2023 Provider Manual

MEDICARE ADVANTAGE PATIENT COVERAGE

Prominence
Medicare Advantage

REV DEC22

Prominence Health Plan

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1. WELCOME

Welcome to Prominence Health Plan and thank you for choosing to participate in our network! To enhance the health and well-being of our members, Prominence is committed to building strong, positive relationships with our provider partners.

Prominence is committed to support provider efforts to deliver coordinated and appropriate health care to our members. Prominence is also committed to providing comprehensive and timely information through this Provider Manual regarding our policies and procedures. This Provider Manual was developed as a guide to assist our contracted providers. While we have tried to cover a broad range of topics, this guide is not all-encompassing and is subject to change without notice. Updates to this Provider Manual will be posted on our website at www.prominencehealthplan.com.

Phone Directory

Department	Phone Number
Member Service *Verify eligibility, benefits, claim status*	855-969-5882
General Provider Inquiries and Utilization Management	800-969-1805
Behavioral Health Utilization Management	844-540-9595
Pharmacy Benefit Manager *Verify eligibility, medication benefits, submit a prior authorization(s)*	BirdiRX 844-587-7389

2. ABOUT PROMINENCE HEALTH PLAN

Introduction

For 30 years, Prominence Health Plan has been keeping families, businesses and communities in Nevada, Florida and Texas healthy by providing health service excellence and quality care to those we serve. We offer a spectrum of products, including employer-sponsored commercial health plans, self-funded administrative services through Prominence Administrative Services, and Medicare Advantage plans.

Through close collaboration with local providers, Prominence is able to deliver better care management, while continuing our strong tradition of excellent customer service.

What makes Prominence Health Plan different?

- Prominence is committed to pay clean claims promptly and accurately, meeting all regulatory guidelines.
- Prominence is committed to operating state-of-the-art information technology for claims processing, member services, enrollment management, provider profiling and data analysis.
- Prominence has exceptionally trained Provider Relations representatives available to answer all provider inquiries.

Medicare Advantage Service Areas

- **Northern Nevada:** Carson City, Churchill, Douglas, Lyon, Storey & Washoe counties
- **Texas:** Brooks, Cameron, Cooke, Deaf Smith, Fannin, Gray, Grayson, Hidalgo, Jim Hogg, Moore, Potter, Randall, Starr, Webb & Zapata counties
- **Florida:** Palm Beach County

D-SNP Service Areas

- **Texas**: Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy & Zapata counties
- **Florida**: Palm Beach County

3. PROVIDER RESPONSIBILITIES

Introduction

This section of the Provider Manual addresses the respective responsibilities of participating providers. Our expanding network of primary care providers, as well as the growing list of specialty providers, makes it more convenient to find Prominence in your neighborhood.

Prominence does not prohibit or restrict participating providers from advising or advocating on behalf of a member about:

- The member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the member to provide an opportunity to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to refuse treatment and express preferences about future treatment decisions. An ancillary provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. A provider must ensure that individuals with disabilities are presented with effective communication on making decisions regarding treatment options.

Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations. As applicable, Prominence shall not prohibit the participating provider from providing inpatient services to a member in a contracted hospital if such services are determined by the participating provider to be medically necessary covered services under Prominence, and/or Medicare contract.

A provider's responsibility is to provide or arrange for Medically Necessary Covered Services for members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. A provider is further responsible to render Medically Necessary Covered Services to members in the same manner, availability and in accordance with the same standards of the profession as offered to the provider's other patients.

Primary Care Provider (PCP) Responsibilities

The following is a summary of responsibilities specific to Primary Care Providers who render services to members:

- Coordinate, monitor and supervise the delivery of health care services to each member who has selected the PCP for primary care services.
- Assure the availability of provider services to members in accordance with Section 3, Access and Availability of the Provider Participation Agreement.
- Arrange for on-call and after-hours coverage.
- Submit a report of an encounter for each visit where the provider services the member or the member receives a Health Plan Employer Data and Information Set (HEDIS) service.

Encounters should be submitted on a CMS 1500 form.

- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Member Service for assistance.
- Ensure members are seen for an initial office visit and assessment within the first 30 days of enrollment.
- A Provider will consider member input into proposed treatment plans.

Specialist Responsibilities

Specialists are responsible for communicating with the PCP in supporting the medical care of a member. Specialists are also responsible for treating members referred to them by the PCP.

Responsibilities of All Participating Providers

The following is an overview of responsibilities for which all participating providers are accountable. Please refer to your contract, or contact your Provider Relations Representative for clarification of any of the following:

- Assure the availability of provider services to members in accordance with Section 3, Access and Availability of the Provider Participation Agreement.
- Provide or coordinate health care services that meet generally recognized professional standards and Prominence guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.
- Use Physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Registered Nurse (APRN) may provide direct member care within the scope or practice established by the rules and State regulations and Plan guidelines.
- The sponsoring provider will assume full responsibility to the extent of the law when supervising PA's and APRN's whose scope of practice should not extend beyond statutory limitations.
- PA's and APRN's should clearly identify their titles to members, as well as to other health care professionals.
- A request by a member to be seen by a Physician, rather than a Physician extender, must be honored at all times.
- Refer members with problems outside of his/her normal scope of service for consultation and/or care to appropriate Specialists contracted with Plan (PCP's only).
- Refer members to participating Providers, except when they are not available, or in an emergency. Providers should contact the Utilization Management department in the event it is medically necessary to refer a member to a non-participating provider for continuity of care purposes.
- Admit members only to participating Hospitals, Skilled Nursing Facilities (SNF's) and other inpatient care facilities, except in an emergency.
- Respond promptly to Plan requests for medical records in order to comply with regulatory requirements, and to provide any additional information about a case in which a member has filed a grievance or appeal.
- In no event, including, but not limited to, non-payment by Prominence, breach of the Agreement, insolvency of Prominence or other financial difficulties of Prominence, shall

provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Prominence member for any fees that are the legal obligation of Prominence. Nothing in this statement is intended to interfere with the provider's ability to collect fees that are not a legal obligation of Prominence, such as member copayments or charges related to services not covered under the member's benefit plan.

- For D-SNP Members, Providers are prohibited from billing dual eligible members for Medicare cost sharing, including deductibles, coinsurance, and copayments. Providers must accept the Prominence Medicare reimbursement as payment in full for services rendered to Dual Eligible Members.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with State and Federal law.
- Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in Prominence's quality improvement guidelines. All entries in the member record must identify the date and the provider.
- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state and federal regulations concerning safety and public hygiene.
- Communicate clinical information with treating providers timely. Communication will be monitored during medical record/chart review. Upon request, provide timely transfer of clinical information to Prominence, the member or the requesting party, at no charge, unless otherwise agreed to.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not to discriminate in any manner between members and non-members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.
- A Provider will consider member input into proposed treatment plans.

Provider Licensure, Credentials & Demographic Information Changes

- Inform Prominence, in writing, within 24 hours of any revocation or suspension of his/her DEA number, and/or suspension, limitation or revocation of his/her license, certification, or other legal credential authorizing him/her to practice in the State.
- Inform Prominence ***immediately*** of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his/her status with Prominence.

Provider Availability & Accessibility

Providers agree to make necessary and appropriate arrangements to ensure the availability of services to members on a 24-hour per day, seven (7) day per week basis, including arrangements for coverage of members after hours or when the provider is otherwise unavailable.

In the event participating providers are temporarily unavailable to provide care or referral services to members, they should make arrangements with another Plan contracted and credentialed provider to provide these services on their behalf.

If a covering provider is not contracted and credentialed with Prominence, he/she must first obtain approval to treat members. The provider should be credentialed by Prominence, he/she must sign an agreement accepting the participating Provider's negotiated rate and agree not to balance bill members. For additional information, please contact your Provider Relations Representative.

Additionally, providers are to establish an appropriate appointment system to accommodate the needs of members, and shall provide timely access to appointments to comply with the following schedule:

- Urgent Care within twenty-four (24) hours of an illness;
- Sick care within one (1) week of an illness; and
- Well visit within one (1) month of an appointment request.

The provider will ensure that members with an appointment receive a professional evaluation within thirty (30) minutes of the scheduled appointment time. If a delay is unavoidable, the patient shall be informed and provided with an alternative.

Vacations

Primary Care Providers should notify Prominence, in writing, of any extended vacation/ time-off of (2) two weeks or more, and disclose the provisions made for provider coverage in the PCP's absence. The provider covering for the PCP must be a participating provider with the Plan.

Appointment Scheduling

The following criteria comply with access standards:

1. **Primary Care Providers** should:
   - Provide medical coverage 24-hours a day, seven days a week
   - Scheduled appointments should be seen within 30 minutes
   - Schedule emergent referral appointments immediately
   - Schedule routine sick care within one (1) week;
   - Schedule well visit within one (1) month.

2. **Specialty Care Providers** should:
   - Schedule well visit within one (1) month;
   - Schedule routine sick care within one (1) week;
   - Schedule urgent referral within 24 hours; and
   - Schedule emergent referral appointments immediately.

Prominence collects and performs an annual analysis of access and availability data, and measures compliance to required thresholds. The analysis can include access to:

- well visit
- sick care
- urgent care
- after-hours care

After-Hours Services

The primary care provider or covering provider should be available after regular office hours to offer advice and to assess any conditions that may require immediate care. This includes referrals to the nearest Urgent Care Center or Hospital Emergency Room in the event of a serious illness.

To assure accessibility and availability, the primary care provider should provide one of the following:

- 24-hour answering service
- Answering system with an option to page the Provider
- An advice nurse with access to the PCP or on-call Provider

Closing Provider Panel

When closing membership panel to new members, providers must:

- Submit a request in writing **60 days** prior to closing the membership panel.
- Maintain an open panel to all members who were provided services prior to closing the panel.
- Submit a written notice of the reopening of the panel, to include a specific effective date.

Prominence will assist providers in providing communication to members with disabilities or language services. Please contact Prominence Health Plan Member Service to arrange services for the deaf, blind, or those who need a language interpreter.

Provider Participating with Telemedicine

If the health plan has approved a provider to provide telemedicine services to Prominence Health members, the provider is required to have protocols in place to prevent fraud, waste and abuse. The provider must implement telemedicine fraud, waste and abuse protocols that address the following:

- Authentication and authorization of users;
- Authentication of the origin of the information;
- The prevention of unauthorized access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage.

Provider Information Changes

30-day prior notice to your Provider Relations Representative is **required** for any of the following

changes:

- Tax identification number
- Group name or affiliation
- Physical address
- Remittance address (must include W9)
- Telephone or facsimile number

Participation & Credentialing

Providers are accepted for participation after being approved by Prominence's credentialing process. Prominence does not discriminate or make credentialing decisions based on applicant's race, creed ethnic/national identity, gender, age or sexual orientation, or on type of procedure or patient in which the provider specializes.

Participating providers are required to notify Prominence immediately when a new provider joins their practice. Notify the local Provider Relations Representative and the representative will send an application for completion. Please see the Credentialing Overview Section to learn more about our credentialing requirements.

Provider Termination

Refer to the participation agreement for provider termination language and terms.

Continuation of Care – Terminated Provider

Prominence will provide continued services to members undergoing a course of treatment by a provider that no longer participates with Prominence, if the following conditions exist at the time of contract termination:

- Such care is medically necessary. Continued care is allowed through the completion of treatment, until the member selects another treating provider, or until the next Open Enrollment period – not to exceed three (3) months after the termination of the provider's contract.

- Continuation of care through the postpartum period for members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated with a terminated treating provider.

For continued care under this subsection, Prominence and terminated provider continue to abide by the same terms and conditions as existed in the terminated contract. However, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

This subsection does not apply to providers terminated from Prominence for cause.

Utilization Management & Quality Management Programs (UM/QA)

The Plan has UM/QM programs that include consultation and collaboration with requesting providers when appropriate. Under the terms of the contract for participation with Prominence's

network, providers agree, in addition to complying with state and federal mandated procedures, to cooperate and participate in Prominence's UM/QM programs, including quality of care evaluation, peer review process, evaluation of medical records, provider or member grievance procedures, external audit systems and administrative review.

Further, to comply with all final determinations rendered pursuant to the proceedings of the UM/QM programs, all participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section.

Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Preferred Drug List

Please refer to the Pharmacy Section of this manual for a description of Prominence's Preferred Drug List and prescribing criteria. Please contact your Provider Relations Representative for a copy of the Preferred Drug List or visit www.ProminenceMedicare.com.

