2017 PROVIDER MANUAL

Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

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RENAISSANCE PHYSICIANS OVERVIEW

The Independent Physicians Association (IPA) is a physician-run organization with local groups of primary care physicians (PCPs) and sub-specialists. The goal is to develop a managed health care delivery system in which the IPA accepts responsibility for a wide range of medical services, including primary care, specialty care, and diagnostic procedures.

The objective of the IPA is to create a PCP-driven delivery system, which allows the PCP to take full advantage of managed care marketing and to provide a steady flow of new patients. Each provider is grouped into a geographic area called a POD (Physician Organized Delivery system) centralized around a group of hospitals with set PCP and Specialist networks.

This manual contains an overview of the general health plan details as they relate to the day-to-day contact of the participating physicians with the customer and the IPA. The IPA encourages continual communication between the physicians and the IPA office to ensure a consistent working relationship. You will receive updates to this manual as changes to the policies or procedures occur.

Your participation and cooperation with the Independent Physicians Association is appreciated.

RENAISSANCE PHYSICIANS

Managed by GulfQuest, LP

Renaissance Physicians

- Non-profit corporation
- Renaissance contracts with health plans
- Renaissance contracts with LLCs and providers
- City-wide specialty panel
- Board comprised of PCPs and specialists
- Physician steering committee

Advantages of Renaissance

- One integrated contracting unit
- HMOs
- Physicians/providers
- Ability to contract with PPOs/direct to employers for potential new business in the future if warranted
- City-wide specialty network
- Specialist satisfaction
- Greater physician-involvement best practices

Renaissance Commitment

- Focus on greater Houston and Golden Triangle market
- Consistency with all health plan relationships
- Financial matrix consistency
- Financial reserve discipline
- Extensive physician profiling

Guiding Principles

- Specialist satisfaction

Improved capitation rates

- Higher rates
- Sub specialty capitation categories
- Specialists brought up to net-city-wide utilization
- Address PCP “dumping”
- Surplus funds distributed based on LLC criteria and not per contractual obligations
- Improved physician representation with LLCs

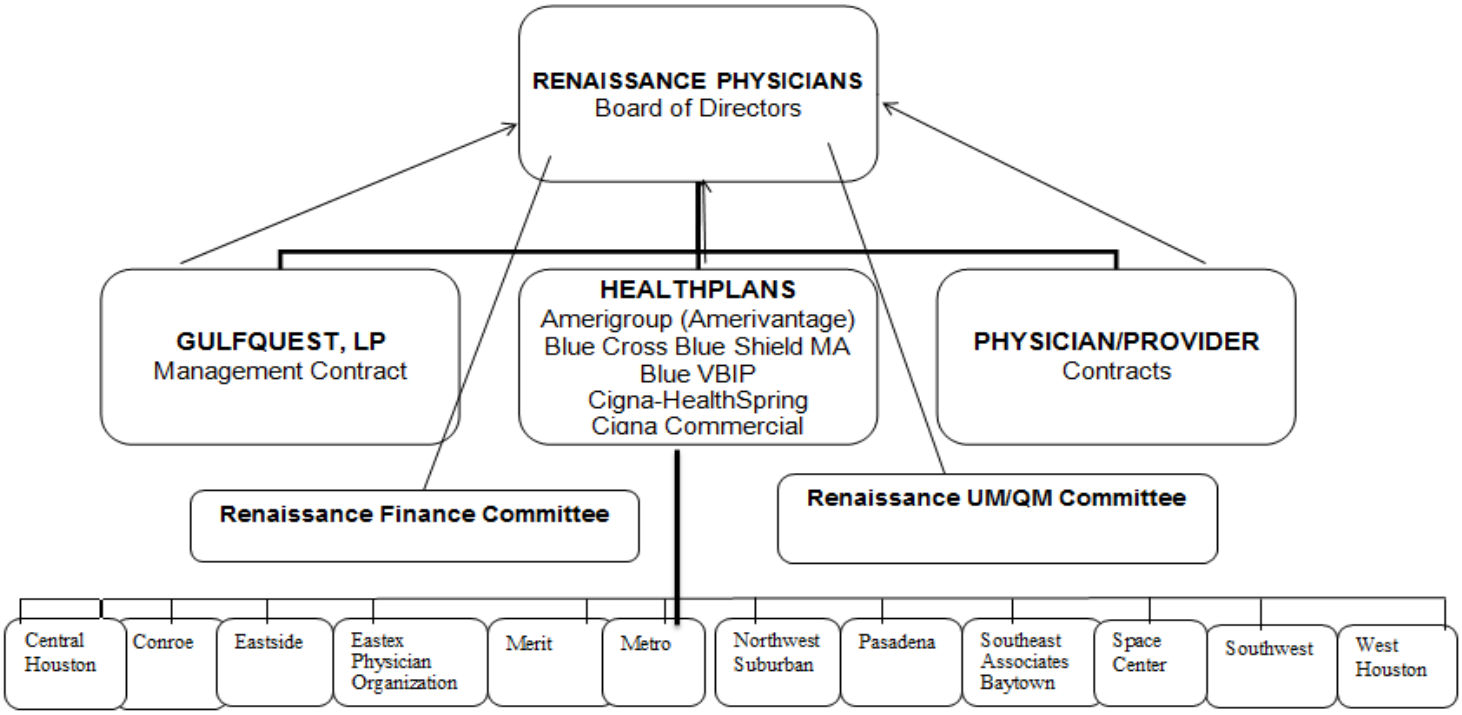
Duties of Renaissance

- Ultimate financial risk
- Credentialing
- Utilization/quality management
- Creation of guiding principles
- Create physician reimbursement guidelines
- Financial reserves

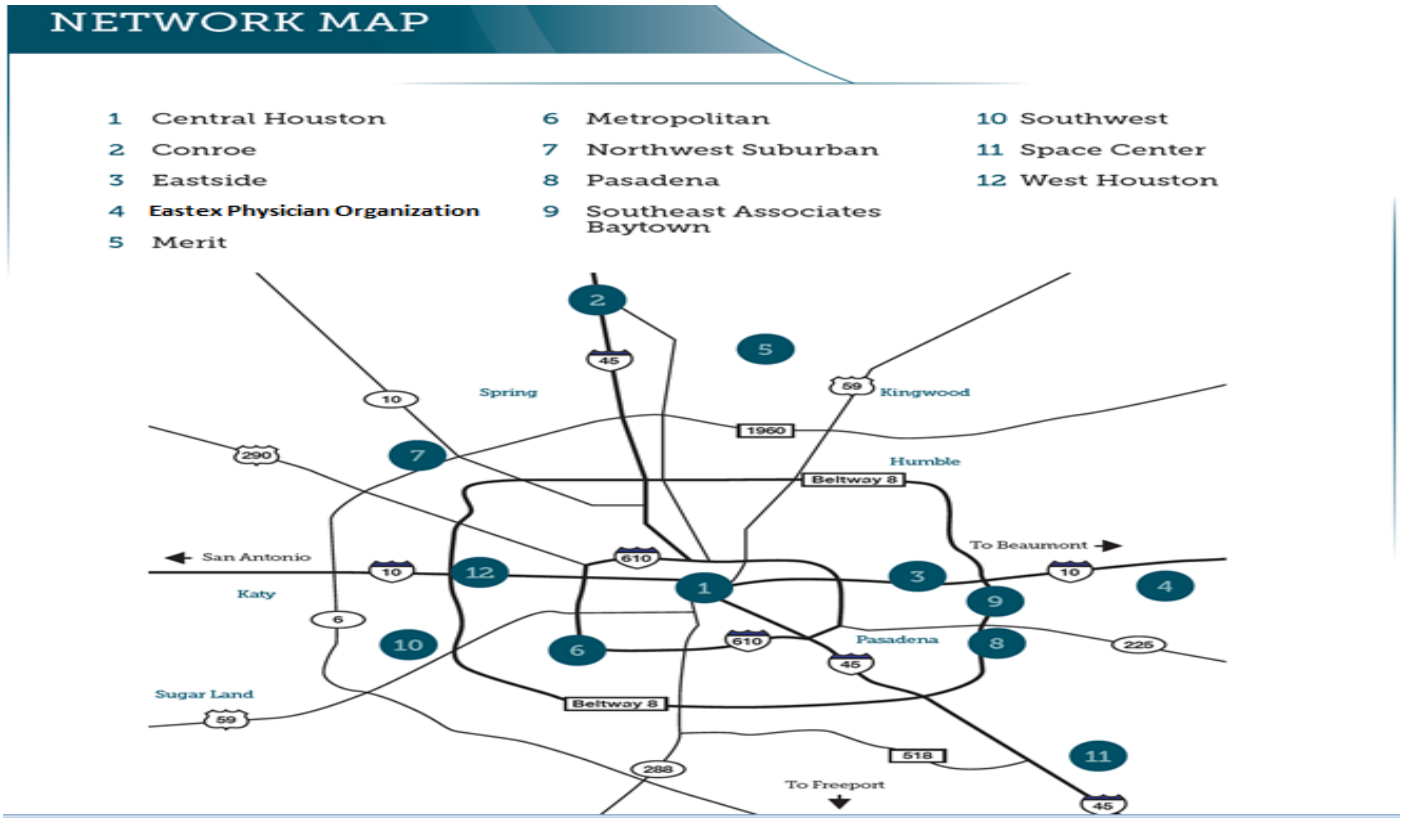
Duties of LLC

- Provider network development
- Management of LLC utilization
- Communication
- Surplus distribution
- Provider satisfaction
- Problem resolution

RENAISSANCE PHYSICIANS STRUCTURE



Service Area Map



CUSTOMER INFORMATION

Eligibility Verification

All participating providers are responsible for verifying a customer's eligibility at each and every visit.

You can verify customer eligibility the following ways:

Call the Health Plan – You must call the Health Plan to verify eligibility when the customer cannot present identification or does not appear on your monthly eligibility list.

Please note: the Health Plan should have the most updated information, therefore, call the Health Plan for accuracy.

- HSConnect – The IPA's web portal, HSConnect, allows our providers to verify customer eligibility online
- Ask to see the customer's Identification Card – Each customer is provided with an individual customer identification card. Noted on the ID card is the customer's identification number, plan code, name of PCP, copayment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the customer is eligible.
- Pursue additional proof of identification – Each PCP and specialist office is provided with a monthly Eligibility Report upon request, which lists new and current IPA's customers with their effective dates. Please be sure to refer to the most current month's Eligibility Report.
- See ID Cards in Health Plan sections.

Eligibility Guarantee Form

If your office decides to see a patient that does not have identification, you should have the patient sign an Eligibility Guarantee form. Please keep a copy of the signed form in patient's file. Forms at end of Customer Information section

Maximum Out-of-Pocket (MOOP)

The Maximum Out-of-Pocket (MOOP) benefit is now a part of all benefit plans. Customers have a limit on the amount they will be required to pay out-of-pocket each year for medical services, which are covered under Medicare Part A and Part B. Once this Maximum Out-of-pocket expense has been reached, the customer no longer is responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the customer's Medicare Part B premium and the IPA's plan premium).

Customer Hold Harmless

Participating providers are prohibited from balance billing the IPA's customers including, but not limited to, situations involving non-payment by IPA, insolvency of IPA, or IPA's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than the IPA, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan.

Customer Confidentiality

We know our customers' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our customers' personal information. IPA does not disclose customer information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to the IPA, we want you to know the steps we have taken to protect the privacy of our customers. This includes how we gather and use their personal information. The privacy practices apply to all of IPA's past, present, and future customers.

When a customer joins a Medicare Advantage plan, the customer agrees to give IPA access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium. Access to PHI allows IPA to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the customers' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows IPA to look at how care is delivered and carry out programs to improve the quality of care customers receive. This information also helps manage the treatment of diseases to improve our customers' quality of life.

Customers have additional rights over their health information.

They have the right to:

- Send IPA a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer customer to the source of the information. Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.

- Receive an accounting of IPA's disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect customer PHI. To discuss any breaches of the privacy of our customers, please contact our HIPAA Privacy Officer at 1-860-787-9801.

Customer Rights and Responsibilities

Customers have the following rights:

The right to be treated with dignity and respect

Customers have the right to be treated with dignity, respect, and fairness at all times. IPA must obey laws against discrimination that protect customers from unfair treatment. These laws say that IPA cannot discriminate against customers (treat customers unfairly) because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If customers need help with communication, such as help from a language interpreter, they should be directed to call Customer Services. Customer Services can also help customers file complaints about access to facilities (such as wheel chair access). Customers can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of customer medical records and personal health information. IPA keeps customers' personal health information private as required under these laws. Any personal information that a customer gives is protected. IPA staff will make sure that unauthorized people do not see or change customer records. Generally, we will get written permission from the customer (or from someone the customer has given legal authority to make decisions on their behalf) before we can give customer health information to anyone who is not providing the customer's medical care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect customer privacy give them rights related to getting information and controlling how their health information is used. All Plans are required to provide customers with a notice that tells them about these rights and explains how the IPA protects the privacy of their health information. For example, customers have the right to look at their medical records, and to get copies of the records (there may be a fee charged for making copies). Customers also have the right to ask plan providers to make additions or corrections to their medical records (if customers ask plan providers to do this, they will review customer requests and figure out whether the changes are appropriate). Customers have the right to know how their health information has been given out and used for routine and non-routine purposes. If customers have questions or concerns about privacy of their personal information and medical records, they should be directed to call Customer Services. The IPA will release customer's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time

Customers will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of IPA. Customers have the right to choose a participating provider (IPA will work with customers to ensure they find physicians who are accepting new patients). Customers have the right to go to a women's health specialist (such as a gynecologist) without a referral. Customers have the right to timely access to their providers and to see specialists when care from a specialist is needed. Customers also have the right to timely access to their prescriptions at any network pharmacy. "Timely access" means that customers can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how customers access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know treatment choices and participate in decisions about their health care

Customers have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. Providers must explain things in a way that customers can understand. Customers have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by IPA. This includes the right to know about the different medication management treatment programs offers and those in which customers may participate. Customers have the right to be told about any risks involved in their care. Customers must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice to refuse experimental treatments. Customers have the right to receive a detailed explanation from IPA if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, customers must request an initial decision. "Initial decisions" are discussed in the customers' Evidence of Coverage.

Customers have the right to refuse treatment. This includes

the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This also includes the right to stop taking their medication. If customers refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to use advance directives (such as a living will or a power of attorney)

Customers have the right to ask someone such as a family customer or friend to help them with decisions about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If a customer wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them if they ever become unable to make decisions for themselves. Customers also have the right to give their doctors written instructions about how they want them to handle their medical care if they become unable to make decisions for themselves. The legal documents that customers can use to give their directions in advance of these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living wills" and "powers of attorney for health care" are examples of advance directives.

If customers decide that they want to have an advance directive, there are several ways to get this type of legal form. Customers can get a form from their lawyer, from a social worker, from IPA, or from some office supply stores. Customers can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document. Customers should consider having a lawyer help them prepare it. It is important to sign this form and keep a copy at home. Customers should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions for them if they cannot. Customers may want to give copies to close friends or family customers as well.

If customers know ahead of time that they are going to be hospitalized and they have signed an advance directive, they should take a copy with them to the hospital. If customers are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If customers have not signed an advance directive form or does not have a copy available during admission, the hospital has forms available and will ask if the customer wants to sign one.

Remember, it is a customer's choice whether he/she wants to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If customers have signed, an advance directive and they believe that a doctor or hospital has not followed the instructions in it; customers may file a complaint with their State Board of Medicine or appropriate state agency (this information can be found in the customer's Evidence of Coverage).

The right to make complaints

Customers have the right to make a complaint if they have concerns or problems related to their coverage or care. Customers or an appointed/authorized representative may file "Appeals," "grievances," concerns and Coverage Determinations. If customers make a complaint or file an appeal or Coverage Determination, IPA must treat them fairly (i.e., not discriminate against them) because they made a complaint or filed an appeal or Coverage Determination. To obtain information relative to appeals, grievances, concerns and/or Coverage Determinations, customers should be directed to call Customer Services.

The right to get information about their health care coverage and cost

The Evidence of Coverage tells customers what medical services are covered and what they have to pay. If they need more information, they should be directed to call Customer Services. Customers have the right to an explanation from IPA about any bills they may get for services not covered by IPA. The IPA must tell customers in writing why IPA will not pay for or allow them to get a service and how they can file an appeal to ask IPA to change this decision. Staff should inform customers on how to file an appeal, if asked, and should direct customers to review their Evidence of Coverage for more information about filing an appeal.

The right to get information about IPA, plan providers, drug coverage, and costs

Customers have the right to get information about the IPA and operations. This includes information about our financial condition, about the services we provide, and about our health care providers and their qualifications. Customers have the right to find out from us how we pay our doctors. To get any of this information, customers should be directed to call Customer Services. Customers have the right to get information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To get any of this information, staff should direct customers to call Customer Services.

The right to get more information about customers' rights

Customers have the right to receive information about their rights and responsibilities. If customers have questions or concerns about their rights and protections, they should be directed to call Customer Services. Customers can also get free help and information from their State Health Insurance Assistance Program (SHIP).

The right to take action if a customer thinks they have been treated unfairly or their rights are not being respected

- If customers think they have been treated unfairly or their rights have not been respected, there are options for what they can do.
- If customers think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, customers should be encouraged to call Customer Services. Customers can also get help from their State Health Insurance Assistance Program (SHIP).

Customers have the following responsibilities:

Along with certain rights, there are also responsibilities associated with being a customer of the IPA's. Customers are responsible for the following:

- To become familiar with their IPA's coverage provider.
- To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Customers must be encouraged to ask questions of their doctors and other providers whenever the customer has them.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their plan premiums and any copayments or coinsurances they may have for the Covered Services they receive. Customers must also meet their other financial responsibilities that are described in their Evidence of Coverage.
- To let IPA know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, and/or IPA's operations.
- To notify Customer Service and their providers of any address and/or phone number changes as soon as possible.
- To use their IPA only to access services, medications and other benefits for themselves.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right is to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare & Medicaid Services (CMS), and our own policies and procedures, IPA requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

The customer may inform all providers contracted directly or indirectly with IPA that the customer has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the customer to provide a copy of the advance directive to be included in his/her medical record.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the customer's written advance directive, he/she must advise the customer and IPA. The IPA and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes to Advance Directives, IPA conducts periodic patient medical record reviews to confirm that required documentation exists. See Appendix for a copy of the Texas Advance Directives.

Benefits and Services

All customers receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, the IPA makes available to each participating Primary Care Physician a list of their active customers. Along with the customer's demographic information, the list includes the name of the plan in which the customer enrolled. Please be aware that recently terminated customers may appear on the list. (See "Eligibility Verification" section of this manual).

- The IPA encourages its customers to call their Primary Care Physician and the rules they must follow to get care as a customer. Customers can use their Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Customers should always be encouraged to call Customer Services if they have any questions or complaints.
- To advise IPA if they have other insurance coverage.
- To notify providers when seeking care (unless it is an emergency) that they are enrolled with IPA and present their plan enrollment card to the to schedule appointments. However, if an IPA's customer calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the customer and explain to them your office policy regarding appointments. If this problem persists, please contact IPA.

Emergency Services and Care After Hours

Emergency Services

An emergency is defined as the sudden onset of a medical condition with acute symptoms. A customer may reasonably believe that the lack of immediate medical attention could result in:

- Permanently placing the customer's health in jeopardy
- Causing serious impairments to body functions
- Causing serious or permanent dysfunction of any body organ or part

In the event of a perceived emergency, customers have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life threatening, customers have been instructed to go immediately to the nearest emergency room facility. Customers who are unable to contact their PCP prior to receiving emergency treatment have been instructed to contact their PCP as soon as is medically possible or within forty-eight (48) hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a customer's emergency care. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to assist customers needing emergency services. The hospital may attempt to contact the PCP for direction. Customers have a copayment responsibility for outpatient emergency visits unless an admission results.

For emergency services outside the service area, IPA will pay reasonable charges for emergency services received from non-participating providers if a customer is injured or becomes ill while temporarily outside the service area. Customers may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent Care Services

Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention. The customer must first attempt to receive care from his/her PCP. IPA will cover treatment at a participating Urgent Care Center without a referral.

Continue or Follow-up Treatment

Continuing or follow-up treatment, except by the PCP, whether in or out of service area, is not covered by IPA unless specifically authorized or approved by IPA. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the customer can reasonably be transported to a participating hospital or returned to the care of the PCP.

Excluded Services

In addition to any exclusion or limitations described in the customer's EOC, the following items and services are not covered under Original Medicare Plan or by IPA:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our plan as a covered service.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan customers. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary or covered under the Original Medicare Plan.
- Private room in a hospital, unless medically necessary.
- Private duty nurses.
- Personal convenience items, such as a telephone or television in a customer's room at a hospital or skilled nursing facility.
- Nursing care on a full-time basis in a customer's home.
- Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services.
- Charges imposed by immediate relatives or customers of the customer's household.
- Meals delivered to the customer's home.
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary.
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care (i.e. cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered.
- Chiropractic care is generally not covered under the plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines.

- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, radical keratotomy, LASIK surgery, vision therapy, and other low vision aids and services unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the customer's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture
- Naturopath services
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the plan, the plan will reimburse veterans for the difference. Customers are still responsible for our plan cost-sharing amount.

Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Grievance and Appeal Process

All telephonic inquiries received by IPA's Medicare Advantage Customer Service Department will be resolved on an informal basis, except for inquiries that involve "appealable" issues. Appealable issues will be routed through either the standard or expedited appeal process. In situations where a customer is not in agreement with the informal resolution, the customer must submit a written request for reconsideration. All other written correspondence received by IPA will be documented and routed through the appropriate appeal or grievance channels.

Customers have the right to file a complaint, also referred to as a grievance, regarding any problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints about services in an optional Supplementary Benefit package.
- Dissatisfaction with the office experience such as excessive wait times, physician behavior or demeanor, or inadequacy of facilities.
- Involuntary disenrollment situations.
- Poor quality of care or service received.

Customers have the right to appeal any decision about IPA's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside of the service area or Emergency Services worldwide.
- A denied claim for any health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by IPA.
- Services not received, but believed to be the responsibility of IPA.
- A reduction or termination of a service a customer feels medically necessary.

In addition, a customer may appeal any decision related to a hospital discharge. In this case, a notice will be given to the customer with instructions for filing an appeal. The customer will remain in the hospital while the appeal documentation is reviewed. The customer will not be held liable for charges incurred during this period, regardless of the outcome of the review. Please refer to the Evidence of Coverage (EOC) for additional benefit information.

Eligibility Guarantee Form

ELIGIBILITY GUARANTEE FORM

_____
Date

I, _____ hereby certify that I am eligible for Health Plan
Member Name

Coverage with _____ as of _____
Health Plan Name Month/Day/Year

through _____.
Employer Group (if applicable)

I have chosen _____
Physician's Name

to be my Primary Care Physician.

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital

Subscriber Health Insurance Agreement, I am liable for all charges for the services rendered. In addition, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted medical provide.

_____ _____
Signature of Member (or Guardian) Office Personnel

_____
Printed Name of Member (or Guardian)

Forma de Garantía de Elegibilidad

FORMA DE GARANTÍA DE ELEGIBILIDAD

_____
Fecha

El suscrito, _____ por este medio certifico que soy elegible para
Nombre del miembro

la cobertura del plan de atención médica de _____ a partir del _____
Nombre del Plan de atención médica Mes/Día/Año

A través de _____. He elegido a _____
Grupo empleador (si aplica) Nombre del médico

para que sea mi médico de cabecera.

Entiendo que si la información anterior es falsa, o si no soy elegible de conformidad con los términos de mi Contrato de seguro de atención médica y hospitales, seré responsable de pagar el costo de los servicios que haya recibido. Además, si la información anterior no es verdadera, acuerdo pagar el costo total de los servicios que reciba en un término de 30 días después de recibir la factura del proveedor médico arriba indicado

_____ _____
Firma del miembro (o Tutor) Personal de la oficina

_____
Nombre completo del miembro (o Tutor)

PROVIDER INFORMATION

Providers Designated as Primary Care Physicians (PCPs)

The IPA recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs).

The IPA may recognize Infectious Disease Physicians as PCPs for customers who may require a specialized physician to manage their specific health care needs.

All contracted credentialed providers participating with IPA are listed in the region-appropriate Provider Directory, which is provided to customers and made available to the public.

The Role of the Primary Care Physician (PCP)

Each customer must select an IPA Participating Primary Care Physician (PCP) at the time of enrollment. The PCP is responsible for managing all the health care needs of customers as follows:

- Manage the health care needs of customers who have chosen the physician as their PCP.
- Ensure that customers receive treatment as frequently as is necessary based on the customer's condition.
- Develop an individual treatment plan for each customer.
- Submit accurately and timely claims and encounter information for clinical care coordination. Comply with pre-authorization and referral procedures.
- Refer customers to appropriate IPA participating providers.
- Comply with Quality Management and Utilization Management programs.
- Participate in Coding and Performance Program.
- Use appropriate designated ancillary services.
- Comply with emergency care procedures.
- Comply with access and availability standards as outlined in this manual, including after-hours care.
- Bill on the CMS 1500 claim form or electronically in accordance with billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a customer's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Comply with Preventive Screening and Clinical Guidelines.
- Adhere to medical record standards as outlined in this manual.

The Role of the Specialist Physician

Each customer is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a Participating Plan's customer as follows:

- Provide specialty health care services to customers as needed.
- Collaborate with the customer's Primary Care Physician to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician in a timely manner.
- Comply with access and availability standards as outlined in this manual including after-hours care.
- Comply with pre-authorization and referral process.
- Comply with Quality Management and Utilization Management programs.
- Bill on the CMS 1500 claim form in accordance with billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a customer's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Refer customers to appropriate IPA participating providers.
- Submit encounter information accurately and timely.
- Adhere to medical record standards as outlined in this manual.

