes/claim-adjustment-reason-codes and Remittance Advice Remark Codes (RARC) can be viewed online at https://x12.org/codes/remittance-advice-remark-codes.

Most providers will receive payments and electronic remittance advice statements through Zelis.

- If Zelis already has a payment contract with the provider, Zelis will send the payments and statements electronically using the options the provider has already chosen. Providers must contact Zelis to obtain information about payment and provider statement.
- If providers have contracted with Zelis to receive statements, then they must log in to the Zelis portal to view the statement (a hard copy will not be mailed).

Zelis Customer Service contact information:

1. Email: clientservice@zelispayments.com
2. Telephone: 877-828-8770 Monday-Friday 9:00am-7:00pm (EST)
3. Live Chat: www.ZelisPayments.com

If the provider does not accept their electronic payment from Zelis within 45 days of the paid date, Zelis will send a paper check and statement. If the provider does not cash the paper check within 90 days of the Zelis mail date, then Zelis returns the funds to MyAdvocate Medicare Advantage and MyAdvocate Medicare Advantage will mail payment and statement.

Providers have an option to opt out of Zelis payments, opt out of Zelis statements, or opt out of both.

MyAdvocate Medicare Advantage Rate Letters from CMS for CAH, RHS and Swing Bed

MyAdvocate Medicare Advantage's reimbursement for inpatient and outpatient services is based on the critical access hospital (CAH), swing bed, or rural health clinic's (RHC) most recent rate letter from the Centers for Medicare and Medicaid (CMS). MyAdvocate Medicare Advantage is not able to access facility rate letters and needs to receive these from providers.

MyAdvocate Medicare Advantage requires Critical Access Hospitals, Swing Bed and Rural Health Clinics to provide MyAdvocate Medicare Advantage with their CMS Rate letter no less than every twelve (12) months or within thirty (30) days of the date it receives (whichever is earlier). MyAdvocate Medicare Advantage shall apply the new rates to the dates of service no later than sixty (60) days after the date it receives the letter from the Facility or Medicare effective date, whichever is later. MyAdvocate Medicare Advantage will not adjust the Critical Access Hospital or Rural Health Clinic's compensation retroactively unless the CMS Rate letter indicates a decrease in reimbursement. In this instance, MyAdvocate Medicare Advantage will reprocess claims back to the effective date of that CMS Rate letter.

The facility should send a copy of its most recent rate letter from CMS to MyAdvocate MA by email or fax:

Attn: Medicare Policy and Reimbursement Specialist

Email: ProviderServices@MyAdvocateMA.com
Subject line: *Updated Rate Letter*

Fax: 715-221-9874

Reference Outside Laboratory Billing Protocol

Referring laboratory is defined as the laboratory that refers a specimen to another laboratory for testing.

Reference laboratory is defined as the laboratory that receives a specimen from another laboratory and that performs one or more tests on such specimen.

In most situations, MyAdvocate Medicare Advantage expects that the Reference Lab bills for the service(s). If the Reference Lab is unable to bill for the services, then we will accept claims from the Referring Lab with a 90 modifier.

MyAdvocate Medicare Advantage follows Medicare guidelines for billing referred laboratory services — https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c16.pdf 40.1.1 Claims Information and Claims Forms and Formats

Referring to laboratory billing

- MyAdvocate Medicare Advantage's billing provider on claim must be an independent clinical laboratory.
  - A claim for a referred laboratory service(s) by any other provider/entity will be denied.
- Bill the appropriate lab CPT code (8XXXX) with 90 modifier to indicate it was referred out.
- Include the reference laboratory's name, address, and ZIP Code in box 32 on the CMS 1500 claim form to show where the service (test) was performed.
- The reference lab's NPI shall be reported in item 32a.
- The CLIA number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.
- Bill the specimen handling (CPT 99000 or 99001) and venipuncture (CPT 36415) when appropriate
  - Only one handling fee (CPT 99000 or 99001) is allowed per member, per provider sending out, per lab, per date of service, regardless of the number of specimens sent to a specific lab.
  - Exception: If different handling or shipping types are needed to send more than one specimen to the same lab. More than one handling fee may be considered if supporting documentation is provided for review. In this instance, bill each handling fee as a separate line item on the claim; do not quantity bill.

MyAdvocate Medicare Advantage's reference lab billing

- Bill the appropriate lab CPT code (8XXXX) with place of service 8.

Reimbursement — General Information

Unless otherwise indicated in the Provider Contract or other legally binding document, MyAdvocate Medicare Advantage follows Medicare reimbursement, including multiple procedure and modifier reductions.

Federal funds

The provider acknowledges that payments the provider receives from MyAdvocate Medicare Advantage to provide services to Medicare Advantage members are, in whole or part, from federal funds. Therefore, the provider and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; and the Americans With Disabilities Act.

Prompt payment

We will reimburse non-affiliated providers within 30 days and affiliated providers within 60 days of receipt of a claim. Claims that require additional information or are subject to coordination of benefits will be paid promptly upon receipt of requested information.

Merit-based Incentive Payment System:

In alignment with CMS guidance, we will apply the Merit-based Incentive Payment System (MIPS) for Medicare Advantage claims. MIPS will apply to service lines paid via the Medicare physician fee schedule (MPFS) and professional services billed on Critical Access Hospital — Method II claim lines if the rendering provider is eligible

for a MIPS adjustment. We apply both positive and negative MIPS adjustments to contracted and non-contracted provider payments. The MIPS adjustment amount can be identified on your Provider Statements with ANSI CO144, OA N807.

Reimbursement for Inappropriate Discharge and Readmission

For hospitals that are reimbursed using inpatient Diagnostic Related Groups (DRG) methodology, if MyAdvocate Medicare Advantage deems an unplanned readmission as inappropriate or preventable, the authorization for the readmission will be denied.

A denied authorization for the readmission will result in a denial of the inpatient facility claim. In this situation the claim will deny using ANSI 249 — This claim has been identified as a readmission. Claim denials for inappropriate or preventable readmissions will be denied to the provider as contractual obligation (CO). **These amounts cannot be billed to the patient.**

For additional information see the following:

- All-cause Readmission Payment Policy Review for Circumvention of Prospective Payment System Medical Policy under the Provider/Medical Policies section of the MyAdvocate Medicare Advantage website.
- Utilization Management — Inappropriate Discharge and Readmission section in the Provider Manual

Reimbursement Recovery Process

If an overpayment is self-identified by the provider, the provider should return any overpayment to MyAdvocate Medicare Advantage within 60 days of discovery.

In the event an error in payment is made by either party, MyAdvocate Medicare Advantage reserves the right to adjust later payments to the Provider to compensate for the overpayment or underpayment after the erroneous payment was made. This right of adjustment exists notwithstanding the fact that later payments might be unrelated to those services for which the erroneous payment was made. With the exception of retro eligibility changes, Fraud, Waste and Abuse, or Governmental audit or review (inclusive of encounter data reconciliation), MyAdvocate Medicare Advantage further agrees to offset such erroneous payment within twelve (12) months of the most recent claim remittance for the services billed, or in a case where Coordination of Benefits is needed, the date of credit action taken. Credit action taken is when it is definitely determined who the appropriate payer is for a claim, including but not limited to COB, workers compensation and other third-party payers.

The reimbursement recovery process allows MyAdvocate Medicare Advantage to recover overpayments made MyAdvocate Medicare Advantage to both contracted and non-contracted providers. All verifiable overpayments of a claim by MyAdvocate Medicare Advantage A will be recovered through a recoupment which is an offset against current claim payments. Prior to each provider payment, MyAdvocate Medicare Advantage will recoup any overpayments that are due from the provider.

Recoupment of overpayments will reflect on subsequent remittances and will include the details for claims paid as well as information identifying the recovered overpaid claims. When payments are recouped on a provider remittance advice statement, and the amount recouped is more than the amount the provider would have been paid on that remittance, it is considered a Balance Due. Future claim payments will continue to be withheld until the Balance Due amount is satisfied. **Note:** If providers are in a recurring Balance Due amount they will need to refer back to the initial statement that put them in a balance due to find the claims that were recovered as overpaid claims and balance their accounts.

If the provider remains in a Balance Due for 30 days, providers will be issued a letter requesting payment with the remittance advice statement that generated the Balance Due amount. Following notification, providers have 60 days to return overpayments. If payment is not received at 60 days, a second request letter will be sent. If a response is not received after 30 additional days, a certified letter will be sent informing the provider the amount will be referred to MyAdvocate Medicare Advantage's collection agency.

Skilled Nursing Facility (SNF) Billing and Reimbursement

All Part A SNF stays require prior authorization. All post-acute facilities (skilled nursing facility, inpatient rehab, or

long-term acute care facility) must notify MyAdvocate MA of an admission within 24 hours or the next business day of admission after receiving the approved authorization. If the member in transitioned to the post-acute facility without prior authorization, the health plan will not guarantee reimbursement.

Please review the 'Skilled Nursing Facility (SNF)" benefit section for additional benefit information.

Claim submission

MyAdvocate Medicare Advantage follows CMS guidelines for billing and payment of skilled nursing facility claims except for the 3-day inpatient hospital stay. Reference "Table 1. SNF Billing Requirements" of the following document: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNFSpellIllnesschrt.pdf.

MyAdvocate Medicare Advantage follows CMS's consolidated billing rules for members in a Medicare-covered SNF stay.

The consolidated billing rule states that the SNF is responsible to bill for all rendered services, including those performed by outside providers, during a Medicare covered Part A stay except for those that are considered excluded from the consolidated billing requirement. MyAdvocate Medicare Advantage

Providers who perform services included in the consolidated billing requirement should seek reimbursement directly from the SNF. Any claims submitted directly to MyAdvocate Medicare Advantage will be denied CO190 'Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay'. It is the provider's responsibility to validate with the SNF that the member is a resident in a covered Part A stay.

MyAdvocate Medicare Advantage for members in a non-covered stay (Part B SNF stay) only specific therapy services are subject to consolidated billing. All other covered part B services can be separately billed to MyAdvocate Medicare Advantage.

Consolidated billing references:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/snf/index.html

https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing

https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing

Skilled Nursing Patient-Driven Payment Model (PDPM)

MyAdvocate Medicare Advantage follows CMS's Skilled Nursing Patient-Driven Payment Model (PDPM).

PDPM references:
https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model

Subrogation

To the extent permitted by law, whenever MyAdvocate Medicare Advantage provides or pays for medical services given to a member, MyAdvocate Medicare Advantage reserves the right to recover the costs of medical services from another person, insurer, or organization found to be responsible for the cost of the services.

- Examples of occurrences which may involve subrogation include:
  - Dog bites by someone else's dog
  - Food poisoning
  - Malpractice
  - Motor vehicle accidents
  - Product liability
  - Slips and falls on someone else's property

- In the event a member is injured by the act or omission of a third party, the provider may elect to bill a potentially responsible party instead of the Plan. If the third party does not pay the claim in full, the provider may balance bill MyAdvocate Medicare Advantage, however the Plan will apply all discounts and member responsibility to the outstanding balance. Members will be required to cooperate with the Plan to facilitate subrogation or other reimbursement from potentially responsible carriers. Should the member not cooperate with the Plan, claims may be denied and will be the responsibility of the member. The provider may not seek payment from MyAdvocate Medicare Advantage for any claim denied due to lack of member cooperation. If the provider elects to bill MyAdvocate Medicare Advantage and later receives payment from any third party, the provider will refund the total amount paid by MyAdvocate Medicare Advantage for services provided.

Timely Filing for Claim Submission

Submit claims to MyAdvocate Medicare Advantage as soon as possible after services occur as this benefits the member, provider organization, and Health Plan.

Unless otherwise defined in your Provider Contract or other legally binding document, claim timely filing limits are:

- **Original claim submission**: 365 days from the date of service.
- **Correction or adjustment claims**: Providers who submit original claims within appropriate timeframe can submit corrected claims or adjustment requests within normal timely filing limits or 60 days from date of payment/denial/rejection, whichever is later. Resubmitted claims outside of normal timely filing limits or 60 days from date of payment/denial/rejection will be denied and cannot be resubmitted for payment.
- **Coordination of Benefits (COB)**: 365 days from the date of service or 60 days from the date of the other payer's statement, whichever is later. When there is COB, claims must be submitted appropriately as indicated.

MyAdvocate Medicare Advantage providers may not seek reimbursement from members for claims denied due to late submission.

MyAdvocate Medicare Advantage Transaction Terms

Terms and conditions

- This section shall be considered part of any other written agreement referencing it. Any electronic data interchange made pursuant to this section shall be subject to such additional requirements, terms, and conditions as are applicable by virtue of regulations or other provisions of law. Upon the effective date of any newly imposed or amended laws, regulations, or other regulatory requirements relating to any standard transaction, this section shall automatically be deemed changed to conform to such laws.
- Subject to the above paragraph, the terms of this section shall prevail in the event of a conflict with the terms and conditions of any other agreement between the parties.

Legal effect of document

Any document properly transmitted pursuant to this section shall be considered to be a "writing" or "in writing." In addition, any such document shall be deemed for all purposes to constitute an original when printed from electronic files or records established and maintained in a party's normal course of business.

Transmission

Proper receipt

Subject to the Garbled Transmission and Test Modifications provisions, a document shall not be deemed to have been properly received until that document is accessible to the receiving party at that party's receipt computer and is found to be a standard transaction. Until a document is properly received, the receiving party shall not have any obligation with respect to such document.