Confidential Member Information & Release of Medical Records

All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with the HIPAA Privacy and Security Rules established on April 14, 2003. All provider practice personnel must be trained on privacy and security rules.

The Practice should ensure that there is a Privacy Officer on staff, that a policy and procedure is in place for confidentiality of member's protected health information and that the Practice is following procedure or obtaining appropriate authorization from members to release protected health information.

All members have a right to confidentiality. Any health care professional or person who directly or indirectly handles the member or his/her medical record must honor this right. Every practice is required to post their Notice of Privacy Practice in the office or provide a copy to members.

Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Confidential Information includes:

1) Any communication between a member and a provider; and
2) Any communication with other clinical persons involved in the member's health, medical and mental care.

Included in this category are:

1) All clinical data, i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number, etc.;
2) Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
3) Any communicable disease (such as AIDS) or HIV testing protected under federal or state law.

When a member enrolls in Prominence, his/her signature on the Enrollment Form automatically gives the healthcare provider permission to release his/her medical record to Prominence, other providers in Prominence's network who are directly involved with the member's treatment plan and agencies conducting regulatory or accreditation reviews.

Before any individual not working for Prominence can gain access to the member's medical record, written authorization must be obtained from the member, member's guardian or his/her legally authorized representative (except when there is a statute governing access to the record, a subpoena or a court order involved). Disclosures without authorization or consent may include, but are not limited to Armed Services Personnel, Attorneys, Law Enforcement Officers, Relatives, Third Party Payers, and Public Health Officials. All disclosures must be made within accordance of the HIPAA guidelines and Privacy Rule.

Health Assessment

A health assessment is performed by a provider to assess the health status of a patient. It is used to detect and prevent disease, disability and other health conditions or monitor their progression. This is an all-inclusive service.

Prominence allows one Annual Wellness Exam and one Annual Comprehensive Physical Exam in a 12-month period, performed by a PCP, at no cost to the member. The Wellness Exam and the Comprehensive Exam may be performed on the same date of service, by the same PCP, as long as documentation of the services is provided in the medical records.

Disease Specific Assessment

When a Medicare member states he/she has one of the diseases listed below, the Care Manager further assesses the condition to determine the level of wellness in each of the specific diseases. A care plan is developed with goals and interventions to help the member achieve self-management of their chronic conditions.

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Cardiovascular Disease
- Congestive Heart Failure

Required Service Components

A PCP who provides health assessments must be able to provide or refer and coordinate the provision of all required screening components. These components must be documented in the member's medical record.

Required components:

1. *Health History*
   At a minimum, the following items must be documented in the member's medical record:

- Present history
- Past history
- Family history
- A list of all known risk factors, allergies and medications, and
- Nutritional assessments

2. *Physical Examination*
   At a minimum, the following items must be documented in the member's medical record:
   - Measurements of height, weight, blood pressure, body mass index; and
   - Physical inspection to include: assessment of general appearance, skin, eyes, ears, nose, throat, teeth, thyroid, heart, lungs, abdomen, breasts, extremities; and a pelvic, testicular, rectal and prostate exam, per gender, as appropriate.

3. *Visual Acuity Testing*
   At a minimum, the testing must document a recipient's ability to see at 20 feet.

4. *Hearing Screen*
   At a minimum, the screen must document a recipient's ability to hear by air conduction.

5. *Required Laboratory Testing*
   At a minimum, the following are required and are included in the reimbursement of an adult health screening:
   - Urinalysis dipstick for blood, sugar and acetone; and
   - Hemoglobin or hematocrit

   Manual or automated dipstick urine, hemoglobin and hematocrit tests performed during an adult health screening are not reimbursable as separate services from the adult health screening.

Recommended service components:

1. *Mammography Screening*
   The American Cancer Society recommends referral for routine screening mammography for all females ages 35 and older. Mammography screening guidelines are as follows:
   - Ages 35 to 39, one screening baseline mammogram; and
   - Ages 40 and older, one screening mammogram every year.

   A screening mammogram is limited to one per year. A diagnostic mammogram used to evaluate or monitor an abnormal finding may be performed more than once a year.

2. *Laboratory Procedures*
   The following laboratory procedures are recommended, when indicated:
   - Stool for occult blood;
   - Tuberculin skin test (can be reimbursed in addition to the adult health screening);
   - Collection of cervical pap smear for sexually active females or all females 18 years old and

older;
- Collection of prostatic surface antigen (PSA), if indicated for males 50 years old and older; and
- Collection of specimens for sexually transmitted diseases.

Cultural Competency

Cultural competency is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals, to work effectively in cross-cultural situations.

Cultural competency occurs in both clinical and non-clinical areas. In the clinical area, it is based on the patient-provider relationship. In the non-clinical arena, it involves organizational policies and interactions that impact health care services.

Anti-Discrimination Rule

Providers may not refuse to serve Medicare members because they receive assistance with Medicare cost-sharing from a State Medicaid program. (Medicare Managed Care Manual, Ch. 4, Section 10.5.2)

Member Rights & Responsibilities

Prominence strongly endorses the rights of members as supported by State and Federal laws. Prominence also expects members to be responsible for certain aspects of the care and treatment they are offered and receive.

All member rights and responsibilities are to be acknowledged and honored by Prominence staff and all contracted providers. Contracted providers are provided with a declaration of Prominence Health member rights and responsibilities in this manual. In addition, providers are given a handout of these rights and responsibilities and are urged to post them in their respective offices.

Members are afforded a listing of their rights and responsibilities as a member in their Prominence Health Plan *Evidence of Coverage*. Member Rights and Responsibilities are posted on Prominence's website at: www.ProminenceMedicare.com

Advance Medical Directives

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. The law provides that each member (age 18 years or older of sound mind) should obtain information concerning this provision and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance. Members may also designate another person or designee to make a decision should they become mentally or physically incapacitated. If a member has executed advance directives, this should be noted in a prominent location in the member's medical file. Providers should request a copy of the executed advance directive to maintain in the medical record.

Network Providers are required to maintain written policies and procedures with respect to the following:

- Documenting in a prominent part of the enrollee's current medical record whether or not the enrollee has executed an Advance Directive;
- Not conditioning the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an Advance Directive;
- Ensuring compliance with requirements of state law (whether statutory or recognized by the courts of the State) regarding an Advance Directive;
- Providing for education of staff concerning its policies and procedures on Advance Directives;
- Providing for community education regarding advance directives that may include material required in 42CFR § 422.128, either directly or in concert with other providers or entities; and
- Ensuring that facilities including hospitals, SNFs, home health agencies, hospice programs and Community-based health service providers give written information on Advance Directives required in 42 CFR § 422.128 to the enrollee, their family or surrogate at the time of admission or enrollment.

Fraud, Waste & Abuse Program

Prominence Health Plan, as a Medicare Advantage Organization (MAO) under contract with the Centers for Medicare and Medicaid Services (CMS), is required to have an effective fraud, waste and abuse (FWA) program. Prominence's FWA program is designed to detect, correct and prevent fraud, waste and abuse by providers.

- **Fraud** is an intentional act of deception, misrepresentation, or concealment by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. **Fraud often involves criminal behavior**.

- **Waste** occurs when **poor or inefficient practices** or the over-use of services that result in unnecessary costs.

- **Abuse** involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse often involves actions which are inconsistent with accepted medical and/or business practices.

Providers engaged in fraud, waste or abuse may be subject to disciplinary and corrective actions, including but not limited to, payment recoupments, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, civil and/or criminal prosecution, fines and other penalties.

Components of the FWA Program

I. Detection and Prevention
   a. Prominence will use procedures to identify and prevent fraud, waste or abuse, including but not limited to data mining and rule-based analysis of provider, facility, pharmacy and member claims data. Patterns of over-utilization, false claims or other unusual billing practices are reviewed.
   b. Investigation procedures include review and analysis of medical records and claims as evidence, in addition to interviews of related parties.
   c. Upon completion of a review, the provider, facility, pharmacy or member will receive an Audit Findings Report detailing the findings and any applicable disciplinary or corrective actions, including any overpayments identified.
   d. The provider will have two opportunities to appeal the findings of the review.

II. Recovery of Duplicate Payments or Overpayments
   Overpayments are funds that a provider, facility, or member has received that exceeds the amount due and payable under the member's benefit plan and/or terms of the provider contract. In the event that an overpayment or duplicate payment is identified, Prominence will offset the overpayment amount against future claim payments in accordance with its agreement and applicable laws.

III. Education
   The Audit Findings Report provided at the completion of the review will detail the findings of the review to educate the provider, pharmacy, or member on any identified fraud, waste, abuse, or errors in billing and coding. Additional industry guidelines and regulations may also be referenced and provided with the report.

IV. Monitoring
   Follow up monitoring will be performed to ensure providers implement required document and/or billing changes. If provider fails to improve, additional reviews, disciplinary actions or termination may occur.

Pertinent Statutes, Laws & Regulations

False Claims Act

The Federal False Claims Act 1985 permits a person with knowledge of fraud against the United States Government, referred to as the "qui tam plaintiff," to file a lawsuit on behalf of the Government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the federal False Claims Act.

A claim is broadly defined to include any submissions that results, or could result, in payment. Claims

submitted to the government includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

Liability can also be created by the improper retention of overpayment.

Examples include:

- A provider who submits a bill for medical services not provided.
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.

Whistleblower & Whistleblower Protections

The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as whistleblowers. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs.
The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Examples include:

- A frequent flyer campaign in which a provider may be given a credit toward airline frequent flyer mileage for each questionnaire completed for a new patient place on a drug company's product.
- Free laboratory testing offered to health care providers, their families and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare programs.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

HIPAA Privacy - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.

HIPAA Security - The Security Rule outlines specific protections and safeguards for electronic PHI.

If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Any loss or inappropriate disclosure of data is presumed to be a breach unless the office can show there is a low probability the information will be used improperly.

Potential FWA committed by Pharmaceutical Manufacturer

- Illegal Off-label Promotion - Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns;
- Illegal Usage of Free Samples - Providing free samples to providers knowing and expecting those providers to bill the federal health care programs for the sample;
- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment or supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using all-inclusive code);
- Failure to properly code using coding modifiers;
- Altering medical records;
- Improper telemarketing practices;
- Compensation programs that offer incentives for items or services ordered and revenue generated;
- Inappropriate use of place of service codes;
- Routine waivers of deductibles/ coinsurance;
- Clustering; and
- Upcoding the level of service provided.

Potential FWA committed by Skilled Nursing Facility ("SNF")

- SNFs improperly upcoding resident RUGs assignments to gain higher reimbursement;
- SNF improperly utilizing therapy services to inflate the severity of the RUG classification to obtain additional reimbursement; and
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the SNF's payment.

Hospital

- Failure to follow the same day rule;
- Abuse of partial hospitalization payments;
- Same day discharges and readmissions;
- Improper billing for observation services;
- Improper reporting of pass through costs;
- Billing on an outpatient basis for inpatient only procedures;
- Submitting claims for medically unnecessary services by failing to follow local policies; and
- Improper claims for cardiac rehabilitation services.

Potential FWA committed by Provider and Others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining Medicare payments;
- A psychiatrist billing Medicare, Prominence, and private insurers for psychiatric services that were provided by his nurses rather than himself;
- Provider certifies on a claim form that he performed laser surgery on a Medicare beneficiary when he knew that the surgery was not actually performed on the patient;
- Provider instructs his employees to tell the OIG investigators that the provider personally performs all treatments when, in fact, medical technicians do the majority of the treatment and the provider is rarely present in the office;
- Provider, who is under investigation by the FBI and Prominence, alters records in an attempt to cover up improprieties;
- Neurologist knowingly submits electronic claims to the Medicare carrier for tests that were not reasonable and necessary and intentionally upcoded office visits and electromyograms to Medicare;
- Podiatrist knowingly submits claims to the Medicare programs for non-routine surgical procedures when he actually performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses; and
- Performing tests on a beneficiary to establish medical necessity.