Administrative, Medical, and Reimbursement Policy Changes

From time to time, the IPA may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific IPA policies and procedures may be obtained by calling our Provider Services Department at 1-832-553-3300.

The IPA's will communicate changes to the Provider Manual using a variety of methods including but not limited to:

- Annual Provider Manual Updates
- Letter
- Facsimile
- Email
- Provider Newsletters

Providers are responsible for the review and inclusion of policy updates in the Provider Manual and for complying with these changes upon receipt of these notices.

Communication among Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the customer's care.
- The Specialist Physician must provide the PCP with information about his/her visit with the customer in a timely manner.
- The PCP must document in the customer's medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Provider Marketing Guidelines

The general guidelines assist Plan providers who have contracted with multiple Medicare Advantage plans and accept Medicare FFS patients determine what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions.

Provider Can:

Mail/call their patient panel to invite patients to general IPA's sponsored educational events to learn about the Medicare and/or Medicare Advantage program. This is not a sales/marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.

- Mail an affiliation letter one time to patients listing only IPA.
- Have additional mailings (unlimited) to patients about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify patients in a letter of a decision to participate in an IPA's sponsored programs.
- Utilize a physician/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have an IPA corner to advise patients of IPA's information.
- Provide objective information to patients on specific plan formularies, based on a patient's medications and health care needs.

Refer patients to other sources of information, such as the State Health Insurance Assistance Program (SHIP), IPA's marketing representatives, state Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a health care enrollment decision.

- Display and distribute in provider offices IPA's MA and MAPD marketing materials, excluding application forms. The office must display or offer to display materials for all participating MA plans.
- Notify patients of a physician's decision to participate exclusively with an IPA for Medicare Advantage or to close panel to original Medicare FFS if appropriate.
- Record messages on our auto dialer to existing IPA's customers as long as the message is not sales related or could be construed as steerage. IPA's Legal /Government programs must review the script.
- Have staff dressed in clothing with the Participating Plan's logo.
- Display promotions items with the IPA logo.
- Allow IPA to have a room/space in provider offices completely separate from where patients have a prospect of receiving health care, to provide beneficiaries' access to an IPA's sales representative.

Provider Cannot:

- Quote specific health plan benefits or cost share in patient discussions.
- Urge or steer towards any specific plan or limited set of plans.
- Collect enrollment applications in physician offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, as health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call customers who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Mail notifications of health plan sales meetings to patients.
- Call patients to invite patients to sales, and marketing activity of a health plan.
- Advertise using IPA's name without IPA's prior consent and potentially CMS approval depending upon the content of the advertisement.

Provider Participation

Providers must be contracted with and credentialed by IPA according to the following guidelines:

Provider	Status	Action
New to plan and not previously credentialed	Practicing in a solo practice	Requires a signed contract and initial credentialing
New to plan and not previously credentialed	Joining a participating group practice	Requires initial credentialing

Provider	Status	Action
Already participating and credentialed	Leaving a group practice to begin a solo practice	Does not require credentialing; however a new contract is required and the previous group practice affiliation is terminated
Already participating and credentialed	Leaving a participating group practice to join another participating group practice	Does not require credentialing yet the group practice affiliation will be amended
Already participating and credentialed	Leaving a participating group practice to join a non-participating group practice	The provider's participation is terminated unless the non-participating group signs a contract with IPA. Credentialing is still valid until re-credentialing due date

PHYSICIAN RIGHTS AND RESPONSIBILITIES

Physician Rights:

- IPA encourages your feedback and suggestions on how service may be improved within the organization.
- If an acceptable patient-physician relationship cannot be established with an IPA customer who has selected you as his/her Primary Care Physician, you may request that IPA have that customer removed from your care.
- You may request claims reconsideration on any claims submissions in which you feel are not paid according to payment policy.
- You may request an appeal on any claims submission in which you feel are not paid in keeping with the level of care rendered or clinical guidelines.
- You may request to discuss any referral request with the Medical Director or Chief Medical Officer after various times in the review process, before a decision is rendered or after a decision is rendered.

Physician Responsibilities:

- You have agreed to treat IPA's customers the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- Primary Care Physicians must provide continuous 24 hours, 7 days a week access to care for Health Plan customers. During periods of unavailability or absence from the practice, you must arrange coverage for your members. Please notify the IPA of the physician who is providing coverage for your practice.
- Primary Care Physicians shall use best efforts to provide patient care to new customers within three (3) months of enrollment with IPA.
- Primary Care Physicians shall use best efforts to provide follow-up patient care to customers that have been in the hospital setting within ten (10) days of hospital discharge.
- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization.
- All providers are required to code to the highest level of specificity necessary to describe a customer's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- All providers are required to actively promote and participate in STARs related activities such as HEDIS chart audits, customer preventive care, and customer satisfaction activities.
- Specialists must provide specialty services upon referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the customer is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for customers.
- Specialists are required to coordinate the referral process (i.e. obtain authorizations) for further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the customer is under the direction of the Specialist.
- In the event you are temporarily unavailable or unable to provide patient care or referral services to an IPA customer, you must arrange for another IPA physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room. For capitated physicians, the covering physician must agree to seek payment for services rendered to your customers from you only.
- You have agreed to treat Participating Plan's patients the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- You have agreed to provide continuing care to participating customers.
- You have agreed to utilize IPA participating physicians/facilities when services are available and can meet your patient's needs. Approval prior to referring outside of the contracted network of providers may be required.
- You have agreed to participate in IPA's peer review activities as they relate to the Quality Management/Utilization Review program.

- You have agreed to manage inpatient care to IPA customers effectively using Inpatient Managers.
- You may not balance bill a customer for providing services that are covered by IPA. This excludes the collection of standard copays. You may bill a customer for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the "Claims" section of this manual.
- You have agreed to provide the IPA Encounter Data for all services outlined in the "Encounter Data" section of this manual. Such data must be received within 95 days from the date of service. Any data received after 95 days will not be included in true-up or any other financial calculations.
- All claims must be received within 95 days from the date of service or the timeframe specified in your contract.
- Required adoption and usage of portals and software applications available to physicians for quality and cost management as well as care coordination.

Customer Assignment to New PCP

IPA's Primary Care Physicians have a limited right to request a customer be assigned to a new Primary Care Physician. A provider may request to have a customer moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits
- The customer is disruptive, unruly, threatening, or uncooperative to the extent that customer seriously impairs IPA's or the provider's ability to provide services to the customer or to obtain new customers and the aforementioned behavior is not caused by a physical or behavioral health condition.
- Threats of physical harm to a provider and/or office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner, which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The customer is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).

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

If the customer's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP should complete the customer transfer request form and submit it to IPA.

IPA will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, IPA will document all actions taken by the provider and IPA to cure the situation. This may include customer education and counseling. An IPA PCP cannot request a disenrollment based on adverse change in a customer's health status or utilization of services medically necessary for treatment of a customer's condition.

Procedure

- Once the IPA has reviewed the PCP's request and determined that the physician/patient relationship has been irreparably harmed, the customer will receive a minimum of thirty (30) days' notice that the physician/patient relationship will be ending. Notification must be in writing, by certified mail, and IPA must be copied on the letter sent to the patient.
- The physician will continue to provide care to the customer during the thirty (30) day period or until the customer selects or is assigned to another physician. The IPA will assist the customer in establishing a relationship with another physician.
- The physician will transfer, at no cost, a copy of the medical records of the customer to the new PCP and will cooperate with the customer's new PCP in regard to transitioning care and providing information regarding the customer's care needs.

A customer may also request a change in PCP for any reason. The PCP change that is requested by the customer will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

Closing Patient Panels

When a participating Primary Care Physician elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating Primary Care Physician closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against customers by closing their patient panels for IPA's customers only, nor may they discriminate among customers by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify the Network Management Department, in writing, at least 30 days before the date on which the patient panel will be closed or the time frame specified in your contract.

Medical Record Standards

The IPA requires the following items in customer medical records:

- Identifying information of the customer.

- Identification of all providers participating in the customer's care and information on services furnished by these providers.
- A problem list, including significant illnesses and medical and psychological conditions.
- Presenting complaints, diagnoses, and treatment plans.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions).
- Information on advanced directives.
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the customer relevant to the particular treatment.

Note: Unless otherwise specifically stated in your provider services agreement, medical records shall be provided at no cost to IPA and IPA customers.

Access and Availability Standards for Providers

A Primary Care Physician (PCP) must have their primary office open to receive customers five (5) days and for at least 20 hours per week. The PCP must ensure that coverage is available 24 hours a day, seven days a week. PCP offices must be able to schedule appointments for customers at least two (2) months in advance of the appointment. A PCP must arrange for coverage during absences with another participating provider in an appropriate specialty, which is documented on the Provider Application and agreed upon in the Provider Agreement.

Primary Care Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Routine and Preventive	Within 30 Business Days
On-Call Response (After Hours)	Within 30 minutes for emergency
Waiting Time in Office	30 minutes or less

Specialist Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Elective	Within 30 days
High Index of Suspicion of Malignancy	Less than seven (7) days
Waiting time in office	30 minutes or less

Behavioral Health Access Standards

Appointment Type	Access Standard
Emergency	Within 6 hours of the referral
Urgent/Symptomatic	Within 48 hours of the referral
Routine	Within ten (10) business days of the referral*

*Revised 03/2013

After-hours Access Standards

All participating providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.

Plan Notification Requirements for Providers

Participating providers must provide written notice to IPA no less than 60 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to by contacting your Network Operation Representative:

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

- Changes in practice office hours, practice limitations, or gender limitations

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory.

Please note: Failure to provide up to date and correct information regarding demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

Provision of Health Care Services

Participating providers shall provide health care services to all customers, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

Participating providers shall provide covered services in a culturally competent manner to all customers by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

IPA offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) customers. Providers can call IPA customer service at 832-553-3300 to assist with translator and TTY services if these services are not available in their office location.

Inpatient Manager Program

IPA requires that in certain IPA PODs, customers admitted to participating health care facilities should be assigned to the designated Inpatient Manager (IPM) for coordination of care throughout the entire stay. Health care facilities will receive notice of the designated Inpatient Manager and are required to follow the proper protocol of assigning customers to the designated Inpatient Manager.

Dispute Resolution

Any controversy, dispute or claim arising out of or relating to your Provider Agreement ("Agreement") or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against IPA, an Affiliate, provider, or any provider ("Defendant"), any cross-claim or third party claim by such Defendant against IPA, an Affiliate, provider, or any provider Facility shall not be subject to arbitration. In the event arbitration becomes necessary, such arbitration shall be initiated by either Party making a written demand for arbitration on the other Party. The arbitration shall be conducted in the county were the majority of the services are performed, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The Parties agree to be bound by the decision of the arbitrator. The Parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party. Notwithstanding this Agreement to arbitrate IPA, an Affiliate, provider, or any provider Facility may seek interim and/or permanent injunctive relief pursuant to this Agreement in the county were the majority of the services are performed in any court of competent jurisdiction. With respect to disputes arising during the life of this Agreement, this Section shall survive the termination or expiration of the Agreement.

STARS GUIDANCE

The Centers for Medicare & Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine how much to compensate Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from five different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

Star Ratings have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark. (A county benchmark is the amount CMS expects it to cost to provide hospital and medical insurance in the state and county.) After 2015, any health plans with Star Ratings below four will no longer receive bonus payments

Star Rating Components

The Star Rating is comprised of over 50 different measures from six different rating systems:

Star Rating System:

- HEDIS-The Health Care Effectiveness Data and Information Set is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been screened for high blood pressure.
- CAHPS- Consumer Assessment of Health Care Providers and Systems is a series of patient surveys rating health care experiences performed on behalf of CMS by an approved vendor.
- CMS- Centers for Medicare & Medicaid Services rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times, and percentage of customers choosing to leave a plan.
- PDE- Prescription Drug Events is data collected on various medications related events, such as high-risk medications, adherence for chronic conditions, and pricing.
- HOS- Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries is drawn from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees and is surveyed. Two years later, these same respondents are surveyed again (i.e., follow up measurement).
- IRE- Medicare Advantage plans are required to submit all denied enrollee appeals (Reconsiderations) to an Independent Review Entity (MAXIMUS Federal Services).

These systems rate the plans based on six domains:

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long term) conditions
3. Customer experience with health plan
4. Customer complaints, problems getting services, and improvement in the health plan's performance
5. Health plan customer service
6. Data used to calculate the ratings comes from surveys, observation, claims data, and medical records.

CMS continues to evolve the Star Ratings system by adding, removing and adjusting various measures on a yearly basis.

CMS weights each measure between one and three points. A three-point measure, or triple weighted measure, are measures that CMS finds most important and should be a focus for health plans. The composition of all rating systems is indicated below.

Health Reform

The Patient Protection and Affordable Care Act (PPACA) requires that Medicare Advantage plans be awarded quality-based bonus payments beginning in 2012, as measured by the Star Ratings system. Bonus payments are provided to MA plans that receive four or more stars.

CMS assigns a benchmark amount to each county within a state, which is the maximum amount CMS will pay to provide hospital and medical benefits. All MA plans submit a bid, which is the projected cost to operate MA within the county. The spread between the bid and original benchmark is called the rebate. A bonus payment is the percentage added to the county benchmark, which increases the spread and the amount of revenue received by the health plan.

Healthcare Plan Effectiveness Data Information Set (HEDIS®)

HEDIS (a standardized data set) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Glaucoma Screening for Older Adults, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually and represent a mandated activity for health plans contracting with the Centers for Medicare & Medicaid Services (CMS). Each spring, the Participating Plan Representatives will be required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Participating Plan's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Participating Plan's HEDIS results are available upon request. Contact the Health Plan's Quality Improvement Department to request information regarding those results.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Star Measure Weighting

Individual Star measures can be single-weighted, 1.5-weighted or triple-weighted, with higher weight being given to those measures that CMS deems most important by which to measure plan quality. Triple-weighted measures are typically outcomes measures that measure a health plan's ability to manage chronic illnesses and keep customers healthy. Certain disease states appear in multiple measures. For example, diabetes directly impacts 7 measures and cardiovascular conditions directly impact 4 measures.

Following is a summary of the weighting of all Star measures:

Part C Star Rating Measure	Weight
Breast Cancer Screening (HEDIS)	1
Colorectal Cancer Screening (HEDIS)	1
Annual Flu Vaccine (CAHPS)	1
Improving/Maintaining Physical Health (HOS)	3
Monitoring Physical Activity (HOS)	1
Adult BMI Assessment (HEDIS)	1
Care For Older Adults -- Medication Review (HEDIS)	1
Care For Older Adults -- Pain Screening (HEDIS)	1
Care For Older Adults -- Functional Status (HEDIS	1
Osteoporosis Fracture Management (HEDIS)	1
Comprehensive Diabetes Care -- Eye Exam (HEDIS)	1
Comprehensive Diabetes Care -- Kidney Disease (HEDIS)	1
Comprehensive Diabetes Care -- HBA1C ≤ 9 (HEDIS)	3
Controlling Blood Pressure (HEDIS)	3
Rheumatoid Arthritis Management (HEDIS)	1
Reducing Risk Of Falling (HOS)	1
Plan All Cause Readmissions (HEDIS)	3
Getting Needed Care Without Delays (CAHPS)	1.5
Getting Appointments And Care Quickly (CAHPS)	1.5
Customer Service (CAHPS)	1.5
Overall Rating Of Health care Quality (CAHPS)	1.5
Overall Rating Of Plan (CAHPS)	1.5
Care Coordination (CAHPS)	1.5
Complaints About The Health Plan (CTM)	1.5
Beneficiary Access And Performance Problems (CMS)	1.5
Customers Choosing To Leave The Plan (CMS)	1.5
Improvement (CMS)	3
Plan makes Timely Decisions About Appeals (IRE)	1.5
Reviewing Appeals Decisions (IRE)	1.5
Foreign language Interpreter and TTY/TDD Availability (Call Center)	1.5
Part D Star Rating Measure	
Foreign language Interpreter and TTY/TDD Availability (Call Center)	1.5
Appeals Autoforward (IRE)	1.5
Appeals Upheld (IRE)	1.5
Complaints About The Health Plan (CTM)	1.5
Beneficiary Access And Performance Problems (CMS)	1.5
Customers Choosing To Leave The Plan (CMS)	1.5
Improvement (CMS)	3
Rating Of Drug Plan (CAHPS)	1.5
Getting Needed Prescription Drugs (CAHPS)	1.5
MPF Pricing Accuracy (PDE)	1
High Risk Medications (PDE)	3
Diabetes Treatment (PDE)	3
Medication Adherence For Oral Diabetes Medications (PDE)	3
Medication Adherence For Hypertension (PDE)	3
Medication Adherence For Cholesterol (PDE)	3

Star Rating Timeline

The Star rating process follows a unique lag timeline that must be iterated. Each year, CMS publishes health plan ratings in October which encompass data collected in the previous year. After ratings are determined, bonuses payments can be included in the bid process for the following year. This means that actions taken to affect Stars in a given year take almost three years to realize financially. For example:

	Year 1	Year 2	Year 3	Year 4	Year 5
	CY2015	CY2016	CY2017	CY2018	CY2019
2017 Star Rating (Publish Oct. 2016	Quality Activities to Impact 2017 Rating	2017 Rating Published (Oct.)	2017 Rating Included in 2018 Bid Process	2017 Rating Bonuses Distributed	N/A

PROVIDER REQUEST FOR CUSTOMER TO TRANSFER CARE TO ANOTHER PROVIDER

The providers in the IPA strive to promote the health and wellness of the customers in managed care plans through participation in a quality, comprehensive, preventive, and therapeutic health care delivery system.

A strong physician/patient relationship is one of the most important factors necessary to accomplish that mission. When there is a breakdown in the patient/physician relationship, it may be in the best interest of all concerned to have the customer transfer to another provider. Having an expedient process for handling such requests, and effecting transfers when appropriate, should have a positive impact on both customer satisfaction and provider morale.

The requesting provider needs to take the appropriate steps to ensure that the transferring customer has continued access to care during the transitional period.

Procedure

A provider may request to have a customer transfer to another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- Threats of physical harm to a provider or office staff.
- Non-payment of required copay for services rendered.
- Receipt of prescription medications or health services in a quantity or manner, which is not medically beneficial or medically necessary.
- Refusal to accept a treatment or procedure recommended by the provider. If refusal is incompatible with the continuation of the patient/physician relationship, the provider should indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan
- Other behavior that has resulted in serious disruption of the patient/ physician relationship.
- The provider should make reasonable efforts to address customer behavior that has an adverse impact on the patient/physician relationship, through education and counseling, and, if medically indicated, referral to appropriate specialists. Such efforts, including efforts to educate the customer regarding office procedures and treatment recommendations, should be carefully documented. A sample letter to address customer education is provided.

A provider who wants to request that a customer transfer to the care of another provider should submit the following to the IPA office:

- Completed form: Physician Requests Transfer of Customer from Panel
- Attach all supporting documentation indicating efforts that have been made to counsel/educate the customer on the importance of being compliant (i.e., letter to customer, medical records, chart notes, documentation of missed appointments, and calls/reminders to the customer).
- Send the form and all supporting documentation to the Provider Relations Representative of the IPA.
- The IPA Medical Advisor reviews all provider requests for adequacy and appropriateness.

The IPA forwards provider requests to the managed care plan for action. The IPA office logs and tracks the provider requests and follows up once a week with the managed care plan.

During the period the provider's request is being processed by the IPA/managed care plan, the provider should continue to provide care to the customer. It is expected that the managed care plan will respond to a provider's request within seven (7) calendar days of receipt. The provider should be aware that the managed care plan may share the provider's request/documentation with the affected customer. If the managed care plan is not able to salvage the relationship, the IPA will be notified. At that time, the requesting provider may, if they choose, notify the customer in writing of thirty (30) day notice to select another provider in accordance with State law.

Generally, it is the responsibility of the managed care plan to send the customer notice that he or she must transfer to another provider. It is expected that the managed care plan will send a copy of such notice to both the IPA and the requesting provider. The IPA expects the managed care plan to instruct the customer to select a new provider within thirty (30) days of receiving the notice (transitional period).

The requesting physician must provide care to the customer during the thirty (30) day transitional period. When the customer selects a new provider, the managed care plan will promptly inform the requesting provider so proper measures can be made to complete the transfer process. If the customer fails to pick a new provider after the thirty (30) day transitional period, the managed care plan will assign the customer to a new provider.

PHYSICIAN REQUESTS TRANSFER OF MEMBER FROM PANEL

Physician Name: _____ **POD:** _____

The member referenced below is not following the accepted standards set by our office in order to maintain an effective treatment plan or a satisfactory patient/physician relationship. The information below is provided so that the Health Plan can notify the member of such termination request advising his/her to select a new Primary Care Physician.

MEMBER NAME: _____ **ID#** _____

HEALTH PLAN: Renaissance Physicians (RP)

This member has displayed the following behavior:

___ Fraudulent use of services or benefits.

___ Threats of physical harm to a physician or his or her office staff.

___ Non-payment of required co-payment for services rendered.

___ Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.

___ Refusal to accept a treatment or procedure recommended by the physician, if such refusal is incompatible with the continuation of the patient/physician relationship. The physician should also indicate if he or she believes that no professionally acceptable alternative treatment or procedure exists.

___ Repeated refusal to comply with office procedures essential to the functioning of the physician's practice or to accessing benefits under the managed care plan.

___ Other behavior which has resulted in serious disruption of the patient/physician relationship.

COMMENTS TO SUBSTANTIATE THE ABOVE BEHAVIOR:

_____

_____

DATE(S) MEMBER WAS COUNSELED/EDUCATED: _____

_____

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO SUBSTANTIATE THAT THE MEMBER WAS COUNSELED/EDUCATED ON THE ISSUES DESCRIBED ABOVE. (i.e., medical records, chart notes, incident reports, that documents the member was called and reminded of the appointment; documentation of no shows; documentation of recommended treatment plan, counseled, etc.)

The above member has been counseled and educated and there has not been any improvement or progress. It is necessary for this member to be removed from my panel and to seek medical services elsewhere. I will continue to provide treatment for 30-45 days to allow the Health Plan to assist the member in the selection of another PCP.

SIGNATURE OF REQUESTING PCP: _____

TYPE OR PRINT NAME: _____

DATE: _____

COUNSELING/EDUCATION LETTER TO MEMBER

DATE

Name
Address
City, State Zip

RE: Patient Name
ID#:

Dear

As your primary care physician, my goal is to advocate and support activities which contribute to your health and wellness. This can be accomplished through a partnership with you in a patient/physician relationship that is based on mutual trust, cooperation and adherence to accepted office procedure.

It has been brought to my attention that this relationship has been threatened by the following:

_____

This behavior is unacceptable and will not be tolerated. The accepted office policy(s)/procedure(s) are:

_____

Unless you are willing to correct this behavior, I will have no choice but to request that you be removed from my panel. A response is requested from you within 14 days of receipt of this letter.

Sincerely,
PCP

CONTRACT EXCLUSIONS

IPA retains the right to deliver certain services through a vendor or contractor. Should IPA elect to deliver certain services for which you are currently contracted to provide through a vendor or contractor, you will be provided a minimum of thirty (30) day's advance notice and your contract terms will be honored during that notice period. After such time and notification, IPA retains the right to discontinue reimbursement for services provided by the vendor or contractor.

EXCHANGE OF ELECTRONIC DATA

Information Protection Requirements and Guidance

IPA follows all applicable laws, rules, and regulations regarding the electronic transmittal and reception of Customer and Provider information. As such, if an electronic connection is made to facilitate such data transfer, all applicable laws must be followed. At all times, a provider must be able to track disclosures, provide details of data protections, and respond to requests made by IPA regarding information protection.

When an electronic connection is needed, relevant connection details will be provided to a customer by the IT Operations team, who will engage with provider's staff to appropriately implement the connection. Any files placed for receipt by provider staff must be downloaded in 24 hours, as all data is deleted on a fixed schedule. If the files are unable to be downloaded, then alternate arrangements for retransmission must be made. The provider and provider's staff will work collaboratively with IPA to ensure information is adequately protected and secure during transmission.