Verification

If verification of a document is required, the receiving party shall, upon proper receipt of such document, promptly transmit a functional acknowledgment to the transmitting party. A functional acknowledgment shall constitute

conclusive evidence that a document has been properly received.

Garbled transmission

If any transmitted document is received in an unintelligible or garbled form, the receiving party shall promptly notify the transmitting party (if identifiable from the received document) within two business days. In the absence of such notification, the transmitting party's records of the contents of the transmitted document shall be presumed to reflect the actual contents of that document. If the transmitting party is unidentifiable, the receiving party shall have no obligation to the transmitting party.

UB-04 Instructions and Sample Claim Form

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison. To access the sample claim form, click the link and then click "CMS-1450". This will open a folder so you can view the front and the back. UB-04 Sample Claim Form

General information

Our claim processing system is designed to process standard health insurance claim forms (UB-04) using Revenue Codes, Health Care Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-10-CM Diagnosis Codes.

Refer to the following resource for guidelines on completing the UB-04:

- Medicare Claims Processing Manual, Chapter 25 — Pub 100-04 Medicare Claims Processing

A claim is considered complete when the following data elements are submitted (numbered as shown on the paper claim form).

Form locator (FL)

FL1: Provider name, address, and telephone number — Enter the name and the complete physical address of the provider submitting the claim. The minimum requirement is the provider name, city, state, and ZIP+4. Do not enter a P.O. Box or a Zip+4 associated with a P.O. Box. The name FL 1 should correspond with the NPI in FL56.

FL2: Pay to or billing address — Name of the provider and address where payment should be mailed.

FL3a: Patient control number — Identified and assigned by provider.

FL3b: Medical record number

FL4: Type of bill — The first digit of the three-digit number identifies the type of facility; the second digit classifies the type of care being billed; and the third digit indicates the sequence of the bill for a specific episode of care.

FL5: Federal Tax Number — Number assigned to the provider by the federal government for tax purposes. Should be reported as XX-XXXXXXX.

FL6: Statement covers period — Used for reporting the beginning and ending dates of service.

FL7: Not required

FL8a: Patient ID — Patient identifier as assigned by MyAdvocate Medicare Advantage. Only report if different than the subscriber identifier in FL60.

FL8b: Patient last name, first name, middle initial

FL9a-e:
Patient address
Street address
City
State
Zip
Country code

FL10: Patient birthdate — MMDDYYYY

FL11: Patient sex — M=male; F=female; U=unknown

FL12: Admission date — Date the patient was admitted or the start date for the episode of care (MMDDYY).

FL13: Admission hour — The hour in which the patient entered the facility. Enter in military time using two numeric characters.

FL14: Type of admission/visit — 1 alphanumeric character that indicates the priority of admission/visit.

FL15: Source of admission — One alphanumeric character that indicates the source of admission or service.

FL16: Discharge hour — The hour in which the patient was discharged from inpatient. Enter in military time using two numeric characters.

FL17: Patient discharge stat — Two numeric characters that indicates the patient's discharge status at the ending date of service.

FL18-28: Condition codes — Two alphanumeric characters that identify conditions that may affect payer processing.

FL29: Accident state — Two-digit character abbreviation of the state where the accident occurred (i.e.: WI).

FL30: Not required

FL31-34: Occurrence codes and dates — Two alphanumeric characters that identify a significant event related to this claim. Date entered in MMDDYY.

FL35-36: Occurrence span codes and dates — Two alphanumeric characters that identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time. Date entered in MMDDYY in each field.

FL37: Not required

FL38: Responsible party name and address.

FL39-41: Value codes and amounts — Two alphanumeric characters that identify data elements that are necessary to process the claim and related dollar amounts or values.

FL42: Revenue code — Report the appropriate revenue code to identify a specific accommodation and/or ancillary service. There is no "Total" line in the charge area. Enter revenue code 0001 as the last line with the sum of the charges billed.

FL43: Revenue description — A description or standard abbreviation for each revenue code reported.

FL44: HCPCS/Rates/HIPPS Rates Codes — The HCPCS applicable to ancillary services for outpatient claims (required), the HIPPS rate code or the accommodation rate for inpatient claims.

FL45: Service date — The date on which the indicated service was provided. Date entered in MMDDYY.

FL46: Service Units — A quantitative measure of services rendered including items such as the number of accommodation days, visits, miles, pints of blood or units of treatments.

FL47: Total charges (by revenue code) — Total charge per line.

FL48: Noncovered charges — Total noncovered charge of the service line.

FL49: Not required

FL50: Payer name — Name of each health plan for which the provider might expect some payment for the bill. Line A = primary payer, line B = secondary payer, line C = tertiary payer

FL51: Health Plan ID — The number used to identify the payer or health plan.

FL52: Rel. Info — Indicates whether the provider has a signed statement from the patient or patient's legal representative permitting the provider to release data to other organizations to adjudicate the claim. This indicator applies to the payers listed in FL50 on lines A, B and C.

FL53: Asg. Ben. — This field shows whether the provider has a signed form authorizing the third-party insurer to pay the provider directly for the service. This indicator applies to the payers listed in FL50 on lines A, B, and C.

FL54: Prior payments — Represents payments received from payers in FL50 on lines A, B, and C.

FL55: Est. Amount due — Represents an estimate by the hospital of the amount due from the indicated payer in FL50 on lines A, B, and C.

FL56: NPI — Unique identification number assigned to provider submitting the bill.

FL57: Other Prv ID — Not required

FL58: Insured's name — Name of the patient or insured individual in whose name the insurance is issued as qualified by the payer organization listed in FL 50 on lines A, B, and C.

FL59: P. Rel — Two alpha-numeric character code that indicates the relationship to the insured individual identified in FL 58 on lines A, B, and C.

FL60: Insured's unique ID — The insured's identification number assigned by the payer organization. This field allows 20 alphanumeric characters in three lines.

FL61: Group name — The group or plan through which the health insurance coverage is provided to the insured.

FL62: Insurance group No. — The identification number, control number or code that is assigned by the insurance company or claims administrator to identify the group under which the individual is covered.

FL63: Treatment authorization codes — A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer indicated in FL 50 on lines A, B, and C.

FL64: Document Control Number (DCN) — Payer's internal control number assigned to the bill as part of the payer's internal control process. Providers requesting an adjustment to a previously processed claim (TOB 0XX7 in FL4) must provide the DCN of the claim to be adjusted.

FL65: Employer name — Name of employer that provides or may provide health care coverage for the insured individual identified in FL58 on lines A, B and C.

FL66: DX — Identifies the version of the ICD being reported.

FL67: Principal diagnosis code — The full ICD-10-CM diagnosis code, including the fourth and fifth digits, if applicable, that describes the principal diagnosis (the condition established after study to be chiefly responsible for causing the hospitalization or use of other hospital services). Present on admission indicator (POA) should be indicated in the field on the far right following the code.

FL67 A-Q: Other diagnosis code — This field contains the full ICD-10-CM diagnosis codes, including the fourth and fifth digits, if applicable, corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that has no bearing on the current hospital stay should be excluded. Present on admission indicator (POA) should be indicated in the field on the far right following the code.

FL68: Not required

FL69: Admit DX — This field is for reporting the complete ICD-10-CM diagnosis code, including the fourth and fifth digits when appropriate, describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration.

FL70: Patient reason DX — Reporting the complete ICD — 10- CM diagnosis code, including the fourth and fifth digits when appropriate, describing the patient's reason for visit at the time of outpatient registration.

FL71: PPS Code — Identifies the DRG assigned to the claim based on the grouper software.

FL72: ECI — External cause of injury code. Contains up to three full ICD-10-CM diagnosis codes, including the fourth and fifth digits when appropriate, pertaining to the external cause of injury, poisoning, or adverse effect.

FL73: Not required

FL74: Principal procedure code/date — The ICD-10-PCS for the principal procedure performed during the period covered by the bill and the date on which the principal procedure described on the bill was performed. For inpatient and home IV therapy services, if surgery is performed during the inpatient stay from which the course of therapy is initiated.

FL74 A-E: Other procedure codes and dates — This field allows reporting of up to five ICD-10-PCS to identify the significant procedures performed during the billing period, other than the principal procedure, and the corresponding dates when the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. For inpatient and home IV therapy services, if surgery is performed during the inpatient stay from which the course of therapy is initiated. Enter the codes in these fields in descending order of importance.

FL75: Not required

FL76: Attending provider name/NPI — Individual who has overall responsibility for the patient's medical care and treatment reported on this claim.

FL77: Operating provider name/NPI — Individual with the primary responsibility for performing the surgical procedure.

FL78-79: Other provider name/NPI — Provider that corresponds to the indicated provider type on this claim.

FL80: Remarks — Additional information necessary to adjudicate claim.

FL81: CC (code-code) — Report overflow or additional codes related to field locators or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Unlisted Codes

MyAdvocate Medicare Advantage requires a complete description to be submitted for all unlisted codes. A complete description explains the procedure/service performed. For drugs, a valid NDC must be included with the HCPCS and is considered a complete description. Refer to the "National Drug Code Requirements" section for more information.

A detailed description should be submitted as:

- CMS 1500:
  - Electronically in Loop 2400 Segment SV101-7
  - Paper in box 19
- UB-04:
  - Electronically in Loop 2400 Segment SV202-7
  - Paper in box 80

Claims received without a description or with a generic description will be denied.

Unlisted codes can be identified with one of the following code descriptions (not all inclusive):

- Not Otherwise Classified or NOC
- Not Otherwise Specified or NOS
- Not Elsewhere Specified or NES
- Not Otherwise
- Unlisted
- Not Listed
- Miscellaneous
- Unspecified
- Unclassified
- Non-specified

Worker's Compensation

- MyAdvocate Medicare Advantage does not cover the cost of services covered by Workers' Compensation. Claims that are determined to be work related will be denied using ANSI code 19. The denial reason will print on

the provider's reimbursement statement. Claims must be submitted to the Workers' Compensation carrier first.

- If claims have already been paid by MyAdvocate Medicare Advantage, related charges will be reversed. The adjustment will be reflected on the provider's reimbursement statement, using ANSI 19.
- If the provider is overpaid due to a payment by the Workers' Compensation carrier, the provider is required to submit a copy of the original claim with a copy of the Explanation of Benefits from the Workers' Compensation carrier. MyAdvocate Medicare Advantage will reverse charges and the adjustment will be reflected on the provider's reimbursement statement.
- If the Workers' Compensation carrier denies a claim, MyAdvocate Medicare Advantage will consider payment if a copy of the Workers' Compensation carrier denial is attached. The provider must submit claims within 180 days from the date of the Workers' Compensation carrier denial. MyAdvocate Medicare Advantage may also pursue directly with Workers' Compensation or an attorney if one has been retained.
- If a settlement has been made that results in the creation of a Medicare Set-aside Account, related charges will be denied. The adjustment will be reflected in the provider's reimbursement statement, using ANSI P3. If claims have already been paid by MyAdvocate Medicare Advantage, related charges will be reversed. The adjustment will be reflected in the provider's reimbursement statement, using ANSI P3.

If the provider has any questions regarding Workers' Compensation, please call 888-213-4883, Monday through Friday between 8 a.m. and 4:30 p.m. or email tpl@myadvocatema.com.

Clinical Practice Guidelines

MyAdvocate Medicare Advantage has adopted the U.S. Preventive Services Task Force (USPSTF) and additional medical guidelines to ensure our members receive high-quality care. These guidelines are intended to be a reference tool for health care professionals when determining the care needs of their patients who are MyAdvocate Medicare Advantage members. USPSTF guidelines help provide an analytical framework for the evaluation and treatment of patients. The guidelines are reviewed annually to assure that they support the quality improvement performance measures, Healthcare Effectiveness Data and Information Set (HEDIS). The Health Plan uses HEDIS to identify which of our members have already received the important care they need and which members are in need of care. The guidelines can be found on our website.

Mental Health Medication Management

MyAdvocate Medicare Advantage billing outpatient medication management services and use of appropriate CPT coding specifically as it relates to split therapy with a psychiatrist and another provider can cause confusion at best. Provision of therapy by more than one provider entails many complex issues. Such relationships imply clinical and ethical responsibilities and liability issues. There are three types of recognized relationships between a psychiatrist and other providers, namely collaboration, consultation and supervision. Delineation of responsibilities should be determined by the collaborators then discussed with the patient to clarify roles and to obtain the patient's consent to arrangement. The plan and consent should be clearly documented in the patient's record.

Evaluation and management codes for new and established patients have clearly defined criteria for documentation of history, examination and complexity of medical decision making. Use of these codes does require a treatment plan.

The use of medicine codes (for example 90805, 90807) implies that psychotherapy is being performed along with medical evaluation management services (medication management). If that psychiatrist is the sole provider and is doing therapy and medication management, then this is an acceptable use of these codes. However, if that patient is in therapy with another therapist such as a social worker or psychologist and is also currently receiving psychotherapy from their psychiatrist, this implies that this is an exceptionally complicated patient and a treatment plan should justify the need for the patient receiving dual psychotherapies and clarify their respective roles. When psychotherapy and medication management are needed or in particularly complicated cases that require simultaneous psychotherapy with one provider along with psychotherapy and medication management with a psychiatrist, this need should be justified and documented.

When each patient of a psychiatrist is billed for CPT code 90805, utilization review again questions the validity of such a practice. Sometimes a medication check is just that and should be billed with a 90862 CPT code. Use of codes 90805 — 90807 implies that the primary focus of the visit is psychotherapy; likewise, use of 90862 indicates the purpose of the visit is mainly medication management.

Comments:

- "I only see patients for 30 minutes; anything less than that is unethical."