Potential FWA committed by Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary;
- Continued billing for rental items after they are no longer medically necessary;
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed;
- Providing and/or billing for substantially excessive amounts of DME items or supplies;
- Upcoding a DME item by selecting a code that is not the most appropriate;
- Providing a wheelchair and billing for the individual parts (unbundling);
- Delivering or billing for certain items or supplies prior to receiving a provider's order and/or appropriate certificate of necessity;
- Completing portions of the certificate of necessity that is reserved for completion by the

treating provider only;
- Cover letters to encourage providers to order medically unnecessary items or services;
- Improper use of ZX modifier;
- Providing false information on the DMEPOS supplier enrollment form;
- Knowing misuse of a supplier number, which results in improper billing;
- Furnishing more visits than as medically necessary;
- Duplicate billing for the same service;
- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service;
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's State licensure;
- Providing services at no charge to an assisted living center

Plan's Processes for Identification of Fraud Waste and Abuse

The Plan has software and monitoring programs designed to identify indicators for fraud and abuse, including, but not limited to:

- Multiple billing: Several payers billed for the same services (e.g. billing medications under Part A or Part B and then billing again under Part D;
- Billing for non-covered services;
- Duplicate Billing;
- Unbundling of charges;
- Up-coding;
- Fictitious providers;
- Billing of unauthorized services;
- Billing with the wrong place of service in order to receive a higher level of reimbursement;
- Claims data mining to identify outliers in billing;
- Billing for services or supplies not provided;
- Improper use of ZX modifier;
- Failure to follow the same day rule (hospital);
- Abuse of partial hospitalization payments; or
- Billing on an outpatient basis for inpatient only procedures.

Reporting Obligation and Mechanisms

If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it.

Providers, Vendors and Delegates can call Prominence's Compliance Hotline at 800-852-3449.

Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

The Plan will notify the CMS Regional office of any issues that involve Medicare members.

Resources

CMS' Prescription Drug Benefit Manual – Chapter 9:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf

Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504):
http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf

Office of the Inspector General: http://www.oig.hhs.gov/fraud.asp

Medicare learning Network (MLN) Fraud and Abuse Job Aid:
http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf

4. CREDENTIALING

Introduction

Review and approval through Prominence's credentialing process is required for network provider participation. During this process, the credentialing application is reviewed against Prominence's policies and procedures and the provider's credentials are verified. Any issues identified such as malpractice claims history, licensure sanction or Medicare sanction is reviewed by the Credentialing Committee, which is the Peer Review Committee of Prominence. It is the provider's responsibility to fully complete the entire credentialing application and supply a written explanation to any item of negative information. Acceptable credentialing applications include the Council for Affordable Quality Healthcare (CAQH) application and the state mandated standardized Credentialing Application. The CAQH application must have a current attestation and be updated with all supporting documents. An application cannot be processed until all areas are completed and all documents are provided. Further, a site inspection evaluation is required for all Primary Care Providers and OB/GYN specialists.

Please note that providers have the following rights in connection with the credentialing process:
The right to review information submitted to support their credentialing application:
Upon request to Credentialing, a provider has the right to review information that is obtained by Prominence from outside sources and which it uses to evaluate the credentialing application. The exception to the information that may be reviewed is peer references and information that is peer review protected.

The right to correct erroneous information:
When information is obtained by Prominence from other sources, and the information substantially varies from that supplied by the provider, in accordance with Credentialing Policy CR 1 Prominence will notify the provider of the right to correct the erroneous information; provide the timeframe for making the changes; the format for submitting the changes; and the name of the person to whom, and the location where the corrected information must be sent.

The right to receive the status of their credentialing or re-credentialing application upon request:
The Plan will respond to a provider's request for status on their credentialing application within fifteen (15) business days. The information provided will advise of any items still needed, or any difficulty or non-response in obtaining a verification response.

The application is then taken through the initial credentialing process and brought to the Credentialing Committee (composed of practicing providers credentialed by Prominence). Any request by the Credentialing Committee for additional information will be immediately requested from the provider. Providers are initially credentialed for a 36-month credentialing period, after which re-credentialing is required. Periodically, Prominence may request updates for expired documentation such as malpractice insurance. If there are changes to any of the information/documentation submitted in support of the application such as board certification status, please let Prominence know.

Credentialed Providers

The following licensed provider types are required to be credentialed in order to provide medical services to Prominence Health members. The provider types include, but are not limited to:

- Medical Doctors (MDs)
- Osteopathic Doctors (DOs)
- Podiatric Doctors (DPMs)
- Chiropractic Doctors (DCs)
- Optometric Doctors (ODs)
- Oral Surgeons (DMDs or DDS')
- Psychologists (PhDs)
- Advanced Practice Registered Nurse (APRN)
- Physician Assistants (PA)
- Certified Nurse Midwife (CNM)
- Licensed Midwives
- Audiologists (AuD)
- Physical Therapists (PTs) - if contracting directly with Prominence. If through an accredited facility, then only the facility needs to be credentialed.
- Occupational Therapists (OT) - Same as PT
- Speech Pathologist (SP) - Same as PT
- Licensed Clinical Social Workers (LCSW)
- Masters in Social Work (MSW)
- Licensed Marriage and Family Therapists (LMFT's)
- Registered Dietician (RD)
- Oriental Medicine (OMD)
- Behavior Analyst

Prominence also credentials Facilities and Ancillary Providers. An Application/Data Collection Form and the following supporting documents are required but are not limited to:

- AHCA Certificate;
- CMS Certificate Accreditation Certificate; and
- General insurances.

Examples of Facilities and Ancillary Providers are, but are not limited to:

- Hospitals
- Ambulatory Surgery Centers (ASC)
- Skilled Nursing Facilities (SNF)
- Diagnostic Facilities
- Inpatient Hospice Facilities
- Dialysis Centers
- Home Health Agencies
- Nursing Homes
- Durable Medical Equipment (DME) providers
- Comprehensive Outpatient Rehabilitation Facilities

- Outpatient Physical, Occupational and Speech Therapy (PT, OT, ST) Facilities
- Inpatient Behavioral Facility
- Long Term Acute Care (LTAC)

NOTE: (a) Hospital based providers are not required to be credentialed/re-credentialed by Prominence; (b) Health Plan requires a signed collaboration statement from supervising M.D. for APRN's and PA's, regardless of the state statute.

Initial Credentialing Process

The Initial Credentialing Process is as follows:

Step 1. The provider fully completes all necessary sections of the credentialing application/form and submits the required documents to Prominence. PCP and OB/GYN Specialists will need to participate in a Site Inspection Evaluation.

Step 2. Primary source verification is performed concerning education, training, board certification, licenses and other submitted documents and information.

Step 3. The Medical Director reviews files prior to the next scheduled meeting and may ask for additional explanations if deemed necessary prior to the application being presented to the Credentialing Committee.

Step 4. The provider's file is then presented to the Credentialing Committee.

Step 5. If approved, the file is noted accordingly and proceeds to step 6. If additional information is requested by the Committee, the request is conveyed to the provider and the file is placed in a pending status, awaiting the requested information. Once received, the Committee will re-evaluate the application.

Step 6. Upon approval, the provider information is loaded into the Prominence database for purposes of claims payment and directory listing.

Step 7. The provider is notified in writing of their credentialed status and the effective date of their contract within 60 calendar days following the Committee's decision.

Step 8. The assigned provider relations representative will conduct an in-service visit with the provider and selected staff.

The credentialing process takes approximately 90-days from receipt of complete application through presentation to the Credentialing Committee.

Re-Credentialing

Credentialed providers must be re-credentialed every thirty-six months. The Credentialing Department establishes this date as 36 months following the provider's approval. The provider

will be notified approximately 120 days prior to the expiration of credentialing. The re-credentialing review process is similar to the initial credentialing process and includes the following:

- Completion of a re-credentialing application or CAQH application
- Verification is performed concerning licenses, board certifications and other submitted documents and information;
- Internal Plan information from provider Services, Member Services, Complaints/Grievances and Quality Management, as applicable.

If a provider fails to return the re-credentialing application in a timely fashion and their credentialing period lapses, the provider may not render services to a member until the initial credentialing process is completed.

Liability Insurance

Prominence credentialing policies concerning liability coverage conform to State Statutes. In the absence of evidence of professional Liability Insurance, providers will be asked for their State financial responsibility form as part of their credentialing packet. This will allow Prominence to confirm compliance with these guidelines.

Upon request, a provider must provide Prominence with evidence of liability coverage and any renewals, replacements or changes.

Updated Documents

Prominence is required to maintain documentation/verification of certain documents that expire throughout the provider's participation with Prominence. These documents include but are not limited to medical license and board certification.

Ongoing Monitoring

After a provider is approved for participation in Prominence, ongoing monitoring of the providers credentials is performed in accordance with Federal, State and NCQA Accreditation requirements.

Ongoing monitoring involves monthly/quarterly review of the following:

- Licensure Sanctions
- OIG Sanctions
- The Excluded Parties Listing System EPLS Sanctions
- Medicare Opt-Out
- Medicare Preclusion List
- Report of providers exceeding the Complaint Volume thresholds

In the event a provider via monitoring process is identified as being removed from participation in Medicare, is excluded via the EPLS, has Opted Out of Medicare, or is included on the Medicare Preclusion List, provider is automatically ineligible to participate with Prominence, and is notified accordingly.

Providers identified with a state licensure sanction that does not remove licensure are requested to provide full information to Prominence, and the information is then reviewed by the Medical Director/Credentialing Committee for acceptance.

When the provider is identified as meeting or exceeding the member compliant volume threshold set by Prominence for receiving member complaints, the provider is notified via letter, and a follow-up from provider relations is made. In the event member complaints exceed Prominence's threshold specific to office site quality, a satisfactory site inspection evaluation is required, and the evaluation is performed by Provider Relations. Information is then submitted to the Medical Director/Credentialing Committee for review and acceptance.

Provider Appeal Rights – Non-Approval of Credentialing

In the event the Committee denies a provider's credentialing, the provider has the right to appeal the decision within 30 days of receiving the denial notice. The appeal rights are provided by the Medical Director, as Chairman of the Credentialing Committee and the notification letter will specify the reason for the non-approval. All credentialing appeals are held in accordance with Prominence's internal policies and procedures.

Provider Appeal Rights

In the event Prominence makes an adverse participation decision against a participating provider for reasons of quality of care or conduct, the affected provider will be notified in writing within 30-days of the adverse decision and will be provided notice of rights to appeal. The letter will specify the reason for the adverse determination and will include if relevant the data used to evaluate the provider. The letter will include the timeframe of 30-days from the provider's receipt of Prominence's letter for an appeal request to be submitted to Prominence; the name of the person to whom the appeal should be submitted; the provider's right to submit any additional information in support of the appeal; and the right to representation by an attorney. If an appeal is requested, the date, time and place where the appeal will be heard will also be provided.

Providers that receive a final termination decision for a validated quality of care issue will be reported to the State Licensure Board and to the National provider Data Bank in accordance with State and Federal requirements.

Information concerning providers denied credentialing is sent to the appropriate State agency as required by state Statue.

5. MEMBER ELIGIBILITY & SERVICES

Member Services

The primary purpose of Prominence's Member Services Department is to answer questions and attempt to resolve issues, problems and concerns raised by members.

Beginning October 1 through March 31 our office is open 7 days a week from 8 a.m. until 8 p.m. From April 1 through September 30 the office is open Monday through Friday from 8 a.m. until 5 p.m.

The Member Services Department can be contacted at 855-969-5882; members with hearing and/or speech impairments should call our toll-free TTY line at 711. We also encourage the use of our website at www.ProminenceMedicare.com.

Members and providers may contact Member Services to:

- Change a primary care provider
- Learn about authorizations
- Dis-enroll from Prominence
- Obtain a new identification card
- Find participating pharmacies
- Verify member eligibility
- Ask co-payment, coinsurance and deductible questions
- Inquire about claims payment
- Learn more regarding member benefits for Medicare Advantage
- File a member complaint/grievance
- Notify Prominence of a change in information – new address, phone number or other personal information
- Receive member assistance with the Appeals and Grievance process.

Staff Selection and Training

The Member Services Department is committed to hiring highly qualified individuals, providing top-notch training and monitoring activities to support attainment of Prominence's service commitments. Telephone calls are monitored to maintain standards regarding information accuracy, timely follow-up and member service attitudes.

Service Standards

The Member Services Department is designed to address issues, solve problems, answer questions and listen to concerns from members and Providers. Our service commitments are to:

1) Answer calls within 30 seconds;
2) Respond to voice mail messages within 24 business hours; and
3) Respond to urgent calls within one (1) hour.