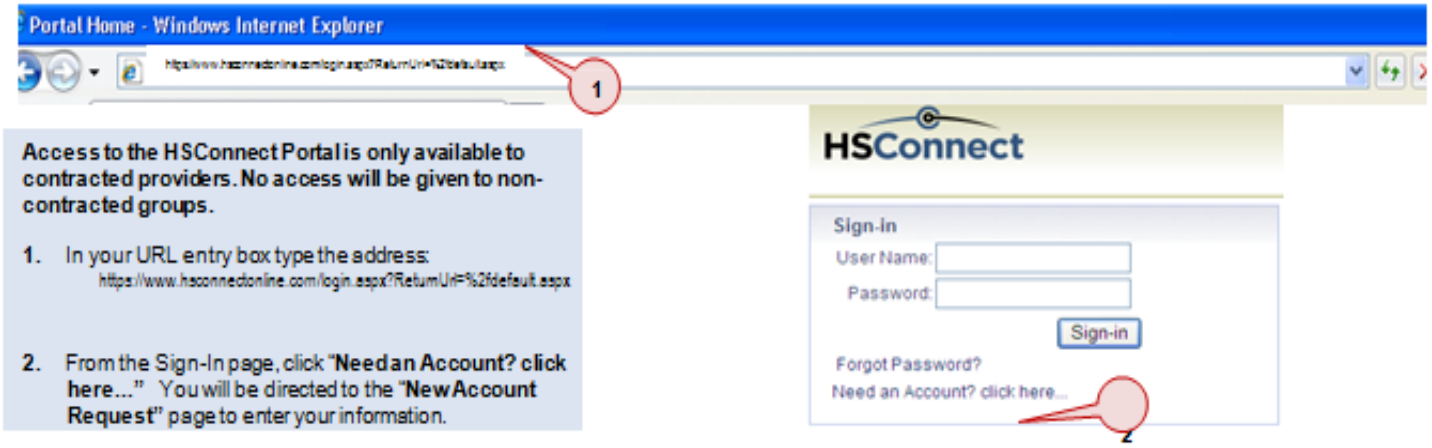
Experience the Ease of HSConnect

- View customer eligibility
- Create referrals and precertifications
- Search authorizations
- Search claims

Need More Help? Contact the HSConnect Help Line: 1-866-952-7596 or e-mail HSConnectHelp@hsconnectonline.com
To register for HSConnect, visit: www.hsconnectonline.com

Register for HSConnect Access

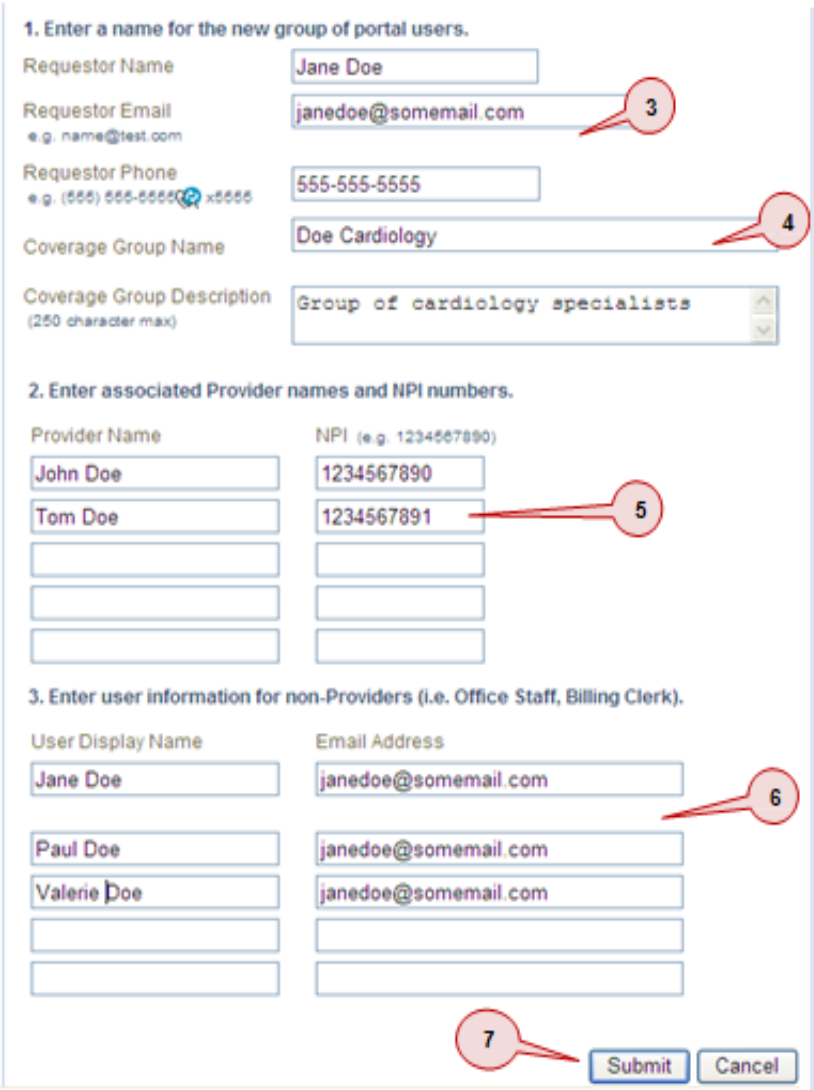
Quick Reference Card: Register for HSConnect Access – Provider Register



Access to the HSConnect Portal is only available to contracted providers. No access will be given to non-contracted groups.

1. In your URL entry box type the address:
   https://www.hsconnectonline.com/login.aspx?ReturnUrl=%2fdefault.aspx

2. From the Sign-In page, click "**Need an Account? click here...**" You will be directed to the "**New Account Request**" page to enter your information.



3. Enter the first and last name of the person requesting the account, practice Phone number, as well as the email address.

   Note: Failure to provide valid information could delay access to the portal.

4. Next, enter the coverage group name & description.
   Coverage Group Name - Operating name and/or name used with general public.
   Coverage Group Description - The provider type of the requesting group. Enter practitioner, facility or ancillary.

5. You must enter the individual NPI's for each provider that you need access for. If you have more than 5 providers, submit an additional request, or email: HSC_Account_Request@hsconnectonline.com

6. Enter the ***first and last names*** for each user needing access, along with a valid email address for each user. If you have more than 5 users, submit an additional request, or email: HSC_Account_Request@hsconnectonline.com

   Note: Failure to provide valid information could delay access to the portal.

7. Click "**Submit**" and your account request will be submitted to the HSC Account Request inbox, to be processed

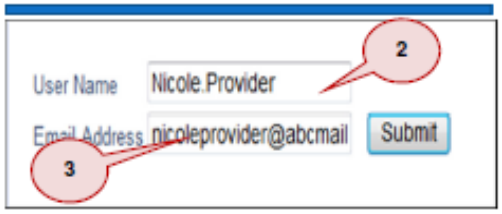
   Note: Some information may be required from provider relations representative, prior to creating the account and granting access.

8. Once all the information has been verified and loaded, users will receive an email notification with usernames and a link to create a password from: do.not.reply@hsconnectonline.com. If you do not receive the notification, please check any spam or junk mail folders you may have.

Request a New Password

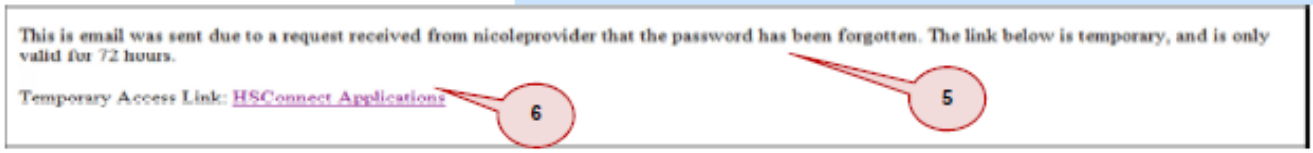
HSConnect

Request a New Password

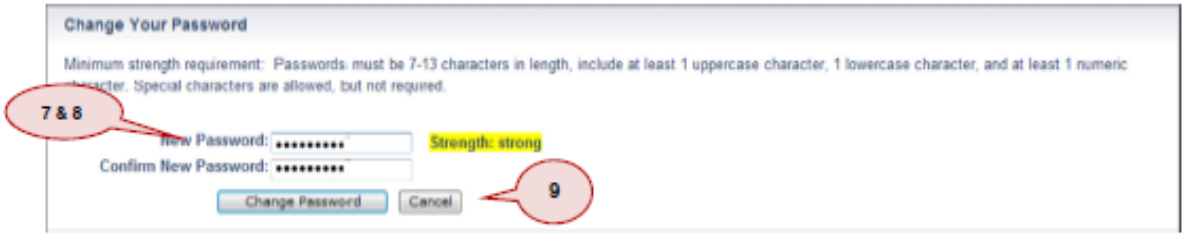


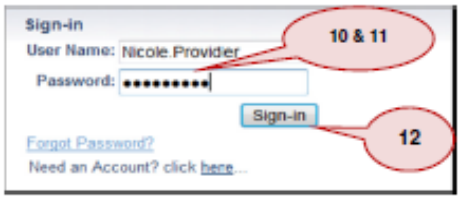
HSConnect Passwords must be changed every 90 days.

1. From the HSConnect Portal Sign-in Page, select the **Forgot Password?** link. The Forgot Password screen displays.
2. Enter your HSConnect **User Name**.
3. Enter your **Email Address** for this User Name.
   Note: The Email Address must match the Email Address on the profile for your User Name.
4. Select **Submit**.
5. Open the email you should have received from do.not.reply@HSConnectonline.com.
   Note: If you do not receive an email, check your Spam or Junk e-mail folder before contacting the HSC Help Desk.
   Note: If you do not receive an email, please contact HSC at 1-866-952-7596 or send an email to HSConnectHelp@HSConnectonline.com.
6. Select the **Temporary Access Link:** HSConnect Applications. The Change Your Password screen displays.



7. Enter a **New Password**.
   Note: The New Password must be 7 to 13 characters in length. Include at least 1 uppercase character, 1 lowercase character, and at least 1 numeric character. Special characters are allowed but not required.
8. Enter the password again in the **Confirm New Password** field.
   Note: A message will prompt as you create password to guide you in password security strength.
9. Select **Change Password**. A message displays stating that "Your password has been changed. Please click **here** to login using the new user account credentials."
10. From the HSConnect portal Sign-in page, enter your HSConnect **User Name**.
11. Enter your new **Password**.
12. Select the **Sign-in** button. If the HSConnect Terms and Conditions screen displays, your entered your new Password correctly.

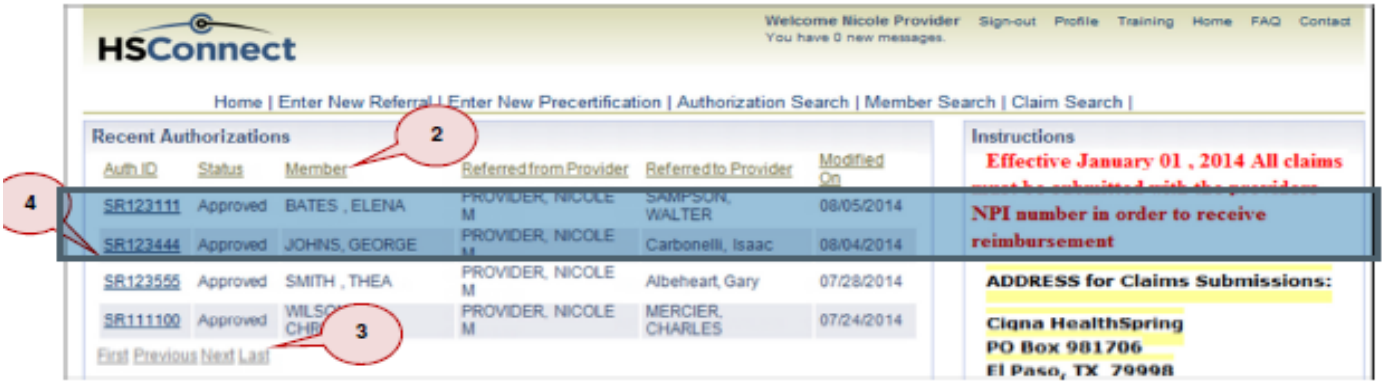




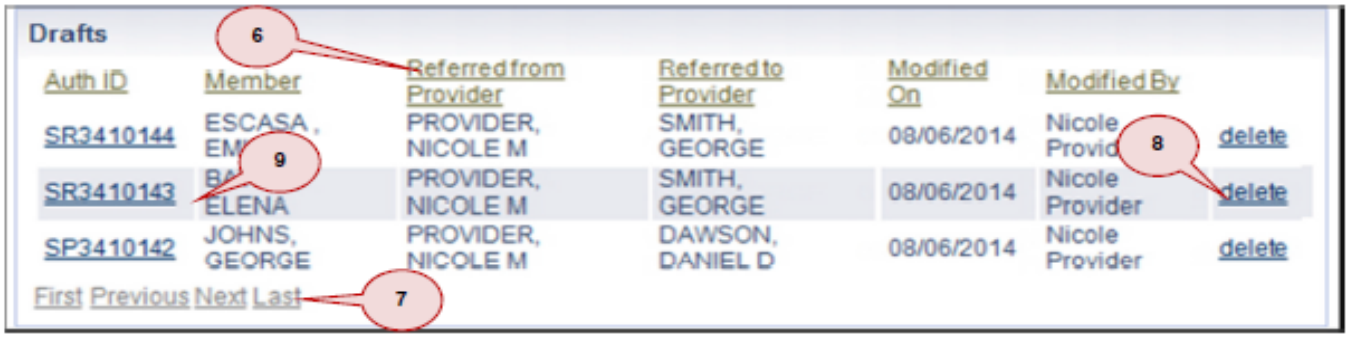
Review Recent and Draft Authorizations

Review Recent and Draft Authorizations

1. Log into the HSConnect portal and accept the terms and conditions. The recent authorizations display in the upper-half of the Home Page.
   Note: Up to thirty of the most recent authorizations (referrals and precertifications) display.
2. (Optional) Select a column heading to sort the authorizations by the data in that column.
3. The first ten authorizations display on the first page. Select the **Next**, **Last**, **First**, and **Previous** links to page through the authorizations.
   Note: If you cannot find the authorization you are looking for, select the **Authorization Search** link at the top of Home Page.
4. Select the **Auth ID** link to view the details for the authorization. Once you display the authorization, you can perform the following tasks:
   - Create another referral for this member.
   - Create another precertification for this member.
   - Extend the end date for an approved referral that has not been previously extended for up to 30 more days.
   - Add additional clinical information for a pended authorization.
   - View a message from a provider on this authorization (this task is based on the user's role and may not display as an option).
   - Send a message to a provider on this authorization (this task is based on the user's role and may not display as an option).
   - Print a copy of this authorization.
   - Search for another authorization.

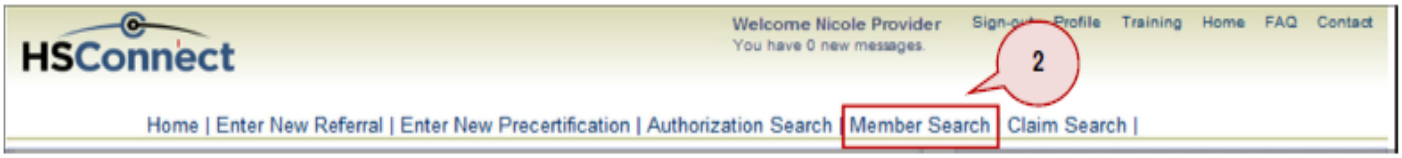


5. View the draft authorizations in the lower-half of the Home Page.
   Note: The draft authorizations (referrals and precertifications) are ones that were saved but never submitted to Cigna-HealthSpring.
6. (Optional) Select a column heading to sort the draft authorizations by the data in that column
   .
7. The first ten draft authorizations display on the first page. Select the **Next**, **First**, **Last**, or **Previous** links to page through the authorizations.
8. (Optional) Select the **delete** link next to the specific draft authorization if you want to delete it from HSConnect. Select **OK** to confirm the deletion.
9. Select the **Auth ID** link to view the details for the draft authorization. Then complete and submit the authorization request to Cigna-HealthSpring.

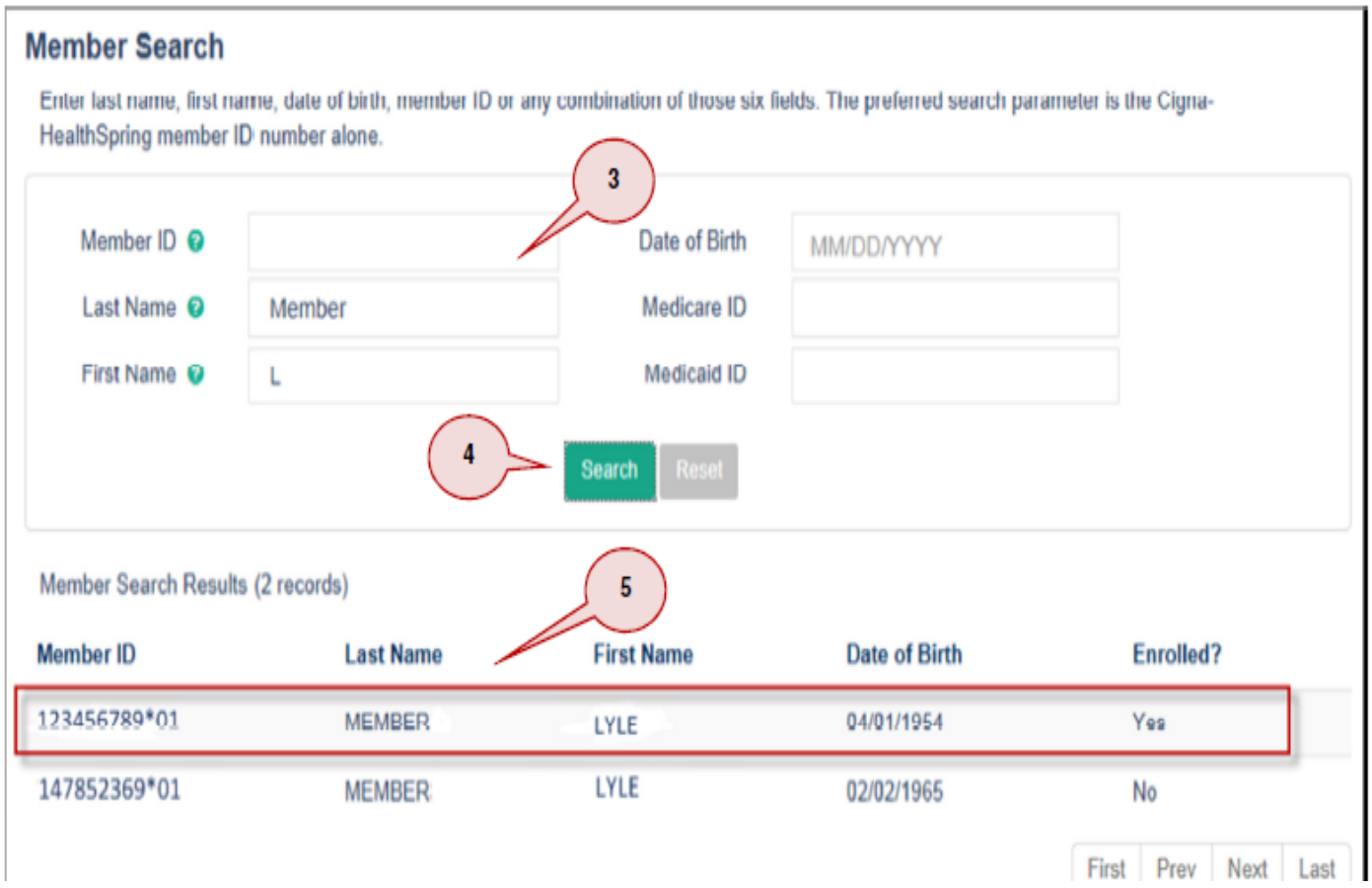


Need More Help? Contact the HSConnect Help Line: 866-952-7596 or E-mail HSConnectHelp@HSConnectonline.com

Locate a Member

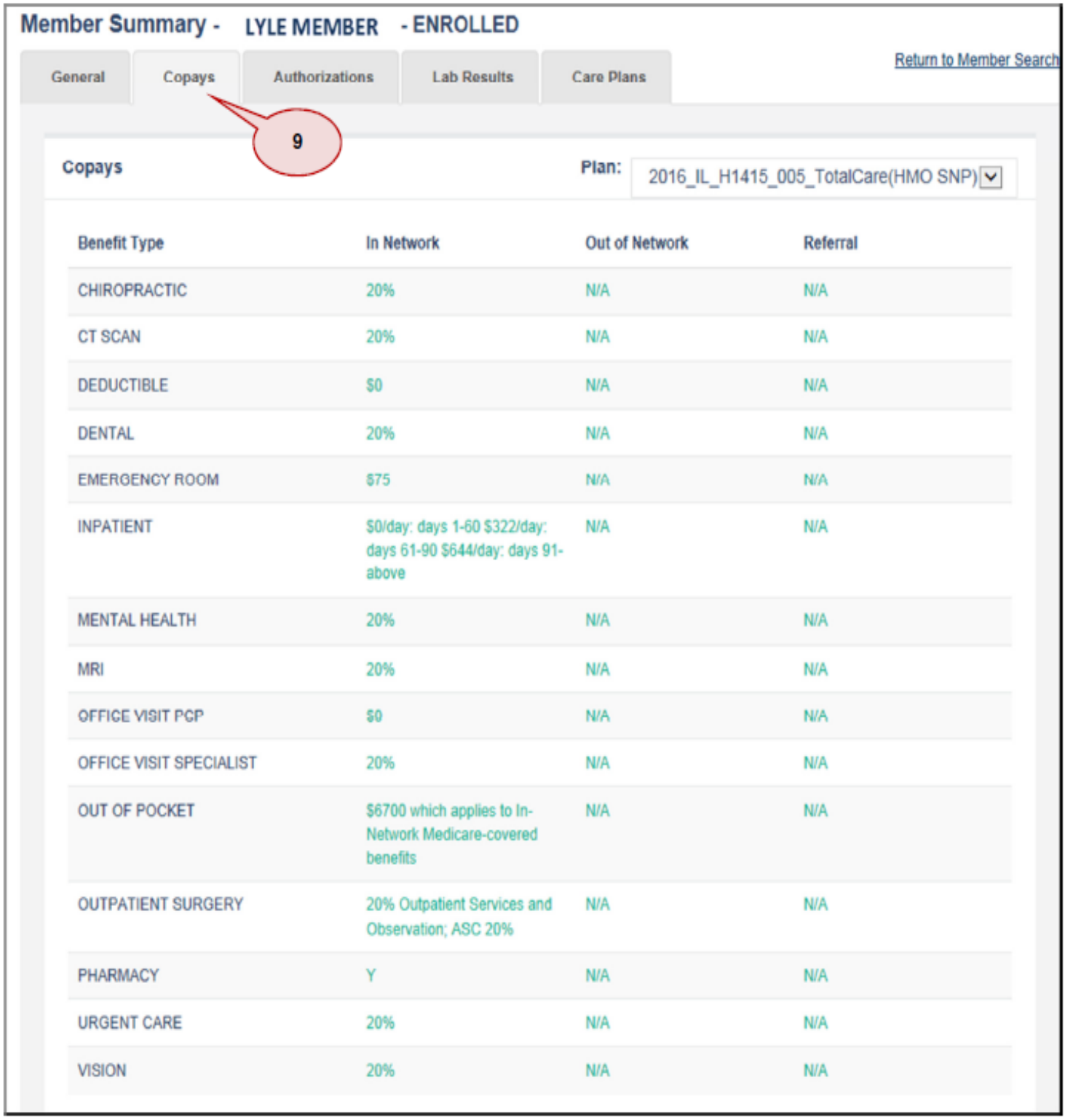


1. Log into the HSConnect portal and accept the terms and conditions.
2. Select the **Member Search** link at the top of the Home Page. The Member Search screen displays.
3. Enter a search term in at least one field. If you enter multiple fields, the search results only display those members where all fields match.
   - **Member Last** or **First Name:** Enter a full or partial name.
   - **Member DOB:** Use with the Name to narrow the search results.
   - **Member ID:** Enter the number that appears on the Member ID card. This may or may not include an *01 at the end of the number.
     Note: Member ID is the preferred and most accurate search term.
4. Select **Search**. The search results display.
   Note: If needed, select **Reset** to clear and enter new search terms.
   The following details apply to the search results:
   - If there are more than 100 matching search results, a message displays stating you have exceeded the current limit of 100.
   - Partial name matches may display, such as Rosemary when you only entered Mary.
   - Use the **First**, **Previous**, **Next**, or **Last** links to page through the search results if there are multiple pages.
5. From the Member Search Results, select the **Member** I to display that member's profile.



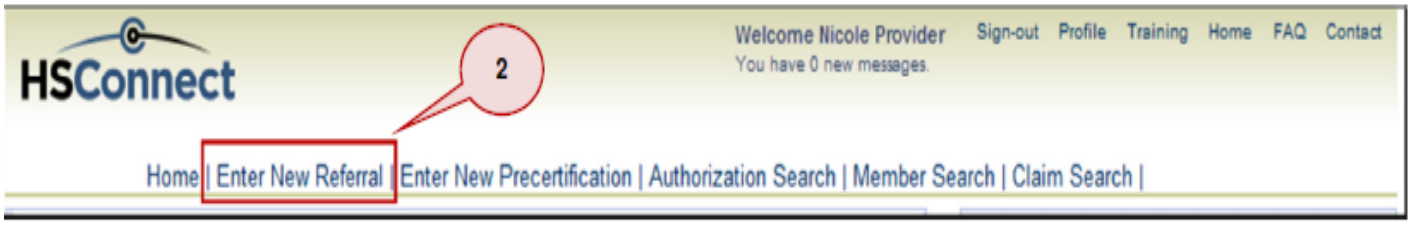
Summary of Member's Benefits

9. View the co-pays the member pays for in-network, out-of-network, and referral services by clicking on the Copays tab. **Note:** To view additional Co-Pay Information please visit www.cignahealthspring.com website to select the member's plan and view specific details concerning the co-pays.



