Medicare Advantage Provider Manual

Medicare Advantage Plans
Provider Services ● 1-833-908-0105

https://IntegraNetHealth.com

September 2019

Table of Contents

1 Overview

1.1 About IntegraNet Health

IntegraNet Health is a well-established Independent Physician Association performing Value-based population health management through Independent Physicians and Health Plans for over 20 years. We are clinically integrated and well-known for providing PCP's the opportunity to participate in beneficial profit-sharing opportunities that are typically unavailable to individual physicians.

1.2 Purpose of the Provider Manual

IntegraNet's Provider Manual is for Physicians, Hospitals and Other Health Care Providers ("Manual"). The Manual is an extension of the participating provider agreement ("Agreement") between IntegraNet and/or all provider types including, but not limited to, physicians, hospitals and ancillary health care providers (hereinafter collectively and/or individually, as the content requires, referred to as "Provider (s)"). This Manual furnishes all such participating Providers and their office staff with important information concerning IntegraNet policies and procedures, claims submission and adjudication requirements, and guidelines used to administer IntegraNet's delegated health plans listed in the Manual. This Manual replaces and supersedes any and all other previous versions and is available on IntegraNetHealth.com. A paper copy may be obtained at any time upon written request to IntegraNet. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the Agreement.

In accordance with Provider Manual references in the Agreement, Providers are contractually required to abide by all provisions contained in this Manual, as applicable. Revisions to this Manual constitute revisions to IntegraNet's policies and procedures. Revisions shall become binding ninety (90) days after the date indicated on any notice that is provided by mail or electronic means, or such other period of time as necessary for IntegraNet to comply with any statutory, regulatory and/or accreditation requirements.

As policies and procedures change, updates will be issued in the form of the Physician Quarterly Newsletter, mail, email or fax notification, and may be incorporated into the electronic version and subsequent paper versions of this Manual. Any change in policies and procedures must be implemented according to the time frame included in the Agreement.

Variations in applicable laws, regulations and governmental agency guidance, including, but not limited to state or federal laws, regulations, and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this Manual that are not expressly set forth in this Manual. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this Manual shall be incorporated herein by this reference and shall apply to Providers and/or IntegraNet where applicable. Such laws and regulations, if more stringent, take precedence over the content in this Manual. Providers are responsible for complying with all laws and regulations that are applicable. Note, however, that state law and/or regulations do not affect the adjudication of claims for Medicare Advantage Members.

2 Medicare Advantage Overview

2.1 About Medicare Advantage

Medicare beneficiaries have a choice of getting their Medicare health care services through original Medicare or through a Medicare Advantage Plan. The Centers for Medicare & Medicaid Services (CMS) mails a copy of the document *Medicare & You* to Medicare beneficiaries describing Medicare benefits and plan choices every fall.

Medicare beneficiaries can enroll in Medicare Advantage plans during election periods. Five important election periods are:

1. **Annual Election Period (AEP):** The AEP occurs from October 15-December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.

2. **Medicare Advantage Disenrollment Period (MADP):** During the MADP, Medicare beneficiaries have the opportunity to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to original Medicare, they have the option of enrolling into a stand-alone prescription drug plan. The time frame for this election period is January 1-February 14 of each year.

3. **Initial Coverage Election Period (ICEP):** When a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, he or she has a seven-month period to enroll in a Medicare Advantage plan. This usually happens around the person's 65th birthday.

4. **Initial Enrollment Period for Part D (IEP):** This is the period when an individual is first eligible to enroll in a Part D plan. An individual is eligible to enroll in a Part D plan when he or she is entitled to Part A or is enrolled in Part B and permanently resides in the service area of the plan. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.

5. **Special Election Period (SEP):** CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, Medicare beneficiaries who are also eligible for Medicaid can enroll in or disenroll from Medicare Advantage plans throughout the year.

   Note:
   Special Needs Plan (SNP): These enrollees may change Medicare Advantage plans at any time during the year with changes effective the first of the following month, subject to CMS approval.

   Dual- Eligible: Medicare covers a diverse group of people. Most are over 65, but 15 percent (nearly 7 million) are people under 65 who have a disability. Almost half (47 percent) have modest or low incomes, and over one-third (36 percent) of the Medicare population has three or more chronic conditions. Medicare also covers many people who have a cognitive or mental impairment (29 percent of the Medicare population).

A significant portion (17 percent) of the Medicare population is also enrolled in Medicaid. These beneficiaries are known as dual-eligibles.

After CMS confirms the enrollee's eligibility, the health plan sends the member a letter to confirm his or her enrollment. A new member will also receive:

1. An ID card
2. A provider directory
3. A formulary (which lists the prescription drugs covered)
4. An *Evidence of Coverage* (*EOC*) document
5. *Summary of Benefits*

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. CMS provides directives on member enrollment and disenrollment dates; they are not determined by the plan. If retro-activity occurs, this may have an impact on claims payments.

IntegraNet is contracted with Medicare Advantage companies that provider Medicare Advantage Special Needs Plans (SNPs) and integrated Medicare Advantage Prescription Drug (MA-PD) plans. All network providers are contracted with IntegraNet through a *Participating Provider Agreement*. As a participating provider in the IntegraNet Medicare network, your contract will have a participation addendum for each plan that includes the rate sheet in which you participate.

2.2 Plans serviced by IntegraNet Health

We have contracted with licensed health maintenance organization who have contracted with CMS to provide Dual-Eligible Special Needs Plans (D-SNPs), Chronic Special Needs Plan (C-SNPs), as well as traditional Medicare Advantage Prescription Drug health plans.

For Amerigroup/Anthem Medicare Advantage we are delegated for the following functions in the Houston, San Antonio and North Texas Markets:

- Provider Relations/Network Management
- Ancillary, Hospital and Physician contracting
- Utilization Management (UM)
- Case Management
- Claims Payment
- Risk Adjustment and Quality Reporting

Plans included are as follows:

- Amerivantage Classic (HMO)
- Amerivantage Select (HMO)
- Amerivantage COPD (HMO SNP)
- Amerivantage Diabetes (HMO SNP)
- Amerivantage Heart (HMO SNP)
- Amerivantage Dual Coordination (HMO SNP)
- Amerivantage Dual Premier (HMO SNP)
- Amerivantage Dual Secure (HMO SNP)

All plans listed above include full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other health care services beyond those offered by traditional fee-for-service Medicare. **Not all plans are offered in all service areas or carry the same supplemental benefits**. Please see the appropriate *Summary of Benefits* document online at https://providers.amerigroup.com or for more information.

Amerivantage Dual Coordination (HMO SNP), Amerivantage Dual Premier (HMO SNP), and Amerivantage Dual Secure (HMO SNP) are available to Medicare beneficiaries who are entitled to Medicare Part A (Part A), enrolled in Medicare Part B (Part B) and eligible for coverage of Medicare cost sharing and in some cases additional Medical Assistance from the state (either as full benefit dual-eligible, Qualified Medicare Beneficiary (QMB or QMB Plus), or Specified Low-income Medicare Beneficiary (SLMB Plus). (Low-income Subsidy [LIS] copays are by the state SNP Agreement). Any cost sharing applied to Medicare-covered medical services can be billed to the appropriate Medicaid carrier for process in accordance to the beneficiary's Medicaid coverage. Please always refer to the *Explanation of Payment* (*EOP*) sent with each claim processed.

Amerivantage Dual Coordination (HMO SNP), Amerivantage Dual Premier (HMO SNP), and Amerivantage Dual Secure (HMO SNP) plans do not have out-of-network benefits. All out-of-network services must be authorized prior to rendering services.

Amerivantage Classic (HMO) and Amerivantage Select (HMO) plans are available to Medicare beneficiaries who are entitled to Part A and enrolled in Part B. These plans have copays for most services. Amerivantage Classic (HMO) and Amerivantage Select (HMO) plans do not have out-of-network benefits. All out-of-network services must be authorized prior to rendering services.

Amerivantage COPD (HMO SNP), Amerivantage Diabetes (HMO SNP), Amerivantage Heart (HMO SNP), and Amerivantage ESRD (HMO-POS SNP) are Chronic Condition Special Needs Plans (C-SNPs). C-SNPs restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum.

We are contracted for Network Management for the following plans, but Utilization Management (UM), Case Management, Claims, Customer Service, etc. are administered by the respective health plans:

- Amerigroup Medicaid
- Aetna
- Oscar

2 Contact Information

3.1 Reporting Changes in Address and/or Practice Status

Any changes in a provider's address and/or practice status can be updated online by logging in to http://integraNetHealth.com or reported to your local IntegraNet office, Provider Relations Department.

Credentialing Address	
IntegraNet Health 2900 N. Loop West # 700 Houston, Texas 77092	Phone: 281-591-5261 or 1-833-908-0108 Fax: 281-591-5261 Credentialing@IntegraNetHealth.com

3.2 Contacting IntegraNet

Market	Provider Relations
Houston	IntegraNet Health 2900 N. Loop West, Suite # 700 Houston, Texas 77092 Phone: 281-447-6800 or 1-833-908-0105 PR@IntegraNetHealth.com
Dallas	IntegraNet Health 3010 LBJ Freeway, Suite 1450 Dallas, Texas Phone: 972-764-0970 or 800-994-0947
San Antonio	IntegraNet Health 736 S. Alamo St, San Antonio, TX 78205 Phone: 210-664-4020 or 800-994-0895 Fax: 210-664-4020

3.3 Contacting Health Plans

Market	Provider Relations Address
Houston, Dallas, San Antonio	https://Amerigroup.com

3.4 IntegraNet Provider Portals

IntegraNet provides access to 3 portals, that contains a full complement of online provider resources. The websites feature online inquiry tools to reduce unnecessary telephone calls by enabling easy access to the following resources:

Online support services, https://InetDr.com :

- New user registration and activation, login help, and username and password reset
- Provider panel reports
- Online daily PCP quality reports
  - Hospital/inpatient admission, transfer and discharge reports
  - HEDIS measures

Online references, https://IntegraNetHealth.com

- Forms to update provider demographics and information such as tax ID or group affiliation changes
  - Interactive look-up tools and reference materials, such as:

- Provider/referral directories
- Precertification lookup tool
- Claims status/submission tool
- Reimbursement policies
- Provider manuals and quick reference cards (provider manuals are available two ways, via the provider website or through your local Provider Relations representative)

Claims portal, https://InetClaims.com:

- Online Claims status
- EOPs

4 ACCESS TO CARE

4.1 Access and Availability Standards

Participating IntegraNet providers must:

- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call IntegraNet provider is available to administer care when the PCP is not available.
- Should not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

Type of appointment (medical or behavioral)	Availability standard
Patient visit with new PCP	Within 30 calendar days
Routine follow-up or preventive care	As soon as possible but within 30 calendar days
Routine/symptomatic	Within 7 days
Nonurgent care	Within 7 days
Urgently needed services	Within 24 hours
Emergency	Immediately

IntegraNet monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing.

Providers and hospitals are expected to treat all plan members with the same dignity and consideration as afforded to their non-Medicare patients.

4.2 Appointment Scheduling

IntegraNet, through its participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The PCP should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

4.3 Covering Physicians

During a provider's absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: 1) make arrangements with one or more IntegraNet network providers to provide care for his or her members or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question.

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider's behalf.

4.4 Nurse Help Line

Health plans provide a nurse help line, which is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. A nurse help line provides triage services and helps direct members to appropriate levels of care.