Prominence will track the types of issues that you and your staff bring to our attention so that we

may correct any underlying problems.

Member Identification Card

Each member will receive an identification card that allows them access to receive services from the Prominence network of participating Providers. A sample of the Prominence identification card for each product is available on the Prominence website. Providers should ask to see the member identification card at each scheduled appointment.

Some important points to remember:

- The practice should make a copy of both sides of the identification card for their member medical record;
- For purposes of privacy, the identification card has a *unique* member number used for most transactions;
- The identification card lists the most common co-payments, co-insurance, and deductible amounts;
- The identification card lists the toll-free Member Service's telephone number;
- The identification card has the address to mail claims;
- The identification card does not reflect the effective date of the provider; it is the effective date the member became effective with Prominence; and
- The Provider can always verify eligibility by requesting to see the member identification card **each time** the member has an appointment. The member should also be asked if there have been any changes since their previous appointment.

Member Transfers

The following guidelines apply to the transfer of a member, **upon his/her request**, from one Primary Care office to another:

- The member's decision to transfer should be **strictly voluntary**;
- The member **must not** have been directly recruited by phone or in person by anyone involved with the Primary Care office;
- The member **must not** have been influenced to transfer to or out of the office due to improper/incorrect information or for medical reasons; and
- Upon the member's request and completion of a *Medical Record Release* Form, the office is **required to** send his/her medical records to the newly selected Primary Care office.

Methods of Eligibility Verification

Providers will have up to three (3) methods to verify member eligibility:

1. *Provider Portal* – Prominence has a Web portal to verify member eligibility, benefits and claims status quickly and efficiently.
2. *Member Services* – Member Services Department staff are available to verify member eligibility toll free at 855-969-5882, from October 1 through March 31, 7 days a week from 8 a.m. until 8 p.m. and from April 1 through September 30, Monday through Friday from 8 a.m. until 5 p.m.

3. *Application Form* – For new members who have not yet received their identification card with the New Member Packet, a copy of their application form will suffice as a form of eligibility verification. We do encourage that network Providers use a second form of verification under these circumstances for non-urgent medical services. This is only applicable to Medicare members.

For questions regarding the Web Portal, please contact your local Provider Relations Representative.

6. UTILIZATION MANAGEMENT DEPARTMENT

Introduction

The Utilization Management (UM) Department is involved in the coordination of care for our members. The roles of the department include utilization review of Prior Authorization requests, concurrent review of members admitted in a facility (acute, LTAC, skilled nursing etc.), disease management (especially for members with high-risk diseases such as diabetes and congestive heart failure) and case management (for members that are high risk due to chronic medical conditions and/or Social Determinates of Health or non-compliance).

The UM Department works closely with provider offices and members to help coordinate care and enhance member adherence to the treatment plan. This includes gathering clinical information from provider offices. All hospitalized members receive a call following discharge to ensure they have all post-discharge medication, equipment and nursing assistance, if required. Prominence encourages members to see their primary care provider within 5 days of discharge from an inpatient stay. The UM Department is also available to assist your office regarding any questions related to the Prior Authorization Request process and case/disease management.

eviCore Healthcare

In our continuing effort to improve the quality of care for our health plan members, Prominence partners with eviCore Healthcare for Nevada Medicare Advantage members. Below are the services that require prior authorization managed by eviCore:

- Radiology
- Cardiology
- Gastroenterology
- Spine Surgery Management
- Joint Surgery Management
- Interventional Pain Management
- Physical Therapy
- Occupational Therapy
- Durable Medical Equipment

To request an authorization:

- Log onto www.evicore.com/pages/ProviderLogin.aspx (preferred)
- Call: 844.303.8454
- Fax:
    - Radiology, Cardiology, Gastroenterology: 800.540.2406
    - Physical Therapy, Occupational Therapy: 855.774.1319
    - Durable Medical Equipment: 866.663.7740

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please submit a request online at www.evicore.com and indicate that the procedure is

NOT routine/standard. Providers can also initiate urgent requests by call our toll-free number at 844.303.8454. Be sure to tell our representative that the request is for medically urgent care.

eviCore healthcare's Clinical Guidelines and request forms are available at www.eviCore.com. Please call the Client and Provider Services department at 800.646.0418 (Option 4) if you have any questions or need more information.

Department Philosophy

The Utilization Management Department's goal is to create partnerships with health care physicians, providers and members that result in the following:

1. Avoidance of acute illnesses and diseases through prevention and/or early detection of medical problems;
2. Enhancement and improvement of general levels of health and fitness;
3. Enabling of members through education, to develop awareness of the importance of prevention and health maintenance as key to general health and fitness; and
4. Assistance for members in understanding their partnership role with health providers.

The Department will strive to achieve these objectives through three methods:

1. Development of an efficient utilization management program as outlined below;
2. Developing strong disease management and lifestyle change programs; and
3. Establishing effective case management programs focused on interventions for potential or existing catastrophic medical situations.

UM Staff Availability

The Utilization Management (UM) department will be available for all Prior Authorization requests from 8 a.m. to 5 p.m. PST on weekdays (excluding holidays).

Contact Information

The Prominence Utilization Management (UM) department may be contacted at:

Prominence Health Plan
Utilization Management Department
P.O. Box 981748
El Paso, TX 79998-1748

Telephone: 800-969-1805
Fax: 775-770-9027

Prior Authorization General Information

The Utilization Management Program is for Medicare Advantage members. The Plan practices the Medical Home Office model in a majority of its counties. It is not required that enrolled members seek a referral from the Primary Care Provider (PCP) before receiving services from a Specialist or other medical provider. However, we strongly encourage the PCP to coordinate care for their

patients and are aware of specialty care the member may receive. The PCP or specialists are responsible for submitting all Prior Authorization requests (see Prior Authorizations) to Prominence.

The timeframes for response for requests are as follows:

- *Standard Requests:* Are processed within 14 calendar days. The department processes all authorization as expeditiously as the member's health condition requires.

- *Expedited/STAT Requests*: Expedited requests are defined by Medicare as one where applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. These requests must be completed and the member notified within 72 hours from the time we receive the request at Prominence. In order for our Prior Authorization request staff to continue to process all requests for service quickly, we ask that you please review all requests your office submits before you write STAT, URGENT, ASAP or EXPEDITED. You can obtain an expedited determination for all services that meet the above definition in **one of two ways**:
    - Submit the prior authorization via the Provider Portal at www.Promeniencehealthplan.com. This is the fastest why to have your request processed.
    - You can use the *Prior Authorization Request* form. There is a section for the provider to confirm the request meets the definition of Expedited. The confirmation will be the provider's signature and a brief note indicating his/her reason why the service requested meets the above Expedite definition; or
    - You as a provider can contact the Utilization Management team anytime to discuss a case by calling 800-969-1605.

Referral Process

Although the Health Plan does not require it, Specialists may require a referral from the PCP due to their own internal processes. Prominence does have an option of submitting a referral through the Provider Portal at www.ProminenceHealthPlan.com.

Out-Of-Network Referrals

Prominence recognizes that there may be instances when an out-of-network referral is justified. Utilization Management will work with the PCP to find appropriate out-of-network providers when medical necessity for services has been determined. Out-of-network referrals will be authorized on a limited basis. Utilization Management may be contacted at 775-770-1500 for questions regarding referrals to out-of-network providers.

Prior Authorizations

Prior Authorization Request Process

Providers may request authorizations via three ways:

1. **Provider Portal** – Providers can enter a request via the Portal directly. This is the fastest

way to have your request processed. You will be guided within the Portal on what information is necessary and once submitted can follow along as to where the authorization is in reference to the process. Visit www.ProminenceProvider.com to access the portal.

2. **Fax a Prior Authorization Request** – A provider may utilize the Prior Authorization form; fill out the form in its entirety and fax it into the office. If all the required information is submitted you will be notified via fax of the approval/denial. If further information is required, you will be contacted.
3. **Telephone Prior Authorization Request** – For Expedited requests, a Provider may call directly into the office and submit a request via phone. Provider's will be asked to fax in the appropriate clinical documentation that supports the request to make an appropriate final decision.

Status of a Prior Authorization Request

A provider may determine the status of an authorization in two ways:

- Access Prominence's Provider Portal. Here you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations Representative for assistance.
- Call the UM department during normal business hours, 8 a.m. to 5 p.m. PST on weekdays, to check the status of a request or;

Members may also contact Member Services to receive information regarding a requested service.

Member Request to Plan for Decision on Services

Medicare mandates that all members have the right to contact the Health Plan directly to request a decision on a service they believe the Health Plan (or Medicare) should provide or pay for. This is considered a request for an organization determination and Prominence must review and respond to this request as it would from any provider.

Member Requesting Specialist visits, diagnostic procedures, or therapeutic treatments

- Member has not spoken to PCP:
  - If a member informs Prominence they want to have a service and they have not spoken with their PCP about this request, Member Services will direct the member to make an appointment with the office to discuss this service.
- Member has spoken with PCP:
  - If the member informs Prominence they have already spoken with the office about this service, our Member Services Department will send this information to the UM Department in order to begin the decision process:
    - UM will call and fax the PCP office three times about this request and inform the office what service(s) the member is requesting. The PCP must respond within two (2) calendar days for a standard request and same day if the request is expedited.
    - A final decision will be made on standard requests within fourteen (14) calendar days and as expeditiously as the member's health condition requires or for expedited requests within seventy-two (72) hours of the request. The decision will be based on information provided and Prominence Medical Director will make a determination of

whether to approve or deny the service.
- The final determination will be communicated to the member and the PCP either orally or in writing depending on the decision.

Criteria

The UM department utilizes the following criteria when making a determination:

- Center for Medicare and Medicaid (CMS) Local and National Coverage Determinations
- MCG (Milliman Care Guidelines)
- Hayes Medical Technology

Local Health Plan Coverage Guidelines - for a copy of the specific UM Review Criteria, please contact the UM department, Monday through Friday, from 8 a.m. to 5 p.m. PST.

The Plan's Medical Director also has access to an external independent review agency consisting of board-certified specialists for consultation on issues that fall outside of his/her expertise.

Medically Necessary Services or Medical Necessity – Services provided in accordance with 42 CFR Section 440.230 and as defined in Section 59G-1.010(166), F.A.C., to include that medical or allied care, goods or services furnished or ordered must:

A. Meet the following conditions:
   1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
   2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
   3. Be consistent with the generally accepted professional medical standards as determined by the program, and not experimental or investigational;
   4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
   5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

B. "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

C. The fact that a provider has prescribed, recommended, or approved medical or allied goods or services, does not make such care, goods or services medically necessary, a medical necessity or a covered service.

Approved Requests - When a Prior Authorization Request is approved, an *Authorization Notification* will be faxed to the PCP and the requesting provider(s). This notice will contain the valid time frame of the authorization, the date of the decision, who requested the authorization, who is authorized to provide the services and which services were authorized. The PCP or provider is delegated the responsibility of notifying the member of the approval and arrange the needed services.

Pended Requests - When the Prior Authorization Request is Pended, the UM department may contact the provider to gather additional information. The requests will be either verbal or faxed to the provider's office, labeled:

- 1st Request for Information
- 2nd Request for Information
- Each request has a specific time frame for response and will also inform the provider of what is required. If the provider does not respond to both requests and the Medical Director is unable to make a decision, the appropriate Denial Letter will be mailed to the member and faxed to the providers.

Denied Requests - If a service is denied, the member, PCP and provider will receive a CMS developed letter informing everyone in detail the reason for the denial, the criteria on which the decision was based, how to access a copy of the criteria, and Appeal rights. This letter will also provide contact information for Prominence Medical Director if the provider would like to discuss the case further. If two (2) business days have elapsed since the initiation of the denial letter, any further action on the request will be handled through the Appeals Process explained in this manual.

The Plan will comply with all Federal and State requirements concerning denial of services. The Plan's Medical Director and UM staff are available during normal business hours to assist providers with inquiries regarding a service denial or to provide a copy of the criteria used to make the determination. Providers should contact the UM department by calling the number listed at the beginning of this section.

Reopenings Post-Determination & Peer-to-Peer Review for Pre-Service Denial Determinations

A reopening is a remedial action taken to change a binding determination or decision even though the binding determination or decision may have been correct at the time the decision was made based on evidence of record. Given the remedial nature of a reopening, CMS expects the reopening process to be used sparingly by the health plan. Prominence shall not use the reopening process in a manner that interferes with the enrollee's access to the appeals process. A reopening shall occur if:

- There is new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the decision. In other words, the decision was clearly incorrect based on all the evidence presented i.e. a clerical error.