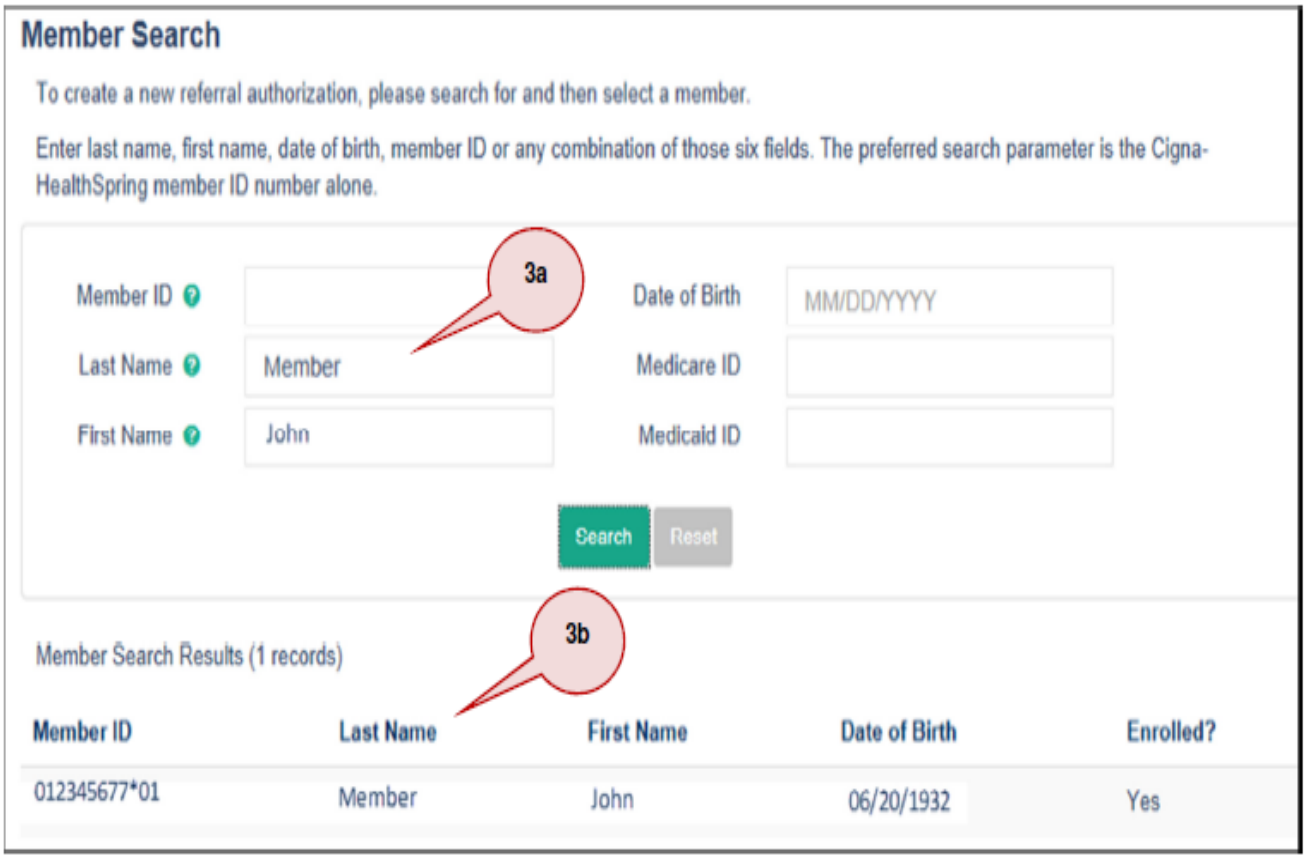
Benefit Type	In Network	Out of Network	Referral
CHIROPRACTIC	20%	N/A	N/A
CT SCAN	20%	N/A	N/A
DEDUCTIBLE	$0	N/A	N/A
DENTAL	20%	N/A	N/A
EMERGENCY ROOM	$75	N/A	N/A
INPATIENT	$0/day: days 1-60 $322/day: days 61-90 $644/day: days 91-above	N/A	N/A
MENTAL HEALTH	20%	N/A	N/A
MRI	20%	N/A	N/A
OFFICE VISIT PCP	$0	N/A	N/A
OFFICE VISIT SPECIALIST	20%	N/A	N/A
OUT OF POCKET	$6700 which applies to In-Network Medicare-covered benefits	N/A	N/A
OUTPATIENT SURGERY	20% Outpatient Services and Observation; ASC 20%	N/A	N/A
PHARMACY	Y	N/A	N/A
URGENT CARE	20%	N/A	N/A
VISION	20%	N/A	N/A

Create and Submit a Referral part 1

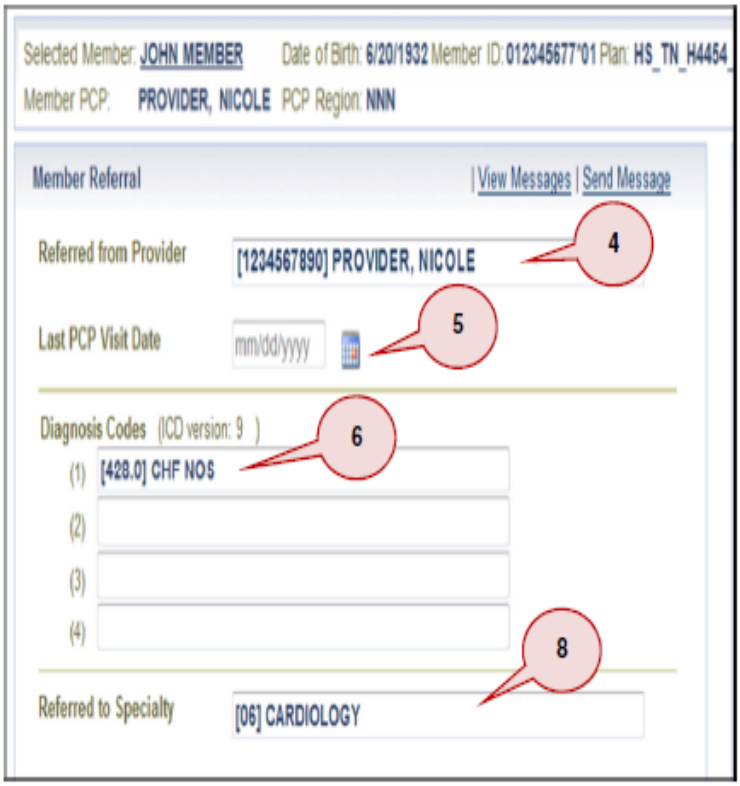


If a PCP wants to send a member to see a Specialist, he or she should complete this task for a one time visit or a specific number of visits before making the appointment with the Specialist.

1. Log into the HSConnect portal and accept the terms and conditions.
2. Select the **Enter New Referral** link at the top of the HSConnect Home Page. The Member Quick Search screen displays.
3. Perform the following to select the member:
   a. Locate the member for the referral.
      Note: Member ID is the preferred method.
      Note: If searching by Member Name, please include, Last Name and First Name. For quicker results, include the Member DOB. Do not include Member ID with member name in the search.
   b. Select the **Member** from the search results. **Note:** Only the members assigned to the PCPs in your coverage group display in the search results.
   c. The Referral screen displays with the member defaulted based on your selection. Verify you selected the correct member

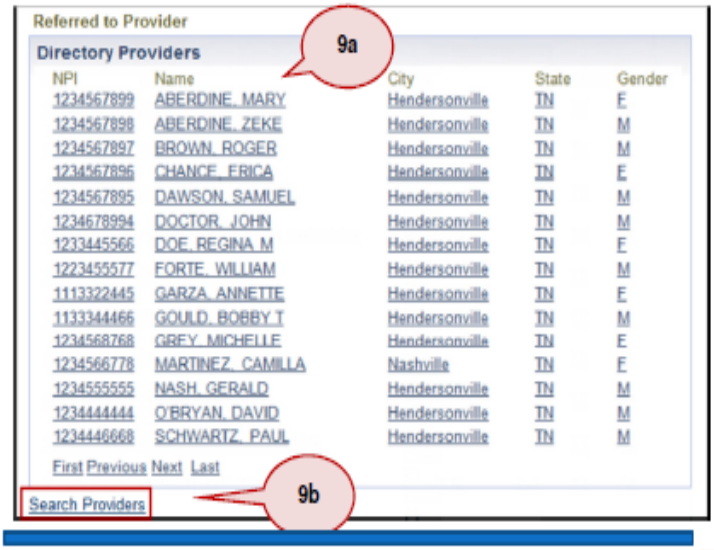


Create and Submit a Referral part 2

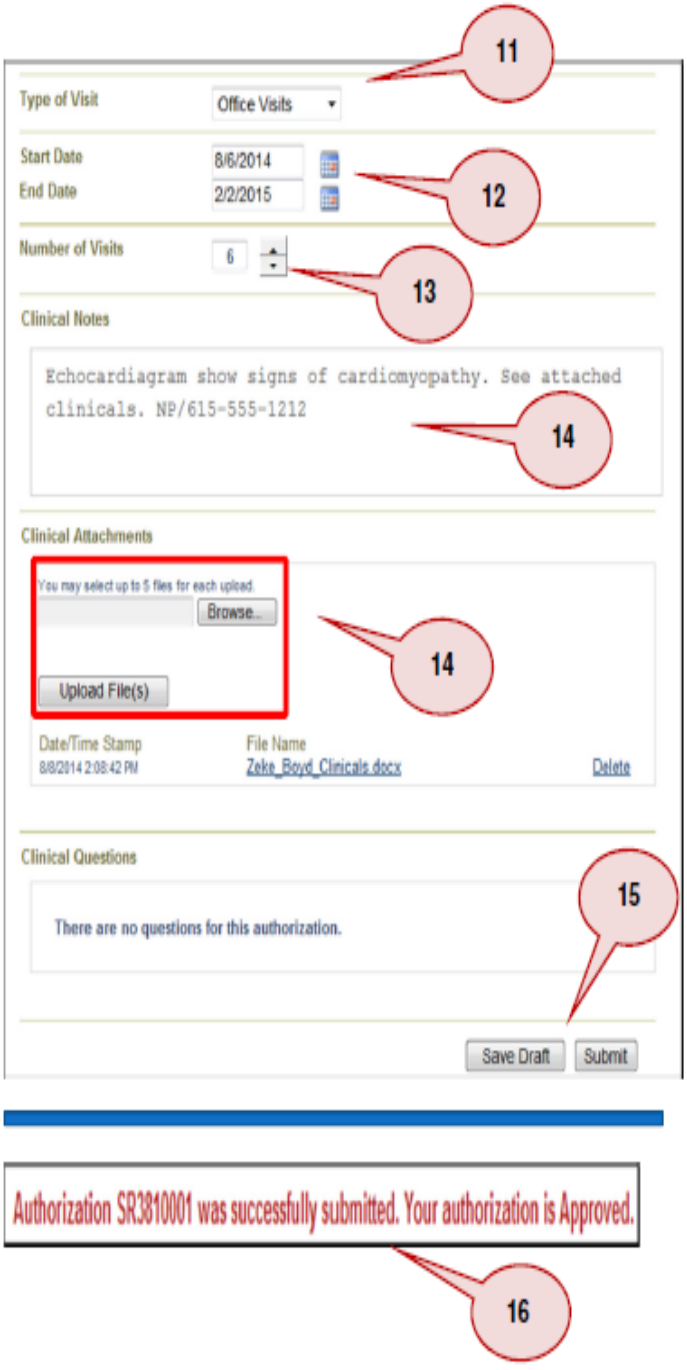


4. This field defaults to the PCP name that is assigned to your login credentials. To change, enter a partial or full name or NPI for the **Referred from Provider**. As you enter the name or NPI, the matching search results display in the drop-down list. Select the provider who is referring the member to visit a Specialist. **Note:** This field only displays the physicians in your coverage group.
5. (Optional) Enter or select the **Last PCP Visit Date**.
6. Enter a partial or full diagnosis code or description in the first **Diagnosis Codes** field. As you enter the code or description, the matching search results display in the drop-down list. Select the diagnosis applicable to the member's condition.
7. (Optional) Enter and select additional **Diagnosis Codes** (up to three additional ones) in the other blank fields.
8. Enter a partial or full specialty code or description in the **Referred to Specialty** field. As you enter the code or description, the matching search results display in the drop-down list. Select the specialty applicable to the specialist you want the member to visit.

9. Use one of the following methods to select the **Referred to Provider** or Specialist you want the member to visit.
   a. The first preference is to select a Specialist from the Directory Providers section. Up to 15 Specialists will display in the directory results at a time. The Specialists display alphabetically by last name. Select the **Next**, **Last**, **First**, or **Previous** links to page through the search results.
   b. You can also select the **Search Providers** link to search directly by NPI or Name. Last name, first name works best for name searches.
   Note: If you search by name, partial name searches will yield results for all providers in that specialty, for all Cigna-HealthSpring Markets, containing that value searched.
   Note: Only contracted providers will populate search results.
   c. If the specialist you want to send the member to is non-par or out-of-network, select the **Enter Non-Participating Provider** checkbox. Complete all the fields, including the **Reason** why this member needs to go to a non-par provider. Choose one of the reasons from selection box
   Note: Please try the Search Providers option to locate your provider, before choosing **Enter Non-Participating Provider.**
10. Once selected, the name of the Referred to Provider displays with his or her NPI.



Create and Submit a Referral part 3



11. Select one of the following options from the **Type of Visit** drop-down list:
    - **Consult Only** - single visit
    - **Office Visits** - multiple visits

12. If you need to modify the **Start Date** and/or **End Date**, enter or select the new dates.
    Note: If you extend or make the dates retroactive, the referral will most likely pend when submitted.

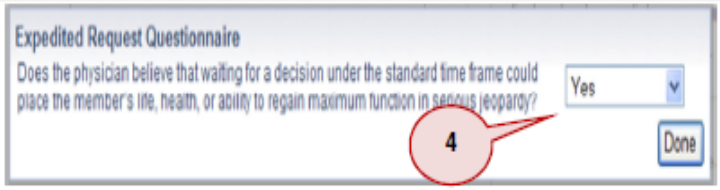
13. Enter or use the arrows to select the **Number of Visits**.
    Note: If you extend a default (other than 0), the referral will most likely pend when submitted. If you selected Consult Only in Step 11, this field is 1.

14. Document the reason for the referral by using one or both of the following methods:
    - Enter free text **Clinical Notes** to document why this request is medically necessary.
      - Copy (**Ctrl/C**) the clinical notes from your EMR and paste (**Ctrl/V**) the notes.
      - Type in a statement that you will fax the clinical to Health Services. If you select this option, reference the Auth ID on the fax.
    - Attach the clinical information as a file. Select **Browse...** to select the file. Select **Upload File(s)** to attach the file to the referral.

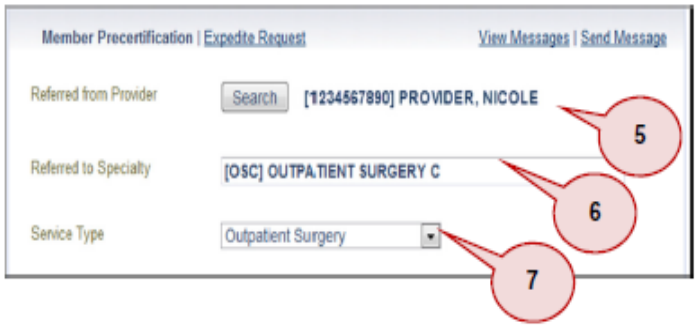
15. Perform one of the following:
    - If you are not ready to send the request to Cigna-HealthSpring for processing, select **Save Draft**.
      Note: You can select the referral from the HSConnect Home Page, under the Drafts section to view or edit at a later time.
    - To submit the referral to Cigna-HealthSpring for processing, select **Submit**.

16. Review the confirmation message at the top of the screen (Approved or Pending) and note the Auth ID. If Pending, Cigna-HealthSpring must review for a final determination. Note if the Service Provider was sent a message or if you will notify him/her manually.

Create and Submit a Precertification



4. (Optional) If the precertification request is expedited, select the **Expedite Request** link. The Expedited Request Questionnaire displays. Otherwise, skip to the next step.
   a. If the member's health is in jeopardy, select **Yes**.
   b. Select **Done** to close the questionnaire.



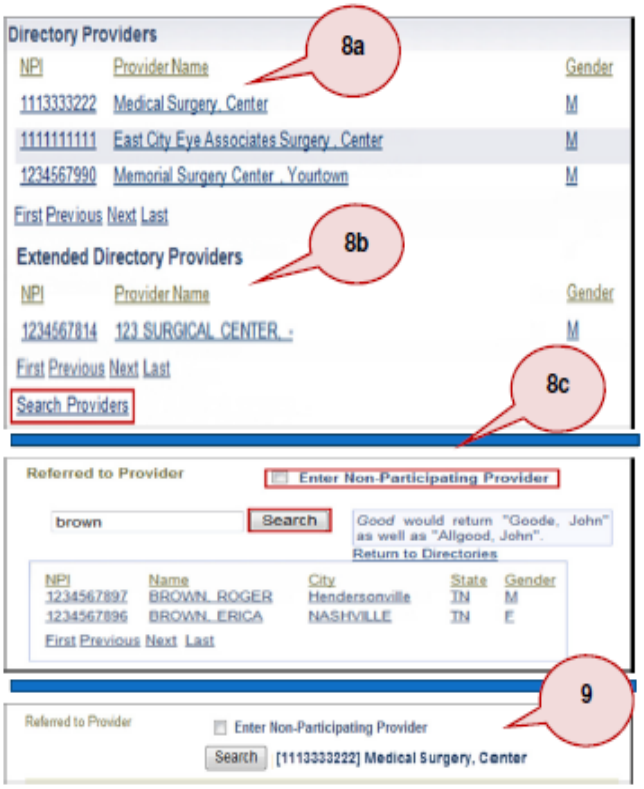
5. Select the **Search** button to select the **Referred from Provider** from the list of providers in your coverage group. This is the provider who is referring the member to the Referred to or rendering provider. Select the **Provider Name** link for the applicable Referred from Provider.

6. Enter a partial or full specialty description in the **Referred to Specialty** field. As you enter the description, the matching search results display in the drop-down list. Select the specialty applicable to the precertification request.
   Note: This entry determines the providers that display in the Referred to Provider section and the entries for the Place of Service. The specialties are not only limited to areas of medicine (Cardiology, Urology, etc.). You can also enter a provider type, such as DME, Hospital, Home Health, or Radiology, if you want to display those selections.

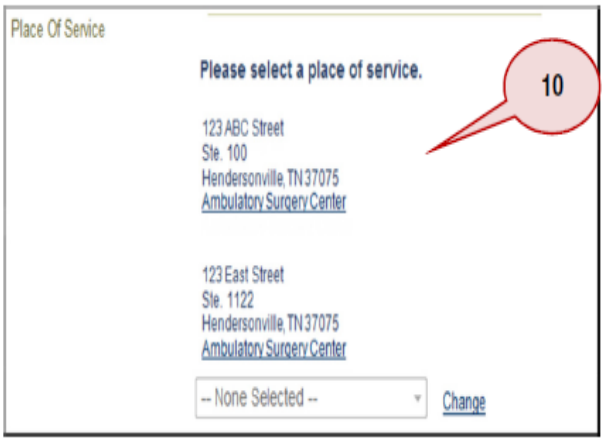
7. Select the **Service Type** that most closely relates to the requested service from the drop-down list.

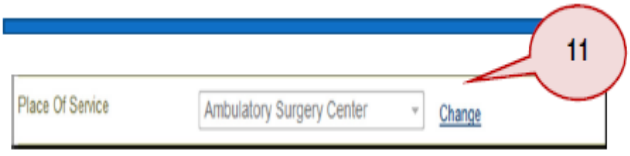
8. Use one of the following methods to select the **Referred to Provider** or the provider that is rendering the requested services.
   Note: If the Referred to Specialty = Outpatient Surgery or Hospital, the Referred to Provider is the name of the facility where the procedure or surgery will take place.
   Note: If the Referred to Specialty = an area of medicine such as Cardiology or Urology, the Referred to Provider is the name of the Specialist.
   a. The first preference is to select one of the providers from the Directory Providers section. The providers display alphabetically. Select the **Next**, **Last**, **First**, or **Previous** links to page through the results.
      Note: You can also select the **Search Providers** link to search directly by NPI or Name. The provider must still be one that would have displayed if you paged through the results.
   b. The second preference is to select one of the providers from the **Extended Directory Providers** section.
   c. If the provider is non-par or out-of-network, select the **Enter Non-Participating Provider** checkbox. Complete all the fields, including the **Reason** why this member needs to go to a non-par provider.
      Note: Please try the Search Providers option to locate your provider, before choosing **Enter Non-Participating Provider.**

9. Once selected, the name of the Referred to Provider displays with the NPI.



Create and Submit a Precertification part 2





10. Depending on your selection for the Referred to Provider, select the **Place of Service** (POS) by location where the provider will perform the requested service by clicking the hyperlink on the appropriate address.
Note: If you do not see an expected address, simply select an alternative address that contains the correct Place of Service Value.

11. After you select the Place of Service (POS) or location, the place of service will display.
Note: Select the **Change** link to modify the POS.

12. Document the reason for the precertification by using one or both of the following methods:
    - Enter free text **Clinical Notes** to document why this request is medically necessary.
    - Copy (**Ctrl/C**) the clinical notes from your EMR and paste (**Ctrl/V**) the notes.
    - Type in a statement that you will fax the clinical to Health Services. If you select this option, reference the Auth ID on the fax.
    - Attach the clinical information as a file. Select **Browse...** to select the file. Select **Upload File(s)** to attach the file to the precertification.
    - Upload up to 5 files at one time.
    - Each file must be 10MB or smaller.
    - To remove a file before you select the Upload File(s) button, select the **remove** link.
    - To remove a file after you select the Upload File(s) button, select the **Delete** link.
    - Once you submit the request, you cannot delete a file attachment.

Create and Submit a Precertification part 3

13. Perform the following steps to add a CPT/HCPCS/revenue code to indicate the specific procedure request:
    a. Select the **Click Here to Add a Service or Procedure** link.
    b. Enter a partial or full CPT/HCPCS/revenue code or description in the **Procedure** field. As you enter the code or description, the matching search results display in the drop-down list. Select the applicable procedure.
    c. Select or enter the number of **Units**.
    d. Select the **Unit Type** from the drop-down list. Be sure to review all the selections and select the correct one.
    e. Enter or select the valid **Start Date** and **End Date** range for the precertification.
    Note: The dates may default based on the selection for the Procedure field.
    f. Select the **save procedure** link to add the procedure to the precertification request.

14. Repeat steps 19a – 19f to add additional CPT/HCPCS/revenue codes to the precertification request.
Note: Select the **delete** link to remove a procedure from the request that you added in error.

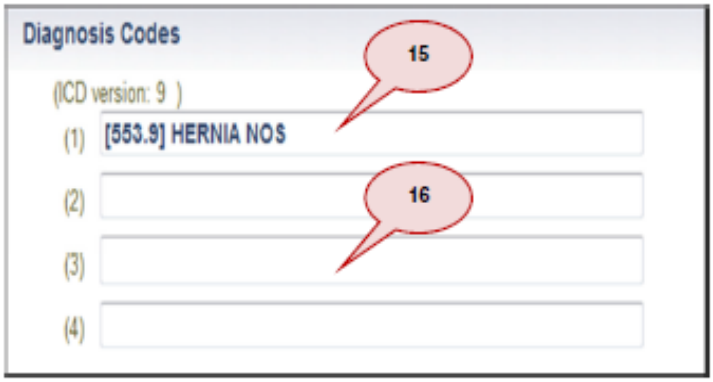
15. Enter a partial or full diagnosis code or description in the first **Diagnosis Codes** field. As you enter the code or description, the matching search results display in the drop-down list. Select the diagnosis applicable to the member's condition.

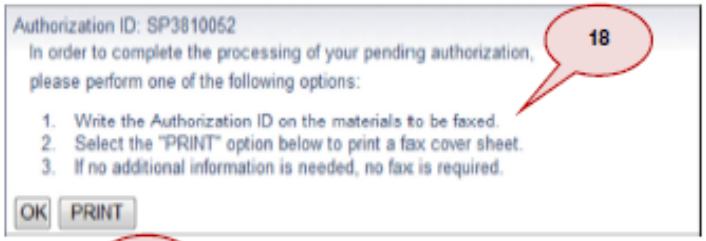
16. (Optional) Enter and select additional **Diagnosis Codes** (up to 3 additional ones) in the other blank fields

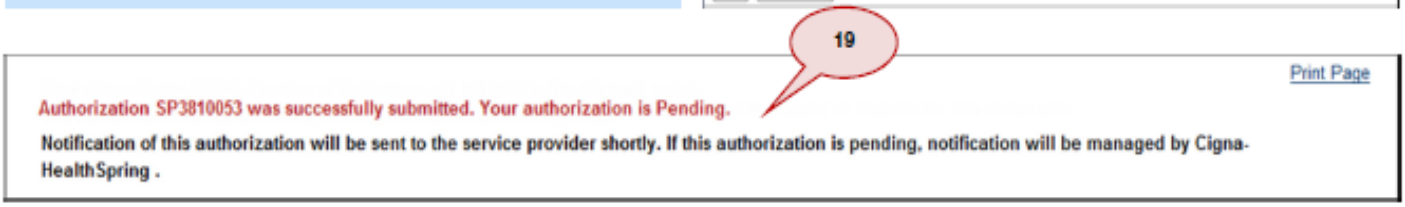
17. Perform one of the following options:
    - If you are not ready to send the precertification to Cigna-HealthSpring for processing, select **Save Draft**.
    Note: You can select the precertification from the HSConnect Home Page, under the Drafts section to view or edit at a later time.
    - To submit the precertification to Cigna-HealthSpring for processing, select **Submit**.

18. If your precertification is pending, a popup message will display with your authorization ID, giving you the option to print a fax cover sheet.
Note: If you are faxing Health Services clinical information, pertaining to this authorization, please include the fax cover sheet and notate the **Authorization ID** on each page.

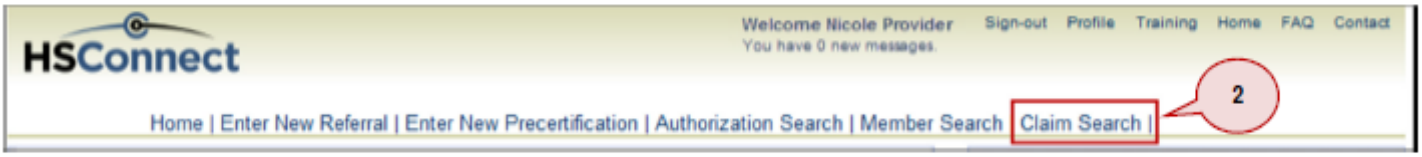
19. Review the confirmation message at the top of the screen (Approved or Pending) and note the Auth ID. If Pending, Cigna-HealthSpring must review for a final determination. Note if the Service Provider was sent a message or if you will notify him/her manually.