The nurse help line telephone number is listed on the member's ID card. This ensures members have an additional avenue of access to health care information when needed. Features of the nurse help line include:

- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to providers' offices within 24 hours of the call

4.5 Nonemergency Services

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than four to six weeks, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 48 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 45 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no

greater than 14 days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

4.6 Emergency Services

IntegraNet does **not** discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for precertification for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

5 Roles and Responsibilities

5.1 The Medicare Advantage Provider Network

Medicare members obtain covered services by choosing a PCP who is part of the network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine and preventive care and behavioral health care).

Note: Some services provided by a specialist may require precertification or a referral. All referrals to a provider that are not within the IntegraNet network requires precertification. Please refer to Provider Obligations — Precertification.

When referring a member to a specialist, it's critical to select a participating provider within our Medicare network to maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services at 833-908-0108. If you believe you must refer to a provider outside of our network, you must notify IntegraNet in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories however does not include urgent or emergent services. Please refer to Provider Obligations — Precertification..

5.2 The PCP Role

Members are asked to select a PCP when enrolling in a plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month

except in extenuating circumstances. IntegraNet contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining precertification for covered services for members. Medicare-participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists or geriatricians. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Any referral to a provider outside of the network will require precertification from IntegraNet.

When coordinating member care, the PCP should refer the member to a participating provider within the IntegraNet network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require precertification from IntegraNet or the services may not be covered. Contact UM at the 281-591-5289 or 888-292-1923 or questions or more information.

5.3 The Specialist Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from IntegraNet before performing certain procedures or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* or *EOC* documents for each health plan for those procedures requiring precertification. You can review precertification requirements online at https://InetDr.com or the health plan's website.

After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP.
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information.

If the specialist needs to refer a member to another provider, the referral should be to another IntegraNet provider. Any referral to a nonparticipating provider will require precertification from IntegraNet. Please refer to Provider Obligations — Precertification..

5.4 Participating Provider Responsibilities

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting IntegraNet standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
- Participate in systems established by IntegraNet to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members
- Provide hearing interpreter services on request to members who are deaf or hard of hearing
- Participate in and cooperate with IntegraNet in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by IntegraNet
- Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 10 years
- Participate in and cooperate with the IntegraNet appeal and grievance procedures
- **Agree to not balance bill** members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually-eligible member covered both by Medicare and Medicaid, federal law requires providers may bill only the member's health plan or the state Medicaid agency for copays or other cost-sharing amounts. **Providers may not bill such members for cost sharing.**)
- Continue care in progress during and after termination of a member's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act of 1990* (*ADA*)
- Support, cooperate and comply with IntegraNet Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Inform IntegraNet if a member objects to the provisions of any counseling, treatments or referral services for religious reasons
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons

- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearched-related care
- Participate in the interdisciplinary care team meetings when necessary
- If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the IntegraNet provider directory to ensure the specialist is in the network. Referrals to IntegraNet-contracted specialists do not require precertification, all referrals to providers outside IntegraNet require precertification unless urgent or emergent services are needed. Some procedures performed by specialist physicians may require precertification. Please refer to the *Summary of Benefits* document for procedures that require precertification or call 281-591-5289. If you cannot locate a provider in the IntegraNet network, you should contact 833-908-0108. You must obtain authorization from IntegraNet before referring members to noncontracted providers. Additionally, certain services/procedures require precertification from IntegraNet.
- Provide **advanced** notification to members of services that are not covered by the plan or Medicare in accordance with Medicare requirements.

Note: IntegraNet does **not** cover the use of any experimental procedures or experimental medications, except under certain circumstances.

6 Provider Network Information

6.1 Enrollment and Eligibility Verification

All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment and coverage by performing the following steps:

- Request the member's IntegraNet ID card; if there are questions regarding the information, call Amerivantage Provider Services at 1-866-805-4589 to verify eligibility, deductibles, coinsurance amounts, copays and other benefit information or use the online provider inquiry tool at https://providers.amerigroup.com
- If the patient does not have an ID card, use the Amerigroup online provider inquiry tool at https://providers.amerigroup.com or call Amerivantage Provider Services at the DSU at 1-866-805-4589
- Copy both sides of the member's IntegraNet ID card and place the copies in the member's medical record
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes

- If you are a PCP, check your IntegraNet Member Panel Listing via https://InetDr.com to ensure you are the member's doctor

6.2 Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. IntegraNet requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at 833-908-0108 to address the situation. IntegraNet staff will contact the member and provide more extensive education and/or case management as appropriate. It is the IntegraNet goal for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

6.3 Second Medical or Surgical Opinion

Members may request a second opinion if they:

- Dispute the reasonableness of a decision.
- Dispute the necessity of a procedure decision.
- Do not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the IntegraNet network.
- Be responsible for the applicable copay.

6.4 Emergency Care

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 result in:

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

IntegraNet covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services.
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard.

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency hospital. Precertification for an emergency medical condition is not required.

6.5 Urgently Needed Care

Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. However, precertification is not required.

Urgently needed services are defined as those that are covered but are not emergent services and are provided:

- When the member is temporarily absent from the IntegraNet service area and such services are medically necessary and immediately required
- As a result of an unforeseen illness, injury or condition
- If it is not reasonable given the circumstances to obtain the services through an IntegraNet network provider

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the IntegraNet provider network is temporarily unavailable or inaccessible.

6.6 Telemonitoring

Telemonitoring is the coverage of in-home equipment (e.g., BP cuff, scale, glucometer and pulse OC) and telecommunication technology from contracted vendors to monitor enrollees with specific health conditions as determined by their physician. Conditions must be appropriate for this service, such as monitoring of weight for CHF and other chronic conditions that require regular monitoring of vital signs and/or other data as required by a physician. This service requires an initial physician visit and a physician's order for data transmission; however, the data will be transmitted at least on a weekly basis. Physicians are trained on monitoring protocols, and follow-up actions are required. The member is instructed on the use of the equipment, proper transmission and related processes. Telemonitoring services supplement but do not replace a face-to-face physician visit.

6.7 Hospital Services

There are two types of admissions:

- Elective inpatient admissions — precertification is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

IntegraNet, in coordination with admitting physicians and hospital-based physicians:

- Coordinates and conducts continued-stay coverage reviews.
- Provides appropriate referrals for extended-care facilities.
- Approves coverage of all services required for adequate discharge.

IntegraNet case managers assist in coordinating all needed services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

6.8 Preventive Services

The following preventive services are offered to members with no member copays or cost sharing:

- Preventive visit
  - Annual physical examination (in addition to the Medicare preventive visits)

    - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
  - Welcome to Medicare exam
  - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap tests, pelvic exams and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screenings
- Medical nutrition therapy services
- Pneumococcal shots
- Smoking cessation (counseling to stop smoking)
- Depression screening

6.9 Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider's agreement with IntegraNet. IntegraNet may also use financial incentives to reward providers for achieving certain quality indicator levels.

IntegraNet does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where IntegraNet approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with Medicare Advantage regulations.

6.10 Laws Regarding Federal Funds

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to *Title VI* of the *Civil Rights Act of 1964* as implemented by 45 CFR Part 84; the *Age Discrimination Act of 1975* as implemented by 45 CFR Part 91; the *Rehabilitation Act of 1973*; and the *Americans with Disabilities Act*.

6.11 Provider Panel — Closing a Panel

When closing a provider panel to new members or other new patients, providers must:

- Give IntegraNet prior written notice to Provider Relations or submission using the online portal/provider website. The Provider must indicate the provider panel is closing to new members as of a specific closing date and accept new members until that closing date.

- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with the health plan
- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers the practice participates
- Give IntegraNet prior written notice when reopening the provider panel, including a specific reopening date

6.12 Provider Panel — Transferring and Terminating Members

Health Plan will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.

A provider may request termination of a member due to fraud, disruption of medical services or the member's repeated failure to make the required reimbursements for services. In such cases, the provider should contact the health plan directly or IntegraNet Provider Relations.

6.13 Reporting Obligations

Cooperation in Meeting CMS Requirements

IntegraNet is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

IntegraNet provides the following information:

- Plan quality and performance indicators
- Information on member satisfaction
- Information on health outcomes
- Performance Data
- HEDIS
- Medical Risk Adjustment

Providers must cooperate with IntegraNet in its data reporting obligations including collection, evaluation and participation in reporting performance data and its Quality Improvement (QI) activities to improve the quality of care, services and member experience.

Certification of Diagnostic Data

IntegraNet is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

6.14 Marketing

Providers may not develop or use any materials that market IntegraNet or the plans without IntegraNet prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long

as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

7 QUALITY MANAGEMENT

IntegraNet maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. Key components of the program include but are not limited to:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The IntegraNet QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members. Practitioners and providers must allow IntegraNet to use performance data in cooperation with our quality improvement program and activities.

7.1 CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families and caregivers for comparing MA-PD plans based on a one to five rating:

- * * * * * equals excellent
- * * * * equals very good
- * * * equals good
- * * equals fair
- * equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

1. Staying healthy — screening, tests and vaccines:
    - Colorectal cancer screening
    - Annual flu vaccine
    - Improving and maintaining physical and mental health
    - Monitoring physical activity
    - Adult body mass index assessment
2. Managing chronic conditions:
    - SNP Care Management
    - Care for the older adult: medication review, functional status assessment and pain screening
    - Managing osteoporosis in women who had a fracture
    - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
    - Controlling blood pressure
    - Managing rheumatoid arthritis
    - Improving bladder control
    - Reducing the risk of falling
    - Plan all-cause readmissions
    - Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

With the growing focus on quality health care and plan member satisfaction, CMS assesses MA plan performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey. Medicare beneficiaries who receive health care services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about his or her access to needed health care services. Several questions directly correlate to a plan's CMS star rating. The survey questions ask the member to report his or her opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

The rating system empowers consumers, families and caregivers with information to compare MA-PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families and caregivers results to make an educated decision about their health care needs. The ratings are posted online and may be accessed at https://www.medicare.gov. Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.

IntegraNet encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual.

- Educating members and talking to them during each visit about their preventive health care needs and disease management goals.
- Ensuring providers answer any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral.
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department and speaking to a case manager.

7.2 Care Coordination Policy Board

The Care Coordination Policy Board has multiple purposes. The CCPB assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The CCPB identifies opportunities to improve services and clinical performance by establishing, reviewing and updating *Clinical Practice Guidelines* based on review of demographic and epidemiologic information to target high-volume, high-risk and problem-prone conditions. The CCPB oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The CCPB advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The CCPB approves and provides oversight of the peer review process, the QM Program and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.

The CCPB's responsibilities are to:

- Utilize an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

7.3 Credentialing Committee

The Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with IntegraNet, and oversight of organizations for which credentialing has been delegated.

The CC's responsibilities are to:

- Consider/act in response to provider sanctions.
- Approve credentialing/recredentialing policies and procedures.
- Review practitioner and provider credentialing and recredentialing applicants for participation in IntegraNet provider networks.
- Provide pre-delegation, ongoing oversight and annual review of delegated entities.

- Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation.
- Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation.

8 HEALTH CARE MANAGEMENT SERVICES

IntegraNet continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with IntegraNet in efforts to promote healthy lifestyles, improve quality of life and wellbeing through member education and removing barriers to health care.

Providers must fully comply with:

- Health care management services policies and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The health care delivery system is a gatekeeper model that supports the role and relationship of the PCP. The model includes PCPs, hospitals, specialty physicians and other providers as required to deliver Medicare benefits, additional benefits and IntegraNet programs for members with complex medical needs.

All members select a PCP upon joining the plan. IntegraNet works with the member, the physician and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

IntegraNet is delegated by the health plan to administer services **except for**:

Pharmacy Benefits (Part D)
Customer Service (such as Cards, PCP selection, etc.)
Transplants
Behavioral Health

We can assist providers with gaining access to any of these services from the health plan, but the health plan administers/manages these services.