Peer-to-peer reviews may be requested if a pre-service medically necessity denial was issued. This is only for pre-service denial determinations to assist with decreasing the potential for an appeal. If a denial was created due to lack of clinical information or not having the most recent clinical information, a peer-to-peer review may be warranted to addend the original decision. To qualify for a peer-to-peer review, the request must be made within 48 hours. A peer-to-peer review will not be used for post service decisions and the appeal process will have to be followed.

To request a peer-to-peer or to reopen a case, please call us at 800-969-1805.

Emergency & Urgent Care Services

An emergency medical condition is 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:

- Place the individual's health in serious jeopardy;
- Result in serious impairment to bodily functions;
- Result in serious dysfunction of a bodily organ or part;
- Result in serious disfigurement; or
- For a pregnant woman, result in serious jeopardy to the health of the fetus.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to perform emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Urgently needed services are covered services that:

- Are not emergency services as defined in this section;
- Are provided when a member is temporarily absent from Prominence's service area (or, if applicable, continuation). (Note that urgent care received within the service area is an extension of primary care services); and
- Are medically necessary and immediately required, meaning that:
    - The urgently needed services are a result of an **unforeseen** illness, injury or condition; and
    - Given the circumstances, it was not reasonable to obtain the services through Prominence's participating provider network.

Note that under unusual and extraordinary circumstances, services may be considered urgently needed when the member is in the service or continuation area, but Prominence's provider network is temporarily unavailable or inaccessible.

Concurrent Review & Discharge Planning

The Utilization Management Department (UM) maintains an active hospital management program comprised of concurrent review and discharge planning. Key to the success of these efforts is the involvement of the member's Primary Care Provider.

Upon notification of an emergency admission, and receipt of the necessary clinical information, Prominence will establish medical necessity and notify the appropriate provider via the secure Prominence Provider portal.

Discharge planning is key to achieving the best outcomes for our members and requires active participation of the facility and providers involved in their care. To discharge any member to a Skilled Nursing Facility, approval must first be obtained from Prominence's UM department. Patients can be admitted to a Skilled Nursing Facility directly from the Emergency Department, their home or from an inpatient or observation stay in an acute care facility.

The UM department staff will assist in coordinating any post-discharge services with participating ancillary providers, including enrollment of members into a Disease Management and/or Case Management Program.

Second Opinions

In accordance with state requirements, a member may request and is entitled to a second medical/surgical opinion when:

- The member feels he/she is not responding to the current treatment plan in a satisfactory manner, after a reasonable lapse of time for the condition being treated;
- The member disagrees with the opinion of a provider regarding the reasonableness or necessity of a medical/surgical procedure; or
- The treatment is for a serious injury or illness related to the medical need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g. diagnostic techniques such as cardiac catheterization and gastroscopy).

The member will select the provider from whom he/she is seeking a second opinion. Options include:

- A participating provider listed in a directory provided by Prominence; or
- If a non-participating in-network provider of the same specialty cannot be located in the same geographical Prominence service area of Prominence the member can be referred to a tertiary care provider.

Any tests or procedures deemed necessary by a non-participating provider should be performed within Prominence's network.

The Plan Physician's professional judgment concerning the treatment of a member after review of a second opinion shall be controlling as to the treatment obligations of Prominence.

Treatment not authorized by Prominence shall be at the member's expense.

Provider Request

All providers requesting a 2nd opinion must utilize Prominence's existing network unless the required specialist is not available. All second opinion requests for non-participating providers must be submitted through the Prior Authorization Request process.

Covered Services

Prominence Health members are eligible for all Medicare covered services, as appropriate. The Plan also offers a variety of added benefits to its members. To learn more about an individual member's covered benefits, please use one of these three resources:

- Prominence: Be sure to use the Provider Portal eligibility verification tool or contact Member Services to find member-specific benefits.
- Search the CMS Medicare Coverage Database available online at: http://www.cms.hhs.gov/mcd/overview.asp. Below is a summary of covered services by Medicare.

Summary of Medicare Part A Covered Services (Inpatient Care – see restrictions in Medicare coverage database)

- Anesthesia
- Chemotherapy
- Room and board
- All meals and special diets
- General nursing
- Medical social services
- Physical, occupational, and speech-language therapy
- Drugs with the exception of some self-administered drugs
- Blood transfusions
- Other diagnostic and therapeutic items and services
- Medical supplies and use of equipment
- Respite care in hospice
- Transportation services
- Inpatient alcohol or substance abuse treatment
- Part A blood (see the restrictions under non-covered services)
- Clinical trials (Inpatient)
- Kidney dialysis (Inpatient)

Summary of Medicare Part B Covered Services (Medically-Necessary Outpatient Services – see restrictions in Medicare coverage database)

- Durable Medical Equipment (DME)
- Home health services
- Outpatient physical, speech, and occupational therapy services
- Chiropractic care
- Outpatient mental health services
- Part B blood
- Physician services
- Prescription drugs
- Preventive care services
- X-rays and lab tests
- Outpatient Surgeries
- Outpatient Infusion, wound care

Florida D-SNP Summary of Medicaid Covered Services (Medically Necessary Services)

- *Allergy Services Coverage Policy*
- *Ambulance Transportation Services Coverage Policy*
- *Ambulatory Surgical Center Services Coverage Policy*
- *Anesthesia Services Coverage Policy*
- *Assistive Care Services Coverage and Limitations Handbook*
- *Behavioral Health Assessment Services*
- *Behavioral Health Community Support Services*

- *Behavioral Health Intervention Services*
- *Behavioral Health Medication Management Services*
- *Behavioral Health Overlay Services Coverage and Limitations Handbook*
- *Cardiovascular Services Coverage Policy*
- *Child Health Services Targeted Case Management*
- *Chiropractic Services Coverage Policy*
- *County Health Department Services*
- *Dental Services Coverage Policy*
- *Dialysis Services Coverage Policy*
- *Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook*
- *Early Intervention Services Coverage Policy*
- *Emergency Transportation Services Coverage Policy*
- *Evaluation and Management Services Coverage Policy*
- *Federally Qualified Health Center Services*
- *Gastrointestinal Services Coverage Policy*
- *Genitourinary Services Coverage Policy*
- *Hearing Services Coverage Policy*
- *Home Health Services Coverage Policy*
- *Inpatient Hospital Services Coverage Policy*
- *Integumentary Services Coverage Policy*
- *Laboratory Services Coverage Policy*
- *Medicaid Forms*
- *Medical Foster Care Services*
- *Mental Health Targeted Case Management Handbook*
- *Neurology Services Coverage Policy*
- *Non-Emergency Transportation Services Coverage Policy*
- *Nursing Facility Services Coverage Policy*
- *Occupational Therapy Services Coverage Policy*
- *Oral and Maxillofacial Surgery Services Coverage Policy*
- *Orthopedic Services Coverage Policy*
- *Outpatient Hospital Services Coverage Policy*
- *Pain Management Services Coverage Policy*
- *Personal Care Services Coverage Policy*
- *Physical Therapy Services Coverage Policy*
- *Podiatry Services Coverage Policy*
- *Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook*
- *Private Duty Nursing Services Coverage Policy*
- *Provider Reimbursement Schedules and Billing Codes*
- *Radiology and Nuclear Medicine Services Coverage Policy*
- *Regional Perinatal Intensive Care Center Services*
- *Reproductive Services Coverage Policy*
- *Respiratory System Services Coverage Policy*

- *Respiratory Therapy Services Coverage Policy*
- *Rural Health Clinic Services*
- *Specialized Therapeutic Services Coverage and Limitations Handbook*
- *Speech-Language Pathology Services Coverage Policy*
- *Statewide Inpatient Psychiatric Program Coverage Policy*
- *Transplant Services Coverage Policy*
- *Visual Aid Services Coverage Policy*
- *Visual Care Services Coverage Policy*

Providers servicing the Florida D-SNP population must comply with all policies, standards, and requirements as outlined in the Florida Agency for Health Care Administration (AHCA) Medicaid Services Coverage and Limitations Handbooks.

Visit online for additional information and resources regarding Texas Medicaid Long Term Supports and Services (LTSS).

Behavioral Health Services

Behavioral health services are available through Prominence Health Plan. Members may self-refer to a participating Behavioral Health provider and schedule an appointment by locating a participating provider as listed in Prominence's Provider Directory. Providers who want to coordinate care on behalf of the member or need to obtain Prior Authorization. Visit the Prior Authorization portion of this manual (Section 6) for additional information.

Clinical Practice Guidelines

The UM Program is based on evidence-based medicine. To support this premise, Prominence has adopted a set of Clinical Practice Guidelines which:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
- Consider the needs of the members;
- Are adopted in a consultation with providers; and
- Are reviewed and updated periodically, as appropriate.

Case Management Program

The purpose of the Case Management Program is to achieve and maintain member wellness through a program of advocacy, communication, education, identification, and facilitation of services. The Plan has a developed Case Management Program that assists members who may have the following disease processes or other similarly complex health issues:

- Complex Case Management
    - Wounds
    - Transplants
    - Multiple hospital admissions for same or related diagnosis
    - Major system failure
    - Multiple trauma

- Head or spine injuries with severe deficits
- High ED utilization
- Cancer with extensive treatment
- Multiple comorbidities or complex medical conditions

Members are identified for Case Management Programs through several sources, including, but not limited to:

- Information from Health Assessment Tool responses
- Discharge planning from acute or skilled services
- Claim or encounter data
- Pharmacy data
- Information through UM services
- Provider referrals

Member participation in the Case Management Program is on a voluntary basis and a member may choose to opt out of participation.

The Case Manager works closely with the member, member's family/caregiver and professional staff in the development of a mutually agreed upon Care Plan. The Case Manager will monitor and assist the member in reaching the goals and outcomes developed in this plan of care and will be in constant communication with the member's provider regarding the member's progress.

To request enrollment or an evaluation for possible enrollment into Case Management; call Member Services at 855-969-5882 and ask for Case Management.

Disease Management Programs

Disease Management Programs provide assessment, education and health coaching for health plan members who share a common diagnosis. The Plan has determined the following diseases to be indicative of the needs of Prominence's population:

Medicare (all covered members):

- Diabetes
- Cardiovascular disease
- Heart failure

Members are identified for Disease Management Programs through several sources, including, but not limited to:

- Claim or encounter data
- Laboratory results
- Pharmacy data
- Information from UM services
- Discharge planning from acute or skilled services
- Member self-referral

- Provider referral, and/or
- Information gathered from member Health Assessment Tool responses.

This program is voluntary to members, who may or may not choose to participate in the program.

To request enrollment or an evaluation for possible enrollment for a patient into a Disease Management Program, call Member Services at 855-969-5882 and ask for the Case/Disease Management Department. Please include all relevant information regarding the referral so that we may assist the member in the timeliest and appropriate manner.

Preventive Health Guidelines

Prominence has adopted the U.S. Preventive Services Taskforce Guidelines. Prominence annually reviews preventive health guidelines to reflect any changes in recommendations regarding screening, counseling, and preventive services. These guidelines can be referenced on the website for the Agency of Health care, Research and Quality at http://www.ahrq.gov/clinic/pocketgd.htm.

Financial Incentives

Prominence makes Utilization Management decisions based only on appropriateness of care and service, in conjunction with member benefits and coverage. The Plan does not reward providers or other individuals for issuing denials of coverage or care. Prominence does not encourage or provide incentives regarding Utilization Management decisions that result in underutilization of health care services.

7. MEDICATION MANAGEMENT

Introduction

Prominence has developed a Preferred Drug List (PDL) to promote clinically appropriate utilization of medication, in a cost-effective manner.

The drugs on Prominence's PDL are set up in a tier system that offers providers and members a choice of medications. Generic medications listed will have the widest choice and the lowest co-payment. Brand medication options could be limited in certain classes or may not be available through Prominence.

Prominence's Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for PDL consideration. The Pharmacy and Therapeutics Committee, is comprised of Prominence's Medical Director, Pharmacy Director, a clinical pharmacist representing Prominence's Pharmacy Benefits Manager, and Physicians from Prominence's provider network. Providers can request the addition of a drug to the PDL by writing to Prominence's Medical or Pharmacy Director. Physicians interested in participating in our Pharmacy and Therapeutics Committee should contact our Medical Director.