Response: CPT code 90862 is not a time-based code. Sometimes a medication check is just a medication check and it is "unethical" to bill using a higher level code unless you are doing psychotherapy.

- "Children are complicated; I always use CPT code 90805."

Response: Some children are more complicated than others. They may require psychotherapy. The definition of CPT 90862 does involve minimal psychotherapy. Is more than minimal psychotherapy required for the routine refill of ADHD meds for children?

- "The doctor is slow, he always uses CPT codes 90805 and 90807, because of time spent."

Response: This is not a justification for the use of these codes.

- "CPT codes 90805 and 90807 pay more."

Response: Again, this is not a justification for the use of these codes.

When psychotherapy and medication management are needed, or in particularly complicated cases that require simultaneous psychotherapy with one provider along with psychotherapy and medication management with a psychiatrist, this need should be justified and documented.

Contact Information

Provider customer service hours:
Monday through friday — 8 a.m.-4:30 p.m.

MyAdvocate Medicare Advantage mailing address
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Fax: 715-221-9500

Phone numbers:
- Provider Customer Service: 888-298-4650
- Health Services Department Notifications: 888-298-4650
  - Follow prompts for desired inquiry

Health services fax numbers
Medical and behavioral health prior authorization requests: 888-298-4650
Precertification for behavioral health, outpatient request, new inpatient (both medical and behavioral health) admission, hospital census: fax 715-221-6616
Clinical information for hospital continued stay (concurrent review): fax: 715-221-9980

Post acute new and continued to stay request (skilled nursing, swing bed, inpatient rehab, and long term acute care): Phone number for customer services: 715-221-9212 or fax: 715-221-9215

MyAdvocate Medicare Advantage pharmacy services
Pharmacy prior authorization: 844-504-5955

MyAdvocate Medicare Advantage claims
Claim status, eligibility, benefits, and prior authorization requirements can be verified on the MyAdvocate Medicare Advantage Provider Portal at provider.myadvocatema.com. If you do not have access, please contact your practice's MyAdvocate Medicare Advantage Provider Portal administrator, or if an account needs to be created click "Need help" and select "Register."

If you are not able to find the information you are looking for on the MyAdvocate Medicare Advantage Provider Portal, please contact Provider Customer Service at 888-298-4650 or via the email addresses listed below. Claim status via phone or email will not be checked until claims are at least 30 days old.

Subrogation: TPL@myadvocatema.com
Phone: 715-221-9443 or 888-213-4883
Fax: 715-221-9420
Workers compensation: TPL@myadvocatema.com
Phone: 888-213-4883
COB inquiries: COB@myadvocatema.com
Phone: 888-298-4650
Inquiries for benefits, eligibility, claim information, or general inquiries:
MyAdvocate Medicare Advantage: ProviderServices@MyAdvocateMA.com
Phone: 888-298-4650
Fax:
Claims: 715-221-9874
Coordination of benefits: 715-221-9507, 800-548-4831, 715-221-9503
Worker's compensation: 888-213-4883

Documentation Requirements

Documentation of Care

Providers are required to maintain a medical record for all members. The following are MyAdvocate Medicare Advantage Medical Record Documentation Standards:

- Each page in the medical record contains patient identification.
- Medical record (paper or computer) includes personal biographical data including the address, employer, home and work telephone numbers, emergency contact person, and marital status.
- All entries in the medical record have author identification. All entries are dated.
- The record is legible by someone other than the writer. Any record considered not legible will be reviewed by a second reviewer.
- Significant illnesses, medical conditions, and medications are indicated on the problem list.
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies (NKDA), this is appropriately noted in the medical record.
- Past medical history is easily identified and includes serious accidents, illnesses, and operations.
- For patients 14 years of age and older there is appropriate notation concerning the use of alcohol, tobacco, and other substances in the past two years.
- History and physical exam records contain appropriate subjective and objective information pertinent to the patient's presenting complaints.
- Laboratory and other studies are ordered as appropriate.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- There is a date for return visit or another follow-up plan for each encounter.
- Problems from the previous visit(s) are addressed.
- There is evidence of appropriate use of consultants, and continuity and coordination of care, between primary and specialty physicians.
- Consultant summaries, lab, and imaging studies results reflect primary care physician review.
- There is no evidence that the patient is placed at an inappropriate risk.
- There is evidence that preventive screening and services have been provided:
  - High risk adults and those over 65 have an up-to-date immunization record/history
  - There is an up-to-date immunization record (0-19 years of age)
  - Patient and/or family member education is appropriate for the patient's history and risks
  - There is periodic screening for high blood pressure and other cardiovascular risk factors (cholesterol 35 years of age and above and blood pressure 20 years of age and above)
  - Mammograms every two years (ages 50-69)
  - Pap test every three years (as appropriate)
  - There are six or more well-child visits (0-15 months of age)
  - There are annual well-child visits (2-6 years of age)
- For patients who had an ambulatory surgery procedure, there is a copy of the operative report.
- There is a discharge summary and/or treatment plan for patients requiring home health services.
- There is a discharge summary or other appropriate communication for patients being discharged to a skilled nursing facility.

- There is a discharge summary or other appropriate communication for patients being discharged from the hospital.

Medical Record Documentation Standards

MyAdvocate Medicare Advantage's medical record documentation standards can be found in the Credentialing Program Manual. To request a paper copy, please call 888-298-4650.

For purposes of claims payment, MyAdvocate Medicare Advantage will not accept an addendum, amendment, correction, or late entry to a medical record dated after a claim denial date. If an addendum, amendment, correction, or late entry to a medical record is legally dated prior to a claim denial, it may be considered for claim payment.

Incomplete or illegible records can result in denial of payment for services billed to MyAdvocate Medicare Advantage. In order for a claim for MyAdvocate Medicare Advantage benefits to be valid, there must be sufficient documentation in the provider's or hospital's records to verify the services performed were "reasonable and necessary" and required the level of care billed prior to the claim being submitted. If there is no or insufficient documentation, then there is no justification for the services or level of care billed. Additionally, if there is insufficient documentation on the claims that have already been adjudicated by MyAdvocate Medicare Advantage, reimbursement may be considered an overpayment and the funds can be partially or fully recovered.

Telehealth Documentation Requirements

In order to ensure that medical records support telehealth services, MyAdvocate Medicare Advantage requires the following, at a minimum, be documented in the medical record must include all of the following when applicable:

- Method of telehealth (e.g., secure two-way interactive video connection, phone call, etc.).
- Provider location (e.g., clinic [city/name], home, other). Listing all clinical participants, roles, and actions (e.g., applicable when member presents at a clinic with MD at another location).
- Member location (e.g., clinic [city/name], home, etc.).
- Time spent in medical discussion must be explicitly documented to support the procedure code billed, including start/stop times, if required for the service (e.g., psychotherapy).
- Patient consent:
  - Providers must document confirmation that a member agrees to receive services via telehealth. Verbal consent to receiving telehealth is an acceptable method but must be documented in the medical record.
- Other documentation requirements are the same as a face-to-face encounter.

HCC Risk Adjustment/Government Programs

Risk Adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by the Centers for Medicare and Medicaid Services (CMS) in 1997. Implemented in 2003, this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual's health conditions and demographic details. The individual's health conditions are identified via International Classification of Diseases — 10 (ICD –10) diagnoses that are submitted by providers on incoming claims. There are more than 9,000 ICD-10 codes that map to 79 HCC codes in the Risk Adjustment model.

CMS requires documentation in the person's medical record by a qualified health care provider to support the submitted diagnosis. Documentation must support the presence of the condition and indicate the provider's assessment and/or plan for management of the condition. This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition.

Resources

CMS Risk Adjustment

Health Equity and Cultural Sensitivity Awareness

Cultural Competence

Cultural competence allows health care providers to care for individuals with diverse backgrounds. Culturally competent care improves health outcomes and quality of overall care. MyAdvocate Medicare Advantage wants to provide you with online tools and resources that support the training of health care professionals on providing more culturally competent care. Click on the titles below to access the resources.

A Physician's Practical Guide to Culturally Competent Care

The Office of Minority Health is committed to improving the health of racial and ethnic minority populations through the development of health policies and programs that will aid in eliminating health disparities. A Physician's Practical Guide to Culturally Competent Care is a free, online learning program accredited for physicians, physician assistants, and nurse practitioners. The program is designed to equip individuals with knowledge, skills, and awareness to best serve all patients, regardless of cultural or linguistic background.

Culturally Competent Nursing Care: A Cornerstone of Caring

The Office of Minority Health developed the Culturally Competent Nursing Care: A Cornerstone of Caring free online learning program accredited for nurses. The program is designed to assist nurses in delivering culturally and linguistically competent care. It is intended to improve the quality of the care to patients from diverse cultural backgrounds.

Think Cultural Health: Effective Cross-Cultural Communication Skills Checklist

A checklist to aid in improving cultural and linguistic appropriateness in health care practices.

The U.S. Office of Minority Health Resources

The Office of Minority Health provides resources for health care professionals with information, continuing education opportunities, and resources to learn and implement Culturally Linguistically Appropriate Services (CLAS) and the National CLAS Standards.

Think Cultural Health Resources

Think Cultural Health provides CLAS resources including articles and presentations. Presented are specific case study video scenarios showcasing best practices.

Lippencott Advisor

This site provides information on cultural perspectives for more than 60 specific cultures. It includes key cultural insights and scenarios.

Cultural Competency and Language Access Awareness

What is cultural competency?

Cultural competency is the ability for an individual to understand, respect, and be aware of the values, beliefs, and attitudes across different cultures. This is particularly important for health care providers so they may provide appropriate health care services to patients with cultures or language backgrounds that may be different from their own. Cultural beliefs, race and ethnic backgrounds, language needs, gender identity, and sexual orientation are key components to be aware of in providing culturally competent health care. Click on the links below to access the resources.

The National Culturally and Linguistically Appropriate Services (CLAS) standards

The National CLAS Standards provide a framework to improve quality and remove health care disparities. Learn more about these 15 standards for health care. (https://thinkculturalhealth.hhs.gov/clas/standards)

Learn more about cultural competency and language access at the Wisconsin Department of Health Services. (https://www.dhs.wisconsin.gov/minority-health/resources/cultural-language.htm)

Health Equity

Health equity means that everyone has a fair and equal opportunity to achieve their fullest health potential. Health equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups. Contributors to health equity are boundless and can connect with an individual's social, political,

economic, and cultural beliefs. Achieving health equity requires addressing social determinants of health and health disparities. Health equity involves providing care catered toward an individual or group to help them achieve the same health outcome as someone in another group. MyAdvocate Medicare Advantage wants to provide you with online tools and resources that support the training of health care professionals on how to aid in providing equitable care. Click on the titles to access the resources.

NCQA Health Equity Resources
The National Committee for Quality Assurance provides resource guides, focus reports, videos, and accreditation information.

WiCPHET Training Health Equity Series
Wisconsin Center for Public Health Education and Training provides a health equity training series. This series explains how different elements of an individual's life contribute to their health. It also provides opportunities to advance health equity in one's practice.

Language Resources

The changing demographics of our community create new challenges for providers of health care. MyAdvocate Medicare Advantage is committed to providing easily accessible online tools and resources to support our network providers' efforts to provide culturally competent care to decrease health care disparities. Click on the titles to access the resources.

MyAdvocate Medicare Advantage Language Line for Providers
For MyAdvocate Medicare Advantage providers with patients that require language assistance, the telephone Language Line is provided free of charge. This line is intended for our contracted providers who do not have access to interpretation services and need to interact with MyAdvocate Medicare Advantage patients who do not speak English or have limited English language proficiency.

Provider Interpretation Language List
A list of languages provided through interpretation services to MyAdvocate Medicare Advantage providers.

Interpretation Services Poster
A 24 language translated poster informing patients that interpretation services are available in each respective language.

Language Identification Guide
A Language Identification Guide provides an accessible method for patients to identify the language they speak.

Working Effectively with an Interpreter Checklist
A checklist to aid in the appropriate utilization of interpreters to enable patients to better comprehend their diagnosis, treatment, and other health information.

Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals
This guide was developed with the collaboration of Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital, Abt Associates, and the U.S. Department of Health and Human Services (HHS), Agency for Healthcare Research and Quality (AHRQ). This guide supports hospital leaders to better understand how to address the issue of limited English proficient patient safety and culturally diverse patients.

Natural Council on Interpreting in Health Care
This site provides additional resources, podcasts, recordings, and events.

Provider News Archive

MyAdvocate Medicare Advantage provides regular provider newsletters which can contain required trainings, education, and other timely topics. Please visit our website for current and past issues: https://www.myadvocatema.com/

Important Disclosures

Confidentiality Statement

MyAdvocate Medicare Advantage BESHP takes confidentiality of medical records and other personal information of our members very seriously. All MyAdvocate Medicare Advantage BESHP employees, including temporary and permanent volunteers, interns, business associates, and when applicable, other individuals or entities such as providers, auditors, agents/brokers, consultants, and employers who have a contract with MyAdvocate Medicare Advantage BESHP must maintain the confidentiality and privacy of all member information in its possession in accordance with applicable federal and state privacy laws and regulations for maintaining confidentiality of records. MyAdvocate Medicare Advantage BESHP has established policies and procedures that require the privacy and confidentiality of our members' information. MyAdvocate Medicare Advantage BESHP has implemented many privacy and security safeguards to protect such information.