8.1 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (e.g., routine physical examinations, prostate screening and preventive women's health services, such as Pap tests)

Except for emergent or out-of-area urgent care and dialysis services, in general, Medicare members must obtain services within the IntegraNet network or obtain a precertification for covered services outside the network. As a contracted provider with the plan, you are responsible for either referring within the network or obtaining prior authorization from the plan.

8.2 Referral Guidelines

PCPs may only refer members to IntegraNet contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, such as an HMO member and has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Provider Services at 833-908-0105. Provider must obtain precertification from IntegraNet before referring members to nonplan providers. Referring a Medicare member out-of-network will result in the claim denying with member liability unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained from the plan.

Providing Noncovered Services Advanced Notification

For services that require prior authorization or are non-covered by the plan (i.e., statutory exclusion), it becomes extremely important that IntegraNet authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow IntegraNet authorization protocols, IntegraNet may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS-issued guidance concerning Advance Notices of Noncoverage. The ABN is an FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS, the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the health plan.

8.3 Precertification

Certain services/procedures require precertification from IntegraNet for participating and nonparticipating PCPs and specialists. Please refer to the list below or for Amerigroup specific codes use the Precertification Lookup tool online @ http://www.providers.amerigroup.com/pages/pluto.aspx or call Utilization Services at 281-591-5289 for more information.

You can also access information concerning precertification requirements and the directory listing of participating providers on our website at https://InetDr.com.

The following are examples of services requiring precertification before providing the following nonemergent or urgent care services:

- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Referrals and services from noncontracted providers

- Durable Medical Equipment (DME)*
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Referrals outside of the IntegraNet network
- Requests for noncovered services under the Medicare program
- Inpatient Admissions
- LTAC
- Inpatient Rehabilitation

The following are examples of services that require precertification from the health plan, not IntegraNet:

- Inpatient mental health services
- Transplant evaluation and services
- Behavioral health partial hospitalization
- Part D Drugs that require Authorization (also see 20 Prescription Drug Coverage)

For services that require prior authorization or are noncovered by the plan (i.e., statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow authorization protocols, IntegraNet may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

A written coverage determination will help ensure that a claim for noncovered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a noncovered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the noncovered service.

Contact us prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with us, you are prevented from billing the Medicare member for any service that is deemed noncovered if you have not ensured this advanced notification has been issued.

8.4 Medically Necessary Services and Medical Criteria

IntegraNet requires precertification for coverage of selected nonemergent outpatient and ancillary services. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the need for the request (14 days' advance notification for standard requests and three days' advance for expedited)

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of provider/physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT code

- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

8.5 Case Management

Multiple clinical and coverage determination guidelines are used to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS, National and Local Coverage and Benefit Guidelines, current editions, MCG Guidelines (formerly Milliman Care Guidelines®), IntegraNet *Medical Policies* and *Clinical Utilization Management Guidelines* to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and comorbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Clinical Care Policy Board and updated when appropriate. Input from the medical community is solicited and used in developing and updating policies. Policies and procedures for application of medical necessity criteria are reviewed and approved annually.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our IntegraNet members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the *Social Security Act*, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the *Social Security Act*, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria are made available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director.

For additional information, to speak to a Medical Director, obtain UM criteria or for any inquiries, contact may be made by calling 281-591-5289.

8.6 Care Transition Protocols Abd Management

Case Management is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional and social needs.

The scope of Case Management includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- Member education
- Community Resources
- Member empowerment using motivational interviewing techniques
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services, community resources, benefits and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

A core feature of Case Management is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional and social needs. The purpose of the program is to engage members of identified risk populations and to follow them across health care settings, to collaborate with other health care team members to determine goals and to provide access to resources and monitor utilization of resources. IntegraNet works with the member to identify specific needs and interfaces with the member's providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, IntegraNet develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to:

- Conditions that compromise member safety

- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

We work closely with the member and providers to develop and implement the plan of care.

If you have identified a patient as a possible candidate for case management and wish to have them evaluated to see if they qualify, you can call 832-456-2600 or 877-356-3705 or ask for someone in the Case Management department. The Case Management department is available Monday-Friday from 8 a.m. to 5 p.m. EST.

8.7 Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and includes changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and care giver, coordination between health care professionals and a provider network with appropriate specialists who can address complex needs. Transitional care includes both the receiving and sending aspects of the transfer.

Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with a goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Managing transitions in care is a responsibility of the interdisciplinary care team (ICT). The membership of the team varies based on the complexity of the member's needs and the desires of the member and type of transition. The team consists of providers, the member and/or care giver, and members of our care management team and/or Community Health Workers.

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider. The provider network includes providers who have an expertise in managing the health care needs. Some of the provider types available in our network to manage the special need of this population include but are not limited to:

- Geriatricians, physical medicine and physiatrists
- Skilled nursing facilities
- Ancillary providers and facilities
- Cardiologists
- Endocrinologist
- Diabetic educators
- Dialysis centers
- Social workers and nursing professionals available through home health agencies
- Behavioral health providers and facilities (through Amerivantage and the Amerivantage Network).

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Those protocols include the following guidelines:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network)
- Provide coverage 24 hours a day, 7 days a week
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Participate in the interdisciplinary care team meetings
- When a member experiences a transition in care, it is the responsibility of the transferring provider to do the following:
    - Notify the member in advance of a planned transition
    - Provide documentation to the provider or facility about the member to assist in providing continuity of care
    - Communicate and follow up with the member about the transition process

- Communicate with the member about his or her health status and plan of care to prevent any gaps post transition
- Provide a treatment plan/discharge instruction to the member prior to being discharged from one level of care to another

- The referring physician or provider should provide the relevant patient history to the receiving provider
- Any pertinent diagnostic results should be forwarded to the receiving provider
- The receiving provider should communicate a treatment plan back to the referring provider
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider

We assist our members and providers in the management of transitions in multiple ways. The actions below represent some of the ways our care team works with our providers and members to coordinate care:

- Communicates with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments
- Coordination between Medicaid and Medicare benefits
- Perform medication reconciliation
- Arranging transportation
- Refer to external or internal programs
- Coordinate care with behavioral health
- Assist with arranging durable medical equipment (DME) and home health services
- Coordinate and facilitate transitions to the appropriate level of care
- Provide the member with disease specific education and self-management techniques
- Contact high-risk members post discharge to reduce unnecessary readmissions
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition

9 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

IntegraNet requires precertification of all inpatient elective admissions. The referring PCP or specialist physician is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the IntegraNet Health Utilization Management Services department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow IntegraNet to verify benefits and process the precertification request. For services that require prior authorization, IntegraNet makes case-by-case determinations that consider an individual's health care needs and medical history, in conjunction with nationally recognized standards of care.

Physician Portal

The IntegraNet physician portal is the preferred method for the submission of preauthorization requests for providers requesting inpatient and outpatient medical services for members.

Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, or online portal).

- Initiate preauthorization requests online, eliminating the need to fax. The portal allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, or portal.
- Instant accessibility from almost anywhere including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates including alerts, faxes and email if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access a link to the portal through our website at www.IntegraNetHealth.com or the portal directly at www.InetDr.com

To register for the portal, visit www.IntegraNetHealth.com

For an optimal experience with the portal Google Chrome is recommended. It is also recommended to clear the cache on a regular basis (browsing history).

For the below services, contact Amerivantage directly:
- Transplant services
- Behavioral Health

Our website will be updated as additional functionality and lines of business are added throughout the year.

Hospitals can confirm a precertification is on file using the portal or by calling Utilization Services at 281-591-5289 or 888-292-1923.

IntegraNet Health accepts electronic notifications of admission 24 hours a day, 7 days a week. The preferred method of electronic submission is through the IntegraNet Health Provider Portal at www.InetDr.com. Providers should contact the health plan directly for all inquiries regarding eligibility and benefits. to accept precertification requests through the portal.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an IntegraNet reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the Medical Director will contact the requesting physician to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse will notify the referring provider to submit the additional necessary documentation.

If the Medical Director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.

Member liability for inpatient admissions will be assigned only:

- When the denial is issued prior to the services being rendered
- When the important message from Medicare is delivered in accordance with CMS guidelines
- When inpatient services were rendered by a nonparticipating facility, were not precertified and are not considered services covered under the plan

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

9.1 Emergent Admission Notification Requirements

IntegraNet prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify IntegraNet of emergent admissions within one business day.

IntegraNet is available 24 hours a day, 7 days a week to accept emergent admission notification via the online portal at InetDr.com.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, an IntegraNet reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, IntegraNet will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

9.2 Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, 72 hours from the date and time of receipt of the admission notification. Urgent and emergent admissions require notification within one business day by the provider. The IntegraNet utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the Medical Director who renders a decision regarding the coverage of hospitalization.

9.3 Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. The IntegraNet concurrent review nurse or case manager (working with the IntegraNet Medical Director) will assist providers and hospitals with the discharge planning process in accordance with requirements of the Medicare Advantage program. At the time of admission and during the hospitalization, IntegraNet will discuss discharge planning with the provider, member and/or member advocate.

When the provider identifies medically necessary and appropriate services for the member, IntegraNet will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

9.4 Emergency Services

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. IntegraNet will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) caring for the member at the treating facility prevails and is binding on IntegraNet. If the emergency department is unable to stabilize and release the member, IntegraNet will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the IntegraNet concurrent review nurse will implement the concurrent review process to ensure coordination of care.

9.5 Post-stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Precertification is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicaid Network Rate. IntegraNet will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

9.6 Affirmative Statement About Incentives

IntegraNet, as a corporation and as individuals involved in UM decisions, is governed by the following statements:

UM decision-making is based only on the appropriateness of care and service and existence of coverage.

- IntegraNet does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for IntegraNet UM decision-makers do not encourage decisions that result in underutilization or create barriers to care or service

10 MEDICAL RECORDS

10.1 Requirements Overview

IntegraNet providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews

- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every member
- Kept in accordance with federal and state standards as described in this manual
- Retained for 10 years from the final date of the contract or from the date of completion of any audit
- Accessible upon request to Health Plan, IntegraNet, any state agency and the federal government

IntegraNet will:

- Systematically review medical records to ensure compliance with standards. The health plan's MAC oversees and directs Health Plans in formalizing, adopting and monitoring guidelines
- Institute actions for improvement when standards are not met
- Maintain a record keeping system that is designed to collect all pertinent medical management information for each member
- Make information readily available to appropriate health professionals and appropriate state agencies
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members

10.2 Member Medical Records Standards

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained and available at the primary care site for patient care.

Members are entitled to one copy of their medical record each year provided at no cost. Members or their representatives should have access to these records.

Medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author
4. Legibility - if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies — must note prominently:
    - Medication allergies
    - Adverse reactions
    - No known allergies (NKA)
6. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
8. Diagnostic information
9. Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
10. Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact the care.
11. All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.

12. Medical information including medication and instruction to patient
13. Identification of current problems
    - Serious illnesses
    - Medical and behavioral conditions
    - Health maintenance concerns
14. Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
15. Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times
16. Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
17. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
18. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
19. *Advance Directive* — must document whether the patient has executed an *Advance Directive* such as a *Living Will* or *Durable Power of Attorney*

10.3 Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A

single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

Other documentation not directly related to the member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

IntegraNet may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Section 1833(e) of the *Social Security Act*, states that Medicare payment can be made only when the documentation supports the service/item. IntegraNet is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

10.4 Patient Visit Data Records Standards

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints.
2. Behavioral health treatment, including at-risk factors:
    - Danger to self/others
    - Ability to care for self
    - Affect
    - Perpetual disorders
    - Cognitive functioning
    - Significant social health
3. Admission or initial assessment must include:
    - Current support systems.
    - Lack of support systems.
4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
    - Decreased
    - Increased
    - Unchanged

- A plan of treatment, including:
  - Activities.
  - Therapies.
  - Goals to be carried out.
  - Diagnostic tests.
  - Evidence of family involvement in therapy sessions and/or treatment.

5. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN.
6. Referrals and results of all other aspects of patient care and ancillary services.

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for 10 years from the date of service.

10.5 Medical Record Review

Federal regulations require Medicare MCOs and their agents review medical records to avoid over or under payment and verify documentation to support the diagnostic conditions. IntegraNet's Quality Management Committee may conduct medical record audits periodically and use the results in the provider recredentialing process.

10.6 Risk Adjustment Data Validation

Participation in risk adjustment data validation is required of all providers, and it is important that you are aware that medical records will be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

IntegraNet collects and reviews records for Risk Adjustment Data Validation on a quarterly basis. Under CFR 164.502 (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the *general consent* of the member. A general consent form should be an integral part of your medical record file.

More information related to risk adjustment can be found at www.cms.gov.

10.7 Quality Improvement and Reporting

Participation in quality improvement programs including HEDIS/5 STAR reporting is required of all providers, and it is important that you are aware that medical records will be requested from your office. Quality Metric abstraction will be performed on medical records to report HEDIS data to the health plan and CMS. Records may be used to evaluate additional resources or assist with predicative modeling to identify resources needed to improve patient wellbeing and quality of life.

10.8 Medical Record Collection

To accomplish 8.5, 8.6 and 8.7 and to eliminate the intrusion in your office and utilization of your resources, IntegraNet collects medical records remotely in quarterly projects. This is accomplished through execution of a data sharing agreement (Electronic Remote Access Agreement) and a Business Associates Agreement.

10.9 Advance Directives

Advance directives are written instructions that:

- Give direction to health care providers as to the provision of health care.
- Provide for treatment choices when a person is incapacitated.
- Are recognized under state law when signed by a competent person.

There are three types of *Advance Directives:*

- A *Durable Power Of Attorney* for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A *Living Will* allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

IntegraNet advance directive policies include:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the *Patient Self-Determination Act* and maintaining written policies and procedures regarding advance directives; providers must adhere to this act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directive form and education from their PCP at their first appointment
- Assisting members with questions about an advance directive; no IntegraNet employee may serve as witness to an advance directive or as a member's authorized agent or representative
- While members have the right to formulate an advance directive, an IntegraNet associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law
- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- IntegraNet or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
  - Describes the range of medical conditions or procedures affected by the conscience objection

- Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must:

- Comply with the *Patient Self-Determination Act* requirements.
- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive.
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member's discussion and action regarding the execution or nonexecution of an advance directive.
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact.
- Make an advance directive part of the member's medical record and put in a prominent place.
- The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician, if applicable.
- If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at http://www.nrc-pad.org.

11 CREDENTIALING

Credentialing refers to a process performed by IntegraNet to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration in the IntegraNet Provider Network. Upon completion of the credentialing process, each applicant is presented to the Credentialing Committee, which is comprised of physicians in various specialties, for review and recommendation. Initial credentialing is performed when an application is received. Recredentialing is conducted at least every three (3) years thereafter or as otherwise required by state regulations and at the discretion of IntegraNet.

Required supporting documentation must be submitted with each credentialing application. Such documentation may include, but is not limited to: licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency. Documentation submitted by an applicant and/or Providers' s office is verified for accuracy and completeness. At the discretion of IntegraNet an applicant may be required to submit additional information.

IntegraNet recognizes a Provider's right to review information submitted in support of his/her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process a Provider may request the status of his/her application by contacting the IntegraNet Credentialing Department. That fact that a Provider is credentialed is not intended to guarantee or promise of any level of care or service.

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit IntegraNet discretion in any way to amend, change or suspend any aspect of its credentialing program nor is it intended to create rights on the part of practitioners who seek to provide health care services. IntegraNet further retains the right to approve, suspend, or terminate individual physicians and health care professional, and sites in those instances where it has delegated credentialing decision making.

IntegraNet Health does not subdelegate credentialing.

11.1 Credentialing Scope

IntegraNet credentials the following licensed/state certified independent health care practitioners:

- Medical doctors
- Doctor of Osteopathic Medicine
- Doctor of Podiatry
- Chiropractors
- Oral maxillofacial surgeons providing Health Services covered under the Health Benefits Plan
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care telemedicine practitioners who provide treatment services under the health benefits plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors or Doctor of Osteopathic Medicine)
- Nurse practitioners
- Physician assistants (as required locally)
- Registered dieticians

Health Delivery Organizations (HDOs):

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Ambulatory surgical centers
- Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting, including:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community mental health centers (CMHC) ○ Crisis stabilization units ○ Intensive family intervention services
  - Intensive outpatient – mental health and/or substance abuse
  - Methadone maintenance clinics ○ Outpatient mental health clinics ○ Outpatient substance abuse clinics
  - Partial hospitalization – mental health and/or substance abuse ○ Residential treatment centers (RTC) – psychiatric and/or substance abuse
- Home infusion therapy agencies

The following HDOs and behavioral health practitioners are not subject to professional conduct and competence review , but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA)
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable X-ray suppliers
- Home infusion therapy when associated with another currently credentialed HDO
- Hospice
- Federally qualified health centers (FQHC)
- Rural health clinics
- Certified behavioral analysts
- Certified addiction counselors
- Substance abuse practitioners

11.2 Credentials Committee

The credentials committee is composed of a chairperson and IntegraNet participating Providers. Functions of the committee include credentialing, ongoing and periodic assessment of current policies/procedures, recredentialing, and the establishment of policies and procedures based on current guidelines and regulations.

11.3 Council for Affordable Quality Healthcare (CAQH)

IntegraNet Health is a member of CAQH, an online single-entry national database that eliminate the need for Providers to complete and submit multiple credentialing applications. Physicians and other health care providers who are members of CAQH can submit an initial credentialing application or the required recredentialing information rather than completing a credentialing application. Please note that non-participating providers interested in joining our network should use our online contact form at IntegraNetHealth.com. Additional information is available by contacting the IntegraNet Credentialing Department.

11.4 Nondiscrimination Policy

IntegraNet will not discriminate against any applicant for participation in its programs or provider network(s) based on race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, the company will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. IntegraNet will audit credentialing files annually to identify discriminatory practices in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, the company will take appropriate action(s) to track and eliminate those practices.

11.5 Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, IntegraNet has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will

review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid Reports
- Office of Personnel Management (OPM)
- State licensing boards/agencies
- Health Plan's Customer Services Departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal IntegraNet Departments
- Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

11.6 Appeals Process

Upon a denial, suspension, termination or nonrenewal of a physician's participation in the provider network, IntegraNet acts as follows:

The affected physician is given a written notice of the reasons for the action, including if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by IntegraNet. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- IntegraNet ensures the majority of the hearing panel members are peers of the affected physician
- IntegraNet notifies the NPDB, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies

InegraNet's decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. IntegraNet notified the NPDB, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to an appeal.

11.7 Reporting Requirements

When IntegraNet takes a professional review action with respect to a practitioner's or HDO, IntegraNet may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current *NPDB Guidebook*, the process in the *NPDB Guidebook* will govern.

12 PERFORMANCE AND TERMINATION

12.1 Performance Standards and Compliance

All providers must meet specific performance standards and compliance obligations. When evaluating a provider's performance and compliance, IntegraNet reviews several clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to health care costs
- Member satisfaction — measured by the members' reports regarding accessibility, quality of health care, member/provider relations and the comfort of the office setting
- Administrative requirements — measured by the provider's methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the provider's involvement with panels used to monitor quality of care standards

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment
- Comply with IntegraNet standards, including:
    - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity).
    - Federal, state and local laws regarding professional conduct.
- Comply with IntegraNet policies and procedures regarding the following:
    - Participating on committees and clinical task forces to improve the quality and cost of care
    - Prenotification and/or precertification requirements and time frames
    - Provider credentialing requirements
    - Referral policies
    - Case Management Program referrals
    - Appropriately releasing inpatient and outpatient utilization and outcomes information
    - Providing accessibility of member medical record information to fulfill IntegraNet business and clinical needs
    - Cooperating with efforts to assure appropriate levels of care
    - Maintaining a collegial and professional relationship with IntegraNet personnel, health plan and fellow providers
    - Providing equal access and treatment to all Medicare members

The following types of noncompliance issues are key areas of concern:

- Unnecessary out-of-network referrals and utilization (which require precertification)
- Failure to provide advance notice of admissions or precertification of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home health care services
- Member complaints and grievances filed against the provider
- Underutilization, overutilization or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Medicare members for monies that are not their responsibility
- Non-supportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, or if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, or has a criminal conviction, or an IntegraNet or health plan determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to covered individuals. Participating practitioners and HDOs whose network participation have been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation have been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

12.2 Physician – Patient Communications

Providers acting within the lawful scope of practice are encouraged to advise IntegraNet members of the following:

- Health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice.
Although coverage under this program is determined by IntegraNet, the provider remains responsible for all treatment decisions related to the Amerivantage plan member.

12.3 IntegraNet Plan-specific Termination Criteria

The occurrence of any of the following is grounds for termination of the IntegraNet provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept, unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet *ADA* guidelines
- Failure to maintain state license or DEA
- Failure to maintain Malpractice Insurance according to state minimum
- Failure to meet *Clinical Laboratory Improvement Amendments* (*CLIA*) guidelines
- Repetitive complaints about office staff demeanor, presentation and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers), Sams List or Preclusion List
- Unfavorable inpatient- or outpatient-related indicators:
    - Severity-adjusted morbidity and mortality rates above established norms

- Severity-adjusted length-of-stay above established norms
- Unfavorable outpatient utilization results
- Consistent inappropriate referrals to specialists
- Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
- Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
- Unfavorable malpractice-related issues
- Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

IntegraNet providers have 30 calendar days to appeal a termination. The IntegraNet process is designed to comply with all state and federal regulations regarding the termination appeal process.

12.4 Notification to Members of Provider Termination

Health plans make a good faith effort to provide at least 30 calendar days written notice of a provider's termination to all members who are seen on a regular basis by that provider before the termination effective date, regardless of the reason for the termination. Health plans may provide member notification in less than 30 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP, all members who are patients of that PCP are notified of the termination by the health plan.

13 Compliance and Ethics

13.1 General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, IntegraNet has a duty to help prevent, detect and deter fraud, waste and abuse. IntegraNet is committed to detecting, mitigating and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal *Deficit Reduction Act*, each provider is required to adopt IntegraNet policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which IntegraNet participates.

The IntegraNet policy on fraud, waste and abuse prevention and detection is part of the IntegraNet Corporate Compliance Program. Electronic copies of this policy and IntegraNet Code of Business Conduct and Ethics can be found on the website at www.IntegraNethealth.com/wfa.

IntegraNet maintains several ways to report suspected fraud, waste and abuse. As a Medicare Advantage provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously at https://www.IntegraNetHealth.com/wfa or by calling 1-855-535-1907. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported via email to privacyofficer@integraNetHealth.com. You can also reach out directly to the IntegraNet Chief Compliance Officer at 832-333-1917 or send an email to complianceofficer@IntegraNetHealth.com.

In order to meet the requirements under the *Deficit Reduction Act*, you must adopt the IntegraNet fraud, waste and abuse policies and distribute them to any staff members or contractors who work with IntegraNet. If you have questions or would like more details concerning the IntegraNet fraud, waste and

abuse detection, prevention and mitigation program, please contact the IntegraNet Chief Compliance Officer.