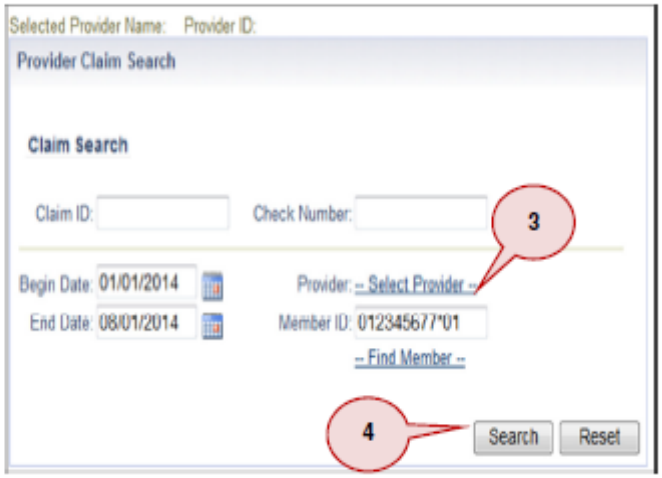


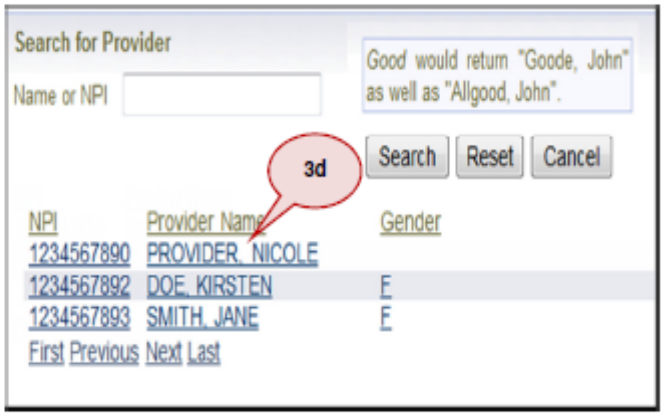


Search for Claims and View Claim Detail

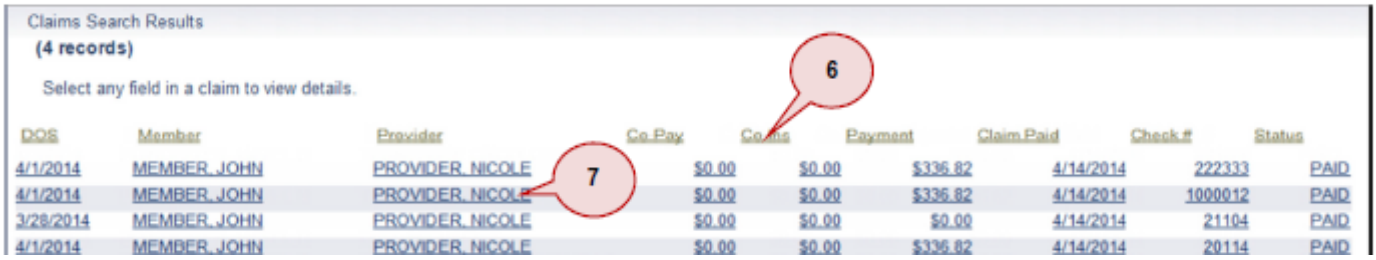


1. Log into the HSConnect portal and accept the terms and conditions.
2. Select the Claim Search link at the top of the Home Page. The Provider Claim Search screen displays.
3. Search for a claim(s) by using one of the following search methods:
   a. **Claim ID**: Enter the claim number assigned by Cigna-HealthSpring.
   b. **Check Number**: Enter the check number issued by Cigna-HealthSpring for payment on the claim.
   c. **Member ID** and **Begin/End Date:**
      - Enter the number assigned to the member by Cigna-HealthSpring (nine digits, an asterisk, and two digit suffix - for example ***123456789***). If you do not know the number, select the **Find Member** link to search for the member.
      - (Optional) Enter a **Begin Date** and **End Date** range for the Dates of Service on the claim(s) to narrow the search results
   d. **Provider** and **Begin/End Date:**
      - Select the **Select Provider** link. The Search for Provider screen displays with the providers in your coverage group. If the provider you are looking for does not display, select the **Next** link until the provider displays. If you work in a very large provider group, you can use the text box to search by provider **Name or NPI.**
      - Select the **NPI** or Provider Name link for the applicable provider.
      - (Required) Enter a **Begin Date** and **End Date** range for the Dates of Service on the claim(s).
4. Select **Search**. The search results display.
   Note: If you searched by **Member ID** or **Provider** and there are more than 300 claims in the search results, you must narrow the date range.





5. Review the matching claims in the **Claims Search Results** section.
6. (Optional) Select any of the column headings to sort the search results by that column heading.
7. Select the link for any row on the screen to view additional details specific to the selected claim and for the option to view the **Remittance Advice.**



CREDENTIALING AND RECREDENTIALING PROGRAM

All practitioner and organizational applicants to IPA must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s). Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the plan. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years in order to maintain their participating status.

Practitioner Selection Criteria

IPA utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unencumbered licensure in the state of practice as required by state and federal entities.
- Holds a current, valid, and unrestricted federal DEA and state controlled substance certificate as applicable.
- Is board-certified or has completed appropriate and verifiable training in the requested practice specialty.
- Maintains current malpractice coverage with limits commensurate with the community standard in which practitioner practices.
- Participates in Medicare and has a Medicare number and/or a National Provider Identification number.
- Has not been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.
- Is not currently opted out of Medicare.
- Has admitting privileges at a participating facility as applicable.

Application Process

- Submit a completed state mandated credentialing application, CAQH Universal Credentialing Application form or CAQH ID, with a current signed and dated Attestation, Consent, and Release form that is less than 90 days old.
- If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information and explanations.
- Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment.

Submit copies of the following:

- All current and active state medical licenses, DEA certificate(s), and state controlled substance certificate as applicable.
- Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
- Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
- If a physician, current and complete hospital affiliation information on the application. If no hospital privileges and the specialty requires hospital privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician should be provided.

Credentialing and Recredentialing Process

Once a practitioner has submitted an application for initial consideration, IPA's Credentialing Department will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank. The credentialing process generally takes up to ninety (90) days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the practitioner will be notified in writing of their participation effective date.

To maintain participating status, all practitioners are required to recredential at least every three (3) years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information at least 4 months in advance of their three-year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request. Practitioners who fail to return recredentialing information prior to their recredentialing due date will be notified in writing of their termination from the network.

Office Site Evaluations (if applicable)

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue, and/or as otherwise mandated by state regulations.

Practitioner offices will be evaluated in the following categories:

- Physical appearance and accessibility
- Patient safety and risk management
- Medical record management and security of information
- Appointment availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit if necessary to ensure that the correction action has been implemented.

Practitioner Rights

- Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the Plan's offices.
- Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.
- Right to be informed of the status of their application upon request. A provider may request the status of the application either telephonically or in writing. The Plan will respond within two business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Organizational Provider Selection Criteria

When assessing organizational providers, IPA utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies.
- Has been reviewed and approved by an accrediting body.
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other plan criteria.
- Maintains current professional and general liability insurance as applicable.
- Has not been excluded, suspended, and/ or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

Organizational Provider Application and Requirements

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc.).
4. Proof of current professional and general liability insurance as applicable.
5. Proof of Medicare participation.
6. If accredited, proof of current accreditation.
7. Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
8. If not accredited, a copy of any state or CMS site surveys that occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Credentialing Committee and Peer Review Process

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or re-approval as a participating provider. The Medical Director may approve providers, who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of contracted primary care and specialty providers, and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and recredentialing process must be obtained and verified within one hundred eighty (180) days prior to presentation to the Medical Director or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-discrimination in the Decision-making Process

IPA's credentialing program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and state regulations as applicable. Through the universal application of specific assessment

criteria, ensures fair and impartial decision-making in the credentialing process, and does not make credentialing decisions based on an applicant's race, gender, age, ethnic origin, sexual orientation, or due to the type of patients or procedures in which the provider specializes.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers are advised to not see IPA's customers until they receive notification of their plan participation and effective date. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Initial Orientation

Network Operations Representative or Administrator:

1. Coordinates orientation of providers within 30 calendar days of their contract effective date. Note: Provider orientation can be conducted in person, though a WebEx, a welcome packet mailing or by emailing the provider a welcome packet. A welcome letter is included in the Welcome packet and will be to all new providers within 30 days of their effective date.

Appeals Process and Notification of Authorities

In the event that a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include a) the reasons for the action, b) outline of the appeals process or options available to the provider, and c) the time limits for submitting an appeal. A panel of peers will review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies. Confidential practitioner credentialing and recredentialing information will not be disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

IPA conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions, and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned, are the subject of a complaint review, or are under investigation for or have been convicted of fraud, waste, or abuse are subject to review by the Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider who's license has been revoked or has been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program or who has opted out of Medicare will be (automatically terminated from the plan.

Renaissance Physicians
CARE THAT REVOLVES AROUND YOU.

2900 North Loop West, Ste. 1300
Houston, Texas 77092
Telephone: (832) 553-3300
Fax: (832) 553-3418

Initial Contracting/Credentialing Information Checklist

PHYSICIAN NAME: _____

PLEASE MAKE SURE TO INCLUDE THE FOLLOWING ITEMS:

- ❑ CAQH Provider ID #: _____
  - o Please re-attest to information in CAQH and verify application & documentation are current (not expired)
  - o Please grant access to Renaissance to view your application
- ❑ Signed attestation pages (pages 11 & 12) – signature & dates must be within 90 days of receipt. The top of Page 11 must indicate **Renaissance Physicians**.

OR

- ❑ Completed 2007 Texas Standardized Credentialing Application (older versions will not be accepted)
  - o Forms also available for download at http://www.tdi.state.tx.us/hmo/crform.html
  - o Pages 11 & 12 – signature & dates must be within 90 days of receipt. The top of Page 11 must indicate Renaissance.

AND

- ❑ Copy of current DEA & DPS Certificates
- ❑ Copy of Board State Medical Permit/License
- ❑ Copy of current Malpractice Insurance (with limits & expiration date)
- ❑ Copy of Board Certificate (if applicable)
- ❑ Complete history of all malpractice claims & complete work history in month/year format (with no unexplained gaps)
- ❑ Completed W-9 Form
- ❑ Signed Contracts (2)
- ❑ Election to Participate (if applicable)
- ❑ Facility Audit Scheduled/Completed (RP PCP, RP OB/GYN or HMO Blue Only) ***if applicable**

Additional Required Information

Specialty: _____

Address: _____

_____

_____

Phone #: _____

Fax #: _____

Individual NPI#: _____

Group NPI#:_____

Medicare #: _____

Medicaid #: _____

Hospital Affiliations: _____

REIMBURSEMENT

Capitation reimbursement will vary according to an actuarial calculation of service requirements based on the age and gender of the customer.

- Payments to Primary Care Physicians (PCP's) will be made on or before the 22nd day of each month for all customers under a PCP's care on the first (1st) day of such month.
- Capitated specialists will receive capitation for all customers enrolled in the respective POD(s).

If a customer is added to a PCP's roster on or before the fifteenth (15th) day of a month, a full month's payment will be made retroactively during the month subsequent. There will be no retroactive payment for customers added after the fifteenth (15th) day of the month.

- Capitation will be paid each month to the physician whether or not the customer receives services that month.
- Capitation amounts are updated with practice and cost trends as experience dictates. See samples of capitation reports.

Primary Care Physician Capitation

The capitation payments the PCP receives will be accompanied by a computer report titled "Capitation Summary." The capitation report is intended for use as a tool to assist in identifying those customers for whom the physician is responsible for providing services.

The report contains a summary of membership by health plan in alphabetical order with the following information:

- Customer name
- Phone number
- ID number
- Gender
- Date of birth
- Copay
- Customer group number
- Product description
- Effective date
- Termination date
- Member months
- Capitation rate
- Risk score
- Last PCP visit

Customers who terminate that month have a date in the termination column. Customers who change PCP's, or whose coverage terminates will not appear on the following month's report. When such retroactivity occurs, the "Member months" column indicates the number of months adjusted for payment purposes.

Capitated services for Primary Care Physicians include:

Office visits for the diagnosis and treatment of an illness or injury.

- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP as medically recommended for the age and gender of the customer, based on apparent medical condition and history of the customer. (This does not include school physicals, employment physicals, sports physicals, or other examinations requested by a third party, which are not medically required, as these are not covered under the health plan).
- Well-baby examinations.
- Vision and hearing screening.
- Voluntary family planning counseling and services if provided by the PCP (except artificial insemination)
- Miscellaneous services (i.e. removal of warts, lesions, etc.) considered by the PCP to be medically vital for removal.

Specialist Capitation

Specialist capitation includes a one-page summary illustrating the payment calculation and a single, consolidated POD(S) membership list in alphabetical order by health plan.

See samples of this report at the end of the section.

For questions about the capitation checks or report, call Provider Relations at 1-832-553-3300.

Copays

It is the responsibility of the physician's office to collect the basic office visit copay at the time of the customer's visit. If the copay is NOT collected from the customer, the IPA will NOT reimburse the physician's office for that payment amount. The IPA would like to be notified of those customers who routinely do not pay their copay. Failure to make the required copay is grounds for possible termination of the customer from the health plan. The copay is a legal debt, owed by the customer to the physician, and can be collected as such.

How is the amount of copay determined?

The amount of the copay is determined by the benefit plan the employer selects.

Maximum Copays

The customer's maximum copay per contract year for any individual and family varies depending on the health plan coverage chosen. Therefore, in some cases, a customer's copay may change during the year.

Primary Care Physician Capitation Detail

Renaissance Physician
Sorted by Line of Business, Health Plan, and Member Name
PCP Cap Detail ReportJanuary 2016
Pod Name
PCP: www.xxxxxx

Member Name	Member ID	Sex	DOB	Copay	Product Description	EffectiveDate	TermDate	MemberGroup #	DiseaseState	Disease Mgmt Prg	RiskScore
Health Plan: Blue Cross MA, Cigna HealthSpring											
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	XX/21/42	$0.00	Cigna-HealthSpring Preferred (HMO)	01/01/16		TX025*MA	Disabled		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	M	5/11/XX	$0.00	Cigna-HealthSpring Advantage (HMO)	01/01/16		TX009*M	Medi/Medi		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	2/XX/30	$0.00	Blue Cross Medicare Advantage Basic (HMO)	01/01/16		TX010*QME	Medi/Medi		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	XX/7/44	$0.00	Total Care	01/01/16		TX001*MA	Other		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	M	2/XX/43	$0.00	Healthy Advantage Preferred	01/01/16		TX010*ME	Disabled		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	XX/9/50	$0.00	Blue Cross Medicare Advantage Basic (HMO)	01/01/16		BC001	Other		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	7/15/XX	$0.00	Blue Cross Medicare Advantage Basic (HMO)	01/01/16		BC001	Disabled		0.00
YYYYYYYY, ZZZZZZZZ - (555) 555-5555	xxxxxxxx-xx	F	10/XX/27	$0.00	Blue Cross Medicare Advantage Basic (HMO)	01/01/16		BC001	Other		0.00

Specialist Capitation Summary

Renaissance Physician
Specialist Capitation Summary
POD Name

Vendor Name: Wwwww Xxxxx
Vendor ID: 123456789
Specialty: Gastroenterology

Line of Business: Commercial Age Band	Member Months	Cap PMPM	Cap Dollars	Current Cap Split	Net Capitation
0-19	32	0.09	2.88	95%	2.74
20-39	50	0.51	25.50	95%	24.23
40+	89	2.28	202.92	95%	192.77
Subtotal for Commercial	171		231.30		219.74

Capitation Split for Commercial by Cap Month

11/15/2012	10/15/2012	9/15/2012	8/15/2012
95%	95%	95%	95%

Line of Business: Medicare Health Plan	Member Months	Cap PMPM	Cap Dollars	Current Cap Split	Net Capitation
City of Houston	54	4.99	269.46	85%	229.04
HealthyAdvantage Preferred	2,469	4.79	11,826.51	85%	10,052.53
Total Care	428	5.98	2,559.44	85%	2,175.52
True Choice	64	4.59	293.76	85%	249.70
Subtotal for Medicare	3,015		14,949.17		12,706.79

Capitation Split for Medicare by Cap Month

11/15/2012	10/15/2012	9/15/2012	8/15/2012
85%	85%	85%	85%

Grand Total for Wwwww Xxxxxxxx – 760xxx401	3,186	15,180.47	12,926.53

CLAIMS

Claims Submission

While IPA prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact Provider Relations for assistance.

All completed claims forms should be forwarded to the address noted below:

Renaissance Physicians
Attn: Claims
PO Box 2888
Houston, TX 77252-2888

RP Professional Claims Electronic Payment ID Numbers:

Availity - RENGQ (all caps) - as payor ID for HCFA only

Emdeon - 76066 - payor ID for HCFA and UB-04

Timely Filing

As a participating provider, you have agreed to submit all claims within 90 days of the date of service. Claims submitted with dates of service beyond 90 days are not reimbursable.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is:
https://www.cms.gov/manuals/downloads/clm104c12.pdf

The IPA can only pay claims, which are submitted accurately. The provider is at all times responsible for an accurate claims submission. While IPA will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their customer in the same group.

Claim Payment

The IPA pays clean claims according to contractual requirements and the Centers for Medicare & Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by IPA or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of IPA, the claim is not considered clean.

Offsetting

As a contracted provider, you will be informed of any overpayments or other payments you may owe us within 365 days of the date on the Explanation of Benefits or within the timeframe as noted in your Agreement. You will have sixty (60) days from receipt of notification seeking recovery to refund us. We will provide you with the customer's name, customer's identification number, and claim number, your patient account number, date of service, a brief explanation of the recovery request, and the amount or the requested recovery.
If you have not refunded us within the sixty (60) days recovery notice period, we will offset the recovery amounts identified in the initial notification, or in accordance with the terms of your Agreement.

Pricing

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

Claims Encounter Data

Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your IPA's Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by IPA. The statement provides a detailed description of how the claim was processed.

Non Payment/Claim Denial

Any denials of coverage or non-payment for services by IPA will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the customer may or may not be billed for services denied by IPA.

The customer may not be billed for a covered service when the provider has not followed the IPA's procedures. In some instances, providing the needed information may reverse the denial (i.e. referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the customer, or the services are not covered, the EOP/RA will alert you to this and you may bill the customer.

Processing of Hospice Claims

When a Medicare Advantage (MA) customer elects hospice care, but chooses not to dis-enroll from the plan, the customer is entitled to continue to receive any MA benefits which are not responsibility of the hospice through the IPA. Under such circumstances the premium the IPA receives from the Centers for Medicare and Medicaid Services (CMS) is adjusted to hospice status. As of the day the customer is certified as hospice, the financial responsibility for that customer shifts from IPA to Original Medicare.

During a hospice election, Original Medicare covers all Medicare–covered services rendered with cost-sharing of Original Medicare. IPA will remain financially responsible for any benefits above Original Medicare benefits that are non-hospice related. Non-Medicare covered services, such as vision eyewear allowable, prescription drug claims, and medical visit transportation will remain the responsibility of IPA. Plan cost-sharing will apply to IPA covered services. If the customer chooses original Medicare for coverage of covered, non-hospice-care, original Medicare services and also follows MA plan requirements, then, the customer pays plan cost-sharing and original Medicare pays the provider. IPA will pay the provider the difference between original Medicare cost-sharing and plan cost-sharing, if applicable. Plan rules must still be followed and apply for both professional and facility charges. An HMO customer who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; A PPO customer who receives services out of network has followed plan rules and is only responsible for plan cost-sharing. The customer need not communicate to the plan in advance his/her choice of where services are obtained.

When a customer revokes hospice care, financial responsibility for Medicare-covered services will return to the plan on the first of the month following the revocation.

The following are the submission guidelines for Medicare Advantage customers enrolled in Hospice:

Hospice-Related Services

- Submit the claim directly to CMS.

Medicare hospices bill the Medicare fee-for-service contractor for customers who have coverage through Medicare Advantage just as they do for customers, or beneficiaries, with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X or 82X. If the customer later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42 should be submitted as soon as possible so the customer's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for customers who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked. MA plan customers that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Non-Hospice Services

- For Part A services not related to the customer's terminal condition, submit the claim to the fiscal intermediary using the condition code 07.

- For Part B services not related to the customer's terminal condition, submit the claim to the Medicare carrier with a "GW" modifier.

- For services rendered for the treatment and management of the terminal illness by a non-hospice employed attending physician, submit the claim to the fiscal Intermediary/ Medicare carrier with a "GV" modifier.

Additional & Supplemental Benefits

- Submit the claim to IPA.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320-Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for customers who have elected hospice coverage. The Medicare Managed Care Manual, Chapter 11, Sections 40.2 and 50, and the CMS Program Memorandum AB-03-049 also outline payment responsibility and billing requirements for hospice services. This documentation is also available online at the CMS website: www.cms.gov.

ICD-10 Diagnosis and Procedure Code Reporting

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors, and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

- ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters
- ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters. Coding under ICD-10-PCS is much more specific.

Note: Procedure codes are only applicable to inpatient claims and not prior authorizations.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT or HCPCS coding for outpatient procedures.

Billable vs. Non-billable Codes

- A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.
- The following is an example of a billable ICD-10 code with corresponding non-billable codes:

Billable ICD-10 Codes	Non-billable ICD-10 Codes
M1A.3110 - Chronic gout due to renal impairment, right shoulder, without tophus	M1A.3 - Chronic gout due to renal impairment
	M1A.311 - Chronic gout due to renal impairment, right shoulder

- It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

Billable Unspecified ICD-10 Codes
I50.9 - Heart Failure, unspecified
J18.9 - Pneumonia, unspecified organism

Questions Concerning ICD-10

If you have a question as it pertains to ICD-10, please consult with your Network Operations Representative.

Dual Eligible Customers

Many of your customers may have an IPA as their primary insurance payer and Medicaid as their secondary payer. This will require you to coordinate the benefits of these "dual eligible" customers by determining whether the customer should be billed for the deductibles and copayments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB-Plus for copayments, coinsurances, and/or deductibles.

Providers will accept as payment in full IPA's payment and will not seek additional payment from the state or dual eligible customers. Additional information concerning Medicaid provider participation is available at www.myrpo.com .

A customer's level of Medicaid eligibility can change due to their medical and financial needs. The IPA encourages you to verify customers' Medicaid eligibility when rendering services, which will help you determine if the customer owes a deductible or copay.

Medicaid eligibility can be obtained by using the Medicaid telephonic Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid provider for additional information.

Please note: Each state varies in their decision to cover the cost-share for populations beyond QMB and QMB+.

Cost-sharing Chart

Patient's Medicaid Plan	Patient's liability Patient owes deductibles and copayments associated with benefit plan	Medicaid provides benefits Patient not liable for deductibles and copayments associated with benefit plan
Medicaid (FBDE)	No	Yes
QMB Only	No	Yes
QMB+	No	Yes
SLMB	Yes	No
SLMB+	Yes	No
QI-1	Yes	No
QDWI	Yes	No

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

Order of Benefit Determination Rule: Rules which, when applied to a particular customer covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that customer. A plan will be determine to have Primary or Secondary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.

Primary: This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other, coverage exists.

Secondary: This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary, for health care services provided as well as covered by the customer's health care plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Basic NAIC Rules for COB

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both customers have the same date of birth, the plan which covered the customer the longest is considered primary.

General Rules: The following table contains general rules to follow to determine a primary carrier:

If the Customer/Beneficiary	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family customer's current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	The Group Health Plan (GHP) pays primary	IPA/Medicare pays secondary
Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family customers current employment	The employer has less than 20 employees	IPA /Medicare pays primary	Group Health Plan (GHP) pays secondary

If the Customer/Beneficiary	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family customers current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	The Large Group Health Plan (LGHP) pays primary	IPA /Medicare pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family customers current employment	The employer employs less than 100 employees	IPA /Medicare pays primary	Large Group Health Plan (LGHP) pays secondary
Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	IPA /Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	IPA/Medicare pays primary	COBRA pays secondary
Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block one above	The Group Health Plan (GHP) pays primary for the first 30 months	IPA/Medicare pays secondary (after 30 months IPA pays primary)
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement Insurance pays primary for the first 30 months	IPA/Medicare pays secondary (after 30 months IPA pays primary)
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the customer drops the COBRA coverage	IPA/Medicare pays secondary (after 30 months IPA pays primary)
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	The Large Group Health Plan (LGHP) pays primary	IPA/Medicare pays secondary (after 30 months IPA pays primary)
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage	COBRA insurance would pay primary for the first 30 months or until the customer drops the COBRA coverage	IPA/Medicare pays secondary (after 30 months IPA pays primary)

Basic Processing Guidelines for COB

For the IPA to be responsible as either the primary or the secondary carrier, the customer must follow all HMO rules (i.e. pay copays and follow appropriate referral process).

When the IPA is the secondary insurance carrier:

- All IPA's guidelines must be met in order to reimburse the provider (i.e. pre-certification, referral forms, etc.).
- The provider collects only the copayments required.
- Be sure to have the customer sign the "assignment of benefits" sections of the claim form.
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of IPA for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When IPA is the primary insurance carrier:

- The provider collects the copayment required under the customer's plan.
- Submit the claim to the IPA first
- Be sure to have the customer sign the "assignment of benefits" sections of the claim form.
- Once payment and/or remittance advise (RA) has been received from IPA, submit a copy of the claim with the RA to the secondary carrier for adjudication.
- Please note that the IPA is a total replacement for Medicare.
- Medicare cannot be secondary when customers have an IPA.
- Medicaid will not pay the copay for the Participating Plan's customers.

Worker's Compensation

The IPA does not cover worker's compensation claims.

When a provider identifies medical treatment as related to an on-the-job illness or injury, the IPA must be notified. The provider will bill the worker's compensation carrier for all services rendered, not the IPA.

Subrogation

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

Claims involving Subrogation or Third Party Recovery (TPR) will be processed internally by the IPA's Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Customers who may be covered by third party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to the IPA with any information regarding the third party carrier (i.e. auto insurance name, lawyers name, etc.). All claims will be processed per the usual claims procedures.