Preferred Drug List

Prominence maintains its own Preferred Drug List (PDL), a listing of medications intended to assist Prominence's Providers and pharmacy providers in delivering comprehensive, high quality, and cost effective pharmaceutical care.

The Pharmacy and Therapeutics Committee reviews all therapeutic classes and selects medications based on effectiveness, safety, and cost. The PDL is posted on Prominence's website at www.ProminenceMedicare.com.

The Preferred Drug List only applies to outpatient medications filled at in network pharmacies and does not apply to inpatient medications or those obtained from or administered by a Provider. Typically, most injectable drugs, except those listed on the PDL, are not covered by the pharmacy benefit. These must be approved through the Utilization Management department.

Generic Substitution

Generic drugs, excluding those with a narrow therapeutic index, should be dispensed when available. The FDA has approved a selection of generic equivalents for branded medications. Generic substitution is mandatory when an A or AB rated generic drug is available. Drugs listed on the State Negative Formulary are exempt from generic substitution requirements.

Drugs Not on the Preferred Drug List

Medications not on the Prominence Preferred Drug List (PDL) are not a covered benefit. A drug override can be requested when a medication is not on the PDL by using the Prior Authorization / Drug Exception Request Form and providing the related clinical information. Approval is based on

the member's medical and prescription benefit coverage, acceptable medical standards of practice and FDA-approved uses.

Prior Authorization (PA)/ Step Therapy (ST)

Some drugs on the Preferred Drug List may have a designation of PA. These are drugs that will require the provider to send in a request to cover this medication. Medical documentation, including any labs, tests, diagnosis and/or previous medications failed, are needed for the request to be considered. There are some drugs that would require the use of first line drugs before the drug being prescribed will be approved. This is called Step Therapy. Documentation that the first line drugs have been tried and failed or are not tolerated by the patient needs to be submitted with the Prior Authorization/Step Therapy Request before the request can be considered. Prior authorization information can be found in Section 5 of the manual.

Copayments

The Preferred Drug List is categorized into 6 Tiers as described below. The copayment varies with each category where the preferred generic has the lowest copayment and the non-preferred brands have the highest. Brands not appearing on the Preferred Drug List are not covered.

- Tier 1: Essential Health Benefit (certain contraceptives, certain vaccines, etc.)
- Tier 2: Preferred Generic
- Tier 3: Preferred Brand
- Tier 4: Non-Preferred Brand
- Tier 5: Specialty
- Tier 6: Select Care - $0 copay to member

Injectables

Most Injectables of all types require authorization through the Prior Authorization Form process with the following exceptions:

- One-time antibiotics;
- Certain vaccines;
- Intra-articular injections of steroids;
- Pain management injections; and
- Intravenous or intra-muscular injection of steroids.

Pharmacy Use

All members should use network pharmacies. A list of participating pharmacies is included in the Provider and Pharmacy Directory. If a member uses a non-network pharmacy, the medication will deny at point of sale. A reimbursement request may be submitted. The reimbursement will pay at the contracted rate of an in-network pharmacy minus any copays, coinsurance and/or deductibles.

Members may use out-of-area pharmacies for emergencies only.

Medication / Treatment Compliance Surveillance is designed to:

- Monitor and enhance medication treatment compliance among members;

- Monitor and evaluate medication treatment patterns among providers; and
- Identify potential negative effects of medication treatment, to include drug-to-drug interactions, contraindications, and medication side effects.

Drug Utilization Review Program

To promote safe and cost-effective utilization, selected high-risk, high cost, specialized use medications, or medications not included on the Prominence's Preferred Drug List (PDL) require a *Prior Authorization / Drug Exception Request*. Approval is granted for medically necessary requests and/or when PDL alternatives have demonstrated ineffectiveness.

When these exceptional needs arise, the Provider should fax a completed Prior Authorization / Drug Exception Request Form to Prominence. Approval for use is based on the member's medical and prescription benefit coverage, acceptable medical standards of practice and FDA-approved uses. Additional forms may be obtained by sending your request to the Prominence Utilization Management Department at 800-969-1805.

8. QUALITY IMPROVEMENT PROGRAMS

Overview

Prominence has established a Quality Improvement (QI) Program designed to comply with state and federal regulations and to promote quality care and service for Prominence Health members. The QI Program also provides a system for improving organizational processes.

Provider contracts require participation in the Prominence QI Program. The ongoing QI Program is based on the guiding quality principle of Continuous Quality improvement (CQI), where performance improvement results from ongoing and systematic measurement, intervention, and follow-up of key clinical and non-clinical aspects of care. The QI Program includes the use of performance data available through standardized measures, state and national benchmarks and root cause analyses that relate to measuring outcomes and identifying opportunities for improvement.

Analytical resources are available through Quality Improvement staffing, and through the employment of project-specific consultants. Our staff has access to end-user data-systems for data including quality, claims/encounters, enrollment utilization, appeals and grievances, credentialing, and member services to provide information for performance measures and quality improvement activities.

A printed copy of the QI Program is available, upon request, to Prominence providers and members.

Goals/Objectives

Program goals are to:

- Improve and maintain Prominence Health Plan members' physical and emotional status;
- Promote health, risk identification, and early interventions;
- Empower members to develop and maintain healthy lifestyles;
- Involve members in treatment and care management decision-making;
- Facilitate the use of evidence-based medical principles, standards and practices;
- Promote accountability and responsiveness to member concerns and grievances;
- Coordinate utilization of medical technology and other medical resources efficiently and effectively for member welfare
- Facilitate accessibility and availability of members to care in a timely manner;
- Promote member safety in conjunction with effective medical care; and
- Promote member safety in conjunction with effective medical care; and
- Provide culturally and linguistically competent health care delivery and promote health care equity.

Primary objectives of the Prominence Quality Improvement Program include:

- Proactively pursue methods to improve care and service for members;
- Develop interventions to improve the overall health of members;
- Develop systems to enhance coordination and continuity of care between medical

and behavioral health services;
- Maintain systematic identification and follow-up of potential quality issues;
- Educate members, Providers, hospitals and ancillary providers Prominence Health Plan's quality management goals, objectives, structure and processes; and
- Promote open communication and interaction between and among providers, members and Prominence.

Prominence Quality Improvement Program components include:
- Member rights and responsibilities;
- Confidentiality of member information;
- Member satisfaction, including grievance and appeals;
- Access and availability of care and services;
- Medical record keeping practices;
- Preventive health and HEDIS measures;
- Clinical quality improvement initiatives;
- Quality of care evaluation;
- Peer review;
- Grievances and appeals;
- Medical management, disease management and case management initiatives;
- Coordination and continuity of care, including medical and behavioral health;
- Credentialing re-credentialing activities;
- Monitoring of delegated services;
- Member safety;
- Risk management;
- Delegation oversight;
- Provider and enrollee communication; and
- Behavioral health.

The Prominence Quality Improvement Program is evaluated and updated at least annually, with input from Prominence staff, network providers, and members.

The Prominence Quality Improvement Program includes a committee structure that incorporates committees designed to review and monitor medical management, quality management, pharmacy and therapeutics, credentialing, peer review, and grievances/appeals activities.

Providers who wish to participate in any of these committees are encouraged to notify Prominence for consideration. A company-wide quality steering committee oversees all quality related activities and reports to the Board of Directors.

Provider Notification of Changes

Prominence will notify Providers of material changes in writing, thirty (30) days prior to putting the change into effect. These changes are communicated via the Prominence website (www.prominencehealthplan.com), the provider Manual, direct mail, and/or the provider

Newsletter.

A material change is a change that may influence a Provider's decision to remain in Prominence's network. Examples of material changes are those that affect the organization's payment structure, the size of member panels, or the scope of a Provider's administrative responsibilities. Please contact your Provider Relations Representative should you have questions related to a change notification.

Medical Health Information

Participating providers are expected to provide information to members regarding their health status and treatment options, including self-treatment. Information provided includes the risk, benefits and consequences of treatment or non-treatment. Providers should also allow members to participate in treatment decisions and to refuse treatment.

Medical Record Standards

In accordance with the Prominence Participation Agreement, the provider shall ensure medical records are accurately maintained for each member. It shall include the quality, quantity, appropriateness and timeliness of services performed under this contract.

Medical records shall be maintained for a period of no less than ten years, including after termination of the Agreement and retained further if records are under inspection, evaluation or audit, until such is completed.

Upon request, Prominence or any Federal or State regulatory agency, as permitted by law, may obtain copies and have access to any medical, administrative or financial record of Provider-related and Medically Necessary Covered Services to any member. The Provider further agrees to release copies of medical records of members discharged from the Provider to Prominence for retrospective review and special studies.

A medical record documents a Prominence Health Plan member's medical treatment, current and past health status, and current treatment plans. A member's medical record is an essential component in the delivery of quality health care. Prominence has established medical record standards available to all participating providers. Providers are required to comply with these standards.

Medical Record Standards

- Every page in the record contains the member's name, member ID number and birth date;
- Includes personal/biographical data including age, date of birth, sex, address, employer, home and work telephone numbers, marital status and legal guardianship;
- The record reflects the primary language spoken by the member and any translation needs of the member;
- All entries are signed and dated;
- All entries include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;

- All entries in the medical record contain legible author identification. Author identification is a handwritten signature, stamped signature, or a unique electronic identifier. Signature is accompanied by the author's title (MD, DO, APRN, PA, MA);
- The record is legible to someone other than the writer;
- The record is maintained in detail;
- Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is noted in the record (no known allergies = NKA);
- Past medical history is easily identified and includes serious accidents, significant surgical procedures, and illnesses. For children and adolescents (21 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses;
- Past medical history (for members seen three or more times) easily identified and includes serious accidents, significant surgical procedures, and illnesses. For children and adolescents (21 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses;
- The immunization record is up to date;
- Diagnostic information, consistent with findings, is present in the medical record;
- A treatment plan, including medication information, is reflected in the medical record;
- A problem list including significant illnesses, medical conditions, health maintenance concerns and behavioral health issues are indicated in the medical record;
- Medical record includes a medication list;
- For members 12 years and over, notation concerning the use of cigarettes and alcohol use and substance abuse is present (for members seen three or more times);
- If a consultation is requested, a note from the consultant is in the record;
- Emergency Room discharge notes and hospital discharge summaries (hospital admissions which occur while the member is enrolled in Prominence, and prior admissions, as necessary) are appropriate and medically indicated in the medical record;
- The record includes all services provided including, but not limited to, family planning services, preventive services and services for the sexually transmitted diseases;
- There is evidence that preventive screening and services are offered in accordance with the Prominence Care preventive services policies, procedures, and guidelines;
- The record contains evidence of risk screenings;
- The record contains documentation that the member was provided with written information concerning member's rights regarding advance directives, and whether or not the individual has executed an advance directive;
- The record contains documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record;
- The record documents members seeking assistance with special communications needs for health care services;
- Documentation of individual encounters provides adequate evidence of:
    - The history and physical expression of subjective and objective presenting complaints, including the chief complaint or purpose of the visit;
    - Medical findings or impressions of the provider, as well as provider's evaluation of the

member;
    - Diagnoses;
    - Treatment plan;
    - Laboratory and other diagnostic studies used or ancillary services ordered;
    - Therapies, home health and prescribed regimens;
    - Encounter forms or notes regarding follow-up care, calls, or visits;
    - Unresolved problems from previous visits;
    - Lab, imaging and other diagnostic reports filed in the chart and initialed by the PCP to signify review;
    - Reports from specialists and other consultative services referred by PCP;
    - Discharge reports from hospitalizations;
    - Disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services
- Medical records are secured in a safe place to promote confidentiality of member information;
    - Records are maintained in a location with access limited to authorized staff;
    - Records are readily available for provision of care;
- Medical records and all member information are maintained in a confidential manner;
    - Minor members' consultations, examinations, and treatment for sexually transmissible diseases are maintained confidentially;
- Additional medical record recommendations include:
    - All entries are neat, legible, complete, clear, and concise, written in black ink;
    - Entries are dated and recorded in a timely manner;
    - Records are not altered, falsified or destroyed;
    - Incorrect entries are corrected by drawing a single line through the error;
    - Avoiding correction fluid or markers that will obscure writing;
    - Dating and initialing each correction;
    - Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation; and
    - All telephone messages and consent discussions are documented.