Members are provided with access to their information in an accurate and timely manner. When MyAdvocate Medicare Advantage BESHP receives a request for confidential information, we release only the minimum amount of information necessary to respond to the request. MyAdvocate Medicare Advantage BESHP reserves the right to decide which information is disclosed on a case-by-case basis. If an employee is found to have disclosed information inappropriately and violated any confidentiality policy, disciplinary action, up to and including immediate termination of employment, may result.

All disclosures or transfers of confidential information will be in accordance with applicable law. MyAdvocate Medicare Advantage BESHP may disclose protected health information without a member's written or verbal authorization for payment and heath care operations. We may also use and disclose member protected health information in certain situations as outlined in our Notice of Privacy Practices document. You may obtain a copy of MyAdvocate Medicare Advantage BESHP's Notice of Privacy Practices form on our website. You may also request copies from MyAdvocate Medicare Advantage BESHP by calling 888-298-4650.

MyAdvocate Medicare Advantage BESHP recognizes that an individual who submits or authorizes his or her health care provider to submit medical or dental claims information for processing and payment has an exception that such information, to the extent it identifies the individual, will not be disclosed in any manner that violates federal or state law or regulation.

MyAdvocate Medicare Advantage BESHP allows its members the opportunity to authorize or deny the release of identifiable protected health information. By law, a member must provide a special authorization for MyAdvocate Medicare Advantage BESHP to release protected health information, including mental health, alcohol and substance abuse, abortion, sexually transmitted diseases, genetic testing and HIV/AIDS-related information. Members may authorize the release of some or all of their protected health information by completing an authorization form. For those members who lack the ability to give authorization, MyAdvocate Medicare Advantage BESHP will obtain authorization from a legally designated, qualified person, such as a member's guardian or person with the member's power of attorney.

MyAdvocate Medicare Advantage BESHP does not provide direct care and does not maintain original medical records or copies of complete medical records. We advise our members to contact their health care provider to obtain medical records. The member has the right to access (copy and inspect) their protected health information maintained by MyAdvocate Medicare Advantage BESHP. The member also has the right to request an amendment of such information and to place limitations on the disclosure of such information.

MyAdvocate Medicare Advantage BESHP provides certain types of information to employers as part of standard health insurance processes. Disclosures of information to employers are limited to summary information and limited information that the employer needs to administer, amend, or terminate a health plan. Employers do not have access to personal health information related to their employees without specific member authorization.

MyAdvocate Medicare Advantage BESHP is committed to ensuring the confidentiality of our member information. We expect our credentialed providers to implement confidentiality policies and procedures that address the disclosure of medical information, patient access to their medical information, and the storage, protection, and destruction of protected health information. MyAdvocate Medicare Advantage BESHP will routinely verify that

providers have policies and procedures in place to ensure that the confidentiality of medical records is maintained appropriately.

Nondiscrimination statement

In selecting providers, MyAdvocate Medicare Advantage BESHP will not discriminate in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

Provider performance data

We want you to be aware of important business practices we've committed to ensure our members, your patients, receive high-quality health care.

MyAdvocate Medicare Advantage BESHP utilizes provider performance data to ensure members receive quality care. Such performance data includes, but is not limited to, HEDIS, access and availability, outcomes of care and information registered by member satisfaction.

Suspension of payment

MyAdvocate Medicare Advantage BESHP will suspend payment for any provider where allegations of fraud, waste and abuse have been substantiated.

Member Information

Appeal/Grievance

Providers should provide Medicare Advantage members with their appeal rights whenever benefits are denied for care the member believes should be covered by MyAdvocate Medicare Advantage. Members should be referred to the Plan's Customer Service to discuss appeal options. If a provider wants to file an appeal on behalf of a member, the member must sign the "Appointment of Representative" form.

Medicare Advantage Member Appeals and Grievance Policies

Information regarding appeals and grievances appears in the Evidence of Coverage (EOC) that Medicare Advantage members receive upon enrollment.

Member Service Representatives

Member Service representatives are available to assist Medicare Advantage members with:

- Resolving questions or concerns
- Benefit and coverage information
- Prior authorization, billing ,and enrollment information
- Changing a personal provider
- Getting a new identification card

Members can contact Customer Service at 888-298-4650 for information. For TTY Services, please call 711. Representatives are available 7 days a week, 8am to 8pm October 1 — March 31; and Monday through Friday, 8am to 8pm, April 1 through September 30. Providers should call to verify member eligibility or check on member benefits at 1-888-298-4650.

Eligibility and Enrollment

Eligibility

Members may enroll in a MyAdvocate Medicare Advantage Medicare Advantage plan if they are entitled to Medicare Part A and enrolled under Medicare Part B and live in the Medicare Advantage service area. A member is eligible to join Medicare Advantage irrespective of any medical condition.

Enrollment

If a member is entitled to Medicare Part A and enrolled in Medicare Part B, and residing in the service area, he/she may enroll in Medicare Advantage. If a member has coverage through another Medicare health plan or prescription drug plan, membership in that plan will automatically end on the effective date of the member's enrollment in Medicare Advantage.

Effective date

MyAdvocate Medicare Advantage will notify the member in writing of his/her effective date of coverage along with a Medicare Advantage membership card. Medicare Advantage member(s) will also be notified of Centers for Medicare and Medicaid Services' (CMS) approval/rejection. If an application for membership is rejected by CMS, the member will be notified in writing, including the reason for the rejection. Medicare Advantage members must use their membership card, not their red, white, and blue Medicare card, when accessing services. Covered benefits and services are listed in the member's Evidence of Coverage. The member must remain enrolled in Medicare Parts A and B. If the member does not have Medicare Parts A and B, neither Medicare nor MyAdvocate Medicare Advantage will pay for those services.

Evidence of Coverage/Member Handbook

Each year, members materials are updated and available on the website or requested in print. They contains important contact information, service area descriptions, member rights and responsibilities, notice of privacy practices, information on the complaints, grievances and appeals process, and other information about using their

health insurance coverage. These books can be found on our website with the links to them below.

Medicare Advantage Evidence of Coverage Medicare Resources and Forms | MyAdvocate Medicare Advantage

For a paper copy of any of the Member Handbooks or Evidence of Coverage, please call 888-298-4650 (TTY 711).

ID Card Sample

MyAdvocate Medicare Advantage will provide a Medicare Advantage member identification (ID) card to each member and confirmation of member eligibility upon approval of plan enrollment. Call Customer Service toll-free at 888-298-4650 to verify member eligibility.

MyAdvocate Medicare Advantage providers shall request members' Medicare Advantage member identification card before services are provided and verify that all demographic and insurance information is correct in order to assure correct registration and reduce the possibility of confusion in billing and reporting processes.

The provider or designee shall contact Customer Service at toll-free at 888-298-4650 for verification of eligibility or verification of personal provider designation as well as any time the provider or designee becomes aware of incorrect member information. MyAdvocate Medicare Advantage is responsible for verification and correction of member information.

Pharmacy

Appeals Process

The appeals process, also referred to as the redetermination process, is used to review an adverse coverage determination made by MyAdvocate Medicare Advantage on the benefits that you believe the patient is entitled to receive. This includes a delay in providing or approving drug coverage (when the delay will affect their health), or on any amounts they must pay for drug coverage. The following information provides a detailed description of the appeals process.

There are two kinds of appeals you can file:

Standard (7 days) — You can ask for a standard appeal. We must give you a decision no later than 7 calendar days after we receive the appeal. If we fail to meet the 7-day deadline, we will automatically forward the appeal to an IRE. This is a reviewer outside MyAdvocate Medicare Advantage.

Fast (72-hour review) — You can ask for a fast appeal if the patient's health could be seriously harmed by waiting too long for a decision.

- If the member asks for a fast appeal without support from a provider, we will decide if the member's health requires a fast appeal. If we do not give a fast appeal, we will decide the appeal within 7 calendar days.
- If the provider asks for a fast appeal and indicates that waiting for 7 days could seriously harm the patient's health, we will automatically give a fast appeal.

We must decide on a fast appeal no later than 72 hours after we get the appeal. If we fail to meet the 72-hour deadline, we will automatically forward your appeal to the IRE.

What do you include with your appeal?

You should include patient's name, address, identification number, reasons for appealing, and any addition evidence you wish to include. You may send in supporting medical records, letters, or other information that explains why we should provide the service.

How do you file an appeal?

For a standard appeal, you or your authorized representative should mail or deliver your written appeal to the address below:

MyAdvocate Medicare Advantage

Attn: Medicare Part B Pharmacy Appeals
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

Providers or their agent(s) also may initiate requests for standard appeals via:

- MyAdvocate Medicare Advantage Pharmacy request line at 844-504-5955
- MyAdvocate Medicare Advantage Pharmacy fax number at 715-221-9989

Email at ProviderAppeals@MyAdvocateMA.com For a fast appeal, call us at 844-504-5955 or fax us at 715-221-9989.

What happens next?

After we receive the written appeal, we will review our decision. If we continue to deny any of the prescription services requested and you disagree with that decision, there are further appeal rights. You have 60 days to file a written appeal with the IRE. Please contact MyAdvocate Medicare Advantage at 844-504-5955 for information regarding the IRE. If you disagree with the IRE decision, there are additional appeal rights. You will be notified of these appeal rights if this happens.

Coverage Determination

Whenever you ask for prior authorization or an exception to the utilization management requirements, the first step is called a coverage determination. When we make a coverage determination, we are making a decision whether to cover a Part D drug or at what cost share. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe your patient needs a drug that is not on our list of covered drugs (formulary) or you believe the patient should get a drug at a lower copayment. If you request an exception, you must provide a statement to support your request.

The following are examples of coverage determinations

- The drug requires prior authorization.
- The Part D drug is not on our formulary. This is a request for a "formulary exception."
- A request for an exception to our plan's utilization management tools — such as dosage or quantity limits. This is a request for a "quantity exception."
- A request to cover a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "copay exception."

How to request a coverage determination

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination. A member, their appointed representative or prescribing physician can submit a request for a coverage determination or exception request either orally or in writing by contacting MyAdvocate Medicare Advantage at:

MyAdvocate Medicare Advantage
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Fax: 715-221-9989

Providers or their agent(s) also may initiate requests for formulary exceptions or Authorizations via:

- MyAdvocate Medicare Advantage OptumRx at 844-504-5955
- MyAdvocate Medicare Advantage OptumRx fax number at 844-403-1028

Standard coverage determination process

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if the patient's health condition requires. However, if the request involves a request for an exception (including a formulary exception, quantity exception, or tiering exception) we must provide our decision no later than 72 hours after we have received the physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

We will provide the member with a decision in writing and fax a copy to the provider. If we do not approve the request, we must explain why and provide appeal rights regarding our decision. If you have not received an answer from us within 72 hours after receiving the request, the request will automatically go to an independent review entity (IRE) for review.

Expedited coverage determination process

A member, their appointed representative, or prescribing physician can request an expedited coverage determination. An expedited request can be submitted orally or in writing. A request made or supported by a prescribing physician will be expedited if the physician indicates that applying the standard timeframe for making a determination might seriously jeopardize life, health, or the ability of the patient to regain maximum function.

When OptumRx on behalf of MyAdvocate Medicare Advantage determines that a request qualifies for expedited handling, we will make our determination as expeditiously as the health condition requires but no later than

24 hours after receiving the request, or for an exceptions request, upon receipt of your physician's supporting statement. The patient and the prescribing physician will be notified of the decision, whether favorable or adverse. If OptumRx first notifies you of a decision orally, we will also fax the provider about the prescription drug requested. The written notice will state the specific reason for the denial in understandable language and contain all of the applicable Medicare appeals language to ensure you are informed of the right to file a redetermination (appeal).

To request an expedited coverage determination, you may call, fax, or mail your written request to OptumRx at the numbers indicated above. If written, the 24-hour review time will not begin until your request is received.

If OptumRx on behalf of MyAdvocate Medicare Advantage determines that the request is not time-sensitive and the patient's health is not seriously jeopardized, OptumRx will notify you verbally and via fax, and will automatically begin processing your request under the standard reconsideration process. If you disagree and believe the review should be expedited, you may file an expedited grievance with MyAdvocate Medicare Advantage. The written notice will include instructions on how to file an expedited grievance.

If OptumRx on behalf of MyAdvocate Medicare Advantage fails to make a coverage determination within the 24-hour timeframe, it constitutes an adverse coverage determination. MyAdvocate Medicare Advantage will send the request to the IRE designated by CMS within 24 hours of the expiration of the adjudication timeframe and the IRE will issue a determination.

Exception Process

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

Formulary exception

- You can ask us to cover a drug that is not listed on our formulary.

Quantity exception

- If the drug has a quantity limit, you can ask us to waive the limit and cover more.

Copay exception (also referred to as tier relief)

- You can ask us to provide a higher level of coverage for drug. For example, if a drug is usually considered a Tier 4 drug, you can ask for coverage as a Tier 3 drug if preferred alternatives have been tried. This would lower the copayment amount paid for the drug.

Please note, if we grant a request to cover a drug that is not on our formulary, a copay exception is not available.

Generally, we will only approve a request for an exception if the preferred alternatives included on the plan's formulary would not be as effective in treating the condition and/or would cause adverse medical effects.

A decision by OptumRx on behalf of MyAdvocate Medicare Advantage concerning an exception request constitutes a coverage determination; therefore, all of the coverage determination requirements and timeframes described in the coverage determination process section apply.

In order to help us make a decision more quickly, you should include supporting medical information in submitting the exception request.

If we approve the exception request, our approval is valid for the remainder of the plan year, so long as you continue to prescribe the drug and it continues to be safe and effective for treating the condition. If we deny the exception request, you can appeal our decision.