The IPA uses an outside vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the customer, provider and attorney's office and assists with settlements. For claims related questions, please contact Provider Customer Service at 1-832-553-3300. A Provider Representative will gladly provide assistance.

Appeals

An appeal is a request for the IPA to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. You must receive a notice of denial, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal. Appeals can take up to 60 days for review and determination. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the IPA agreement.

You may appeal a previous decision not to pay for a service. For example, claims denied for no authorization or no referral, including a decision to pay for a different level of care; this includes both complete and partial denials. Examples of partial denials include denials of certain levels of care, isolated claim line items, or a decreased quantity of office or therapy visits. Total and partial denials of payment may be appealed using the same appeal process. Your appeal will receive an independent review by the IPA's representative not involved with the initial decision. Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision.

Appeals can take up to 60 days for review and determination. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the IPA's agreement. An appeal is a request for IPA to review a previously made decision related to medical necessity or clinical guidelines. You must receive a notice of denial, of medical non-coverage, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal.

You should submit your appeal using the "Request for Appeal or Reconsideration" form and medical records. There are several ways to submit your appeal to the IPA. You may fax the appeal request to our secure fax line at 1-832-553-3418. Alternatively, for large medical record files, you may mail

the appeal request form attached to a CD containing medical records to:

Part C Appeals Address and Fax Number:

Renaissance Physicians
Attn: Appeals Unit
PO Box 2888
Houston, TX 77252-2888

Phone: 1-832-553-3300

Fax: 1-832-553-3418

Reconsiderations

You have up to 180 days to request reconsideration of a claim. You may request claim reconsideration if you feel your claim was not processed appropriately according to the IPA's claim payment policy or in accordance with your provider agreement. A claim reconsideration request is appropriate for disputing denials such as coordination of benefits, timely filing, or missing information. Payment retractions, underpayments/overpayments, as well as coding disputes should also be addressed through the claim reconsideration process. The IPA will review your request, as well as your provider record, to determine whether your claim was paid correctly. You may request reconsideration by submitting the completed request form to:

Renaissance Physicians
Attn: Reconsiderations
PO Box 2888
Houston, TX 77252-2888

Fax: 1-832-553-3418

HEALTH SERVICES

The Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the customers.

The Utilization Management staff base their utilization-related decisions on the clinical needs of customers, the customer's Benefit Plan, Interqual Criteria, Milliman Guidelines, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically based clinical criteria and treatment guidelines in the context of provider and/or customer-supplied clinical information and other such relevant information.

The IPA in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the customer's health plan benefits.
- To monitor utilization practice patterns of IPA's contracting physicians, contracting hospitals, contracting ancillary services, and contracting specialty providers.
- To provide a system to identify high-risk customers and ensuring that appropriate care is accessed.
- To provide utilization management data for use in the process of re-credentialing providers.
- To educate customers, physicians, contracted hospitals, ancillary services, and specialty providers about IPA's goals for providing quality, value-enhanced managed health care.
- To improve utilization of IPA's resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Departmental Functions

- Prior authorization
- Referral management
- Concurrent review
- Discharge planning
- Case management and disease management
- Continuity of care

Prior Authorization

The Primary Care Physician (PCP) or Specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a customer for an elective admission, outpatient service, and for requesting services in the home. The IPA recommends requesting prior authorization at least seven (7) days in advance of the admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. For prior authorizations, providers should call 1-800-511-6932. You may also submit most requests via our online portal 24 hours per day, 7 days per week at: https:// www.hsconnectonline.com

Services requiring prior authorization are listed in the appendix or Health Plan section of this manual, as well as on IPA's website. The presence or absence of a service or procedure on the list does not determine coverage or benefits. Log in to HSConnect or contact customer service to verify benefits, coverage, and customer eligibility.

The Prior Authorization Department, under the direction of licensed nurses, clinical pharmacists, and medical directors, documents and evaluates requests for authorization, including:

- Verification that the customer is enrolled with IPA at the time of the request for authorization and on each date of service.
- Verification that the requested service is a covered benefit under the customer's benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Verification that the service is being provided by the appropriate provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The Prior Authorization Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider of the determination.

Examples of information required for a determination include, but are not limited to:

- Customer name and identification number
- Location of service (e.g., hospital or surgi-center setting)
- Primary Care Physician name
- Servicing/attending physician name
- Date of service
- Diagnosis
- Service/procedure/surgery description and CPT or HCPCS code

- Clinical information supporting the need for the service to be rendered

For customers who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a customer appears at an emergency room for care, which is non-emergent, the PCP should be contacted for direction. The customer may be financially responsible for payment if the care rendered is non-emergent. The IPA also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment.

Emergency admissions must be pre-certified by IPA within twenty-four (24) hours, or the next business day, of admission. Please be prepared to discuss the customer's condition and treatment plan with our nurse coordinator.

Outpatient Prior Authorization Department

Triage Unit:

- Consists of non-clinical personnel
- Receives all faxes and phone calls for services that require prior authorization
- Handles issues that can be addressed from a non-clinical perspective:
  - Did you receive my fax?
  - Does this procedure/service require prior authorization?
  - Setting up "shells" for services that must be forwarded to clinical personnel for determination

Prior Authorization Unit:

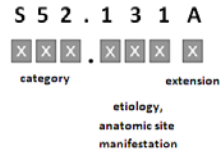
- Consists of RN's and LPN's
- Teams of nurses are organized based on customer's PCP or provider specialty
- Handles all issues that require a clinical determination, such as:
  - Infusion
  - Outpatient Surgical Procedures
  - DME / O&P
  - Ambulance transports
  - Outpatient Diagnostic Testing
  - Outpatient Therapy

ICD-10 Diagnosis and Procedure Code Reporting

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors and other health care professionals, as well as vendors and trading partners.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters adding more specificity.



Displaced fracture of neck of right radius, initial encounter for closed fracture

ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric characters

Coding under ICD-10-PCS is much more specific

Resection of appendix, percutaneous endoscopic approach

Note: Procedure codes are only applicable to inpatient claims and not prior authorizations.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT or HCPCS coding for outpatient procedures.

ICD-10 Authorization Guidelines

Health care professionals must be prepared to comply with the transition to ICD-10 by the new compliance date.
The IPA will strictly adhere to the following guidelines:

- Prior authorizations and referrals for date of service or admission on or after the new compliance date must be submitted with ICD-10 diagnosis codes.
- Prior authorizations and referrals will only accept code type ICD-10 based on date of service or admission.

Billable vs. Non-billable Codes

- A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.
- A non-billable ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.
- The following is an example of a billable ICD-10 code with corresponding non-billable codes:

Billable ICD-10 Codes	Non-billable ICD-10 Codes
M1A.3110 - Chronic gout due to renal impairment, right shoulder, without tophus	M1A.3 - Chronic gout due to renal impairment
	M1A.311 - Chronic gout due to renal impairment, right shoulder

- It is acceptable to submit a claim using an unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

Billable Unspecified ICD-10 Codes
I50.9 - Heart Failure, unspecified
J18.9 - Pneumonia, unspecified organism

Questions Concerning ICD-10

If you have a question as it pertains to ICD-10, please consult with your Network Operations Representative.

Decisions and Time Frames

Emergency - Authorization is not required

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;
- Or, serious dysfunction of any bodily organ or part.

Expedited:

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the customer's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within 72 hours or as soon as the customer's health requires.

Routine:

If all information is submitted at the time of the request, CMS mandates a health plan determination within 14 calendar days.

Once the Precertification Department receives the request for authorization, we will review the request using nationally recognized industry standards or local Coverage Determination criteria. If the request for authorization is approved, the IPA will assign an authorization number and enter the information in our medical management system. This authorization number can be used to reference the admission, service or procedure.

The requesting provider has the responsibility of notifying the customer that services are approved and documenting the communication in the medical record.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines/criteria to support the claim adjudication process after the opportunity for precertification or concurrent review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:

- Authorizations for claims billed to an incorrect carrier
  - As long as you have not billed the claim to IPA and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.
  - If the claim has already been submitted to IPA and you have received a denial, the request for retro authorization then becomes an appeal and you must follow the guidelines for submitting an appeal.
- Services/Admissions after hours, weekends, or holidays
  - IPA will retrospectively review any medically necessary services provided to IPA's customers after hours, holidays, or weekends. The IPA does require the retro authorization request and applicable clinical information to be submitted to the Health Services dept. within 2 business days of providing the service or admitting the customer.
  - In accordance with IPA's policy, retrospective requests for authorizations not meeting the scenarios listed above may not be accepted and these claims may be denied for payment.
  - After confirming the customer's eligibility and the availability of benefits at the time the service was rendered, providers should submit all supporting clinical documentation with the request for review and subsequent reimbursement via fax to 1-832-553-3420. Please refer to the Prior Authorization Grid in the appendix section on your specific service for authorization guidelines and/or requirements.

- The requesting provider has the responsibility of notifying the customer that services are approved and documenting the communication in the medical record.

Discharge Planning and Acute Care Management

Discharge Planning is a critical component of the process that begins with an early assessment of the customer's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the customer and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. The IPA will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan.

In designated contracted facilities, IPA also employs ACCMs to assist with the process, review the inpatient medical record, and complete face-to-face customer interviews to identify customers at risk for readmission, in need of post-discharge complex care coordination and to aid the transition of care process. This process is completed in collaboration with the facility discharge planning and acute care management team customers and other IPA staff. When permissible by facility agreement, the ACCM also completes the Concurrent Review process onsite at assigned hospitals. The role of the ACCM onsite reviewer then also includes the day-to-day functions of the Concurrent Review process at the assigned hospital by conducting timely and consistent reviews and discussing with an IPA medical director as appropriate. The reviewer monitors the utilization of inpatient customer confinement at the assigned hospitals by gathering clinical information in accordance with hospital rules and contracting requirements including timelines for decision-making. All clinical information is evaluated utilizing nationally accepted review criteria.

The ACCM onsite reviewer will identify discharge-planning needs and be proactively involved by interacting with attending physicians and hospital case managers in an effort to facilitate appropriate and timely discharge. The onsite reviewer will follow the policies and procedures consistent with the guidelines set forth by IPA Health Services Department and the facility.

Adverse Determinations

Rendering of Adverse Determinations (Denials)

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits, or eligibility.

Every effort is made to obtain all necessary information, including pertinent clinical information and original documentation from the treating provider to allow the Medical Director to make appropriate determinations.

Only an IPA Medical Director may render an adverse determination (denial) based on medical necessity but he/she may also make a decision based on administrative guidelines. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service, or extension of stay, the IPA notifies the facility or provider's office of the denial of service. Such notice is issued to the provider and the customer, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

The IPA's employees are not compensated for denial of services. The PCP or attending physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

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

- For non-urgent pre-service decisions – within 14 calendar days of the request.
- For urgent pre-service decisions - within 72 hours or three calendar days of the request.
- For urgent concurrent decisions – within 24 hours of the request.
- For post-service decisions – within 30 calendar days of the request.

*Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than 3 calendar days after the oral notification

Peer-to-Peer information is provided.

The IPA complies with CMS requirements for written notifications to customers, including rights to appeal and grievances. For urgent care requests, the IPA notifies the provider(s) only of the decision since the treating or attending practitioner is acting as the customer's representative. If the denial is either concurrent or post service (retrospective) and the customer is not at financial risk, the customer is not routinely notified.

Appeals

An appeal is a request for the IPA to review a previously made decision related to medical necessity, clinical guidelines, or

prior authorization and referral requirements. You must receive a notice of denial, or remittance advice before you can submit an appeal.

You may appeal a health services or Utilization Management denial of a service not yet provided, on behalf of a customer. The customer must be aware that you are appealing on his or her behalf. Customer appeals are processed according to Medicare guidelines.

An appeal must be submitted within 60 days of the original decision unless otherwise stated in your provider agreement. With your appeal request, you must include a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay, or office visit, and a copy of the insurance verification completed on the date of service.

Appeals can take up to 60 days for review and determination. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the IPA's agreement. An appeal is a request for IPA to review a previously made decision related to medical necessity or clinical guidelines. You must receive a notice of denial, of medical non-coverage, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal.

REFERRAL PROCESS

The Primary Care Physician (PCP) is the customer's primary point of entry into the health care delivery system for all outpatient specialist care.

The PCP is required to obtain a referral for most outpatient specialist visits for IPA's customers.

Referrals can be requested through several methods, such as:

- HSConnect
- Phone

Your Network Operations representative can provide additional details regarding preferred method of communication in your area. Likewise, the specialist is required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Electronic submission/retrieval of referrals through HSConnect helps to ensure accurate and timely processing of referrals.

All referrals must be obtained prior to services being rendered. No retro-authorizations of referrals will be accepted. Please note that we value the PCP's role in taking care of our IPA's customers and that the PCP has a very important role in directing the customer to the appropriate specialist based on your knowledge of the patient's condition and health history. It is also absolutely essential that customers are directed to participating providers only. In order to ensure this, please refer to our online directory or contact Customer Service for assistance.

Remember: An authorization number does not guarantee payment – services must be a covered benefit. Please verify benefits before providing services.

Referral Guidelines

- PCPs should refer only to IPA's participating specialists for outpatient visits.
- Non-participating specialist's visits require prior authorization by IPA.
- Referrals must be obtained PRIOR to specialist services being rendered.
- PCPs should not issue retroactive referrals.
- Most referrals are valid for 180 days starting from the issue date.
- All requests for referrals must include the following information:
  - Customer Name, Date of Birth, customer ID
  - PCP Name
  - Specialist Name
  - Date of Referral
  - Number of visits requested

If a customer is in an active course of treatment with a specialist at the time of enrollment, The IPA will evaluate requests for continuity of care. A PCP referral is not required, but an authorization must be obtained from IPA's Prior Authorization Department. For further details, please refer to the Continuity of Care section in Health Services.

Please note: A specialist may not refer the patient directly to another specialist unless within scope of treatment. If a patient needs care from another specialist, he/she must obtain the referral from his/her PCP.

Self Referrals

Customers have open access to certain specialists, known as self-referred visits/services; these include but are not limited to:

- Emergency medicine (emergency care as defined in the provider contract)
- Obstetric and Gynecological care (routine care, family planning)

Please refer to IPA's website to view the current provider directory for Participating Specialists. If a customer has a preference, the PCP should accommodate this request if possible. The only exceptions where the customer may self-refer are:

- To a Participating Gynecologist for annual gynecological exam except for infertility and to see a non-participating OB/GYN. The PCP may perform the annual exam if agreed upon by the customer.

Primary Care Physician's Referral Responsibilities

A PCP is responsible for ensuring a customer has a referral prior to the appointment with the specialist.

There are two ways a PCP can obtain referral to specialists:

- Log in to HSConnect.
- Submit all referrals through HSConnect
- Call in to the Referral Department: If the referral is an emergency, or you simply would like to speak with a referral department representative, you may obtain a referral by phone by calling:
- Precert:
  Local: 1-713-497-3060
  Toll Free Fax: 1-855-700-2928
  Local Fax: 1-832-553-3420

Specialist Physician's Referral Responsibilities

Specialists must have a referral from a PCP prior to seeing a customer if the customer's plan requires a referral. Claims will be denied if a specialist sees a customer without a referral when the health plan requires a referral. The IPA is unable to make exceptions to this requirement. If a referral is not in place, specialists must contact the customer's PCP before the office visit. In order to verify that a referral has been made, the specialist may log in to HSConnect or the specialist may call to verify.

Instructions for a Specialist to Obtain Referrals:

The specialist can obtain referrals directly for the customer to another Specialist with the following limits:

1. The PCP referred the customer to the specialist
2. The following five (5) conditions must be met:
   - Diagnosis must be related to the specialty and/or service to be obtained;
   - Diagnosis must be related to reason PCP referred to referring Specialist;
   - Must be a covered benefit of the health plan;
   - The customer must be currently under the care of the referring specialist;
   - And, Referral must be made to a participating provider.
3. The specialist provides follow-up documentation to the PCP for all referrals obtained for further specialty care.
4. Referrals for the following specialty care are excluded from this process and must be referred back to the PCP to obtain referral: Non-participating providers, Chiropractor, Dermatology, Otolaryngology, Maxillofacial Surgeon, Podiatry, Optometry, Transplant Specialist, and Reconstructive (Plastic) Surgeon with the exception of breast reconstruction.
5. The referral must be obtained prior to the services being rendered.

Note: If all elements within the limits above cannot be met, the specialist must defer back to the PCP for further services.

The specialist may obtain referrals via HSConnect or telephone.

*Please refer to page 22 of provider manual for examples on how to utilize HSCONNECT.

PHARMACY QUALITY PROGRAMS

Narcotic Case Management

IPA works with each individual Health plan to provide Pharmacy Quality Programs.

Customers with potential overutilization or inappropriate utilization of narcotics are identified based on approved criteria and reports are produced monthly. Customers with at least three (3) controlled opioid pharmacy claims, four (4) different prescribers, four (4) different pharmacies and 120mg MED (morphine-equivalent dose) for 90 consecutive days within the reporting period of 180 days are included for case management. Any individual with cancer or on hospice care is excluded from the program. The Participating Plan's Clinical staff review claims data and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, the case manager will send written notification to all prescribers by fax requesting information pertaining to the medical necessity of the current narcotic regimen. IPA will reach out to discuss the case and consensus must be reached by the prescribers if action is required. In the most severe cases, to assist with control of overutilization, point-of-sale edits may be implemented if the prescriber desires.

Medication Therapy Management

Medication Therapy Management (MTM)-eligible customers are offered a comprehensive medication review (CMR) annually. The welcome letters sent to the eligible customers, IPA encourages each customer to call to complete their CMR before their annual comprehensive visit with their primary care provider so the customer can take their medication list to the appointment. After the completion of the CMR, any potential drug therapy problems (DTPs) that are identified are sent to the prescribing provider and/or primary care provider by mail or fax. Along with DTPs, the provider also receives a list of the customer's prescription history through the previous 4 months. If the customer has any questions or comments about the DTP recommendations, a fax and phone number is provided for follow up. In addition to the CMR, providers may also receive targeted medication reviews (TMRs) quarterly. The TMRs are completed electronically to look for specific DTPs. If any DTPs are identified, a letter may be mailed or faxed to the provider.

Drug Utilization Review

The IPA completes a monthly review of drug utilization data of in order to determine the effectiveness, potential dangers, and/or interactions of the medication(s). Retrospective Drug Utilization Review (rDUR) evaluates past data and Concurrent Drug Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before each prescription is dispensed, typically at the point-of-sale or point of distribution. The IPA tracks and trends all drug utilization data on a regular basis to enable clinical staff to determine when some type of intervention may be warranted. Targeted providers and/or customers will receive information regarding quality initiatives by mail. Current Retrospective Drug Utilization Review (rDUR) studies that may be communicated to customers or providers include:

- Overutilization of medications (≥10 drug prescriptions per month).
- Failure to refill prescribed medications.
- Drug to drug interactions.
- Therapeutic duplication of certain drug classes.
- Narcotic safety including potential abuse or misuse.
- Use of medications classified as High Risk for use in the older population.
- Customers with a probable diagnosis of Diabetes and Hypertension without a prescription for an ACE Inhibitor or ARB medication.
- Use of multiple antidepressants, antipsychotics, or insomnia agents concurrently.
- Multiple prescribers of the same class of psychotropic drug.

Letters to customers will focus on the rationale for medication adherence and/ or the safety issues involved. Letters to providers will include the rationale of the particular concern being addressed and will include all claims data for the selected calendar period applicable to that initiative. From any initiative, if a provider indicates that they did not write a prescription that has been associated with them or that they were not providing care for the customer at the time the prescription under investigation was written please notify IPA using the contact information on the letter.

A multidisciplinary team develops and determines the direction of pharmacy quality initiatives and the initiatives come from a variety of sources, including but not limited to, claims data analysis, Centers for Medicare & Medicaid Services (CMS) guidance, Pharmacy Quality Alliance (PQA), Food and Drug Administration (FDA) notifications, drug studies, and publications.

QUALITY CARE MANAGEMENT PROGRAM

Mission Statement

IPA is dedicated to improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

Values

- Integrity – We always conduct ourselves in a professional and ethical manner.

- Respect – We all have value and will treat others with dignity and esteem.
- Team – We recognize that employees are our main asset and encourage their continued development.
- Communications – We encourage the free exchange of thoughts and ideas.
- Balance – We manage both our personal and company priorities.
- Excellence – We continuously strive to exceed our customers' expectations.
- Prudence – We always use the company's financial resources wisely.

Quality Principles

IPA shall apply the guiding values described above to its oversight and operation of its system and:

- Provide services that are clinically driven, cost effective and outcome oriented.
- Provide services that are culturally informed, sensitive and responsive.
- Provide services that enable customers to live in the least restrictive, most integrated community setting appropriate to meet their health care needs.
- Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural and urban differences.
- Foster an environment of quality of care and service within the IPA, the Senior Segment of IPA and through our provider partners.
- Promote customer safety as an over-riding consideration in decision-making.

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the IPA and its affiliates.

The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and service provided to enrollees for both their physical and behavioral health. The program also defines the methodology for identifying improvement opportunities and for developing and implementing initiatives to impact opportunities identified.

- All aspects of physical and behavioral care including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services provided through IPA and contracted providers and organization.
- All aspects of provider performance relating to access to care, quality of care including provider credentialing, confidentiality, medical record keeping and fiscal and billing activities.
- All services covered.
- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient and home health.
- All providers and any delegated or subcontracted providers.
- Management of behavioral health care and substance abuse care and services.
- Aspects of IPA's internal administrative processes which are related to service and quality of care including credentialing, quality improvement, pharmacy, health education, health risk assessments, clinical guidelines, utilization management, customer safety, case management, disease management, special needs, complaints, grievances and appeals, customer service, provider network, provider education, medical records, customer outreach, claims payment and information systems

Quality Management Program Goals

The primary objective of the Quality Improvement program is to promote and build quality into the organizational structure and processes to meet the organization's mission of improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

The goals the organization has established to meet this objective are:

- Maintain an effective quality committee structure that:
  - Fosters communication across the enterprise;
  - Collaboratively works towards achievement of established goals;
  - Monitors progress of improvement efforts to established goals;
  - And, provides the necessary oversight and leadership reporting.
- Ensure patient care and service is provided according to established goals and metrics.
- Ensure identification and analysis of opportunities for improvement with implementation of actions and follow-up as needed.
- Promote consistency in quality program activities.
- Ensure the QI program is sufficiently organizationally separate from the fiscal and administrative management to ensure that fiscal and administrative management does not unduly influence decision-making regarding organizational determinations and/or appeals of adverse determinations of covered benefits.

- Assure timely access to and availability of safe and appropriate physical and behavioral health services for the population served by IPA.
- Ensure services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service customers with special needs.
- Promote the use of evidence-based practices and care guidelines.
- Improve the ability of all IPA's staff to apply quality methodology through a program of education, training, and mentoring.
- Establish a rigorous delegation oversight process.
- Ensure adequate infrastructure and resources to support the Quality Improvement program.
- Assure provider involvement in maintaining and improving the health of IPA's customers, through a comprehensive provider partnership.

CODING AND PERFORMANCE MANAGEMENT INITIATIVE

ENHANCED ENCOUNTER: Lumeris

Lumeris is an accountable care delivery innovation company offering health systems, payers, and providers operational support, technology, and consulting services. Lumeris' innovative solutions help health care organizations design, build, operate, measure, and optimize any accountable care model to accomplish the Triple Aim *Plus* One: improved quality, cost, and patient and physician satisfaction.
An Enhanced Encounter is a comprehensive patient exam designed to accurately and compliantly document a patient's health history, current conditions, quality measures and future risk areas. The Enhanced Encounter program is used in conjunction with the Audit Tool. As Enhanced Encounter forms are submitted they are incorporated into the Audit Tool and reviewed, and can result in feedback to the providers.
For Registration and Training please contact your local Provider Relations Administrator.

Need Help? Call Lumeris Customer Support Desk
(866) 397.2812 or email customersupport@lumeris.com

COMPREHENSIVE MEDIAL CHART REVIEWS (CMCR):

Every year, the coding team reviews 100% of our PCP charts to extract applicable diagnosis codes for submission to CMS. The external coding reps, along with outside independently contract nurses/coders, schedule the chart reviews. Office staff pulls the charts and we travel to the individual offices to conduct the reviews. All diagnosis data obtained is then entered into our database for submissions to CMS.

The coding team continues to focus on PCPs and highly utilized specialists for the comprehensive chart reviews. Some high utilized specialties are oncology/hematology, cardiology, neurology, nephrology and gastroenterology.

- If the contracted reviewers and/or coding department identify an issue related to scheduling or maintaining an appointment with a Physician's office, the Provider Relations Representatives or Administrators are notified. They are responsible for assisting the Coding Department with scheduling issues and discussing the importance of the CMCR project

CODING DEPARTMENT TEAM:

Manager of Provider Coding and Education - Coding currently has four Managers who report to the Director of Coding and Performance. Two of the managers focus on educating our Providers. The Provider Coding/Education Specialist report to these Managers, both internal and external. The other Managers are responsible for the chart reviews that are done by the coding team. These Managers work with our internal and contractual coders in the field conducting reviews.

Provider Coding/Education Specialist – The Provider Coding/Education Specialist is responsible for conducting provider training on health plan coding initiatives as well as reviewing provider performance goals. Provider Educators have the ability to identify and communicate documentation deficiencies to providers to improve documentation for accurate risk adjustment coding, this is accomplished by developing relationships with clinical providers/staff and traveling to the individual practices performing side-by-side education interconnecting coding and documentation guidelines requirements of the Risk Adjustment coding.

Medical Records Coder
Responsible for the Comprehensive Medical Chart Review (CMCR) of electronic medical records or paper charts conducted in person at facility, provider's office or remotely. This retroactive review helps to identify clinical documentation deficiencies and coding opportunity. Our coders maintain expertise in reviewing and assigning accurate medical codes for diagnoses performed by physicians and other qualified healthcare providers in the office or facility setting (e.g., inpatient hospital). These coders have a sound knowledge of medical coding guidelines and regulations including compliance and reimbursement risk adjustment payment models.