13.2 Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting.

Many types of fraud, waste and abuse have been identified, including the following:

Provider fraud, waste and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member fraud, waste and abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. IntegraNet may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** the plan member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their IntegraNet member ID card at all times, and report any lost or stolen cards to the health plan as soon as possible.

IntegraNet believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members

to protect their IntegraNet ID card can help prevent fraud, waste and abuse. IntegraNet encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and IntegraNet will make every effort to maintain anonymity and confidentiality.

13.3 Health Insurance Portability and Accountability Act

The *Health Insurance Portability and Accountability Act* (*HIPAA,* also known as the *Kennedy-Kassebaum Bill*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

IntegraNet strives to ensure both IntegraNet and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the *HIPAA* privacy regulations.

IntegraNet recognizes its responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting IntegraNet. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by IntegraNet to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to IntegraNet, verify the receiving fax number is correct, notify the appropriate staff at IntegraNet and verify the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to IntegraNet (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at IntegraNet.

The IntegraNet voicemail system is secure and password-protected. When leaving messages, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting IntegraNet, providers should be prepared to verify their name, address and tax identification number or national provider identifier number.

13.4 Prohibition Against Discrimination

Neither IntegraNet nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members for any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

13.5 Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Strive to expand cultural knowledge.
- Understand cultural and linguistic differences.

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include but are not limited to:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the United States health care system
- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

To be culturally competent, IntegraNet expects providers serving members within their geographic locations to demonstrate the following:

Cultural Awareness

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity

Cultural Knowledge

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person's rejection or acceptance of medical advice and treatment
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

Cultural Skills

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

13.6 *Americans With Disabilities Act* Requirements

IntegraNet policies and procedures are designed to promote compliance with the *ADA*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair

- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street side parking
- Street-level access

13.7 Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from IntegraNet to ensure no misrouted PHI is included. Misrouted PHI includes information about members whom a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Relations to report the receipt of misrouted PHI.

13.8 Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage program and provisions of *HIPAA* concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

14 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

14.1 Claims — Billing and Reimbursement

Clean claims for Medicare members are generally adjudicated within 30 calendar days from the date IntegraNet receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by IntegraNet and the information required from the provider in order to adjudicate the claim. IntegraNet produces and mails an *Explanation of Payment* (*EOP*) on a daily basis. The *EOP* delineates for the provider the status of each claim that has been paid or denied.

Medicare members must **not** be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Medicare members are also not held liable for noncovered services where the provider failed to provide advanced notice of noncoverage via the organization determination process. Reimbursement by IntegraNet constitutes payment in full except for applicable copays, deductibles and coinsurance. These amounts will be indicated on the *EOP* and direction provided based on whether IntegraNet is responsible for processing both the primary and secondary claims or not. In instances where IntegraNet is only responsible for processing primary claims, the provider should

bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for Specialty + Rx plan members.

Provider must use *HIPAA*-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the *Participating Provider Agreement* will not be required to replace such billing codes. IntegraNet follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with *HIPAA*. IntegraNet will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim "Corrected Claim." Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

Provider Obligations — denial notification and member complaints, appeals and grievances Providers are required to adhere to CMS and IntegraNet requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans

14.2 Claim Status

Providers should access the IntegraNet online claim status inquiry tool at https://Inetclaims.com or call 541-464-6296 to check claim status. An enrollment packet must be completed to access the portal. The enrollment packet is located online at https://IntegraNetHealth.com.

14.3 Provider Claims

Providers should submit claims to IntegraNet as soon as possible after service is rendered. Claims should be filed using the *CMS-1500* (02-12) or *CMS-1450* (UB-04) claim form or filed electronically.

14.4 Coordination of Benefits

IntegraNet and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When IntegraNet is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if IntegraNet does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

IntegraNet will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, IntegraNet will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post payment to determine likely cases based on information obtained through communications with members and providers. IntegraNet handles the filing of liens and settlement negotiations both internally and externally via its vendors.

IntegraNet requires members to cooperate in the identification of any and all other potential sources of payment for services.

Skilled Nursing Facilities and Home Health Agencies

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued to a Medicare member at least two days prior to discharge, or in advance of the last two covered visits This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and IntegraNet is required to ensure proper delivery and that the member's signature is obtained. The member's signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a member refuses to sign the notice, the provider may contact the member's representative to have that person sign. If no representative is available, the provider may annotate the notice to indicate the refusal and document that notification was provided to the member, but the member refused to sign. If in-person notification cannot be provided to a representative, he or she can be contacted telephonically to advise him or her of the notice and their appeal rights. If agreed by both parties, the notice can then be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). The notice should be annotated by the person providing the notification to the representative indicating the date, time, person name, relation to the member, telephone number called, and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or IntegraNet Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be

issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

14.5 Provider Obligations — In-office Denials

In the event a member disagrees with the provider's decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by the plan or Medicare. At each patient encounter with a Medicare member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from IntegraNet regarding the member's services. The provider must request us to provide a detailed notice of a provider's decision to deny a service in whole or part; in turn, we must give the member advanced written notice of the determination, by following the precertification process (outlined below).

For services that require prior authorization or are noncovered by the plan (i.e., statutory exclusion), it becomes extremely important that IntegraNet authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow IntegraNet authorization protocols, IntegraNet may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The CMS has established guidelines concerning *Advance Notices of Non-Coverage* (*ABN*). The *ABN* is a FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS, The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

A written coverage determination will help ensure that a claim for noncovered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a noncovered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the noncovered service.

Please contact IntegraNet prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with IntegraNet, you are prevented from billing the Medicare member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

14.6 Provider Obligations — Precertification

Providers are responsible for obtaining precertification from IntegraNet before performing certain procedures, when rendering noncovered services or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* document for those procedures that require precertification or

call Provider Services at the DSU at 1-866-805-4589. IntegraNet will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between IntegraNet and the provider will not generate a member denial letter.

- An initial *organization* determination is any determination (e.g., an approval or denial) made by IntegraNet for coverage of medical services (Part B-covered services).
- An initial *coverage* determination is any determination (e.g., an approval or denial) made by IntegraNet for coverage of prescription drugs (Part D-covered services).

When IntegraNet Health processes a coverage request that involves a prior authorization (PA) or other utilization management (UM) requirement, such as step therapy for IntegraNet Health determination on whether to grant approval of a service for a provider constitutes an initial determination and is subject to appeal. In addition, if IntegraNet Health denies coverage of a service 28 or a because the provider failed to seek PA or failed to comply with similar limits on coverage, the denial also constitutes an initial determination and is subject to appeal.1

Thus, the adjudication timeframe, notice, and other requirements applicable to coverage determinations or organization determinations under, subpart apply to requests that involve a PA or other UM requirement in the same manner that they apply to all coverage requests. If a provider requests coverage of a service, item, or drug that involves PA, the plan must accept and process the request as a coverage determination or organization determination and should contact the physician or prescriber for information needed to satisfy the PA, in accordance with the outreach guidance at IntegraNet Health.

14.7 Electronic Submission

Payer ID: INET1

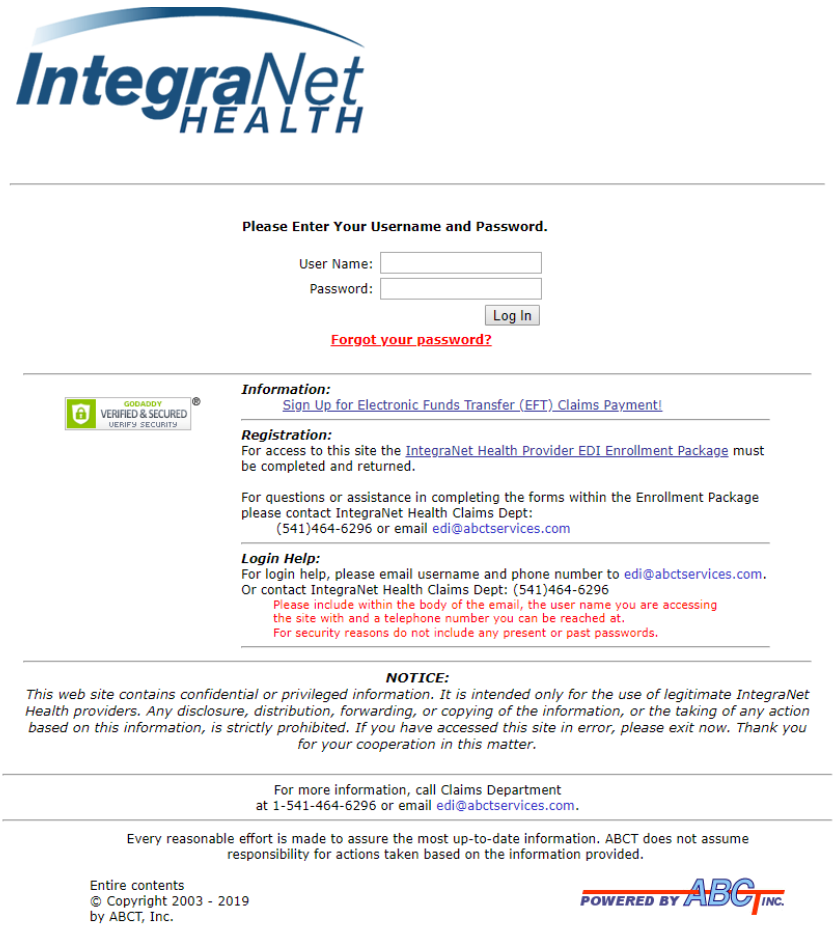
Clearinghouse	Payer number	Website
VisibilEDI	INET1	https://www.visibiledi.com/integranet
TriZetto	INET2 & INETU(UB04)	

You may use your existing clearing house or use the IntegraNet clearing house - VisibilEDI.
To enroll with VisibilEDI, go online to https://www.visibiledi.com/integranet/Home/Login

The most common clearing houses
IntegraNet Health Payor ID for professional Claims: INET1

Change
IntegraNet Health Payor ID for Professional Claims: INET2
IntegraNet Health Payor ID for Institutional Claims: INETU

**** clearing houses may have variation of "INET". Contact your clearing house directly would provide the correct payor ID variation.**

Portal	Electronic claims Submission **Claims may also be submitted directly into the claims system electronically on the claims portal at:** **Https://Inetclaims.com** 

Timely filing for each market is within the number of days listed in the table below from the date of service.

Market	Timely filing (days from Date of Service)
Texas	95

95 days for contracted providers
365 days (1yr) non-contracted providers

14.8 Paper Claims Submission

Providers also have the option of submitting paper claims. IntegraNet uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt

- Immediate image retrieval by IntegraNet staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500* (*08-05*) within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, IntegraNet now requires the use of the new *CMS-1500* (*08-05*) for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, IntegraNet now requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (*08-05*) and *UB-04 CMS-1450* must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-9 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- IntegraNet provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

IntegraNet cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. IntegraNet will not accept claims from those providers who submit entirely handwritten claims, except in New Jersey where providers are permitted to submit handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service:

Market	Timely filing (days)
Texas	95

Submit paper claims to the following address:

Market	Submit paper claims to:
Paper claims for all Medicare markets	2900 North Loop W, Ste 700 Houston, TX 77092

14.9 Claims Adjudication

All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or an *UB-04* or *CMS-1450* and provider claims using the *CMS-1500*.

Providers must use *HIPAA*-compliant billing codes when billing IntegraNet. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. IntegraNet will not pay any claims submitted using noncompliant billing codes.

IntegraNet reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and IntegraNet is notified of the eligibility/enrollment.
- Claims submitted after the market specific timely filing deadline will be denied.