Assessing the Quality of Medical Record Keeping

Prominence will assess provider compliance with these standards, and monitor the processes used in provider's offices. Prominence establishes performance goals for compliance with our medical record documentation standards.

Improving Medical Record Keeping

If a provider does not meet Medical Record standards, both Provider Relations and Quality Management staff will work with the provider to improve medical record keeping. Providers with identified deficiencies may be sent suggestions of how to improve their medical record-keeping practices, record-keeping aids, or examples of best practices that meet Prominence's record-keeping standards.

Medical Record Review

The Plan adheres to the Privacy Rule established by the Health Insurance and Portability Act of 1996 (HIPAA), which outlines national standards to protect individuals' medical records and other personal health information. The rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. It also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

To ensure HIPAA compliance, Prominence performs on-site medical record audits at the time of re-credentialing and during routine medical record evaluations. Medical records are reviewed for compliance with documentation requirements as outlined by regulatory and accreditation agencies. They are also evaluated for compliance with preventive, chronic and acute health care standards. Providers who do not meet Prominence standards for medical record documentation will be referred to the Medical Director for follow-up, or to the Quality Management Committee for further action.

Note that in accordance with the HIPAA guidelines, explicit member authorization is not required for release of records to the Health Plan in the course of Health Care Operations. For further information, please refer to 45 CFR 164.506, Uses and Disclosures for Treatment, Payment, and Health Care Operations.

Medical Record Privacy & Confidentiality Standards

Standard 1: Medical Record Privacy and Confidentiality

All Prominence Health members' individually identifiable information whether contained in the member's medical record or otherwise is confidential. Such confidential information, whether verbal or recorded, in any format or medium, includes but is not limited to, a member's medical history, mental or physical condition, diagnosis, encounters, authorization, medication or treatment, which either identifies the member, or contains information that can be used to identify the member.

Standard 2: Medical Record Privacy and Confidentiality

In general, medical information regarding a Prominence Health member must not be disclosed without obtaining written authorization. The member, the member's guardian, or conservator must grant the authorization. If the member signs the authorization, the member's medical record must not reflect mental incompetence. If authorization is obtained from a guardian or conservator, evidence such as a Power of Attorney, Court Order, etc., must be submitted to establish the authority to release such medical information.

Standard 3: Medical Record Privacy and Confidentiality

To release member medical information, the requesting entity must use a valid and completed Medical Information Disclosure Authorization Form, prepared in plain language. The form must include the following:

- Name of the person or institution providing the member information;

- Name of the person or institution authorized to receive and use the information;
- The member's full name, address, and date of birth;
- Purpose or need for information and the proposed use thereof;
- Description, extent or nature of information to be released identified in a specific and meaningful fashion, including inclusive dates of treatment;
- Specific date or condition upon which the member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation;
- Date that the consent is signed, which must be later than the date of the information to be released;
- Signature of the member or legal representative and his or her authority to act for the member;
- The member's written acknowledgment that member may see and copy the information described in the release and a copy of the release itself, at reasonable cost to the member;
- The member's written acknowledgment that information used or disclosed to any recipient other than a health plan or provider may no longer is protected by law;
- Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization; and
- A statement that the member can refuse to sign the authorization.

Standard 4: Medical Record Privacy and Confidentiality

Pursuant to laws that allow disclosure of confidential medical information in certain specific instances, Prominence may release such information without prior authorization from the member, the member's guardian, or conservator for the following reasons:

- Diagnosis or treatment, including emergency situations;
- Payment or for determination of member eligibility for payment;
- Concurrent and retrospective review of services;
- Claims management, claims audits, billing and collection activities;
- Adjudication or subrogation of claims;
- Review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges;
- Coordination of benefits;
- Determination of coverage, including pre-existing conditions investigations (as applicable);
- Peer review activities;
- Risk management;
- Quality assessment, measurement and improvement, including conducting members satisfaction surveys;
- Case management and discharge planning;
- Managing preventive care programs;
- Coordinating specialty care, such as maternity management;

- Detection of health care fraud and abuse;
- Developing clinical guidelines or protocols;
- Reviewing the competency of health care providers and evaluating provider performance;
- Preparing regulatory audits and regulatory reports;
- Conducting training programs;
- Auditing and compliance functions;
- Resolution of grievances;
- Provider contracting, certification, licensing and credentialing;
- Due diligence;
- Business management and general administration;
- Health oversight agencies for audits, administrative or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions;
- In response to court order, subpoena, warrant, summons, administrative request, or similar legal processes;
- To comply with State law relating to workers compensation;
- To County coroner, for death investigation;
- To public agencies, clinical investigators, health care researchers, and accredited non-profit educational or health care institutions for research, but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed;
- To organ procurement organizations or tissue banks, to aid member medical transplantation;
- To state and federal disaster relief organizations, but only basic disclosure information, such as member's name, city of residence, age, sex and general condition;
- To agencies authorized by law, such as the FDA; an
- To any chronic disease management programs provided member's treating Provider authorizes the services and care.

Standard 5: Medical Record Privacy and Confidentiality
All individual Prominence Health Plan member records containing information pertaining to alcohol or drug abuse are subject to special protection under Federal Regulations (Confidentiality of Alcohol and Drug Abuse member Records, Code 42 of Federal Regulation, chapter 1, Subchapter A. Part 2). An additional and specific consent form must be used prior to releasing any medical records that contain alcohol or drug abuse diagnosis.

Standard 6: Medical Record Privacy and Confidentiality
Special consent for release of information is needed for all members with HIV/AIDS and mental health disorders. In general, medical information for members who exhibit HIV/AIDS and/or mental health disorders will always be reported in compliance with state law. Additional information will be released regarding a member infected with the HIV virus only with an authorized consent.

Information released to authorized individuals/agencies shall be strictly limited to the information required to fulfill the purpose stated in the authorization. Any authorization specifying “any and all medical information” or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

9. CLAIMS

General Payment Guidelines

Claims should be submitted in one of three formats:

- Electronic claims submission,
- CMS 1500 Form, or
- UB04 Form.

Providers are required to use the standard CMS codes for ICD-10, CPT, and HCPCS services, regardless of the type of submission.

Claims processing is subject to change based upon newly promulgated guidelines and rules from CMS and AHCA.

For payment of Medicare claims, Prominence has adopted all guidelines and rules established by CMS and uses reimbursement amounts as published in the Medicare fee schedules. Practitioners may be reimbursed different amounts for different specialties and reimbursement may differ for practitioners in the same specialty based on contracted rates. Prominence Medicare members may only be billed for their applicable co-payments, co-insurance, deductibles, and non-covered services.

Mail Medicare claims to:

Prominence Health Plan
C/O Claims Processing
PO Box 981748
El Paso, TX 79998

Medicaid services administered for Prominence Florida D-SNP members will also be processed by Prominence Health Plan. Florida D-SNP Medicaid claims may be mailed to the address above.

Member Responsibility

The Provider should collect the following payments from the member based upon the terms of your contract and the benefit plan design:

- Copayments
- Deductibles
- Coinsurance

Charges that can be billed and collected from the member will be indicated on the *Explanation of Benefits* (EOB) notice from Prominence. **The provider gets an Explanation of Payment (EOP).**

For D-SNP Members, Providers are prohibited from billing dual eligible members for Medicare cost sharing, including deductibles, coinsurance, and copayments. Further, Providers shall not seek additional payment from applicable Medicaid State Agencies for such cost sharing obligations.

Providers must accept the Prominence Medicare reimbursement as payment in full for services rendered to Dual Eligible Members.

Prohibition of Billing Members

As a participating provider you have entered into a contractual agreement to accept payment directly from Prominence. Payment from Prominence constitutes payment in full, with the exception of applicable co-payments, deductibles, and/or co-insurance as listed on the EOB/EOP.

You may not balance bill members for the difference between actual billed charges and your contracted reimbursement rate. A member cannot be *"balance billed"* for covered services denied for lack of information. Failure to notify Prominence of a service that requires prior authorization will result in payment denial. In this scenario, members may not be balance billed and are responsible only for their applicable co-payments, deductibles, and/or co-insurance.

A member cannot be billed for a covered service that is not medically necessary. Unless the member's informed written consent is obtained prior to rendering a non-covered service. This consent must include information regarding their financial responsibility for the specific services received.

Timely Submission of Claims

The Plan abides by State Prompt Payment provisions. The Plan also follows CMS guidelines for Medicare timely submission of claims.

Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute, unless your contract stipulates something different.

Members cannot be billed for services denied due to a lack of timely filing. Claims appealed for timely filing should be submitted with proof along with a copy of the EOP and the claim.

Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of Prominence, or a similar receipt from other commercial delivery services.

Maximum Out-of-Pocket Expenses (MOOP)

The term Maximum Out-of-Pocket (MOOP) refers to the limit on how much a Medicare Advantage Plan enrollee must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. Copayments, coinsurance and deductibles comprise member expenses for purposes of MOOP. MOOP is not applicable to the member's Medicare Part B Premium.

All of our plans have a MOOP. If a member reaches a point where they have paid the MOOP during a calendar year (coverage period), the member will not have to pay any out-of- pocket costs for the remainder of the year for covered Medicare Part A and Part B services. If a member reaches this level, Prominence will no longer deduct any applicable member expenses from the

provider's reimbursement.

The MOOP can vary by Plan and may change from year to year. Please refer to the *Summary of Benefits* available online at our website: www.ProminenceMedicare.com. You may confirm that a member has reached their MOOP by contacting the Member Service Department.

Physician & Provider Reimbursement

Reimbursement for covered services is based on the negotiated rate as established in the Physician or Provider Agreement. Services that require a prior authorization will be denied if services were rendered prior to approval. Please refer to your Physician or Provider Agreement to determine the method that applies to your contract.

Electronic Claims Submission

Electronic data filing requires billing software through which you can electronically send claims data to a clearinghouse. Since most clearinghouses can exchange data with one another, you can continue to use your existing clearinghouse even when it is not the clearinghouse selected by Prominence.

Prior to submitting claims through a clearinghouse exchange, you must check with your existing clearinghouse to make sure they can complete the transaction with the Prominence vendor. If you do not have a clearinghouse, or have been unsuccessful in submitting claims to your clearinghouse, please contact your Provider Relations Representative for assistance.

Our trading partner, Change Healthcare, can help establish electronic claims submissions connectivity with our Plan. You will need our payer number for Prominence Medicare Advantage, (distinct for each plan and state) which is **93082** in Nevada, **80095** in Texas, and **83352** in Florida.

Tips on successfully submitting electronic claims:

- Ensure your clearinghouse can remit information to our trading partner, Change Healthcare. You may reach Change Healthcare at 800-845-6592.
- Use the billing name and address on the electronic billing format that matches our records.
- Please notify our office of any name and address changes in writing.
- Field NM1 relates to box 33 of a CMS1500 or the UB04 for all electronic claims transmissions and 837's.
- Contact Change Healthcare with any transmission questions at 800-845-6592.

**Currently not available for dual specialty providers, PCP's with IPA affiliations, anesthesiology or ambulance providers.*

Completion of "Paper" Claims

Paper claims should be completed in their entirety including but not limited to the following elements:

- The member's name and their relationship to the subscriber

- The subscriber's name, address, and insurance ID as indicated on the member's identification card
- The subscriber's employer group name and number (if applicable)
- Information on other insurance or coverage
- The name, signature, place of service, address, billing address, and telephone number of the Provider performing the service
- The tax identification number, NPI number, for the Provider performing the service
- The appropriate ICD-10 codes at the highest level
- The standard CMS procedure or service codes with the appropriate modifiers
- The number of service units rendered
- The billed charges
- The name of the referring Provider
- The dates-of-service
- The place-of-service
- The authorization number
- The NDC for drug therapy; and
- Any job-related, auto-related, or other accident-related information, as applicable.

Electronic Transactions & Code Sets

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes a series of administrative simplification provisions including the adoption of national standards for electronic health care transactions.

On October 16, 2003, the Electronic Transaction and Code Set provision of HIPAA went into effect. Law requires payers to have the capability to send and receive all applicable HIPAA-compliant transactions and code sets.