Hybrid HEDIS Administrator – The coding team has an internal team of HEDIS Specialists who are responsible for Q/A and reviewing hybrid HEDIS medical records. These specialist work directly with clinicians and staff to retrieve medical records to capture HEDIS specifications. The following are examples of Hybrid HEDIS measures: BMI, Colonoscopy, COA, Rx Review, Functional Status, Pain Screening, HbA1c, DRE, Micro Albumin, Ace Inhibitors, BCS, Osteo, DM BP. Supplemental HEDIS data can be faxed to the Hybrid HEDIS Administrator Fax Line (855) 500.2801

CODING RESOURCES/TOOLS/EDUCATION:

Quick Reference Guides/Optum ICD-10-CM books – QRGs provide an abridged legal-sized reference guide providing a list of common diagnosis codes that may be more specific than the codes found on a practice superbill, thus allowing for better definition of the patient's condition. We also distribute ICD-10-CM books to all PCPs in the network at the CDI Seminars.

One-on-one Coding Education – The coding department is available for detailed office-based training sessions with our Physicians. The provider coding/education representatives tailor the education sessions according to the Physician's needs and develop presentations that will allow Physician and

office staff interaction. The coding/education representatives also provide re-education and are available to assist with any office issue surrounding ICD-9-CM coding.

Clinical Documentation Integrity – CDI Education - The Coding Department host CDI Seminars with a focus on common clinical documentation errors that plague clinicians. These CDI seminars are completely interactive with complex case scenarios' incorporated with the use of ICD-10-CM coding books. Providers will have the opportunity to share best practices while learning current coding guidelines and trends. Key Note Speakers: Dr. William H. Torklidsen, CCS; Chairman, Valley Organized Physicians and Chaun Tatum-Williams, CPC, CPMA, CPCO, CDEO, CRC, CPC-I; Director, Coding and Performance Care Allies

Disease Specific Coding Webinars

Cigna-HealthSpring will be hosting online ***disease specific*** documentation and coding education meetings during 2017. These sessions are 15 to 30 minutes in duration. We have scheduled multiple dates and sessions to provide an opportunity for everyone to participate. Each session provides valuable insight about how to document and code diseases more specifically. Clinicians, coding professionals, and the office administration staff are highly encouraged to attend. A question and answer session will follow each meeting. Please see the schedule below:

Instructions to attend webinar:

- https://go.mc.iconf.net/fl/0oxz6bf
- Select '*Dial In Now*' from the pop-up window that appears. You should see the conference call phone number '*1-888-534-8066*' and code number 3085470487.
- Dial into the meeting on your phone. Click '*Join Meeting*' for access to the presentation.

1. Go to the web link
2. Set up the audio by:
    a. Selecting "Dial-In Now" from the pop-up window that appears
    b. Using your phone call: 1-888-534-8066
    c. When prompted dial the conference code: 3085470487
    d. Click "Join Meeting" to gain access to the presentation

Date	Time CST	Topic
1/17/17	7:00 a.m.	Depression
1/17/17	11:30 a.m.	Depression
1/17/17	3:00 p.m.	Depression
2/21/17	7:00 a.m.	CVA's
2/21/17	11:30 a.m.	CVA's
2/21/17	3:00 p.m.	CVA's
3/21/17	7:00 a.m.	Diabetes
3/21/17	11:30 a.m.	Diabetes
3/21/17	3:00 p.m.	Diabetes
4/18/17	7:00 a.m.	CKD
4/18/17	11:30 a.m.	CKD
4/18/17	3:00 p.m.	CKD
5/16/17	7:00 a.m.	Cancer
5/16/17	11:30 a.m.	Cancer
5/16/17	3:00 p.m.	Cancer
6/20/17	7:00 a.m.	COPD
6/20/17	11:30 a.m.	COPD
6/20/17	3:00 p.m.	COPD
7/18/17	7:00 a.m.	CHF
7/18/17	11:30 a.m.	CHF
7/18/17	3:00 p.m.	CHF
8/15/17	7:00 a.m.	HTN
8/15/17	11:30 a.m.	HTN
8/15/17	3:00 p.m.	HTN
9/19/17	7:00 a.m.	Osteoporosis
9/19/17	11:30 a.m.	Osteoporosis
9/19/17	3:00 p.m.	Osteoporosis
10/17/17	7:00 a.m.	PVD
10/17/17	11:30 a.m.	PVD
10/17/17	3:00 p.m.	PVD
11/21/17	7:00 a.m.	Anti-coagulation
11/21/17	11:30 a.m.	Anti-coagulation
11/21/17	3:00 p.m.	Anti-coagulation
12/19/17	7:00 a.m.	Obesity
12/19/17	11:30 a.m.	Obesity
12/19/17	3:00 p.m.	Obesity

HEALTH PLANS

CIGNA

- Cigna-HealthSpring
- Cigna CAC
- Cigna HMO (City of Houston)

BLUE CROSS BLUE SHIELD TX

- Blue Cross Blue Shield (MAPD)
- Blue Value Based Incentive Plan (VBIP)

Cigna-HealthSpring

Transportation Benefit

Customers may schedule transportation with Access2Care 24 hours a day, seven days a week by calling toll-free 1-866-214-5126. To schedule transportation:

To a doctor's visit

Customer should call Access2Care:

- By 4:00 pm, 24 hours in advance, to schedule a trip.
- 72 hours in advance to schedule trip to plan's Customer Orientation Meeting.
- If someone will accompany them (limited to one adult).
- If they will be using a wheelchair.

Important: Customer must be ready for pick-up at LEAST one hour before their medical appointment. Driver will arrive at customer's residence up to one hour before scheduled medical appointment. To cancel, customer must call AT LEAST three hours before scheduled pick-up time.

From a doctor's visit

Customer should:

- Call the phone number on the card that the driver gives them upon arrival at appointment
  - Call when they are ready for their return trip.
  - Driver will arrive within one hour of the call.
  - Do not call Access2Care.

To a pharmacy on the way home

Customer should call Access2Care:

- Before the driver picks up customer for the return trip
- Pharmacy trips are allowed after a medical appointment or hospital discharge
- Pharmacy trips are not allowed as a stand-alone trip

Please note:

- Each trip is limited to 70 miles one way from customer's residence or Adult Day Care to health care professional's office.
- Transportation to health care professional's office and transportation to return home (round trip) is considered two trips.
- Customer must check their benefits to determine eligibility and number of trips available per benefit year.

Case Management Services

Participating Plan's case management program is an administrative and clinically proactive process that focuses on coordination of services for customers with multiple comorbidities, complex care needs and/or short-term requirements for care. The program is designed to work as a partnership between customers, providers, and other health services staff. The goal is to provide the best clinical outcomes for customers. The central concept is early identification, education, and measurement of compliance with standards of care. The case management staff strives to enhance the customer's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. Staff customers with specific clinical expertise provide support services and coordination of care in conjunction with the treating provider.

Case Management Program Goals

The Health plan has published and actively maintains a detailed set of program objectives available upon request in our case management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic and epidemiologic data, and survey data are used to select program objectives, activities, and evaluations.

Case Management Approach

The Participating Plan's has multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications and improve customer quality of life. It is important to note that the Health plan treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity. In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

The Health plan employs a segmented and individualized case management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently. Our aim is to assess the needs of individual customers, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims

data, and diagnostic values are combined using proprietary rules, and used to identify and stratify customers for case management intervention. The plan uses a streamlined operational approach to identify and prioritize customer outreach, and focuses on working closely with customers and family/caregivers to close key gaps in education, self-management, and available resources. Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target customer groups.

Customers are discharged from active case management under specific circumstances, which many include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, customer specific goals obtained; or the customer has been referred to Hospice. A customer's case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to case management.

How to Use Services

Customers that may benefit from case management are identified in multiplies ways, including but not limited to: utilization management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a customer for case management services, please call 1-888-501-1116. In addition, our customers have access to information regarding the program via a brochure and website and may self refer. Our case management staff contacts customers by telephone or face-to-face encounter. The customer has the right to opt out of the program. If the customer opts in, a letter will be sent to the customer and you as the provider. Once enrolled, an assessment is completed with the customer and a plan of care with goals, interventions, and needs is established.

Behavioral Health

The Health plan provides comprehensive mental health and substance abuse services to its customers. Its goal is to treat the customer in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality.

The Participating Plan's network is comprised of mental health and substance abuse services and providers who identify and treat customers with behavioral health care needs.

Integration and communication among behavioral health and physical health providers is most important. The Health plan encourages and facilitates the exchange of information between and among physical and behavioral health providers. Customer follow-up is essential. High risk customers are evaluated and encouraged to participate in Participating Plan's behavioral health focused case management program where education, care coordination, and support is provided to increase customer's knowledge and encourage compliance with treatment and medications. The Health plan works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services

Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the customer's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a customer may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health services include:

- Access to Participating Plan's customer Service for orientation and guidance.
- Routine outpatient services to include psychiatrist, addicitionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice.
- Initial evaluation and assessment.
- Individual and group therapy.
- Psychological testing according to established guidelines and needs.
- Inpatient hospitalization.
- Inpatient and outpatient detoxification treatment.
- Medication management.
- Partial hospitalization programs.

Responsibilities of Behavioral Health Providers

The Health plan encourages behavioral health providers to become part of its network. Their responsibilities include but are not limited to:

- Provide treatment in accordance with accepted standards of care.
- Provide treatment in the least restrictive level of care possible.
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the customer.
- Direct customers to community resources as needed to maintain or increase customer's functionality and ability to remain in the community.

Responsibilities of the Primary Care Physician:

The PCP can participate in the identification and treatment of their customer's behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues.

- Treating customers with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be customers with co-morbid physical and minor behavioral health problems or those customers refusing to access a mental health or substance abuse provider, but requiring treatment.
- Consultation and/or referral of complex behavioral health patients or those not responding to treatment.
- Communication with other physical and behavioral health providers on a regular basis.

Customers may access behavioral health services as needed:

- Customers may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Customers may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network mental health or substance abuse services.
- Customers and providers can call the Participating Plan's Behavioral Health Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations. (See Quick Reference Guide for phone numbers in the Appendix.)

Medical Record Documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-IV multi-axial classification system and document a complete diagnosis. The provision of behavioral health services require progress note documentation that correspond with day of treatment, the development of a treatment plan, and discharge plan as applicable for each customer in treatment.

Continuity of Care

Continuity of Care is essential to maintain customer stability. Behavioral health practitioners and PCPs, as applicable, are required to:

- Evaluate customer if he/she was hospitalized for a behavioral health condition within 7 days post-discharge.
- Provide customers receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the customer and the provider.
- Evaluate customer needs when the customer is in acute distress.
- Communicate with the customer's other health care providers.
- Identify those customers necessitating follow-up and refer to Participating Plan's behavioral health focused case management program as necessary.
- Discuss cases as needed with a peer reviewer.
- Make request to Health plan for authorization for customer in an active course of treatment with a non-participating practitioner.

Utilization Management

The Participating Plan's Health Services Department coordinates behavioral health care services to ensure appropriate utilization of mental health and substance abuse treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically-appropriate, and cost-effective manner for the customers.

The Participating Plan's Utilization Management staff base their utilization-related decisions on the clinical needs of customers, the customer's Benefit Plan, Interqual Criteria, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or customer-supplied clinical information and other relevant information. For requests for behavioral health services that require authorization, the Health plan will approve the request or issue a notice of denial if the request is not medically necessary.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission or skilled nursing facility or other inpatient admission in order to ensure:

- Covered services are being provided at the appropriate level of care;
- And, services are being administered according to the individual facility contract.

The Health plan requires admission notification for the following:

- Elective admissions
- ER and Urgent admissions
- Transfers to Acute Rehabilitation, LTAC and SNF admissions *These levels of care require pre-authorization*
- Admissions following outpatient procedures or observation status
- Observation status

- Newborns remaining in the hospital after the mother is discharged.

Emergent or urgent admission notification must be received within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the customer's condition is unstable and the facility is unable to determine coverage information, Health plan requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

The Participating Plan's Health Services department complies with individual facility contract requirements for concurrent review decisions and timeframes. The Participating Plan's nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct medical necessity review. The Health plan is responsible for final authorization.

Participating Plan's preferred method for concurrent review is a live dialogue between our Concurrent Review nursing staff and the facility's UM staff within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information health plan has available. If it is not feasible for the facility to contact health plan via phone, facilities may fax the customer's clinical information within 24 hours of notification to 1-832-553-3420. Skilled Nursing Facility (SNF) Reviews should be faxed to 1-713-437-3130. For SNF admission requests, a recent PM&R or physical, occupational and/or speech therapy consult is requested along with the most recent notes for therapy(ies) or recent medical status and expected skilled treatment and service requirements.

Following an initial determination, the concurrent review nurse will request additional updates from the facility on a case-by-case basis. The health plan will render a determination within 24 hours of receipt of complete clinical information. Participating Plan's nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a favorable determination. Clinical update information should be received 24 hours prior to the next review date.

The health plan's Medical Director reviews all acute, rehab, LTAC, and SNF confinements that do not meet medical necessity criteria and issues a determination. If the health plan's Medical Director deems that the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider(s) e.g. facility, attending/ordering provider verbally and in writing of the adverse determination via notice of denial. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made. Call 1-832-553-3333.

In those instances where the attending provider does not agree with the determination, the provider is encouraged to contact Participating Plan's Medical Director for Peer-to-Peer discussion. The telephone number to contact our Medical Director for the discussion call is 1-832-553-3333.

Following the Peer-to-Peer discussion, the Medical Director will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For customers receiving hospital care and for those who transfer to a Skilled Nursing Facility or Acute Inpatient Rehabilitation Care, the health plan will approve the request or issue a notice of denial if the request is not medically necessary. The health plan will also issue a notice of denial if a customer who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the customers' or their Representatives' right to file an expedited appeal, as well as instructions on how to do so if the customer or customer's physician does not believe the denial is appropriate.

The health plan also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. This notice will be sent by fax to the SNF or HHA. The facility is responsible for delivering the notice to the customer or their authorized representative/power of attorney (POA) and for having the customer, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is requested and expected to fax a copy of the signed NOMNC back to Health Services at the number provided. The NOMNC includes information on customers' rights to file a fast track appeal.

Readmission

The Health Services Department will review all readmissions occurring within 31 days following discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high quality cost effective health care services for health plan customers.

The Health Services Utilization Management (UM) staff will review acute Inpatient and Observation readmissions. If admissions are determined to be related; they may follow the established processes to combine the two confinements.

The Role of the ACCM (Acute Care Case Manager)

Health plan Acute Care case managers (ACCMs) are

registered nurses. All ACCMs are expected to perform at the height of their license. They understand Participating Plan's plan benefits and utilize good clinical judgment to ensure the best outcome for the customer.

The Acute Care Case Manager has two major functions:

- Ensure the customer is at the appropriate level of care, in the appropriate setting, at the appropriate time through utilization review.
- Effectively manage care transitions and length of stay (LOS).

Utilization review is performed utilizing evidence-based guidelines (Interqual) and collaborating with Primary Care Physicians (PCP), attending physicians, and Participating Plan's Medical Directors.

The ACCM effectively manages all transitions of care through accurate discharge planning and collaboration with facility personnel to prevent unplanned transitions and readmissions via interventions such as:

- Medication reconciliation.
- Referral of customers to Participating Plan's programs such as: CHF CCIP Program, Respiratory Care Program, and Fragile Fracture Program.
- Appropriate coordination of customer benefits.
- Obtaining needed authorizations for post-acute care services or medications.
- Collaborating with attending physician and PCP, as needed.
- Introducing and initiating CTI (Care Transition Intervention).
- Addressing STAR measures, as applicable: Hgb A1C and foot care, LDL, colorectal cancer screening, osteoporosis management in women who had a fracture, falls, emotional health, flu and pneumonia vaccines and medication adherence.
- Facilitating communication of care level changes to all parties.
- The goals of the ACCM are aligned with the goals of acute care facilities.
- Customers/patients receive the appropriate care, at the appropriate time, and in the most appropriate setting.
- Readmissions are reduced and LOS is managed effectively.

We strive for Primary Care Physicians (PCP), attending physicians, and acute care facility personnel to view the Participating Plan's ACCM as a trusted resource and partner in the care of our customers (your patients).

Special Needs Plan - Model of Care

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of customers with special health care needs.

The three specific groups are:

- "Dual eligible" beneficiaries (individuals who are eligible for both Medicaid & Medicare);
- Individuals with Chronic conditions;
- And, individuals who are residents of long-term care facilities or require that level of care and reside in the community.

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans have a filed and approved Model of Care by January 1, 2010.

The Model of Care is an evidenced-based process by which we integrate benefits and coordinate care for customers enrolled in Participating Plan's Special Needs Plans. The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of customers with complex care needs, as well as the coordination of care to improve their overall health.

Special Needs Plan Model of Care has the following goals:

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

Importantly, the Model of Care focuses on the individual SNP customer. SNP customers receive a health risk assessment within 90 days of enrollment and then, annually, within one year of completion of the last HRA. Based on the results of this assessment, an individualized care plan is developed using evidence-based clinical protocols. All SNP customers must have an individualized care plan. Interdisciplinary care teams are responsible for care management, support the assessment, and care planning process.

PCPs that treat Special Needs Plan customers are core participants of their Interdisciplinary Care Teams and oversee clinical care plan development and maintenance. Interdisciplinary care team participants include PCPs as well as practitioners of various disciplines and specialties, based on the needs of the customer. The customer may participate in the care team meetings, as may all health care providers. The plan-developed individualized care plan is recorded centrally so that it may be shared with all customers of the interdisciplinary care team, as indicated. All providers are

encouraged to participate in the SNP Model of Care and interdisciplinary care teams.

The health plan uses a data-driven process for identifying the frail/disabled, customers with multiple chronic illnesses and those at the end of life. Risk stratification and protocols for interventions around care coordination, care transitions, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the needs of plan customers, a specialized provider network is available to assure appropriate access to care, complementing each customer's primary care provider.

The health plan uses care transitions protocols and specific programs to support customers through transitions, connect customers
to the appropriate providers, facilitate the communication process between settings, promote customer self-management and reduce the risk for readmissions. Care transitions, whether planned or unplanned, are monitored, and PCPs are informed accordingly. PCP communication to promote continuity of care and interdisciplinary care team involvement is a critical aspect of Participating Plan's care transitions protocols.

Implementation of the Model of Care is supported by systems and processes to share information between the health plan, health care providers and the customer. The SNP Model of Care includes periodic analysis of effectiveness, and the Quality Improvement Program supports all activities.

For Dual SNP customers:

Providers may contact our Health Risk Assessment department to request patients' HRA results at 1-800-331-6769.

To discuss and/or request a copy of a patient's care plan, refer a patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Case Management department at 1-888-501-5116.

For Chronic SNP customers:

Providers may contact our Health Risk Assessment department to request patients' HRA results at 1-800-331-6769.

To discuss and/or request a copy of a patient's care plan, refer a patient for an Interdisciplinary Care Team meeting or participate in an Interdisciplinary Care Team meeting, please contact our Case Management department at 1-888-501-1116.

Fraud, Waste, and Abuse

In order to protect Medicare trust funds from fraud, waste and abuse, to ensure Part D drugs are prescribed only by qualified suppliers, and to follow the recommendations from the Office of Inspector General (OIG); the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicare participation requirements related to Drug Enforcement Administration (DEA) certification of registration.

Pharmacy Prescription Benefit

Part D Drug Formulary

Formulary listings, utilization management criteria, and formulary changes for formularies can be found at: http://www.cigna.com/medicare/resources/drug-list-formulary.

The health plan utilizes the USP classification system to develop Part D drug formularies that include drug categories and classes covering all disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. The health plan includes all or substantially all drugs in protected classes, as defined by CMS. All formularies are reviewed for clinical appropriateness by the health plan's Pharmacy and Therapeutics (P&T) Committee, including the utilization management edits placed on formulary products. Health plan's submits all formulary changes to CMS according to the timelines designated by CMS.

A Part D drug is a drug that meets the following criteria: may be dispensed only by prescription; is approved by the FDA; is used and sold in the US; is used for a medically accepted indication; includes FDA-approved uses; includes uses approved for inclusion in the American Hospital Formulary Service Drug Information (AHFS DI), Micromedex, National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, plus other authoritative compendia that the Secretary of Health and Human Services identifies, as off-label uses described in peer-reviewed literature are insufficient on their own to establish a medically accepted indication; and finally includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems).

Drugs excluded under Part D include the following: drugs for which payment as so prescribed or administered to an individual is available for that individual under Part A or Part B; drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid (with the exception of smoking cessation products); drugs for anorexia, weight loss or weight gain; drugs to promote fertility; drugs for cosmetic purposes and hair growth; drugs for symptomatic relief of coughs and colds; vitamins and minerals (except for prenatal vitamins and fluoride preparations); non-prescription drugs; outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements); agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for medically-accepted indications such as pulmonary hypertension).

Part D Utilization Management

Health plan's formularies include utilization management requirements that include prior authorization, step therapy and quantity limits.

- Prior Authorization (PA): For a select group of drugs, the health plan requires the customer or their physician to get approval for certain prescription drugs before the customer is able to have the prescription covered at their pharmacy.
- Step Therapy (ST): For a select group of drugs, the health plan requires the customer to first try certain drugs to treat their medical condition before covering another drug for that condition.
- Quantity Limits (QL): For a select group of drugs, the health plan limits the amount of the drug that will be covered without prior approval.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Pharmacy Quality Alliance (PQA), has identified certain medications as high risk when used in the elderly. This list is based upon the American Geriatrics Society (AGS) 2012 Updated Beers Criteria. All medications on the list are ones for which the AGS Expert Panel strongly recommends avoiding use of the medication in older adults. Use of these medications in the elderly may result in increased rates of adverse drug events, potential drug toxicity, and an increased risk of falls and/or fractures. Due to these safety concerns, the health plan requires prior authorization for these medications in all customers aged 65 and older in order to confirm that the benefits outweigh the risks, and that safer alternatives cannot be used.

How to file a Coverage Determination

A Coverage Determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. Coverage Determinations may be received orally or in writing from the customer's prescribing physicians.

For the Provider Call Center, please call 1-877-813-5595 or fax 1-866-845-7267.
The mailing address is:
Coverage Determination & Exceptions
PO Box 20002
Nashville, TN 37202

The Provider Call Center is open from 7 a.m. CST to 8 p.m. CST Monday through Friday. Any call received after 8 p.m. CST will be routed to a voicemail box and processed daily. To ensure timely review of a CD and that the prescriber is aware of what requires for the most commonly requested drugs, forms are available online at http://www.cigna.com/medicare/resources/2015-customer-forms or by requesting a fax when calling 1-877-813-5595. A provider will receive the outcome of a Coverage Determination by fax no later than seventy-two (72) hours after receipt for standard requests or receipt of the supporting statement and no later than twenty-four (24) hours after receipt for urgent requests or receipt of the supporting statement. The following information will be provided: 1) the specific reason for the denial taking into account the customer's medical condition, disabilities and special language requirements, if any; 2) information regarding the right to appoint a representative to file an appeal on the customer's behalf; and 3) a description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process. The fax cover sheet includes the peer-to-peer process if a provider has questions and wants to review with a clinical pharmacist.

How to file a Part D Appeal

A Part D appeal can be filed within 60 calendar days after the date of the Coverage Determination decision, if unfavorable. The health plan will ask for a statement and select medical records from the prescriber if a customer requests a Part D appeal. For an expedited appeal, the health plan will provide a decision no later than seventy-two (72) hours after receiving the appeal, and for a standard appeal, the timeframe is seven (7) days. If the request is regarding payment for a prescription drug the customer already received, an expedited appeal is not permitted.

Part D Appeals may be received orally or in writing from the customer's prescribing physicians by calling 1-866-845-6962 or fax 1-866-593-4482.

The mailing address is:
Part D Appeals
PO Box 24207
Nashville, TN 37202−9910

The DEA implements and enforces the Controlled Substances Act (CSA). The CSA makes possession of authority under state law to dispense controlled substances a requirement for both obtaining and maintaining a DEA certificate of registration. CMS equates a DEA certificate of registration to prescribe controlled substances as similar to a state's requirement that a physician or eligible professional be licensed or certified by the state to furnish health care services.

To ensure additional controls are in place to protect the Medicare trust funds from any fraud, waste and abuse the following changes were finalized:

- Granting CMS the authority to deny a physician or eligible professional's Medicare enrollment application if: (1) his or her DEA certificate is currently suspended or revoked; or (2) the applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date he or she submits his or her enrollment application to the Medicare contractor.

- Granting CMS the authority to revoke a physician or eligible professional's Medicare enrollment if: (1) his or her DEA certificate is suspended or revoked; or (2) the applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes his or her ability to prescribe drugs.

CMS considers the loss of the ability to prescribe drugs, via a suspension or revocation of a DEA certificate or by state action, a clear indicator that a physician or eligible professional may be misusing or abusing his or her authority to prescribe such substances. These changes are consistent with the CMS requirement that suppliers maintain compliance with all applicable licensure and certification requirements.

Cigna Commercial

Cigna Collaborative Accountable Care

Access Standards

A Physician Group entering into a Collaborative Accountable Care (CAC) Program with Cigna must meet the following, minimum standards when providing care:

- Daily acute care: Group shall extend daily hours as needed until last urgent care patient is seen. Urgent care services may be delivered in an alternate facility, but Group will use best efforts to ensure care is delivered in a Group facility;
- Telephonic triage: Group shall provide clinically capable evening and weekend telephonic consultation and triage service;
- Evening and weekend acute care: Group shall provide evening and weekend office hours, which may be provided on a regional basis or other reasonable limited location basis;
- Access to care: Group shall ensure that Cigna Participants receive physician access equal to or better than that of any other payer.