After filing a claim with IntegraNet, review the weekly *EOP*. If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the IntegraNet website at http://www.InetClaims.com/ .

If the claim is not on file with IntegraNet, resubmit your claim within 90 days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

14.10 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner.
- Is accurate to include all required information and supporting documentation
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS 1450 or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by IntegraNet.

Clean claims are typically adjudicated within 30 calendar days of receipt. If IntegraNet does not adjudicate the clean claim within the time frames specified above, IntegraNet will pay all applicable interest as required by law.

IntegraNet produces and mails an *EOP* on bi-weekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, IntegraNet should complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the IntegraNet contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, IntegraNet will pay at least 95 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 calendar days of the date of receipt. IntegraNet will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date IntegraNet receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

14.11 Claim Inquiry

A question about a claim or claim payment is called an Inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. in other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

14.12 Claim Payment Disputes

Provider Claim Payment Dispute process

If you disagree with the outcome of a claim, you may begin the IntegraNet provider payment dispute process. There are two types of submissions that are handled within the dispute process:

- **Provider Payment Dispute**: The claim has been finalized but you disagree with the amount that you were paid;

- **Provider Administrative Plea/Appeal**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are ***not*** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** When IntegraNet requests further information to finalize a claim.

Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials is in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the existing provider post-service appeal process. An example of a post-service medical necessity appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied. For more information on each of these, please refer to the appropriate section in this provider manual.

The IntegraNet provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. **Claim Payment Reconsideration:** This is first step in the IntegraNet provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim Payment Appeal:** The second step in the IntegraNet provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues
- Disagreements over reduced claims or zero-paid claims not related to medical necessity
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

*Timely filing issues.

IntegraNet will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

14.13 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling our claims analyst at (832) 320-7220.

Web Portal (Reconsideration and Claim Payment Appeal): Reconsiderations and claim payment appeals via the secure Payment Appeal Tool at **https://inetclaims.zendesk.com**

- by submitting a ticket and supporting documentation. You will receive immediate acknowledgement of your web submission.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  IntegraNet
  Claims Department – Provider Disputes
  2900 North Loop West, #700
  Houston, Texas 77092

Required Documentation for Claims Payment Disputes

IntegraNet requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their IntegraNet or Medicare ID number.
- A listing of disputed claims, which should include the IntegraNet claim number and the date(s) of service(s).
- All Supporting statements and documentation.

14.14 Claim Payment Reconsideration

The first step in the IntegraNet claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

IntegraNet accepts reconsideration requests in writing, verbally and through our provider web portal within 120 days from the date of the Explanation of Payment (EOP). Non contracted providers must submit a request for a partially denied or fully denied claim within 60 days from the date on the EOP. A waiver of liability is required for non-contracted provider reconsideration requests. Reconsideration requests not filed in the time frames permitted will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

Providers are encouraged to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate IntegraNet clinical professionals.

IntegraNet will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days.

We will send you our decision in a determination letter when upholding our decision, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider's right to request a claim payment appeal within 180 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately. Overturned decisions will result in an adjustment and EPOs.

14.15 Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination you may submit a claim payment appeal. When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

IntegraNet will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claim payment appeal request.
2. A statement of what action the plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

<u>Appeals submission by mail</u>:

IntegraNet Health Attn: Claims
2900 North Loop West #700
Houston, TX 77092

Submission via web: IntegraNet Provider Portal: https://inetclaims.zendesk.com/hc/en-us/requests/new Submission by phone (Verbal): (832) 320-7220
Submission by Fax: 1-800-783-9885
*Appeals form must be filled out and submitted with any supporting documentation for review.

There are two steps in the internal complaint process:

· Initial Review
· Second-Level Review

The first level in the appeals process
Which involves a review of an adverse organization determination by IntegraNet Health, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS.

The second level in the appeals process
Which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the provider submits, or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C appeals process in which an independent review entity reviews an adverse plan decision.

Initial Review

1. Complaints may be verbal or in writing. The request should indicate the remedy or corrective action being sought. For example, a complaint may deal with a claim denial, and the remedy being sought is payment of the claim.

2. IntegraNet Health acknowledges the reconsideration and determines if there is further documentation needed. If additional information is needed the provider will be contacted to obtain additional documentation.

3. The Initial Complaint Review Committee investigates the complaint. The committee, which consists of one or more IntegraNet Health employees who were not involved in a prior decision to deny the claim, investigates the reconsideration.

4. The committee decides and notifies the provider. The committee makes a decision within 30 calendar days of receiving a complaint. The provider will be notified within five business days of the committee's decision. The notification states the reason for the decision and the providers appeal rights.

If a provider accepts the decision of the Initial Complaint Review Committee, no further action is required; however, if the provider appeals the decision, the complaint procedures continue with the Second-Level Review.

Second-Level Review

1. Provider appeals the decision of the Initial Review Committee (Level one reconsideration).

2. Within 60 calendar days of the decision of the Initial Complaint Review Committee, a provider may file an appeal in writing to IntegraNet Health Second-Level Review Committee. This committee consists of three or more people who did not participate in the matter under review.

3. IntegraNet Health acknowledges the appeal and begins to process.

4. IntegraNet Health conducts a Second-Level Review Committee meeting. The committee makes a decision based upon the Second-Level Review Committee hearing.

5. Second-Level Review Committee makes a decision. The Second-Level Review Committee issues a written notification within five business days of making its decision, specifying its reasons. The decision letter includes information about how to file a complaint with a government agency.

14.16 Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, IntegraNet makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, IntegraNet will use it to finalize the claim.

The following table provides examples the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the email **claims@integranethealth.com** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence 2900 North Loop W, Ste 700 Houston, TX 77092
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence 2900 North Loop W, Ste 700 Houston, TX 77092

Need to submit a Corrected Claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to: Corrected Claim 2900 North Loop W, Ste 700 Houston, TX 77092 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to IntegraNet to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence 2900 North Loop W, Ste 700 Houston, TX 77092

14.17 Cost Sharing

Billing Members & Balance Billing

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost-sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS 5010* claims form; in such a case, no balance billing is permitted.

In the case of dual-eligible members covered by both Medicare and Medicaid, federal law requires providers to bill only the member's Medicaid health plan or the state Medicaid agency for copays or other cost-sharing amounts. Providers may not bill such members for cost sharing. The chart below indicates how cost sharing is paid, either by IntegraNet or the state Medicaid agency. IntegraNet processes the claim for reimbursement when IntegraNet has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when IntegraNet does not have an arrangement with the state Medicaid agency. In states where IntegraNet pays cost sharing, claims will be processed under the member's account for both Medicare and

Medicaid benefits. In the states where IntegraNet does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by IntegraNet. Please check your *EOP* upon claims adjudication.

14.18 Cost-Sharing Responsibility for Special Needs Plan Members

Amerivantage SNP + RX Member	Amerivantage Classic + Rx Member	Amerivantage Balance + Rx Member	Rationale
Claim is process at 100 percent of the provider's contract rate.	Claim is process according to your contracted rate minus any applicable cost sharing as filed in the member's benefit package.	N/A	Health plan pays cost sharing as field in their Medicare bids. The provider does not bill the state.

NOTE: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the *Balanced Budget Act of 1997*. Providers that service dual eligible beneficiaries must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

The rules governing balance billing as well as the rules governing the MA payment of MA-plan, noncontracting and Original-Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider. There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare) participating provider. The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the member's cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing. MA-plan, noncontracting, nonparticipating DME supplier.

The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or

- The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to nonnetwork providers may be found in *MA Payment Guide for Out-of-network Payments* at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefits* their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting nonparticipating Medicare provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

14.19 Overpayment Process

Overpayments: An overpayment can be identified by the provider or IntegraNet Cost Containment Unit (CCU). If the provider identifies the overpayment, they can either submit a refund check all with an explanation of refund and/or Explanation of Payment (EOP) to IntegraNet or they can call Claims at (832) 320-7220 and approve a recoupment from any future payments to the provider. If IntegraNet identifies the overpayment, a recovery letter will be sent to the provider, the provider has 45 days to submit a refund check or appeal the refund request. If the provider doesn't respond within 45 days from the date of the recovery letter, then recoupment will begin on any future payments. Refund checks along with explanation of refund can be sent to: IntegraNet Claims Department 2900 North Loop West, Ste 700 Houston, TX 77092

IntegraNet uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

14.20 Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice

IntegraNet offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive IntegraNet payments electronically through Direct deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- *HIPAA*-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by IntegraNet

Benefits providers may experience include:

- Faster receipt of payments from IntegraNet
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

To register for ERA/EFT, please visit our website at https://InetClaims.com or the forms are also on IntegraNetHealth.com

Primary Care Provider Reimbursement

IntegraNet reimburses PCPs according to their contractual arrangement.

Specialist Reimbursement

Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with IntegraNet.

Specialty care providers must obtain IntegraNet approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization, as appropriate, and receipt of the required claims and encounter information to IntegraNet.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's IntegraNet benefit plan. These policies can be accessed at These policies can be accessed at:
https://www.IntegraNetHealth.com/page/reimbursement-policies
Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

Provider are required to use industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The

billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current *Reimbursement Policies* are not followed, IntegraNet may:

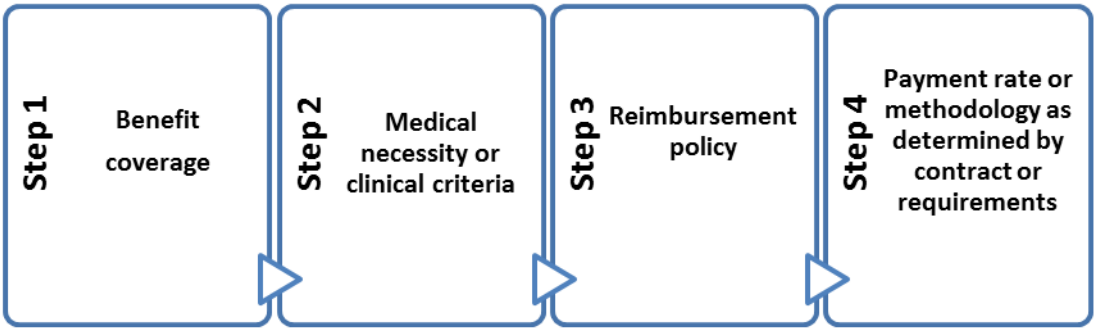
- Reject or deny the claim.
- Recover and/or recoup claim payment.

IntegraNet's *Reimbursement Policies* are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, IntegraNet strives to minimize these variations.

IntegraNet reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy at https://IntegraNetHealth.com

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered conditions of payments.



Review Schedules and Updates

Reimbursement Policies undergo reviews for updates to state contracts, federal or CMS requirements, and/or IntegraNet business decisions. We reserve the right to review and revise our policies when necessary. Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements and/or IntegraNet business decision. When there is an update we will publish the most current policy at; https://www.IntegraNetHealth.com/page/reimbursement-policies

Reimbursement by Code Definition

IntegraNet allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

1. Evaluations and management
2. Anesthesia

3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure.

14.21 Loss of Medicaid Coverage for Special Needs Plan Members

Amerigroup/Amerivantage

Amerivantage Dual Coordination (HMO SNP) members are either full dual-eligible beneficiaries (FBDE) with both Medicare and full Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB Plus). In New Jersey, New Mexico and Texas, individuals considered Specified Low-Income Medicare Beneficiaries (SLMB Plus) can also enroll in the Amerivantage Dual Coordination (HMO SNP). Medicare members who temporarily lose their Medicaid coverage may be required to pay cost sharing and copays for services until their Medicaid coverage is re-established. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

14.22 Administrative Appeals

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

14.23 Member Liability Appeals

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals and Grievance (MCAG) department at AmeriVantage.