One requirement is that the payer must be able to accept a HIPAA-compliant 837 electronic claim transaction, in standard format, using standard code sets and standard transactions. Specifically, claims submitted electronically must comply with the following provider-focused transactions:

- 270/271 – Health Insurance Eligibility/Benefit Inquiry and Response;
- 276/277 – Health Care Claim Status Request and Response;
- 278 – Health Care Services Review – Request for Review and Response; and
- 835 – Health Care Claim Payment/Advice

The X12N-837 claims submission transactions replaces the manual CMS 1500/UB92 forms. All files submitted must be in the ANSI ASC X12N format, version 4010A, as applicable.

Encounter Data

Encounter Data is a record of covered services provided to our members. An Encounter is an interaction between a patient and provider (health plan, rendering provider, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient.

Prominence requires the submission of claims for all encounters in order for Prominence to achieve state and federal reporting requirements.

Providers reimbursed on a capitation basis must file claims for all services. Claims submitted under a capitation contract are referred to as encounter data. Encounter data can be submitted on a paper claim format or through Electronic Data Interface (EDI) following the same rules as submitting claims. Prominence recognizes these services as paid under the capitation contract and not paid to the Provider directly. These services become an integral part of the Prominence claims history database and are used for analysis and reporting.

Capitated Providers who do not submit encounter data could be terminated from Prominence.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the procedure used to process health care payments for a patient with one or more insurers providing health care benefit coverage. Prior to claims submission, it is important to identify if any other payer has primary responsibility for payment. If another payer is primary, that payer should be billed prior to billing Prominence.

When a balance is due after receipt of payment from the primary payer, a claim should be submitted to the Prominence for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of their explanation of payment statement. Upon receipt of the claim, Prominence will review its liability using the COB rules and/or the Medicare crossover rules—whichever is applicable.

Prior Authorization requirements apply for patients with one or more insurers providing health care benefit coverage.

Correct Coding

Prominence has adopted a policy of reviewing claims to ensure correct coding. Prominence utilizes a corrective coding software, which is integrated with our claims payment system. CMS guidelines are uses as the basis for applying coding policy.

Industry standard payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB) including but not limited to:

- Status of "B" = Bundled Codes
- Global Surgery
- Multiple Procedures (Modifier 51)
- Bilateral Surgery (Modifier 50)
- Assistant at Surgery (Modifier 80, 81, 82)
- Co-surgeons (Modifier 62)
- Team Surgery (Modifier 66)

Claims Appeals

Claim appeals for denials should be submitted to the attention of the Appeals and Grievance Department. The time frame for appealing a claim denial is 60 days from the date of the denial on the explanation of benefits/payment. Cases appealed after the 60-day time limit will be denied for untimely filing. Please include documentation explaining why an authorization was not obtained, any pertinent medical records, a copy of the claim(s), and a copy of the denial statement received.

There is no second level consideration for appeals outside the timely filing requirement. Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of Prominence, or a similar receipt from other commercial delivery services.

Parts C & Level 1 Appeal Adjudication Timeframes

TYPE	PART C	PART C & EXTENSION	PART D
Standard Pre-Service or Benefits	30 days	44 days	7 days*
Expedited Pre-Service Benefit or Part B Drug	72 hours	17 days**	72 hours*
Part B Drug	7 days	N/A**	N/A
Payment	60 days	N/A	14 days

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

The Plan is not responsible for payment of medical records generated because of a claims appeal. Cases received for lack of necessary documentation will be denied. The Provider is responsible for providing the requested documentation within 60 days of the denial in order to reopen the case. Records and documents received after that timeframe will not be reviewed and the case will be closed.

In the case of a review in which the Provider has complied with Plan guidelines and services are determined to be medically necessary, the denial will be overturned. The Provider will be notified in writing to re-file the claim for payment. If the claim was previously submitted and denied, Prominence will adjust it for payment after the decision is made to overturn the denial.

Payment Integrity and Bill Review

Prominence Health Plan operates a review program to detect, prevent and correct fraud, waste and abuse and to facilitate accurate claim payment. To further this program, Prominence conducts reviews on prepayment and post payment bases. Physicians and other health care professionals may have the right to dispute results of reviews as stated in the Claims Appeals section of the manual.

Reimbursement for Covering Providers

Covering Providers for Primary Care Providers must agree to abide by Utilization Management and Quality Management guidelines. The payment rate is according to the Physician or Provider Agreement between the contracted PCP and Prominence. The covering Provider shall not seek payment from Prominence or the member with the exception of those services for which the assigned PCP would have been permitted to collect, i.e., copayments, deductibles, and/or coinsurance from the member.

Fee Schedule Updates

Prominence updates fee schedules per the below schedule if fee schedule is based off current year Medicare:

- Ambulance – 01/01
- ASA – 01/01
- ASP – Updated Quarterly
- ASC - Current Year Medicare (Updated within 30 days following CMS release) **
  - ASC claims must be billed on CMS-1500 claim form
- DME – 01/01
- Hospital - Current Year Medicare (Updated within 30 days following CMS release) **
- PFS (Physician) – 01/01
- RBRVS – Updated Quarterly
- SNF/HH - Current Year Medicare (Updated within 30 days following CMS release) **

**Claims are processed and paid per the CMS price in effect for the date and time the claim was processed. Claims will not be reprocessed due to underpayments derived from CMS publishing updates late.

10. GRIEVANCE & APPEALS

Introduction

Prominence provides for members and providers grievances and appeals, as established by the Medicare Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Definitions

Adverse Determination – An adverse determination is a decision regarding admission, care, continued stay or other health care services to deny, reduce, or terminate services based on Prominence's approved criteria for medical necessity, appropriateness, health care setting, level of care or effectiveness and coverage for the requested service.

Appeal – An appeal is a request to review a decision made regarding health care services or payment.

Grievance – A grievance is any complaint, other than one involving an organizational determination (appeal), expressing dissatisfaction with health care services received from or through Prominence. Both verbal and written complaints are considered grievances.

Grievance & Appeals System

Prominence Health members have the right to express verbal or written grievances and appeals, as outlined in Member Rights and Responsibilities. These rights are provided in the Evidence of Coverage Document sent to all our members. Prominence has developed a system to receive process and resolve member grievances and appeals to support these rights. All grievances and appeals are handled by the Prominence Grievance and Appeals Department.

Prominence will assist with the grievance and appeals filing processes. Providers may also contact Prominence to file or support a member filing of an appeal or a grievance. Members may also contact Prominence to file an appeal or request a grievance form. Appeals and grievances are filed with Prominence by mail, telephone or fax at:

Part C Grievances:
Prominence Health Plan
Attn: Part C Grievances
1510 Meadow Wood Ln.
Reno, NV 89502
Fax: 775-770-9036

Part C Appeals:
Prominence Health Plan
Attn: Part C Appeals
1510 Meadow Wood Ln.
Reno, NV 89502
Fax: 775-770-9036

Part D Grievances:
Prominence Health Plan
c/o MedImpact
10181 Scripps Gateway Court
San Diego, CA 92131
Fax: 844-587-7399

Part D Appeals:
Prominence Health Plan
c/o MedImpact
10181 Scripps Gateway Court
San Diego, CA 92131
Fax: 858-790-6060

Member Services staff and the Grievance and Appeals Coordinator are available from 8 a.m. to 5 p.m. to assist with questions regarding grievances and appeals. Members may be assisted or represented by an outside legal advisor, provider, or other designated representative during the appeal or grievance processes. Prominence requires written documentation of such representation, and advanced notice in the event that the representative needs to attend any scheduled meetings or hearings.

Providers who want to file an Appeal or request additional information regarding Prior Authorization denials, grievances or Prior Authorization denial appeals, may contact the Grievance and Appeals Specialist. If the appeal or request is submitted in writing, providers should include what is requested and any additional information to support the request.

Grievance & Appeals

This section of the Provider Manual provides guidance to participating providers on Prominence's appeal process. Member appeals are detailed in the *Evidence of Coverage* (EOC). The appeals process for members of a Medicare Advantage plan is the same regardless of the type of plan in which the member is enrolled.

Member Grievance & Appeals

All participating providers or entities delegated for Network Management and Network Development are to use the same standards as defined in this section. Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Participating Provider Claims Reconsiderations

This section explains the reconsiderations process for denied **claims** only. The process for **pre-service denials** can be found in the Utilization Management Section of this manual.

The terms and conditions of payment to participating providers follow the mutual obligations of Prominence and providers per our Provider Agreement. Per our Agreement, Providers may not bill our members, except for any co-payments or co-insurance. Any claims disputes for services provided to our members have to be resolved per the contract's terms and conditions.

Balance billing members is also prohibited by Medicare regulations. Claims may be denied for reasons including, but not limited to:

- Lack of authorization;
- Services not billed as authorized;
- Billing with an incorrect code;
- Place of service billed wrong; or
- Provider not member's PCP on date of service.

The specific reason for denial of the claim will be provided in the Evidence of Payment document that is sent to providers along with all paid/denied claims.

Once a claim is denied, the provider may request a reconsideration regarding Prominence's

decision. Providers must make this request in writing within 90 days of receipt of the initial claims denial and send the request to the address provided. Additional information to support the request may be sent at this stage.

Submit written claims reconsiderations to:

Prominence Health Plan Inc.
C/O Reconsiderations
1510 Meadow Wood
Reno, NV 89502
Fax: 775-770-9004

Non-participating Providers Appeal

Prominence encourages the use of participating providers but when a non-participating provider is used, the non-par provider must follow these steps:

Step 1. Contact Prominence for all Prior Authorization requests. All claims of non-par providers for services provided without a proper authorization will be denied.

Step 2. If a claim is denied, the non-par provider can file an appeal within sixty (60) calendar days of the Initial Organization Determination to file an appeal with the Plan. However, all non-par providers must sign a *Waiver of Liability* Form for the claim to be reconsidered for payment. The *Waiver of Liability* Form is attached to the Appeal Acknowledgement Letter. If the *Waiver of Liability* Form is not completed and returned, the case is prepared and sent to the Maximus CHDR (the Independent Review Entity) for dismissal.

Step 3. Upon receipt of the *Waiver of Liability* Form, the claim and reason for the denial are reviewed. The Grievance and Appeals staff either pays the claim or presents the case for administrative review.

Step 4. Providers and members are notified in writing of approved or denied claims. Claims approved for payment on appeal are processed and paid within established time frames to either the provider or member—whichever is appropriate.

Step 5. Claims denied for payment after the appeal review, are processed and forwarded to Maximus Federal Services, the Independent Review Agency (IRE) contracted by CMS.

Expedited Claims Appeals

Providers can request an expedited appeal for Prior Authorization Requests only. There is not an expedited appeal for post-service denials.

Medicare Grievance Process

Providers cannot file a grievance but are able to submit a complaint. Please see the Provider Complaint Process that appears further in this section. Medicare members may file a grievance within 60 days of the event that initiated the grievance. Prominence will resolve the grievance within 30 days of receipt but may extend the resolution period by up to 14 days if additional

information is required.

Provider Complaint Process

Initial Complaint

A Provider Relations Representative is assigned to each contracted provider to assist in the administration of services to members. Any provider who has a complaint may call the Care Advocate Department at 855-969-5882. A Care Advocate will assist the provider to resolve the complaint.

Complaint Procedures

Formal complaints will be handled by the Grievance Department with the cooperation of other departments involved with the complainant's concerns should the Provider Relations Representative be unable to resolve the issue.

- All issues with medical management will be reviewed confidentially by Prominence's Utilization Management Department.
- A resolution to the provider's complaint will be due within 60 days from the receipt of the formal complaint, except when information is needed from non-participating providers or providers outside of Prominence's service area. In such cases, this period may be extended an additional 30 days, if necessary.
- The complainant will receive a written notice when an extension is necessary. The time limitations requiring completion of the grievance process within 60 days will be paused after Prominence has notified the complainant in writing that additional information is required to review the complaint properly. Upon receipt of the additional information required, the time for completion of the grievance process will resume. The Plan will communicate with the complainant during the formal grievance process.
- A resolution letter with Prominence's findings and/or decision will be sent to the provider by mail.
- The Plan will provide to the complainant written notice of the right to appeal upon completion of the full complaint review process.

The Plan will maintain an accurate record of each provider complaint. Each record will include the following:

- Complete description of the complaint;
- Complainant's name and address;
- Complete description of factual findings and conclusions after the completion of the formal complaint process; and
- Complete description of Prominence's conclusions pertaining to the complaint, as well as Prominence's final disposition of the grievance.