Providers or their agent(s) may initiate requests for formulary exceptions or authorizations via:

- OptumRx request line at 844-504-5955 OptumRx fax number at 844-403-1028.

Formulary

Use our interactive formulary to view a list of drugs covered for MyAdvocate Medicare Advantage members. An interactive formulary allows you to view the most current tier placement, pharmaceutical management restrictions (such as prior authorization, step therapy, or quantity limits), specialty pharmacy requirements, and any additional coverage details. The interactive formularies are updated monthly and are available online.

Please call OptumRx at 1-844-504-5955 for additional information.

Prior Authorization — Medical Pharmacy

For certain other specialty medications, MyAdvocate Medicare Advantage will internally complete prior authorization (PA) and/or post-service claim edits (PSCE).

Prior authorization lists

Please note: If a drug is denied due to the review processes outlined below, any administration fee associated to that drug will also be denied.

Identifying which specialty medications require PA and/or PSCE

The Medical pharmacy authorization and home infusion webpage lists the most recent medications requiring PA and/or PSCE.

Medications requiring prior authorization through MyAdvocate Medicare Advantage

- Medication instructions will include, "Prior authorization is required" and direct you fax the completed Prior Authorization Request form to MyAdvocate Medicare Advantage.

Prior Authorization — Pharmacy

Certain prescription drugs require prior authorization (PA) from Medicare Advantage before being covered under the Part D drug coverage. They appear on the formulary with the "PA" designation. Below is a list of drugs that require prior authorization with a brief description of the criteria used to make the coverage determination. In addition, there are other drugs on our formulary that require prior authorization to determine whether they are covered under Medicare Part B instead of Part D. To view the prior authorization criteria, please click here Pharmacy and Drug Coverage | MyAdvocate Medicare Advantage.

Providers or their agent(s) may initiate requests for formulary exceptions or authorizations via:

- OptumRx request line at 844-504-5955
- OptumRx fax number at 844-403-1028

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year.

Primary Care Provider

Model of Care

The primary care provider will provide overall coordination of care for MyAdvocate Medicare Advantage's members and will work in a collaborative relationship with other health care professionals to improve the quality of the members' care and to ensure the appropriate utilization of health care services. It is expected that the primary care provider will provide appropriate care within his/her scope of practice and refer to consultants when services are necessary and outside of his/her area of expertise.

Provider Directory

Provider Directory

The MyAdvocate Medicare Advantage online provider directory gives members the most up-to-date list of MyAdvocate Medicare Advantage's affiliated providers. Members can search for providers by the type of insurance coverage the member has, provider name or specialty, facility name or type, city, zip code, or county. There is also an advanced search feature allowing members to search by a provider's gender, hospital affiliation, foreign languages spoken, and whether they are accepting new patients. The provider directory can be accessed online using the link below.

MyAdvocate Medicare Advantage Provider Directory (myadvocatema.com/doctors-and-pharmacies)

The Centers for Medicare and Medicaid Services (CMS) and the No Surprises Act require health plans to verify and update provider directory information every 90 days. MyAdvocate Medicare Advantage collaborates with a vendor to verify provider information for accuracy. Providers are required to maintain accurate information with MyAdvocate Medicare Advantage and to cooperate with verification efforts.

Rights and Responsibilities

Access Standards

All members have the right to receive timely access to medically necessary health care services. To facilitate this, the Quality Improvement (QI) Committee approves member access standards and annually evaluates MyAdvocate Medicare Advantage's affiliated providers' compliance with these standards.

Standards

An expectation of in-office wait time for appointments is no longer than 20 minutes.

Members with life-threatening emergencies will have immediate access to care, 24 hours a day, every day of the year without prior authorization from MyAdvocate Medicare Advantage. Members may receive such emergency care from either affiliated or nonaffiliated providers at hospitals that are within or outside of MyAdvocate Medicare Advantage's service area. All hospitals in MyAdvocate Medicare Advantage's service area offer emergency room services 24 hours a day.

Primary care appointment accessibility

Appointment	Access
Emergency services	Immediate access
Urgent care	Within 24 hours
Non-urgent but requiring medical attention	Within 7 calendar days
Routine primary care	Within 10 business day
Preventive care visit	Within 30 calendar days

Behavioral health appointment accessibility

Appointment	Access
Emergency services	Immediate access
Non life-threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Non-urgent but requiring medical attention	Within 7 business days
Routine — Initial visit	Within 10 calendar days
Routine– Follow-up visit	Within 30 calendar days

Specialist care appointment accessibility

Appointment	Access
Urgent appointment	Within 24 hours
Non-urgent appointment	Within 30 calendar days

After-hours coverage for providers

Physicians who accept "on-call" responsibility for network primary care providers and specialty care providers are subject to the same standards for access and availability.

Primary care providers and behavioral health providers must have a system in place for ensuring after-hours accessibility for their patients, and for informing their patients how to access after-hours care. After-hours patient telephone calls should be returned within 1 hour from the time placed by the patient.

All providers will be required to provide patients with an emergency number for use after regular office hours. Telephone numbers should include a description of 24-hour access to health care.

Providers must be consistent and not discriminate toward Medicaid Managed Care members regarding appointment availability.

Anti-Kickback Statute

There are criminal penalties for individuals or providers that knowingly and willfully offer, pay, solicit, or receive remuneration (payment) in order to induce or reward businesses payable (or reimbursable) under Medicare or other federal health care programs. In addition to applicable criminal sanctions, an individual or provider may be excluded from participation in the Medicare and other federal health care programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The False Claims Act

Any person who:
(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.

When submitting claims data to CMS for payment, providers must certify that the claims data is true and accurate to the best of their knowledge and belief. The False Claims Act is enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal

government. In addition, parties have a continuing obligation to disclose to the government any new information indicating the falseness of the original statement.

Fraud, Waste, and Abuse

Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone. The Plan encourages providers, members, affiliates, facilities, vendors, consultants, and contractors to report any suspected fraud, waste, or abuse to the Plan's Compliance Officer directly by calling, emailing, or anonymously through the hotline.

The Plan will protect its corporate assets and the interests of its members, employers, and providers against those who knowingly and willingly commit fraud or other wrongful acts. We will identify, resolve, recover funds, report, and when appropriate, take legal action if suspected fraud, waste, and/or abuse have occurred.

A provider's submission of a claim for payment also constitutes the provider's representation that the claim is not submitted as a form of, or part of, fraud, waste, and abuse as listed below, and is submitted in compliance with all federal and state laws and regulations. The definitions of fraud, waste, and abuse and examples follow.

The provider is responsible for providing guidance to employees, independent contractors, and subcontractors regarding how to report potential compliance issues. The provider is responsible for promptly addressing and correcting all issues brought to your attention.

Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents. MyAdvocate routinely verifies charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the member's medical record. All payments are subject to prepayment audits, post-payment audits, and retraction of over-payments. Any amount billed by a provider in violation of this policy and paid by MyAdvocate Plan constitutes an overpayment and is subject to recovery. A provider may not bill members for any amounts due resulting to a violation of this policy.

Prevention techniques

Fraud, waste, and abuse can expose a provider, contractor, or subcontractor to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

The provider is responsible for implementing methods to prevent fraud, waste, and abuse. Listed below are some common prevention techniques. This list is not meant to be all-inclusive.

- Education related to fraud, waste, and abuse.
- Validate all member ID cards prior to rendering service (cross-checking with another form of government issued photo ID is a good practice).
- Ensure accuracy when submitting bills or claims for services rendered.
- Submit appropriate Referral and Treatment forms.
- Avoid unnecessary drug prescription and/or medical treatment.
- Report lost or stolen prescription pads and/or fraudulent prescriptions.
- Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities.
  - Two of the review resources are:
    - SAM– The Excluded Parties List System ("EPLS") is maintained by the GSA, now a part of the System for Awards Management ("SAM"). The EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States. sam.gov
    - LEIE — List of Excluded Individuals and Entities list is maintained by HHS OIG and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, Marketplace and all Federal health care

programs. Individuals and entities who have been reinstated are removed from the LEIE **exclusions.oig.hhs.gov**.

How to report

The Plan requires everyone to exercise due diligence in the prevention, detection, and correction of fraud, waste, and abuse (FWA). The Plan promotes an ethical culture of compliance with all State and Federal regulatory requirements and mandates the reporting of any suspected or actual FWA to the Plan's Compliance team. The compliance team can be reached by emailing compliance@myadvocatema.com or calling the anonymous Compliance Hotline: (877) 473-0911.

Special Investigations Unit (SIU)

The Plan is committed to program integrity efforts by early identification, correction, and prevention of health care FWA through its Special Investigations Unit (SIU). The SIU utilizes various methods in its efforts to address FWA including, but not limited to, investigation and data analytics tools. These resources assist in detecting unusual claim patterns, outlier behavior, over-utilization, and potentially inappropriate billing practices.

Procedures are in place to promptly address non-compliance and potential FWA issues as well as reporting identified issues to appropriate authorities. Actions taken by the SIU may include things such as interviews, medical record reviews, verbal/written provider education, written and documented corrective action plans, recoupment of funds, appropriate federal and state law enforcement/MEDIC referrals, or other legal action.

The provider shall give the SIU the right to audit, evaluate and inspect books, contracts, documents, papers, medical records, patient care documentation, and any other pertinent records. A provider audit may result in recoupment, suspension, or termination. The provider shall be notified of the determination by letter. The date on the letter will be deemed as the date of the determination.

If a provider disagrees with the audit results, they may dispute it by responding to the Special Investigations Unit as outlined in the determination letter. Disputes must be submitted to the Plan within 30 days of the initial determination. Providers are entitled to one dispute per audit granted there are no extenuating circumstances.

Definitions and examples

Fraud is defined as knowingly and willingly executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. Health care fraud examples include but are not limited to the following:

- Misrepresentation of the type or level of service provided.
- Misrepresentation of the individual rendering service.

Waste is defined as practices which directly or indirectly result in unnecessary costs such as overusing services. It is the misuse of resources.

Abuse is defined as the practice of directly or indirectly, result in unnecessary costs and includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards.
Examples of abuse include:

- Billing for unnecessary medical services.
- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes.

Medical Policies

Medical Policy information is available on the resources page of our website: https://myadvocatema.com/resources/medical-policies

Prohibition of Interference with Health Care Professionals Advice to Medicare Advantage Members

MyAdvocate Medicare Advantage advocates and upholds the patient/provider relationship and does not prohibit or otherwise restrict a health care professional acting within his/her lawful scope of practice from providing advice to an individual who is a patient and enrolled in a Medicare Advantage plan.

Provider Contracting

Agreement with contracting and subcontracting entities

When the provider or contracted entity provides services under the affiliated provider agreement through subcontracts with other individuals or entities, the provider shall require those individuals or entities to meet the requirements as outlined by CMS.

Termination of provider or contracting entity

Consistent with MyAdvocate Medicare Advantage's contract with CMS and related affiliated provider agreements, MyAdvocate Medicare Advantage reserves the right to terminate or nonrenewal a contract with any provider or other contracted entity for failure to be compliant with any of the following:

- Persistent non-compliance with MyAdvocate Medicare Advantage policies and/or procedures.
- Breach of the provider agreement without remedy of such breach after 60-day notification.
- Upon receipt of written notice that the provider can no longer meet the obligations required under the agreement including but not limited to suspension, revocation, or expiration of any license or certificate that is necessary to perform required obligations under this affiliated provider agreement.
- Upon notification of bankruptcy or insolvency.
- Notification of any sanction, remedial actions or revocation of Medicare participation, or that of applicable state or federal agency.
- In the event that in the judgment of MyAdvocate Medicare Advantage, continuation of the agreement would jeopardize the health and welfare of Medicare Advantage members.

Medicare preclusion list

The Centers for Medicare and Medicaid Services (CMS) issues a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services, or Part D drugs furnished or prescribed to Medicare beneficiaries. CMS will make the preclusion list available to Part D sponsors and Medicare Advantage plans.

- Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.
- Medicare Advantage plans will be required to deny payment for a health care item or service furnished by an individual or entity on the preclusion list.

Why was the list created?

- To replace the Medicare Advantage and prescriber enrollment requirements.
- To ensure patient protections and safety, and to protect the Trust Funds from prescribers and providers identified as "bad actors."

Who is on the list?

Individuals or entities who are currently:

- Revoked from Medicare.
- Under an active reenrollment bar.
- AND determined by CMS that the underlying conduct, which led to the revocation, is detrimental to the best interests of the Medicare program.

- Or
  - Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare.
  - AND CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

For providers on the preclusion list

- You will receive an email and letter from CMS/Medicare Administrative Contractors in advance of your inclusion on the preclusion list.
- The email and letter will be sent to your Provider Enrollment Chain and Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPPES) mailing.
- The letter will contain the reason you are precluded, the effective date of your preclusion, and your applicable rights to appeal.

For MyAdvocate Medicare Advantage affiliated providers or facilities on the preclusion list

- You will be removed from printing in the MyAdvocate Medicare Advantage provider directories immediately.
- You will be terminated from MyAdvocate Medicare Advantage 's products 90 days from the date you are listed on the Preclusion list. This 90-day period is divided into a 30-day member notification period and a 60-day provider termination period.
- You will receive a notice from MyAdvocate Medicare Advantage outlining your termination from its plan.
- After the 90 days, claims will be denied to the provider/practice responsibility, not to the member responsibility. Providers cannot bill members for these denied claims.

If Provider and/or facility is removed from the Preclusion list, they will need to reapply for affiliation with MyAdvocate Medicare Advantage product.