14.24 Provider Liability Appeals

A provider liability appeal is a request for IntegraNet to review a decision by IntegraNet to deny payment (without member liability) for services already rendered. To submit a request for appeal, send in a copy of the *Explanation of Payment* received along with all medical records to IntegraNet. The provider is responsible for sending in all necessary information, after which time the appeal will be reviewed and a determination rendered based on the information provided.

15 PROVIDER COMPLAINT AND GRIEVANCE PROCEDURE

IntegraNet has a formal process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see Provider Payment Disputes. For Medicare member liability appeals, see Medicare Member Appeals. Providers may access this process by filing a

written grievance. Provider grievances will be resolved fairly and consistent with IntegraNet policies and health plan covered benefits.

Providers are not penalized for filing complaints. Supporting documentation should accompany the complaint and be forwarded to the nearest IntegraNet office location.

MARKET	PROVIDER RELATIONS ADDRESS
Texas: **Dallas/Fort Worth**	IntegraNet Health
Houston	IntegraNet Health 2900 North Loop W, Ste 700 Houston, TX 77092
San Antonio	IntegraNet Health 736 S Alamo St San Antonio, TX 78205

16 INTEGRANET COMPLAINTS, APPEALS, GRIEVANCES AND DISPUTES

16.1 Distinguishing between IntegraNet, Health Plan, Provider and Medicare Advantage Member

Complaints, Appeals and Grievances

There are separate and distinct processes for requests to reconsider an IntegraNet decision on an authorization or request for payment upon claims submission. On processing each request, assignment of liability for the service is determined.

All Medicare member liability denials are subject to the Medicare Complaint, Appeal & Grievance (MCAG) process as outlined in the member appeals and grievances section. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member would follow the IntegraNet participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with IntegraNet and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow IntegraNet to make an expedited decision. Your participation in, along with the member's election of the Medicare Advantage plan, are an indication of consent to release those records as part of the health care operations.

Medicare Member Liability — IntegraNet has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare member cost-share. Any time a member liability denial letter is issued, the member appeals process should be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *Medicare Managed Care Manual*, *Chapter 13: Appeal rights* with subsequent review by the Independent Review Entity (IRE).
- Notice of Medicare Non-Coverage (NOMNC) is issued as per the *Medicare Managed Care Manual*, *Chapter 13: Appeal rights* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- an *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

NOTE: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the *Balanced Budget Act of 1997*. Providers that service dual-eligible beneficiaries must accept the amounts paid by Medicare as payments in full, as well as any payment under the state Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Participating Provider Liability — IntegraNet has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating providers are prohibited from billing a Medicare member for services unless the health plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability — IntegraNet has determined that the nonparticipating provider with the plan has failed to follow Medicare processing guidelines nonparticipating providers are prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

16.2 IntegraNet Participating Provider Appeals and Disputes

Participating Provider Appeals follow the standard IntegraNet process for provider appeals IntegraNet participating providers may initiate provider appeals under the provider complaint and appeal procedures. The processing of a particular provider appeal may vary depending on whether or not it involves a review of medical necessity. The provider complaint and appeals procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The provider complaint and appeal procedures are designed to permit IntegraNet to examine issues fully and fairly before completion of the IntegraNet internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. IntegraNet typically determines provider appeals within 60 days (for utilization review cases) or 60 days (for other cases) when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal

A formal request for review of a previous IntegraNet decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing
- Submitted within 180 days* from the IntegraNet decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute the original decision
  - Include necessary attachments:
  - Copy of the original IntegraNet decision
  - All applicable medical records

NOTE: IntegraNet will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:
Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
2900 N. Loop West #700
Houston, Texas 77092

Providing the above information will enable the IntegraNet Participating Provider Appeals team to properly and timely review requests within 60 business days. Requests that do not follow the above may be delayed.

*Days from original denial date may differ, depending upon the contract and/or state requirement

Medicare Participating Provider Administrative Plea/Appeal

A formal request for review of a previous IntegraNet decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered.

Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved. Provider Administrative Plea/Appeals Responsibility:

All requests must be:

- Submitted in writing
- Submitted within 180 days* from the IntegraNet decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the administrative rules were not followed and requires an exception to be made or extenuating circumstance that warrants a re-review of the request for provision of payment.
- Include necessary attachments:
  - Copy of the original IntegraNet decision

- All applicable medical records

NOTE: In the event IntegraNet waives the administrative requirement, should your request require a medical review, IntegraNet will not request additional records to support the providers argument and expects the provider to submit the necessary information to substantiate their request for payment.

Requests should be mailed to:

IntegraNet Health
Attention: Claims Department
2900 North Loop West #700
Houston, Texas 77092

Providing the above information will enable the IntegraNet Participating Provider Appeals team to properly and timely review requests within 60 business days. In the event IntegraNet waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable time frames.

Requests that do not follow the above may be delayed.

*Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP)

Medicare Provider Payment disputes (Claims Re-review)
A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or/and claims payment determinations have already been rendered.

All payment disputes must be:

- Submitted in writing
- Submitted within 60 days from the IntegraNet original payment
- Include a cover letter with:
  - Claim Identifiable information
  - Specific rationale as to why the payment made is not appropriate or needs adjust
- Include necessary attachments:
  - Copy of the original IntegraNet payment (*EOP*)
  - All applicable medical records or other attachments supporting additional payment

NOTE: IntegraNet will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Providing the above information will enable the IntegraNet Payment Dispute Unit to properly and timely review requests. Requests that do not follow all the above may be delayed.

*NOTE: Days from original denial date may differ, depending upon the contract and/or state requirement (MMP/DSNP)

16.3 IntegraNet Nonparticipating Provider Payment Disputes

Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process.

16.4 IntegraNet Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment, the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability* form must be included. To obtain this form, please go to:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip. The purpose of the *Waiver of Liability* form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing and mailed to:**

Grievances and Appeals
2900 North Loop West Ste, #700
Houston, Texas 77092
Or filed online at **https://inetclaims.zendesk.com**
Fax: 832-320-7221

16.5 IntegraNet Member Complaints, Appeals and Grievances

Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

16.6 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants IntegraNet to reconsider and change an initial coverage/organization determination (by IntegraNet or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether IntegraNet will reimburse for a service, benefit, or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and IntegraNet denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by IntegraNet or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by IntegraNet concerning reimbursement for a health care service
- An adverse initial organization determination by IntegraNet concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by IntegraNet or a provider concerning authorization for prescription drugs

Appeals should be sent to:
Medicare Complaints, Appeals & Grievances
Attention: Member Appeals Unit
2900 North Loop West #700
Houston, Texas 77092
Fax: 281-447-6802

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request standard service or expedited appeals on behalf of their members; however, if not requested specifically by the attending, an *Appointment of Representative Form* to submit an appeal on behalf of a Medicare member, may be required. The *Appointment of Representative Form* can be found online and downloaded at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be used when requesting services and initiating the appeals process **Appeal time frames**
- Members or their authorized representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.
- For standard service appeals, service and payment issues must be resolved within 30 calendar days from the date the request was received.
- If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal are may be submitted orally or in writing. Such appeals generally resolved within 72 hours, unless it is in the member's interest to extend this time period.
- For payment appeals, service and payment issues must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

16.7 Further Appeal Rights

If IntegraNet is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- IntegraNet will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and decide:
  - Within 72 hours if expedited
  - Within 30 days* if the appeal is related to authorization for health care
  - Within 60 days* if the appeal involves reimbursement for care
  - Prescription drug appeals are not forwarded to the IRO by IntegraNet but may be requested by the member or representative; information will be provided on this process during the IntegraNet member appeals process
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ)
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court

*Some plans may have different turnaround times due to state requirements.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to the expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When a Medicare Advantage member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than noon of the first working day after the member receives the Notice of Discharge and Medicare Appeal Rights. The QIO will decide within one full working day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, IntegraNet continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

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

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

16.8 Medicare Member Grievance

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with IntegraNet, health plan or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

If a Medicare member has a grievance about IntegraNet, health plan a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card.

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for the most current information regarding Member Grievances.

17 MEMBER RIGHTS AND RESPONSIBILITIES

Providers are required to adhere to CMS and IntegraNet requirements concerning issuing letters and notices. IntegraNet members have the right to timely quality care and treatment with dignity and respect. Each member should receive a copy of the *Explanation of Coverage* from the health plan which outlines the member's rights and responsibilities. Providers must respect the rights of all IntegraNet members.

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for a list of the members rights and responsibilities.

18 MEMBER MANAGEMENT SUPPORT

18.1 Health Promotion

Health plans develop or purchase educational materials and disseminated to members. Health education classes are coordinated with community organizations and network providers.

IntegraNet's Population Outreach Department utilizes Texas State Certified Community Health Workers (CHWs) to engage patients in their health care using community resources and health plan educational material.

The CHWs also visit patients in their homes to offer one-on-one assistance.

18.2 Member Rewards for Health Program*

Health plans may offer Health Programs that reward members for receiving preventative health care services. Members have the option of receiving up to a total of $50 in gift cards per calendar year per CMS.

You may be asked to review or sign a form from the health plan. The member will return the form. For additional information regarding the Health Programs offered by the health plans, please refer to their webpage.

The goal of the program is to increase early detection, decrease the cost of treatment and improve members' quality of life.

19 BENEFITS

19.1 Summary of Benefits Tables

Benefits are administered and managed by each health plan for their respective benefit plans.

19.2 Supplemental Benefits

Supplemental benefits are those benefits in addition to the basic Medicare services offered through Medicare Part A and B, they are not benefits offered under the federal Medicare program. Please refer to the health plan's applicable *Summary of Benefits* for specific supplemental benefits being offered for each plan, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under the health plan. Members cannot be billed for non-covered services unless notified in advance.

Supplemental benefits vary by plan, product and state. Please refer to the *Summary of Benefits* documents for details on which plans cover certain supplemental benefits. Providers are encouraged to call the toll-free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

NOTE: Not all supplemental benefits are available in all plans, and some limitations and restrictions apply. Some supplemental benefits must be rendered by the delegated vendor to be covered.

19.3 Dental Services

Some plans include preventive dental services that are covered by the health plan through a contracted dental vendor, except for dental services covered as emergency services. Please see the health plan's *Summary of Benefits* documents for more information on dental benefits.

19.4 Optometry And Audiology Services

Some plans include coverage of routine vision and hearing services, including:

- Routine yearly visual exams.
- Screening for glaucoma.
- Hearing screening.

Please see the health plan's *Summary of Benefits* documents for more information on vision and hearing benefits. Contracted network providers, assisted by the IntegraNet Case Management Program, can coordinate benefits for lenses and hearing aid devices when covered by the plan.

19.5 Over-The-Counter Items

Some plans include coverage of OTC items and health-related supplies. For those plans that include this benefit, members are provided with a monthly or quarterly allowance to obtain the items and supplies. For plans with a quarterly allowance, the benefit replenishes at the beginning of each quarter and carries across quarters, but any unused portion of the benefit does not carry over to the next year. For plans with a monthly allowance, the benefit replenishes at the beginning of each month, but any unused portion does not carry over to the next month. OTC products are described in a printed catalogue available to members.

19.6 Nonemergent Transportation

In many markets and benefit plans, health plans provide nonemergent transportation through a contracted vendor. See the health plans *Summary of Benefits* documents for more information.

Contact the Patient Health Outreach Services department for additional assistance at 832-333-1900.