In the event of termination, MyAdvocate Medicare Advantage will do all of the following

- Notify the provider or contracting entity of termination, including effective date and, if applicable, reasons for termination, right to appeal decision, and obligations of the provider in the termination process.
- Notify members and coordinate transfer of member care to other MyAdvocate Medicare Advantage providers.
- Notify any state, federal, or regulatory agency, if applicable.

Termination of providers will be consistent with MyAdvocate Medicare Advantage's policies and procedures and any applicable state or federal laws.

Provider Credentialing Process

The credentialing process enables MyAdvocate Medicare Advantage to appropriately affiliate quality qualified Medicare eligible healthcare providers, including but not limited to physicians, advanced practice professionals, allied health professionals, hospitals, other facilities and entities (Provider) to the network. MyAdvocate Medicare Advantage makes available the following paths for credentialing:

If you are a Medicare-eligible provider, and

- Hold current successful credentialing with Midlands Choice, MyAdvocate will accept their approval in lieu of separate credentialing.
- Hold current successful credentialing with Sanford Health Plan/Good Samaritan Insurance Plan of NE, MyAdvocate will accept their approval in lieu of separate credentialing.
- If neither option above applies, please visit our website for more information at https://www.myadvocatema.com/providers for instructions on next steps.

Provider Reporting of Member Complaint

In an effort to maintain patient satisfaction, and regulatory, and quality standards, MyAdvocate Medicare Advantage affiliated providers are required to have a formal mechanism in place for the prompt response to and resolution of member complaints.

The following provider responsibilities apply and may be audited by state/federal agencies or MyAdvocate Medicare Advantage at any time:

- Have a primary contact person for complaint management.
- Have a documented process for complaint handling.
- Investigate and provide a prompt response to facilitate complaint resolution.

If there are any questions or concerns, please contact Customer Service at 888-298-4650.

Provider Response Requirements for Member Complaints

Timely response required, from Provider, for Quality of Clinical Care (QCC) or Quality of Service (QS) member complaint(s)

MyAdvocate Medicare Advantage responds to all member complaints thoroughly and consistently within established time frames. MyAdvocate Medicare Advantage 's review of QCC and QS complaints includes Provider outreach to assist in investigation and resolution of member complaints. MyAdvocate Medicare Advantage processes all complaints as outlined in the applicable accreditation and regulatory standards. MyAdvocate Medicare Advantage has a **30-day time frame** (start to finish) to maintain compliance with these standards. For this reason, it is extremely important for our Provider partners to respond timely to requests for information to investigate/resolve a member complaint (we allow 5 business days to respond to our initial request). As a contacted provider with MyAdvocate Medicare Advantage, a member Release of Information is not required to provide the requested information as it relates to the member's complaint.

Quality of Clinical Care complaint

A Quality of Clinical Care (QCC) complaint is expressed by a member or member's authorized representative related to health care services provided by a participating provider. QCC complaints are defined as: Complaints related to clinical services provided by a participating provider/facility that allegedly decreased the likelihood of desired health outcomes and/or were not consistent with current professional knowledge and professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings. Clinical care is care provided in a clinical or medical setting and documented in the member's medical record.

Quality of Service complaint

A Quality of Service (QS) complaint is expressed by a member or member representative providing information related to services provided in a medical/clinical care setting by a participating provider/facility and is not directly related to clinical care.

Provider System Outages and or Material Breach

MyAdvocate Medicare Advantage requires all contracted HIPAA covered entities and their business associates to develop and maintain an emergency preparedness communication plan. The emergency preparedness communication plan must have a system in place that provides timely notification to MyAdvocate following a material breach or system outage.

MyAdvocate Medicare Advantage requires the communication plan to provide, at a minimum, the following topics:

- Immediate notification of incident to MyAdvocate Medicare Advantage's Provider Network Management Team.
  - Email: ProvNetEngage@MyAdvocateMA.com
- MyAdvocate Medicare Advantage with primary contacts throughout the duration of the incident.

- Initial details of the incident including,
  - anticipated member impact;
  - anticipated Health Plan impact; and
  - restoration time frame.
- Communication related to the below areas of operation to define how operation of systems has been affected in order for MyAdvocate Medicare Advantage to provide feedback for temporary work around for:
  - Medical management for inpatient and outpatient.
  - Vendor authorization management Claim submissions.
  - Retro review audits.
  - Medical record request.
- Provide MyAdvocate Medicare Advantage weekly updates of incident downtimes based on impact to operations.

MyAdvocate Medicare Advantage requirements may be modified based on provider partner incident severity.

Providers' Expectations of MyAdvocate Medicare Advantage

Providers of care can expect MyAdvocate Medicare Advantage to:

- Assist the provider in meeting the expectations of MyAdvocate Medicare Advantage.
- Pay claims fairly and efficiently.
- Provide due process to the provider when complaints or grievances are lodged against him or her, or when a provider wishes to appeal MyAdvocate Medicare Advantage decisions.
- Strive to interfere as little as possible with the process of care, unless there are significant issues related to quality, cost, or coverage.
- Support the provider in practice by identifying opportunities to improve care when information is available on a practice basis or an individual member basis.
- Maintain an appeals process that can respond quickly and appropriately to members and providers.
- Educate and encourage members to be seen for appropriate preventive services.
- Inform providers of initiatives that may affect them or MyAdvocate Medicare Advantage members before such interventions occur, and before members are aware of them (such as educational programs which may result in questions being asked of the provider).
- Maintain internal processes to improve service to members and providers.
- Review clinical information when making decisions about coverage; staff do not receive financial compensation for denying benefits for health care services nor is MyAdvocate Medicare Advantage's performance measured on such denials.
- Inform providers of changes in benefit administration policies that may affect them or MyAdvocate Medicare Advantage members' awareness.
- Provide a written copy of MyAdvocate Medicare Advantage's Quality Improvement program evaluation upon request.

MyAdvocate Medicare Advantage's Expectations of Providers

- Act in the best interest of members
- Communicate fully with members regarding their illness, as well as diagnostic and therapeutic options available to them.
- Ensure member has access to interpreter services as needed.

- Refer members for specialty care or second opinions within the MyAdvocate Medicare Advantage provider network and obtain approval from the MyAdvocate Medicare Advantage's medical director when care is necessary outside of the health plan network.
- Maintain awareness of MyAdvocate Medicare Advantage technology assessment and drug evaluation committee decisions to the extent possible.
- Participate in MyAdvocate Medicare Advantage utilization management and quality improvement initiatives, including allowing MyAdvocate Medicare Advantage reasonable access to member medical records.
- Recognize that there are multiple, well-accepted means of diagnosis and treatment for many conditions.
- Inform the medical director when MyAdvocate Medicare Advantage procedures or actions are perceived as threatening the health or well-being of the member.
- Recognize that conflict occasionally occurs between providers and MyAdvocate Medicare Advantage, or members and MyAdvocate Medicare Advantage, and that these should be resolved within the appeals process outlined in MyAdvocate Medicare Advantage documents.
- Understand that MyAdvocate Medicare Advantage does not deny patient care but simply makes payment decisions based on the member's coverage through MyAdvocate Medicare Advantage. Members have the right to appeal any decision made by MyAdvocate Medicare Advantage. Information on how to appeal to a decision can be requested by calling MyAdvocate Medicare Advantage's Customer Service at 888-298-4650.
- Communicate with members and MyAdvocate Medicare Advantage in a way that assumes that all parties are acting in good faith with the goal being the best care possible for the member.
- Recognize that MyAdvocate Medicare Advantage is obligated to develop policies and procedures on benefit administration and to administer these in a fair and consistent manner even though this occasionally results in denial of payment for individual members.
- Understand that MyAdvocate Medicare Advantage's objective is to improve access to and quality of health care
- Refrain from making comments or offering advice on payment or insurance coverage issues
- Refer patients with payment or insurance coverage issues to MyAdvocate Medicare Advantage's Customer Service at 888-298-4650.
- All providers are required by law to report suspected child abuse and neglect and must know how to understand the laws, identification requirements, and reporting procedures for reporting child abuse and neglect.

Skilled Nursing Facility Denial of Medicare/Medicaid Payment

MyAdvocate Medicare Advantage requires affiliated skilled nursing facilities (SNF) to notify MyAdvocate Medicare Advantage within 3 business days if the Department of Health Services Bureau of Quality Assurance imposes a denial of Medicare payment for new and/or existing admissions or imposes the restriction of no admissions. In addition, MyAdvocate Medicare Advantage requires full cooperation during the investigation period. MyAdvocate Medicare Advantage also requires immediate notification of resolution of imposed remedies.

Procedure

MyAdvocate Medicare Advantage requires affiliated SNF's to submit the following information when the Department of Health Services Bureau of Quality Assurance imposes a denial of payment for new and/or existing admissions or imposes the restriction of no admissions:

- A copy of the Department of Health Services Statement of Deficiencies identifying corrective action needed.
- A copy of the letter from the Department of Health Services indicating the enforcement remedies, state violations, and date the plan of correction is needed.
- A copy of any subsequent letter from the Department of Health Services indicating SNFs substantial

compliance with state and federal participation requirements.

Information should be stamped confidential, include reference to MyAdvocate in our subject, and faxed to MyAdvocate's Provider Network Engagement Department at 715-221-9699. Please include the name and number of a contact person MyAdvocate Medicare Advantage can call to discuss the information you submit.

If the SNF does not remedy the deficiencies and the SNF is excluded, MyAdvocate Medicare Advantage's contract language is imposed: Section 1.11 Exclusion From Federal Health Care Programs. The affiliated facility hereby represents and warrants that it is not and at no time has been excluded from participation in any federally funded health care programs, including Medicare and Medicaid.

The affiliated facility hereby agrees to immediately notify MyAdvocate Medicare Advantage if it or any of its employees are threatened to be or are excluded from any federally funded health care program, including Medicare and Medicaid. In the event that the affiliated facility or any of its employees are excluded from participation in any federally funded health care program during the term of this agreement, or if at any time after the effective date of this agreement it is determined that the affiliated facility is in breach of this requirement, this agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

If Medicare is not paying for any new and/or existing admissions, payment will not be made under this MyAdvocate Medicare Advantage product for such admissions, per the Medicare Advantage Affiliated Skilled Nursing Facility contract.

Suspension of Payment

MyAdvocate Medicare Advantage will suspend payment for any provider where allegations of fraud, waste, and abuse have been substantiated.

Utilization Management

Eviti

MyAdvocate Medicare Advantage requires prior notification for oncology treatment plans. Eviti will review all chemotherapy and radiation oncology treatment plans regardless of how or where chemotherapy is administered. Once a treatment plan is approved, the ordering provider or designee will receive an Eviti approval code. Prior authorization is required for affiliated providers, and facilities prior to performance, with administrative claim denial for non-compliance. Services performed without authorization may be denied for payment; and you may not seek reimbursement from members. The ordering provider maintains final decision authority on the services provided. If an affiliated provider fails to prior notify, retro-notification will be accepted.

Request for authorization

- Prior authorization can be submitted: Online through the eviti website at https://connect.eviti.com/Connect
- Contact Eviti Customer Support at (888) 482-8057 or clientsupport@nanthealth.com

eviCore

MyAdvocate Medicare Advantage is partnering with eviCore to manage high-end imaging and muscoloskeletal procedures.

- High-end imaging — Cardiac imaging and elective heart catheterization
- High-end imaging
- Musculoskeletal procedures (joint, spine and pain management interventions)

Request for authorization

- Register online for an account
- Online — 24 hours a day, seven days a week at https://www.evicore.com/

To request an authorization, submit your request online, by phone, or fax:

- Call eviCore at 888-693-3211 and choose option 4 for physicians. Here, providers may request or schedule a live peer-to-peer conversation. Please have the case or authorization number on the denial/fax letter ready.
- Log into https://www.evicore.com/.
- Phone at 888-693-321.
- Fax an eviCore request form (available online) to 888-693-3210.

High-End Imaging — Cardiac Imaging and Elective Heart Catheterization

High-end imaging

MyAdvocate Medicare Advantage requires prior notification for outpatient high-end imaging tests for cardiac imaging and elective heart catheterization. A complete list of CPT codes requiring notification can be found below. Services performed without authorization may be denied for payment; and you may not seek reimbursement from members.

MyAdvocate Medicare Advantage a prior notification is required for affiliated providers, facilities, and ancillary providers for aforementioned high-end imaging procedures prior to performance, with administrative claim denial for non-compliance. The ordering provider maintains final decision authority of which high-end imaging test is performed. If an affiliated provider fails to prior notify, retro-notification will not be accepted.

The ordering provider or designee is responsible for obtaining a notification number prior to scheduling high-end outpatient imaging procedures. Prior notification can be completed online via MyAdvocate Medicare Advantage's provider portal.

Authorization is required for

- Cardiac Advanced Imaging: CT, MR, PET

- Nuclear Cardiology (includes nuclear stress testing)
- Echo Stress Testing
- Echocardiography
- Diagnostic Heart Catheterization

Request for authorization

- Register online for an account
- Online — 24 hours a day, seven days a week at https://www.evicore.com/

To request an authorization, submit your request online, by phone or fax:

Call eviCore at 888-693-3211 and choose option 4 for physicians. Here, providers may request or schedule a live peer-to-peer conversation. Please have the case or authorization number on the denial/fax letter ready.

- Log into https://www.evicore.com/.
- Phone at 888-444-6185.
- Fax an eviCore request form (available online) to 885-511-0403.

High-End Imaging

High-end imaging

MyAdvocate Medicare Advantage requires prior authorization for all outpatient high-end imaging tests: MRI, CT (excluding SPECT), and PET scans. A complete list of CPT codes requiring prior authorization can be found below. Services performed without authorization may be denied for payment. You may not seek reimbursement from members for these services.

A prior authorization is required for all providers, facilities, and ancillary providers for aforementioned high-end imaging procedures prior to performance, with administrative claim denial for non-compliance. The ordering provider maintains final decision authority of which high-end imaging test is performed. If an affiliated provider fails to prior notify, retro-notification will not be accepted.

The ordering provider or designee is responsible for obtaining a prior authorization number prior to scheduling high-end outpatient imaging procedures. It is the rendering provider's responsibility to ensure prior authorization requirements are met before a member's scheduled appointment. If prior authorization requirements are not met, claims could be denied.

Authorization is required for:

- MRI
- MRA
- CT
- CTA
- PET
- Nuclear cardiac

Request authorization:

- Register online for an account
- Online — 24 hours a day, seven days a week at www.evicore.com/

To request an authorization, submit your request online, by phone or fax:

Call eviCore at 1-888-693-3211 and choose option 4 for physicians. Here, providers may request or schedule a live peer-to-peer conversation. Please have the case or authorization number on the denial/fax letter ready.

- Log in to www.evicore.com/
- Phone: 1-888-693-3211
- Fax an eviCore request form (available online) to 1-888-693-3210

Resources

Visit our provider website for more information.

eviCore healthcare's Clinical Guidelines and request forms are available at: www.evicore.com or click here to access guidelines specific to MyAdvocate Medicare Advantage please call the Client Provider Operations Department at 1-800-646-0418, option 4, if you have any questions or need more information.

Continuity and Care Coordination

MyAdvocate Medicare Advantage believes its members should receive seamless, continuous, and appropriate care through communication between behavioral health providers and primary care providers. The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations support the Health Plan's interest in patient safety and coordination of care.

- When patients present for behavioral health care, they need to be informed about how their records will be handled and, in certain circumstances, to give consent or authorization regarding what information can be shared and with whom. Coordination of care reduces the risk of problems when patients see multiple providers in different settings and when providers lack access to the patient's complete medical record. Important mental health information to be shared would include patient diagnosis, medication(s), and/or treatment plan.
- In the Health Plan's effort to provide high-quality health care, the Health Plan requires affiliated behavioral health providers to communicate with primary care providers. MyAdvocate Medicare Advantage monitors this activity through an annual provider survey sent to both behavioral health providers and primary care providers. Providers indicate if they believe it is important to share this information as well as if the sharing of this information occurs.
- The Health Plan appreciates providers' help and cooperation in this matter to improve communication between providers through continuity and coordination of care.

Home Health

Home health includes health care services provided directly to a member in the member's home such as skilled nursing, physical therapy, occupational therapy, and speech therapy services. A written home care plan signed by an attending or the member's primary care physician and/or provider is required for submission when requesting home health services.

MyAdvocate Medicare Advantage requires prior authorization for home health. Prior authorization is required by going to the MyAdvocate Medicare Advantage provider portal or when submitting a fax request. By using the MyAdvocate Medicare Advantage secure portal, providers can submit authorizations, view their status, and see their determinations.

For the initial review, use the Create Service/Procedure Authorization tab. The Create tab should only be used when starting an initial request for home health care services. If continued home health services are needed, the initial authorization has ended, or the authorized visits have all been utilized, the provider can once again go into MyAdvocate Medicare Advantage portal, find the member and the initial authorization, and extend the initial authorization. The Create Service/Procedure Authorization tab should never be used when requesting to extend home health care services.

For more information, visit the provider prior authorization page.

Hospice Protocols

Hospice services reverts back to original Medicare and is not managed by MyAdvocate Medicare Advantage.

Hospital Inpatient Utilization Review

- Medicare Advantage members admitted to "Hospital Inpatient" status must meet InterQual inpatient criteria for the hospital to receive inpatient reimbursement.
- When Medicare Advantage members are admitted to "Hospital Outpatient Observation" status as defined by Medicare, hospitals will receive reimbursement for the stay per Medicare outpatient observation guidelines.

- The physician services provided to Medicare Advantage members, whose inpatient hospitalization has been denied due to the lack of inpatient criteria, will not be reimbursed.

Providers are responsible for determining the medical necessity for a MyAdvocate Medicare Advantage member to be hospitalized as "inpatient" or "observation." MyAdvocate Medicare Advantage uses InterQual criteria to review hospital inpatient admissions for medical necessity. In cases where inpatient criteria are not met, MyAdvocate Medicare Advantage will not reimburse for the inpatient DRG, per diem rate (Critical Access Hospital), or physician services.

MyAdvocate Medicare Advantage has identified some hospital admissions that do not meet inpatient InterQual criteria. In these cases, the members' conditions lacked severity of illness, or the level of service provided lacked intensity. Medicare may reimburse for these situations under "Hospital Observation" status if the physician admits the recipient to "Hospital Observation" status and bills for such outpatient observation services. MyAdvocate Medicare Advantage also reimburses for "Hospital Observation" status per Medicare guidelines and reimbursement rates for eligible members.

The physician's admission order must clearly indicate whether the admission is for "Inpatient Hospital" or "Hospital Observation" status.

Medicare information is available on the Centers for Medicare and Medicaid Services (CMS) web site at www.cms.hhs.gov.

If you have additional questions, please contact your MyAdvocate Medicare Advantage 888-298-4650

Hospital Urgent/Observation Admission

Observation care is clinically appropriate services which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment, as hospital inpatients or if they are able to be discharged from the hospital. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care, or to admit the patient as an inpatient, can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

- Claims submitted need to match the appropriate dates and level of care indicated for the authorization number(s) granted. Claims submission must follow Medicare billing guidelines. If the provider fails to provide the needed clinical information within 24 hours of inpatient admission and 48 hours of observation admission hours of the notification of admission (Observation and/or Inpatient), MyAdvocate Medicare Advantage will deny for provider contract requirement. Provider cannot bill the member for these denied charges.
- If ultimately it is determined that the patient did not meet medical necessity for the admission, payment for services will be denied to the Provider. Provider cannot bill the member for these denied charges. Provider may appeal through MyAdvocate Medicare Advantage's Appeal Process. The appeal process can be found here.

Contact the MyAdvocate Medicare Advantage utilization review coordinator at 800-991-8109 or 888-298-4650

Hospital responsibilities include:

- Notify of initial admission or sending a daily census file for MyAdvocate Medicare Advantage by submitting authorization request via the provider portal or fax at fax at 715-221-6616 within 24 hours of inpatient admission or 48 hours of all observation with length stay greater than 48 hours and acute inpatient admissions within 24 hours.
- For concurrent review, please submit clinical information via provider portal or fax to 715-221-9980.
- Failure to provide this information means MyAdvocate Medicare Advantage will not be able to perform timely initial or concurrent review of the admission. MyAdvocate Medicare Advantage will therefore not reimburse the facility for covered services incurred prior to the performance of the initial or concurrent review of the admission.
- The facility shall not bill, charge, collect a deposit from, seek remuneration or compensation from the

MyAdvocate Medicare Advantage member, or any person acting on the member's behalf, for covered services incurred prior to the performance of the initial or concurrent review.

Inappropriate Discharge and Readmission

MyAdvocate Medicare Advantage reviews inpatient admissions that have been identified as a readmission within 30 days for the same or similar diagnosis to the same facility, or another facility that:

- Operates under the same facility agreement.
- Has the same tax identification number.
- Is under common ownership.

For hospitals that are reimbursed using inpatient Diagnostic Related Groups (DRG) methodology and for provider organizations providing professional services during the inpatient readmission, if MyAdvocate Medicare Advantage deems a readmission as inappropriate or preventable, the authorization for the readmission will be denied. A denied authorization will result in claim denials.

A 30-day readmission will be considered inappropriate or preventable under the following circumstances:

- Readmission up to 30 days from discharge to the same facility for the same or related condition, illness, or injury.
- The same or closely related condition or procedure as the prior discharge.
- An infection or complication of care within 30 days of discharge.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A complication or issues caused by a premature discharge from the same facility.
- Please review the readmission policy.

Exceptions:

- Readmissions that are planned for repetitive or staged treatments such as chemotherapy.
- Readmissions associated with specific complex conditions such as oncology, burns, cystic fibrosis, or sickle cell anemia.
- Readmissions where the initial admission had a discharge status "left against medical advice."
- Obstetrical readmissions.
- Transplant services, including organ and tissue transplantation from a live or cadaveric donor.
- Readmissions for mental health or substance use disorders.

For additional information see the following:

- All-cause Readmission Payment Policy Review for Circumvention of Prospective Payment System Medical Policy under the Provider/Medical Policies section of the MyAdvocate Medicare Advantage website — Medical Policies | MyAdvocate Medicare Advantage
- Claims Processing Policies and Procedures — Reimbursement for Inappropriate Discharge and Readmission section in the Provider Manual

Inpatient Acute Rehabilitation/Long Term Acute Care

MyAdvocate Medicare Advantage covers medically necessary inpatient rehabilitation. Precertification of all inpatient rehabilitation admissions is required. Providers must prior authorize by going to MyAdvocate Medicare Advantage provider portal or faxing 715-221-9215. Affiliated providers will notify MyAdvocate Medicare Advantage of all proposed transfers to an acute, inpatient rehabilitation facility.

Providers must prior authorize Long Term Acute Care (LTAC) admissions with MyAdvocate Medicare Advantage

going to MyAdvocate Medicare Advantage provider portal or faxing 715-221-9215. Affiliated providers will notify MyAdvocate Medicare Advantage of all proposed transfers to a Long Term Acute Care facility.

MyAdvocate Medicare Advantage will follow the inpatient rehab/LTAC stay concurrently for medical necessity and intensity of service. Clinical is required for all concurrent reviews. Please fax to MyAdvocate Medicare Advantage 1-715-221-9215. Alternate levels of care will be discussed with the attending physician the facilities discharge planners as appropriate.

Medical Necessity

Medically necessary for Medicare Advantage is defined as services, supplies or drugs that are needed for the prevention, diagnosis or treatment of your medical condition; meet accepted standards of medical practice and are within the scope of a Medicare benefit category.

Musculoskeletal Procedures

eviCore healthcare is contracted by MyAdvocate Medicare Advantage to provide prior authorization (PA) review of certain musculoskeletal services.

These authorizations are for members enrolled in MyAdvocate Medicare Advantage plans.

It is the rendering provider's responsibility to ensure prior authorization requirements are met before a member's scheduled appointment. If PA requirements are not met, claims could be denied. If a provider changes any of the prior authorized service(s) during surgery to perform services other than the ones for which PA was obtained, the provider must contact MyAdvocate Medicare Advantage within **72 business hours** of the procedure to provide the new CPT code(s) that were performed. The provider must notify eviCore at 1-888-444-6185 with the updated information. **If the provider does not notify eviCore of the changes within 72 business hours of procedure, the claims for the unauthorized codes will be denied.** Rendering providers should contact eviCore to obtain PA for members per the guidelines outlined above and with the provider training materials.

Therapy services performed in conjunction with an inpatient stay, 24-hour observation, or emergency room visit are not subject to prior authorization requirements.

Authorization is required for

- joint surgeries,
- spine surgeries, and
- interventional pain management.

Request for authorization

To request a prior authorization:

- Log in to www.evicore.com/pages/ProviderLogin.aspx
- Call eviCore at 1-888-444-6185
- Fax an eviCore health care request form (available at www.evicore.com) to 1-885-511-0403

For urgent requests

If services are required in less than 48 hours due to the severity of the clinical presentation, please call eviCore's toll-free number or you can initiate a case via the eviCore web portal for expedited prior authorization review. Be sure to tell the eviCore representative that the prior authorization request is for an urgent clinical presentation. If initiating the urgent request via the web, you will have to upload clinical documentation with the case initiation. To request an authorization, submit your request online, by phone, or fax.

eviCore healthcare's Clinical Guidelines and request forms are available at: www.evicore.com or click here to access guidelines specific to MyAdvocate Medicare Advantage. Please call the Client Provider Operations Department at 1-800-646-0418, option 4, if you have any questions or need more information.

- Benefits are limited to the number of days specified in the member's plan. Coverage is provided to members with a skilled nursing facility (SNF) benefit. The member's medical condition must also require daily nursing

or therapy care. The patient must require daily skilled services as certified by the member's physician. SNF must prior authorize skilled nursing facility admissions by going to the MyAdvocate Medicare Advantage provider portal or fax to 715-221-9215.

- Confinement in a swing bed in a hospital is considered the same as SNF confinement. Services require prior authorization and approval by MyAdvocate Medicare Advantage in order to be considered for coverage. Prior authorization is required going to the MyAdvocate Medicare Advantage provider portal or fax to 715-221-9215.
- Custodial care is excluded from coverage. This includes, but is not limited to, care provided by community-based residential facilities (CBRF), intermediate care facilities (ICF), day care and group facilities, and residential hospice facilities.

Pre-Certification Notification and Concurrent Review Guide

Provider responsibilities include:

- Pre-certify all elective inpatient admissions/surgeries and outpatient procedures such as, but not limited to:
  - Joint surgeries, back surgeries, and cardiac surgeries.
- Notify MyAdvocate Medicare Advantage by fax (715-221-6616) of all direct/urgent inpatient admissions.
- Notify MyAdvocate Medicare Advantage about any of the following changes prior to services being provided:
  - level of care,
  - procedural changes,
  - site of service,
  - date of service, and
  - provider rendering service.