20 PRESCRIPTION DRUG COVERAGE

IntegraNet is not delegated for Part D. All claims, policies, processes, benefits are determined and administered by the respective health plans.

All Amerivantage plans (Dual Coordination (HMO SNP), Classic HMO and ESRD (HMO-POS SNP) plans) include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

20.1 Part D Prescription Drugs

Medicare Part D prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications.

Amerigroup/Amerivantage

Part D prescription drugs covered by Amerivantage are listed in the Amerigroup five-tier formulary. The formulary includes all generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. A copy of the formulary on the Amerigroup website at https://providers.Amerigroup.com. From the *Provider Resources and Documents library*, select **Pharmacy Tools**, then **Medicare Formulary** or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Amerigroup Provider Services at 1-866-805-4589. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician's prescription.

Please refer to the formulary when prescribing for Amerigroup members. Though most medications on the formulary are covered without Prior Authorization (PA), a few agents will require you to obtain an authorization.

For Amerivantage Part B, please call 281-591-5289, Option 1, from 8 a.m. to 8 p.m. local time, Monday through Friday. For Amerivantage Part D, contact Express Scripts Provider Services at 1-800-338-6180, 24 hours a day, 7 days a week.

20.2 Prescription Drugs by Mail Order

AmeriVantage

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for the most current information regarding Mail Order for prescription drugs.

20.3 Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered DME, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician's service require precertification from IntegraNet. Please call 281-591-5289 for additional information.

20.4 Covered Vaccines

CMS, IntegraNet and Amerigroup, through the Amerivantage plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D and those covered under either Medicare Part B or Part D coverage.

20.5 Vaccines and Vaccine Administration Coverage Under Part B Benefits

Medicare Part B (Medical) benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine
- Hepatitis B vaccine

Providers who have a supply and administer the vaccine in their office should collect the member's copay at time of service and submit the claim for the vaccine and administration on a *CMS 1500* (*08-05*) form to:
IntegraNet Health
Attn: Claims Department
2900 North Loop West #700
Houston, Texas 77092

20.6 Vaccines and Vaccine Administration Coverage Under Part D Benefits

Medicare Part D (pharmacy) generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the health plan formulary located online at https://providers.amerigroup.com.

From the *Quick Tools* link, select **Pharmacy Tools**, then **Medicare Formularies**. Providers who do not have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.

Providers who have a supply and administer the vaccine in their office should collect the member's copay at time of service and submit the claim for the vaccine and administration on a *CMS 1500* (*08-05*) form to:
Attn: Claims Department
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

To streamline your claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX, a clearinghouse for claims submission for Part D coverage. To use TransactRX please contact the clearinghouse at the web site (http://www.transactrx.com) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

For member copayment information, please call Amerigroup at 1-866-805-4589.

20.7 Vaccines Covered Under Either Part B or Part D Benefit Coverage

Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Anthrax vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) on a CMS 1500 (08-05) claims form and submit to:

Providers who have a supply and administer the vaccine in their office should collect the member's copay at time of service and submit the claim for the vaccine and administration on a *CMS 1500* (*08-05*) form to:
Attn: Claims Department
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at https://www.cms.gov.

20.8 Coverage Determinations for Part D Prescription Drug Benefits

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for the most current information regarding coverage determinations for Part D Prescription Drug benefits.

20.9 Formulary Exceptions

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for the most current information regarding Formulary Exceptions.

20.10 Transition Policy

New members in plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next.

Please refer to the Amerigroup Provider Manual on their website at https://providers.Amerigroup.com for the most current information regarding Transition Policy.

Please note the IntegraNet transition policy applies only to those prescription drugs that are Part D drugs.

21 FORMS

Note: Do not use the Authorization Form if you are submitting a refund check. If you would like to submit a refund, please use the Overpayment refund notification form. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments

Provider authorization to adjust claims and create claim offset

Authorization Form

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name:	
Provider NPI:	
Provider tax identification No.:	
Provider contact information:	
Cost Containment project number	(If applicable)
Document Identification No.	(if applicable)
Total recoupment dollar amount:	

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at 833-908-0105

I authorize IntegraNet to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____ _____

Print Name Signature

Mail this form to:
IntegraNet
Attn: Cost Containment – Disputes
2900 N. Loop West, #700
Houston, Texas 77092

Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an IntegraNet check, please include a completed form specifying the reason for the check return.

Provider Name/Contact _____

Contact Number _____

Provider ID _____

Provider Tax ID _____

Subscriber ID _____

DCN Number (Displayed on CCU Letter) _____

Member Name _____

Member Account Number _____

Date of Service: [to] _____

Total Billed Charges: $_____

Total Check Amount: $_____

Claim Number(s):

Reason for Refund or Check Return:

□ Health Plan Letter
□ Contract Rate Change
□ Duplicate Payment
□ Incorrect Member
□ Incorrect Provider
□ Negative Balance
□ Other Health Insurance/Third-Party Liability
□ Payment Error
□ Billed in Error/Adjusted Charge
□ Other: _____

All refund checks should be mailed with a copy of this form to:

IntegraNet Health
Attn: Claims Dept.
2900 N. Loop West, #700
Houston, Texas 77092

Once IntegraNet has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this Overpayment Refund Notification Form.

Portal Submission Request Form

RE: CHANGE IN AUTHORIZATION REQUEST PROCESS FOR AMERIVANTAGE – INTEGRANET HEALTH

IntegraNet Health is delegated to perform utilization management services for Amerivantage patients of IntegraNet Health Primary Care Physicians.

Providers may submit authorization request online in the IntegraNet Health Provider Portal.

To submit a request, please identify a member(s) of your staff who will request authorizations. Complete and return the Portal Submission Request Form below and a user name and temporary password will be created for the Provider Portal. The user name and password will be emailed to the person identified on the form. **The email will come from noreply@aaneel.com** **NOTE: Should Portal access expire, enter user id and reset password

Upon entry into the Portal, the user will be required to change the password before proceeding any further.

Portal web address is: ***www.INETDR.COM***

The Portal can be used to submit prior authorization request(s), check authorization status, upload clinical documents to support the request, download and print determination letters, etc.
A step by step guide to access the portal is available at www.integranethealth.com for review. Please do not hesitate to contact the Utilization Management or Provider Relations Staff for questions, comments, etc. Your assistance in this matter is greatly appreciated.

Sincerely,
Utilization Management Department

Please Print

NPI #:	Provider Name:
Submitter's Last Name:	Submitter's First Name:
Email:	Address:
City:	State: Zip:
County:	Phone:

Please fax completed form to: **(281) 405-3431 , ATTN: UM Department.**
For assistance with the Provider Portal, contact (281) 591-5289

23 GLOSSARY OF TERMS

Appeal: any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by IntegraNet, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/dispute process.

Balance + Rx Plan: The Balance + Rx Plan provides coverage of major medical services after satisfaction of an annual deductible. Outpatient services, such as primary care and specialist visits, are covered with reasonable copays for professional services outside of the deductible. This includes Medicare Part D prescription coverage. This plan has no out-of-network benefits

Basic benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all health care services covered under Medicare Part A and B programs, except for hospice services. IntegraNet also provides supplemental benefits not covered by fee-for-service Medicare

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.

Classic + Rx Plan: The Classic + Rx Plan has copays for most services, and includes Medicare Part D prescription coverage

Contracting hospital: a hospital that has a contract to provide services and/or supplies to Medicare members

Contracting medical group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members

Contracting pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the IntegraNet contract

Coverage determination: the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug

Covered services: those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by IntegraNet or its providers
- Emergency services and urgently needed services that may be provided by non-par providers
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Dual-eligible: a Medicare enrollee who is eligible for Medical Assistance from the state and for whom the state has a responsibility for payment of Medicare cost-sharing obligations under the state plan. Dual-eligibles are limited to the following categories of recipients: Qualified Medicare Beneficiary (QMB)

Only, QMB Plus, Specified Low-income Medicare Beneficiary (SLMB) Plus and other Full Benefit Dual Eligible (FBDE) recipients.

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

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

Emergency services: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard

Experimental procedures and items: procedures and items determined by IntegraNet and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, IntegraNet will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare.
Section 1862(a)(1)(E) of the *Social Security Act*, prohibits payment for procedures that are deemed experimental and/or investigational in nature

Exceptions: an exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the IntegraNet tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

Fee-for-service Medicare: a payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare)

Full Benefit Dual-Eligible (FBDE): an individual who is eligible for both Medicare Part A and/or Part B and for state benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan

Grievance: a complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff

Home health agency: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by their primary care physician

Hospice: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families

Hospital: a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent

nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living

Hospitalist: a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's primary care physician during the member's inpatient stay.

Independent practice association: a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices

Medicaid: the federal health insurance program established by *Title XIX* of the *Social Security Act* and administered by states for low-income individuals

Medically necessary: medical services or hospital services determined by IntegraNet to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by IntegraNet. *Section 1862(a)(1)(A)* of the *Social Security Act*, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.

Medicare: the federal health insurance program established by *Title XVIII* of the *Social Security Act* and administered by the federal government for elderly and disabled individuals

Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.

Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer

drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B premium: a monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by health maintenance organizations. The health maintenance organization must provide all Part A and B services in its plan and may offer additional benefits to the beneficiary.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. IntegraNet offers MA-PD plans in specific markets.

Medicare Advantage (MA) agreement: the agreement between IntegraNet and CMS to provide Medicare Part C and other health plan services to IntegraNet members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Amerivantage plan is a kind of MA plan.

Member: a Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in a Medicare Advantage plan and whose enrollment has been confirmed by CMS

Noncontracting medical provider or facility: any professional person, organization, health facility, hospital or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish health care services; and that is neither employed, owned, operated by nor under contract with IntegraNet to deliver covered services to Medicare members.

Provider: any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with IntegraNet to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.

Provider liability appeal: a request for IntegraNet to review a decision by the IntegraNet Health Care Management department for services already rendered and denied without Medicare member liability.

Provider payment dispute: a request for IntegraNet to review the claim adjudication as the provider feels payment was not rendered as per the contractual agreement between IntegraNet and the provider.

Primary Care Provider (PCP): a provider physician selected by a member to coordinate the member's health care. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Specified Low-income Medicare Beneficiary (SLMB) without other Medicaid (SLMB only): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the Federal Poverty Level (FPL) but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for Supplement Security Income (SSI) eligibility and who is not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-income Medicare Beneficiary with full Medicaid (SLMB Plus): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the FPL but less than 120 percent of the FPL, and his or her resources do not exceed twice the limit for SSI eligibility and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Qualified Medicare Beneficiary (QMB): an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance and copays (except for Medicare Part D). Collectively these benefits (services) are called QMB Medicaid benefits (services). Categories of QMBs covered by this contract are as follows:

- QMB Only — QMB who is not otherwise eligible for full Medicaid
- QMB Plus — QMB who also meets the criteria for full Medicaid coverage and is entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients

Service area: a geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Special Needs Plan (SNP): a type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of the IntegraNet SNP, the special class of members is comprised of persons who are both Medicare and Medicaid eligible. Plans offering SNPs receive special approval from CMS. A SNP also provides Medicare Part D drug coverage.

Dual Coordination, Dual Premier, and Dual Secure Plan: the IntegraNet dual-eligible special needs plan available to full benefit dual-eligible, Qualified Medicare Beneficiaries (QMB/QMB Plus), and Specified Low-Income Medicare Beneficiaries (SLMB Plus), depending on the state. Although this plan has cost sharing for certain services, cost sharing is paid by the state Medicaid agency or by IntegraNet through an arrangement with Medicaid. There are low copays for Medicare Part D prescription coverage. This plan has no out-of-network benefits.

Urgently needed services: those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.