Skilled nursing facility and acute rehab facility responsibilities include:

- Prior authorize skilled nursing/acute rehab facility admissions in the MyAdvocate Medicare Advantage provider portal or fax to 715-221-9215.
- If admission is after normal business hours, notify MyAdvocate Medicare Advantage within 24 hours of the admission or on the first business day after admission, whichever is sooner.
- Cooperate with concurrent review activities (telephonic or onsite), which include providing MyAdvocate Medicare Advantage with timely concurrent review within 24 hours of last certified day.
- Failure to obtain prior authorization for skilled nursing facility admission will cause the reimbursement period to begin on the day MyAdvocate Medicare Advantage is notified. However, the member's actual admission day will be considered the first day of the benefit period. If an Affiliated Facility fails to obtain prior authorization, Plan will not reimburse Affiliated Facility for covered services incurred prior to the day Plan is notified of the admission; and Affiliated Facility shall not bill, charge, collect a deposit from, seek remuneration or compensation from Plan member, or any person acting on the member's behalf, for covered services incurred prior to the day Plan is notified of the admission.
- Failure to obtain prior authorization means Plan will not be able to perform timely concurrent review of the admission and Plan will therefore not reimburse Affiliated Facility for covered services incurred prior to the performance of the concurrent review of the admission; and Facility shall not bill, charge, collect a deposit from, seek remuneration or compensation from Plan member, or any person acting on the member's behalf, for covered services incurred prior to the performance of the concurrent review.

Pre-certification of hospital admissions

Based on medical diagnosis or proposed surgery and medical information, MyAdvocate Medicare Advantage will:

- Authorize coverage for a length of stay based on InterQual Level of Care Criteria, which are a minimum

length of stay consistent with high-quality care, not an average or maximum. Actual length of coverage for a stay is based on medical necessity and intensity of service.

- Upon request, send a copy of the appropriate InterQual Level of Care Criteria. Contact the MyAdvocate Medicare Advantage utilization review coordinator to make such a request.
- Follow the admission with the hospital utilization review department if the member is not discharged within the pre-certified time frame. The admission will be reviewed for medical necessity and intensity of service.
- Contact the provider for additional information if not available through the hospital utilization review department to determine if additional days will be covered or denied based on medical necessity for an acute care setting. Alternate settings and appropriate home health services will be explored for members who do not meet criteria for continued coverage of acute care.

The provider, not the member, is responsible to pre-certify an admission to the hospital for medical and/or surgical treatment.

Facilities to Deliver Standard Determination Approval Notices

When a MyAdvocate Medicare Advantage member is in a hospital (inpatient or observation status), the facility is required to provide notice of approvals and denials for services members request as part of the Standard Determination process. The process is outlined below to help your staff deliver the approvals and denials.

Notice of approved benefit determination

An approved benefit determination notice is provided to the requesting facility.

- Notice includes a reference identifier and indicates the service to which the coverage has been applied.
- When notice is required by law or per account contract to be provided to the member, it may be provided verbally, via secure internet portal, or in writing.
- The ordering and/or rendering provider/facility requesting the benefit on behalf of the member will be required to notify the member of approval and deliver a faxed copy of the approval.
- The member, ordering and rending provider will receive a written determination letter.

Notice of adverse (not approved/ not certified) benefit determination

- MyAdvocate Medicare Advantage must follow up to provide written notice directly to the member and the ordering and/or rendering provider.
- MyAdvocate Medicare Advantage will fax the denial letter to the hospital and instructs hospital staff to provide a paper copy of denial to the member.

Prior Authorization

Link to: https://www.securityhealth.org/providers/authorizations?utilization-management-medicare-advantage

Technology Assessment

Technology Assessment is a formal review process of new medical technology and new applications of existing medical technology to ensure that members have equitable access to safe and effective care. You may request review by contacting ProviderServices@MyAdvocateMA.com.

When assessing new technology, MyAdvocate Medicare Advantage uses information from the following sources:

- Centers for Medicare and Medicaid Services (CMS)
- Symplr Evidence Analysis (previously known as Hayes Medical Technology Assessment)
- UpToDate
- Society Clinical Practice Guidelines
- Evidence-Based Criteria and Guidelines (InterQual®)
- Scientific evidence from peer-reviewed publications
- FDA
- Medical device manufacturers

The following criteria must be met for coverage to be considered:

- Scientific Evidence: There is sufficient scientific evidence to permit conclusions concerning the effect of the technology on health outcomes, such as length of life, quality of life, and/or functional ability.
- Sufficient Peer Review and Acceptance: The technology has been sufficiently demonstrated by published peer-reviewed medical journals and studies, and is generally accepted by medical practitioners, either in terms of improvement in objective measures of mortality or morbidity, or in the overall quality of life and improve the health status of the members.
- Regulatory Approval: The service (e.g., medical device, drug, or biological product) has received final approval from the appropriate government regulatory bodies, such as the United States Food and Drug Administration (FDA), and is approved for the specific indication being treated. Interim approvals are not a sufficient basis for evaluation of clinical use.
- Attainable Outside Investigational Settings: The improvement achieved by the procedure is attainable outside controlled investigational research settings.
- Safety: The technology is recognized as safe and effective by the appropriate specialties of the United States medical profession for the clinical indication(s) for which it is intended.
- Not Primarily for Convenience: The procedure is not primarily for the convenience of the member or physician, but rather clinically appropriate and considered effective for the member's condition.
- Coverage of new technology is consistent with insurance industry standards.

The MyAdvocate Medicare Advantage Utilization Management Work Group is responsible for the final determination of inclusion in the benefit package for health care services, behavioral health, procedures, medical equipment, and supplies.

Utilization Management General Information

People often have misconceptions about utilization management (UM) programs. At MyAdvocate Medicare Advantage, all of our decisions are based on making sure our members have the appropriate care and services. Our utilization management professionals have no financial incentives to deny services. Our UM decision-making is based only on appropriateness of care and service and existence of coverage. We work with our affiliated providers to elevate and improve delivery of health care and to improve outcomes. Our philosophy is to provide the appropriate care at the appropriate time in the appropriate setting for the appropriate length of time. Key components of the Utilization Management program followed for our members are described below:

- Prior Authorization and Pre-Certification
- Attestation of non-compensation:
  - MyAdvocate Medicare Advantage utilization management (UM) decisions are based on nationally recognized and accepted clinical criteria and internal policy for determining appropriateness of care and availability of coverage.
  - MyAdvocate Medicare Advantage does not specifically reward providers or other individuals for issuing denials of coverage, nor does MyAdvocate Medicare Advantage make decisions regarding hiring, promoting, or terminating individuals in UM decision-making based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.
  - MyAdvocate Medicare Advantage does not have financial incentives in place for UM decision makers; therefore, UM decision makers are not encouraged to make decisions that result in underutilization.
- How to access the medical director:
  - Affiliated providers may discuss a utilization management decision with the MyAdvocate Medicare Advantage medical director by calling 888-298-4650.
- How to access utilization management criteria:
  - Physicians and nurses at MyAdvocate Medicare Advantage use clinical criteria to make coverage decisions based on medical necessity. Nationally recognized guidelines that are modified with identification of those services available within the MyAdvocate Medicare Advantage network are used to make consistent decisions. Some examples of these guidelines are: Hayes Medical Technology; Change Healthcare; InterQual Level of Care Criteria; and American Society of Addiction Medicine aa. InterQual Level of Care Criteria are used to evaluate admission into inpatient procedures and transitional services as well as for concurrent review. Hayes Medical Technology is used to identify those services that are considered to be experimental or investigational.
  - If seeing a MyAdvocate Medicare Advantage member and there are questions regarding the Change Healthcare InterQual criteria used to make a determination of coverage, call MyAdvocate Medicare Advantage and receive a copy of the criteria at 888-298-4650.
- Technology Assessment
  - Formal review process of new medical technology and new applications of existing medical technology to ensure that members have equitable access to safe and effective care.
- Medical Policies

MyAdvocate Medicare Advantage will make a final claim decision after we review the claim, verify eligibility, and determine whether the service performed is a covered benefit under the policy.

Utilization Management for Behavioral Health

MyAdvocate Medicare Advantage provides coverage of various mental health/AODA (alcohol and other drug abuse) benefits to Medicare Advantage members. These benefits are managed by MyAdvocate Medicare Advantage. Members can seek care from any affiliated provider without primary care provider referral.

Behavioral health benefits are renewed on a calendar year basis and are divided into three benefit categories:

inpatient, transitional, and outpatient services. Benefits are not interchangeable between categories.

Providers are encouraged to call Customer Service at 888-298-4650 to verify a member's eligibility and benefits. To obtain the information by fax, use the fax number 715-221-9767.

Precertifications

- Precertification is required for all behavioral health inpatient admissions and all admissions to residential treatment.
- To pre-certify inpatient admissions or transitional care services, please fax 715-221-6616 or enter the authorization request and clinicals into the provider portal.

Authorizations

- MyAdvocate Medicare Advantage members may choose to see any affiliated provider.
- ALWAYS call to verify eligibility and benefits.
- Submit claims in a timely fashion.
- MyAdvocate Medicare Advantage requires the use of CPT coding.
- MyAdvocate Medicare Advantage requires the use of ICD-10 coding.
- MyAdvocate Medicare Advantage will deny claims if ICD-10 coding is not used.
- MyAdvocate Medicare Advantage will make a final claim decision after review of the claim, eligibility determination, and determination of whether the service performed is a covered benefit under the policy.

Authorization of inpatient care admission and discharge

- Notification of emergent/urgent admissions and notification of discharge is required of the hospital within 24 hours or the next business day via fax.
- MyAdvocate Medicare Advantage Admission and Discharge fax number: 715-221-6616.
- MyAdvocate Medicare Advantage hours of operation are: Monday through Friday 8:00 a.m.-4:30 p.m. CST.

MyAdvocate Medicare Advantage provides coverage for medically necessary emergency care per the member's-contract limits. When the emergency results in an admission to an inpatient facility, MyAdvocate Medicare Advantage **requires** the following information be submitted via fax at 715-221-6616 or submitted via the provider portal. Information is required upon **admission** and **again at discharge** for authorization and payment for services. If the information is not received within the noted timeframes, payment for services will be denied to the provider. The following is the admission and discharge of information required via fax to MyAdvocate Medicare Advantage:

Admission information (within 24 hours or next business day)

- Admitting reason/symptoms
- Updated demographic sheet
- Expected length of stay

Discharge information (within 24 hours of discharge or next business day)

- Discharge plan
- Discharge diagnosis
- After care plan
- Follow up appointment information (date, provider)

Facilities may fax documents that contain the required information to Utilization Management at 715-221-6616.

Transitional services

Transitional care is defined as services that are not as intensive as hospital inpatient, but more intensive than outpatient care. Transitional services is defined as:

- Certified mental health and AODA day treatment programs.
- Certified mental health and AODA residential treatment programs (coverage is based on members benefit plan).
- Certified community support programs.
- Intensive AODA outpatient programs provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.
- Crisis intervention services.

Affiliated outpatient services do not require notification

- Individual, group, and family outpatient care does not require notification or prior authorization.

Authorizations of residential admission and discharge

- Notification of residential admission and discharge is required of the hospital within 24 hours or the next business day via fax.
- MyAdvocate Medicare Advantage Admission and Discharge fax number: 715-221-6616.
- MyAdvocate Medicare Advantage hours of operation are Monday through Friday 8:00 a.m.-4:30 p.m. CST.

MyAdvocate Medicare Advantage provides coverage for medically necessary care per the member's Evidence of Coverage.

Outpatient Services provided by an affiliated provider do not require notification.

- Individual, group, and family outpatient care does not require notification or prior authorization

Attestation of non-compensation

- MyAdvocate Medicare Advantage utilization management (UM) decisions are based on the use of nationally recognized and accepted clinical criteria and internal policy for determining appropriateness of care and availability of coverage.
- MyAdvocate Medicare Advantage does not specifically reward providers or other individuals for issuing denials of coverage.
- MyAdvocate Medicare Advantage does not have financial incentives in place for UM decision makers; therefore, UM decision makers are not encouraged to make decisions that result in underutilization.

How to access the medical director:

Affiliated providers may discuss a utilization management decision with the MyAdvocate Medicare Advantage Behavioral Health medical director by calling 888-298-4650.

Utilization Management Timeliness Standards

Medical Pre-Certification:	Non-Urgent	Retrospective	Expedited
Initial decision-making and notification	within 14 calendar days of receipt of request	within 30 calendar days of receipt of request	no later than 72 hours after receiving request
Written notification of denial to member and provider if applicable	within 14 calendar days of receipt of request	within 30 calendar days of receipt of request	no later than 72 hours after receiving request
Written notification of approval to member and provider if applicable	within 14 calendar days of receipt of request	within 30 calendar days of receipt of request	no later than 72 hours after receiving request
Pharmacy Pre-Certification:	Non-Urgent	Retrospective	Expedited
Initial decision-making and notification	no later than 72 hours after receiving request	within 30 calendar days of receipt of request	no later than 24 hours after receiving request
Written notification of denial to member and provider if applicable	no later than 72 hours after receiving request	within 30 calendar days of receipt of request	no later than 24 hours after receiving request
Written notification of approval to member and provider if applicable	no later than 72 hours after receiving request	within 30 calendar days of receipt of request	no later than 24 hours after receiving request
Verbal notification of denial to member and provider if applicable	no later than 72 hours after receiving request	No verbal notification	no later than 24 hours after receiving request