Embedded Care Coordination Interventions

Cigna will provide an Embedded Care Coordinator Resource Guide that outlines the detailed requirements of an Embedded Care Coordinator. Embedded Care Coordinator requirements include but are not limited to the following:

- Referral to and coordination with Cigna or otherwise agreed upon utilization and disease management programs for Cigna Participants, consultation with Cigna on specific issues related to evidence based guidelines, gaps in care, and overall care plans, and coordination of patient care and communication for specific Participants.
- Development of collaborative, coordinated care plans with Cigna Case Managers for Cigna Participants in case management programs.
- Development of specific care plans for Participants who are at high risk for hospital readmission, as soon as possible post-discharge (diagnosis, medications, f/u appointments, red flag signs to prompt calling the doctor). These Participants are "tagged" as high- risk in the system, have pre-visit review, and are provided with extra visit time including patient self-management support.
- Tracking of actions taken for all Participants who have been hospitalized, including follow-up office visits, medication reconciliation, and other interventions as medically appropriate.
- Review of Participants that are high-risk for health deterioration (assessment, development of collaborative written care plan that is shared with patient and all key health care professionals including goals, action steps for patient, red flag signs for patient, and action steps for all key health care professionals). These Participants are tagged as "high-risk" in the system, have pre-visit reviews, and are provided with extra visit time including patient self-management support materials.
- Engagement of Participants identified with a clear gap in care in instances where the Participant is not scheduled for an appointment. In instances where a Participant with a gap in care is scheduled for an appointment and engagement can be reasonably delayed without detriment, Group or CAC Participating Providers will engage Participant at the next scheduled visit. Unless clinically inappropriate, Group or CAC Participating Providers will strongly encourage the Participant to take action consistent with the evidence-based measures. Documentation of these activities will be evident in the Participant's records. Furthermore, Embedded Care Coordinator will coordinate with Cigna Care Coordinator on these Participants.

Embedded Care Coordinator Resource Guide

Cigna has developed a Resource Guide for the Embedded Care Coordinator that provides information on day-to-day administration of the CAC Program by the Group. The Resource Guide will be provided to the identified Embedded Care Coordinator upon execution of the Amendment.

Assignment of Aligned CAC Participants

Aligned CAC Participants will be identified every twelve (12) months using the methodology described below. Participants with GWH-Cigna ID cards and those associated with Shared Administration plans will not be included as CAC Participants. Participants in Benefit Plans which have elected to not participate in the CAC program are also excluded.

- Cigna uses 24 months of retrospective medical claim data.
- Records are selected for a specific market(s); claim records are assigned a market based on the servicing physician's zip code.

The alignment uses records where:

- Servicing physician is a PCP (specialty of Family Practice - FP, General Practice - GP, Internal medicine - IM, pediatrics – PD, Adolescent Medicine – AM, Geriatric Medicine - GE*)
- 29 evaluation and management (E&M) codes are used for alignment:
  - Office Visit E&M, New & Established (99201 – 99205; 99211 – 99215)
  - Office Visit Preventive, New & Established (99381 – 99387; 99391 – 99397)
  - Office Consult (99241 – 99245)

- Alignment – Step 1 (most recent 12 months)
  - Services for the 29 established E&M codes and totaled by Participant and PCP (sorted by Participant and number of visits).
  - Participant is assigned to the PCP with the most visits.
  - If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most recent visit.
- Alignment – Step 2 (prior 12 months)
  - For Participants NOT aligned for the most recent 12 months (no PCP visit), services for the 29 E&M codes for the prior 12 months (sorted by service date).
  - Participant is assigned to the PCP with the most recent visit.
  - If Participant is no longer an active Participant with Cigna in the most recent 12 months, they will be excluded.
- Claim Assignment (most recent 12 months)
  - All Participant claim activity occurring nationwide over the most recent 12 month period attributed to the aligned PCP.
  - If a Participant's zip code is greater than 100 miles from the aligned PCP, Participant is aligned to the "next best" aligned PCP within 100 miles. If there is no other service to an aligned PCP within 100 miles, the Participant is not aligned.
  - Based on CMS "switcher" methodology, any Participant will be excluded who is aligned to the market peer group in the current year, but was an Aligned Participant the previous year.

*Alignment to OB/GYN's, Nurse Practitioners, and Physician Assistants will occur when Participants do not have a visit with one of the physician specialties described above.

Key Focus Action Plan

The Key Focus Action Plan is jointly developed by the parties to implement and maintain the CAC Program and includes information about access, engaging Participants, evidence based care, informatics enabled Embedded Care Coordination, and value referrals.

The Key Focus Action Plan is available on the Cigna for Health Care Professionals websites, CignaforHCP.com> Clinical Health and Wellness Program>Collaborative Accountable Care.

Patient Level Actionable Reports

The following reports will be provided to the group:

- PreVise: a Cigna developed predictive model, which measures the likelihood of an individual incurring high health care expenditures in a twelve-month period. The data utilized in this model includes information from medical claims, pharmacy claims, demographic data, lab results, gap scores, and episode treatment groups (ETGs).This model looks at hundreds of variables to project a risk level for every Participant.
- Well Informed Gaps in Care (Gaps in Care): This report identifies Participants who may need additional services based on past claims history. Gaps are identified at a patient level on a monthly basis using clinical rule-based software. The software evaluates all the medical, pharmacy, and lab data to first identify whether or not a patient has a condition. It then identifies if there is a potential gap in care.
- Daily Case Management Report: There are three types of case management referral reports provided:
- Case Management (Start Up) Activity Report: This report includes patients who have been identified for a Cigna case management program within the past six months and their current case management status.
- Case Management Daily Referral Report: This report identifies all CAC-aligned Participants with new referrals into Cigna case management.
- Monthly Closed Case Referral Report: This is a summary of all CAC-aligned Participants in which a case management case was closed during the past month.

Participant Communications

Cigna expects the Group to issue the following communications to Cigna Participants:

- The availability of comprehensive, coordinated care within the Group every six months or as otherwise mutually agreed to.
- Furthermore, Group will provide written information regarding availability of services at the time of each visit.
- Group will encourage Participants to enroll in Cigna disease management and other programs where there is a likely benefit to the Participant. Documentation of these activities will be evident in the Participant's records.
- No later than year two of the addendum, Group will implement patient satisfaction surveys. Thereafter, annual surveys should be completed.
- Group will collaborate on development of mutually agreed joint communications to Cigna Participants at the time-enhanced access to Covered Services, or new Covered Services are initially offered by Group.

Performance Reports

Cigna will provide the following reports on a quarterly basis:

- Total Medical Cost: This report lists all Covered Services rendered to align CAC Participants during the reporting period.
- Total Medical Cost Sub Minor: This report shows a breakdown of the Total Medical Cost report by different medical categories.
- Patient Alignment: This report provides a list of all patients who meet the criteria to be an aligned CAC Participant.
- Specialty Care Utilization summary
- Advanced Imaging summary and patient detail
- Emergency Department summary and patient detail
- Inpatient Facility Summary and patient detail

Quality Index

Quality Index is determined using the Quality Measurement for the Cigna Care Designation Process.

Quality Evaluation

The quality of physician care is evaluated using a claims-based assessment based on EBM rules derived from rules endorsed by the National Quality Forum (NQF), Ambulatory Care Quality Alliance (AQA), Healthcare Effectiveness Data Information Set (HEDIS), or developed by physician organizations. For more information on the EBM rules, please reference the current Cigna Care Designation Methodology located on the Cigna for Health Professionals website, (CignaforHCP.com > Resources > Clinical Health & Wellness Programs > Cigna Care Designation).

EBM Assessment Process

- An EBM rule is only included for review at the market level for a physician/physician group if there are at least 20 opportunities for the rule within the specialty type and market.
- The average adherence to each rule is calculated within the specialty type for each market to derive the peer/market expected results.
- Opportunities and successes for a rule are aligned to the appropriate individual physician (using the visit methodology and relevant specialty).
- A physician is considered responsible for adherence to the EBM rule if the physician had at least:
- Two office visit encounters with an individual with Cigna coverage during the claim review period, and
- One of the office visit encounters occurred in the last 12 months of the claim review period.
- The adherence rate for the individual physician at the rule and market level is compared to the market expected adherence rate.
- Individual physicians are aligned to groups/practices and then opportunities, successes, and expected successes are summed to obtain group totals.
- The adherence rate for the physician group/practice is compared to their expected adherence rate, which is derived using their unique mix of EBM rules and opportunities.
- A Quality Index is calculated by dividing the physician group/practice actual adherence rate by the expected adherence rate.

Study Participation

Cigna requires that Group use best efforts to participate with Cigna in a pilot study within six months of the effective date of the program. A pilot study aids in the design and evaluation of key focus actions, as detailed in the Key Focus Action Plan. A typical study would have the practice identify a set of activities that constitute “Usual Care,” and to that add other workflows that constitute “Enhanced Care.” Cigna then uses rigorous methods to build credible comparison groups under these two options and measure resulting patient outcomes. The intent of these pilots is to support the continuous cycle of innovation in understanding which interventions work as designed and implemented and which must be otherwise modified.

*Please refer to the next section for information on each individual health plan including ID cards, quality measures, important contact numbers and behavioral health.

Renaissance Physicians Health Plan Election to Participate Form

This Election to Participate form confirms the undersigned health care provider's (who is referred to as "You") agreement to participate in the health plan programs listed below with Renaissance Physicians ("IPA").

Health Plan Participation Option: Answer Yes or No

Plan Option	Elect to Participate	Open Panel	Closed Panel	Current Patient Only	Age Limitation Please Specify
Amerigroup (Amerivantage MAPD)					
Cigna HealthSpring					
Cigna Collaborative Accountable Care (CAC)					
Cigna HMO (City of Houston)					
Blue Cross Blue Shield HMO (MAPD)					
Blue Value Based Incentive Plan (VBIP)					

1. You understand that your participation in the Cigna-IPA CAC will become effective upon notice from IPA.
2. You understand and agree that if you are a Primary Care Physician (specialty of Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, and Geriatric Medicine) you may only participate in one Cigna CAC program at a time.
3. You acknowledge that your agreement through which you participate in the Cigna provider network ("Participation Agreement") remains in full force and effect. Should your Participation Agreement terminate for any reason, your participation in the Cigna-IPA CAC program immediately and automatically terminates.
4. You acknowledge that your participation in the Cigna-IPA CAC program immediately and automatically terminates if the CAC agreement between Cigna and IPA terminates.
5. You acknowledge and agree that Cigna and IPA or its designee are authorized to exchange data specific to CAC provision of covered services to Cigna members in furtherance for the CAC to include, but not be limited to, facilitating data reporting and assessment related to the CAC.
6. Your effective date with CAC will be the 1st of the month depending upon completion of credentialing and receipt of the signed ETPF form. See below for tentative effective dates.

Your effective date with CAC will be the 1st of the month depending upon completion of credentialing and receipt of the signed ETPF form. See below for tentative effective dates.

CAC Effective Date Timeline 2017		
Quarter	ETPF Received by Date	Effective Date with CAC LOB
January 1st	November 15th	January 1st
April 1st	February 15th	April 1st
July 1st	May 15th	July 1st
October 1st	August 15th	October 1st

Provider Printed Name: _____

Provider Signature: _____

Provider Tax Identification Number: _____

Medicare ID Number: _____

Provider Address: _____

POD: _____

Effective Date: _____

Please fax this form to:

- *Provider Relations at 832-553-3418*

BEHAVIORAL HEALTH SERVICES QUICK FACTS AND PHONE GUIDE

Cigna-HealthSpring is committed to providing our customers with the highest quality and greatest value in healthcare benefits and services. Managing the behavioral health benefits of our customers allows Cigna-HealthSpring the opportunity to demonstrate this commitment by recognizing overall needs and providing better care.

Cigna-HealthSpring will continue to offer the outpatient services listed below without the requirement of a prior authorization. Any service not listed will continue to utilize the standard authorization process.

Services Requiring No Authorization by Participating Provider

CPT Code	DESCRIPTION	Report with Psychotherapy Add-On Codes
90791	Psychiatric diagnostic evaluation (no medical services)	
90792 (or New Patient E & M codes)	Psychiatric diagnostic evaluation with medical services	
Out Patient 99201-99205 99211-99215	New Patient Visit (10-60 min) Established Patient (5-25 min)	Psychotherapy Add On Codes: (when appropriate) 90833-30 min 90836-45 min 90838-60 min
Nursing Facility 99304-99306 99307-99310	New Patient Visit (10-45 min) Established Patient (10-35 min)	
90832	Psychotherapy (30 min)	
90834	Psychotherapy (45 min)	
90837	Psychotherapy (60 min)	
90846	Family Psychotherapy (without patient present)	
90847	Family Psychotherapy (with patient present)	
90853	Group Psychotherapy (other than of a multiple–family group) *Physician's Office Only ~ Facilities Require Prior Authorization.*	
Q3014	Telehealth	

FUNCTION	PHONE/ADDRESS	DESCRIPTION OF SERVICES
Member Eligibility/Benefits	800-453-4464 **(*IVR)**	Verification of coverage and benefits; for facility admissions and other facility services, consult the Common Working File if member does present ID card.
Authorization Line	866-780-8546 Fax: 866-949-4846	Prior authorization is required for services not listed above.
Inpatient Admissions	866-780-8546 Fax: 866-949-4846	Notification is required within 24 hours of admissions; clinical staff available 24 hrs a day/7 days a week to assist with notifications and precertification.
Claims Submission (paper)	Cigna-HealthSpring P.O. Box 981706 El Paso, TX 79998	
Claims Submission (electronic)	Clearing Houses: *Emdeon, *Relay Health, *Proxymed, *OfficeAlly * SSIGroup, * Availity *Medassets *Zirmed *GatewayEDI **Payor ID 63092**	
Claim Status Inquires	800-453-4464 **(*IVR)**	
HSConnect	**www.hsconnectonline.com**	Access to on-line provider portal for verification of member eligibility, authorization, and claim payment review. Select Providers tab, then HSConnect to access portal.

***(IVR) Interactive Voice Response System**

LUMERIS

Lumeris is an accountable care delivery innovation company offering health systems, payers, and providers operational support, technology, and consulting services. Lumeris' innovative solutions help health care organizations design, build, operate, measure, and optimize any accountable care model to accomplish the Triple Aim *Plus* One: improved quality, cost, and patient and physician satisfaction.

More specifically, the Lumeris Platform is:

- A population health management platform that aggregates several sources of data for one point of vision into a patient's health.
- Allows anyone with access to see what is happening with a patient at that point in time (ex. Pharmacy, high risk meds).
- Driven from claims including specialists, ancillary, labs, CMS files, acute facility admission and ED visits

Benefits of tool:

- Cloud Based: Remote Log-in Available
- Paper Waste Minimized
- Enhanced Encounters Available for each Patient
- Coordination of STARs Gaps Closed
- Better Patient Care and Management
- ICD-10 Compliant
- Better Data Integrity
- Targeted Work lists and Timely Reporting by user, as needed
- Real time insight to patient medication compliance
- Highlights high risk meds (HRM)

*To schedule training for providers and/or staff members in your office, please contact your Provider Relations Representative or Coding Educator.

The Lumeris Platform, also known as the ADSP (Accountable Delivery System Platform), is utilized by Primary Care Physicians to complete **Enhanced Encounters** *for their Cigna-HealthSpring patients.*

Effective 1/1/2017, certain sections of the Enhanced Encounter will be pre-populated based on the prior year's form. If a form was not completed in the previous year, there will not be any data available to pre-populate.

Sections for Pre-Population:

- Past Medical History
- Surgical History
- Medications
- Allergies

Access to Lumeris is only available to contracted PCPs. Contact your Provider Relations Representative to request access for your provider office. Your PR Rep can also assist you with adding/removing users and changing levels of access for existing user accounts.

Visit Lumeris online at: www.lumerislogin.com

What if I can't remember my password?
You can reset your password on the main login screen by clicking the Forgot Your Password? link. You will need the answer to the secret question you selected at the time of account registration in order to reset your password.

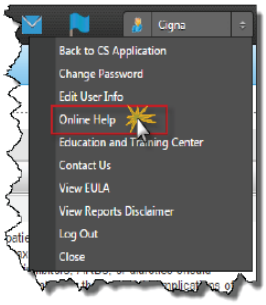
What if I can't remember my secret question or user ID?
Please contact the Lumeris Help Desk by phone at 1-866-397-2812 - option 1, or by email at customersupport@lumeris.com.

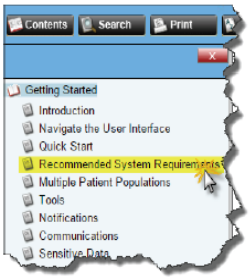
LUMERIS ADSP Troubleshooting

Verify ADSP System Requirements Are Met

A listing of system requirements for ADSP can be viewed in the General Information section of Online Help.

1. Click to expand the **Utility Menu.**
2. Select **Online Help.**
3. Click to expand the **Getting Started** section.
4. Click **Recommended System Requirements.**
5. View system requirements.





Ensure Pop-up Blocker is Turned Off

Add **https://www.lumerislogin.com** to your web browser Pop-up Blocker exceptions list.

Internet Explorer

1. Click the **Tools** menu.
2. Select **Pop-up Blocker Settings** from the Pop-Up Blocker menu.
3. Type **https://www.lumerislogin.com** in the "Address of website to allow" box.
4. Click **Add.**
5. Click **Close.**

Chrome

1. Click the **Chrome** menu ☰ from the top right corner.
2. Click **Settings.**
3. Click the **Show Advanced Settings** link.
4. Click **Content Settings** under Privacy.
5. Under Pop-Ups, click **Manage Exceptions**.
6. Enter **https://www.lumerislogin.com** in the Hostname pattern box and select **Allow** from the drop-down.
7. Click **Done.**

Add Site to the Trusted Sites Zone

Add https://www.lumerislogin.com to your web browser Trusted Sites zone list.

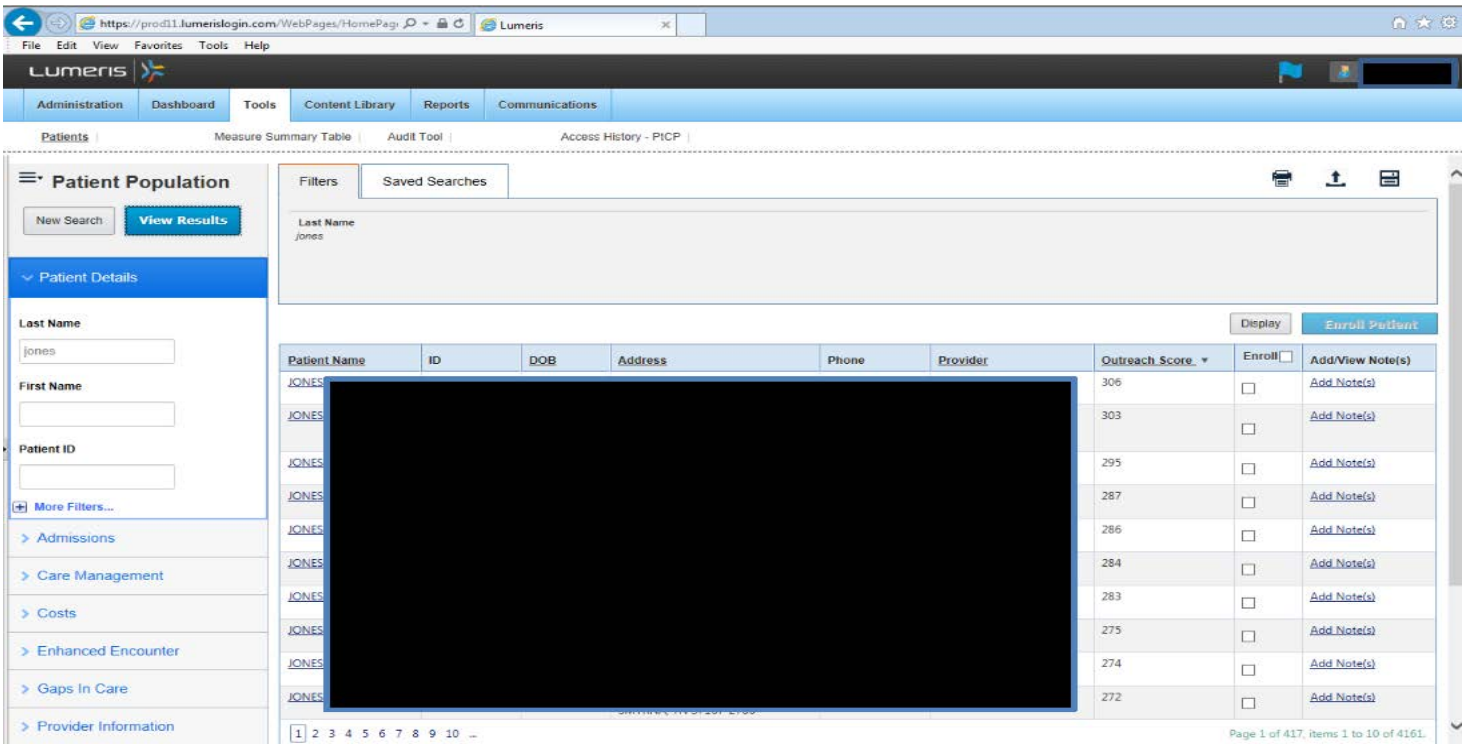
Internet Explorer

1. Click the **Tools** menu.
2. Select **Internet Options.**
3. Click the **Security** tab.
4. Click to select the **Trusted Sites** checkmark.
5. Click **the Sites** button.
6. Type **https://www.lumerislogin.com** in the "Add this website to the zone" box.
7. Click **Add**.
8. Click **Close**.
9. Click **OK**.

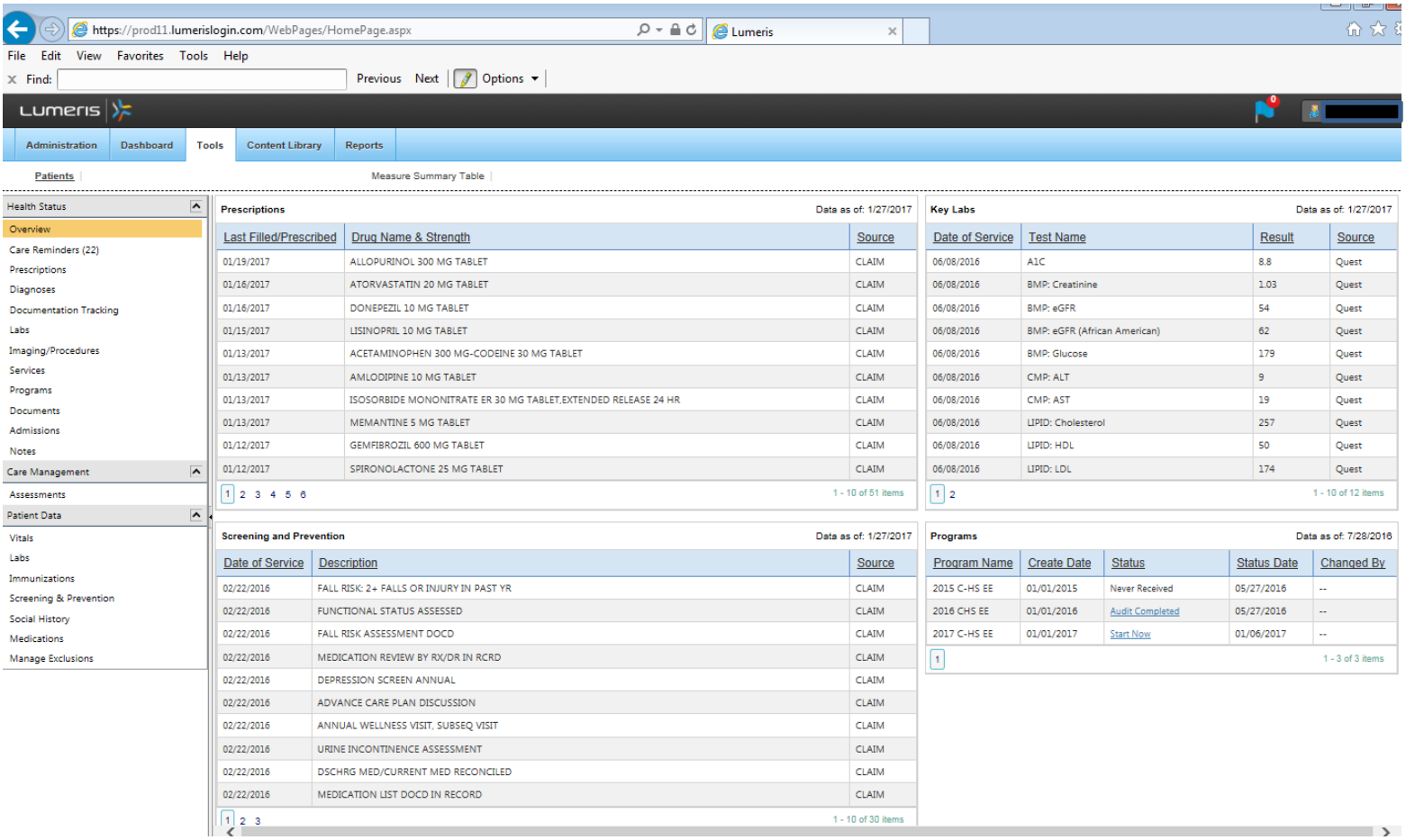
Chrome

1. Click the **Chrome** menu ☰ from the top right corner.
2. Click **Settings.**
3. Click the **Show Advanced Settings** link.
4. Click **Change Proxy Settings** under Network.
5. Click the **Security** tab.
6. Click to select the **Trusted Sites** checkmark.
7. Click **the Sites** button.
8. Type **https://www.lumerislogin.com** in the "Add this website to the zone" box.
9. Click **Add.**
10. Click **Close.**
11. Click **OK.**

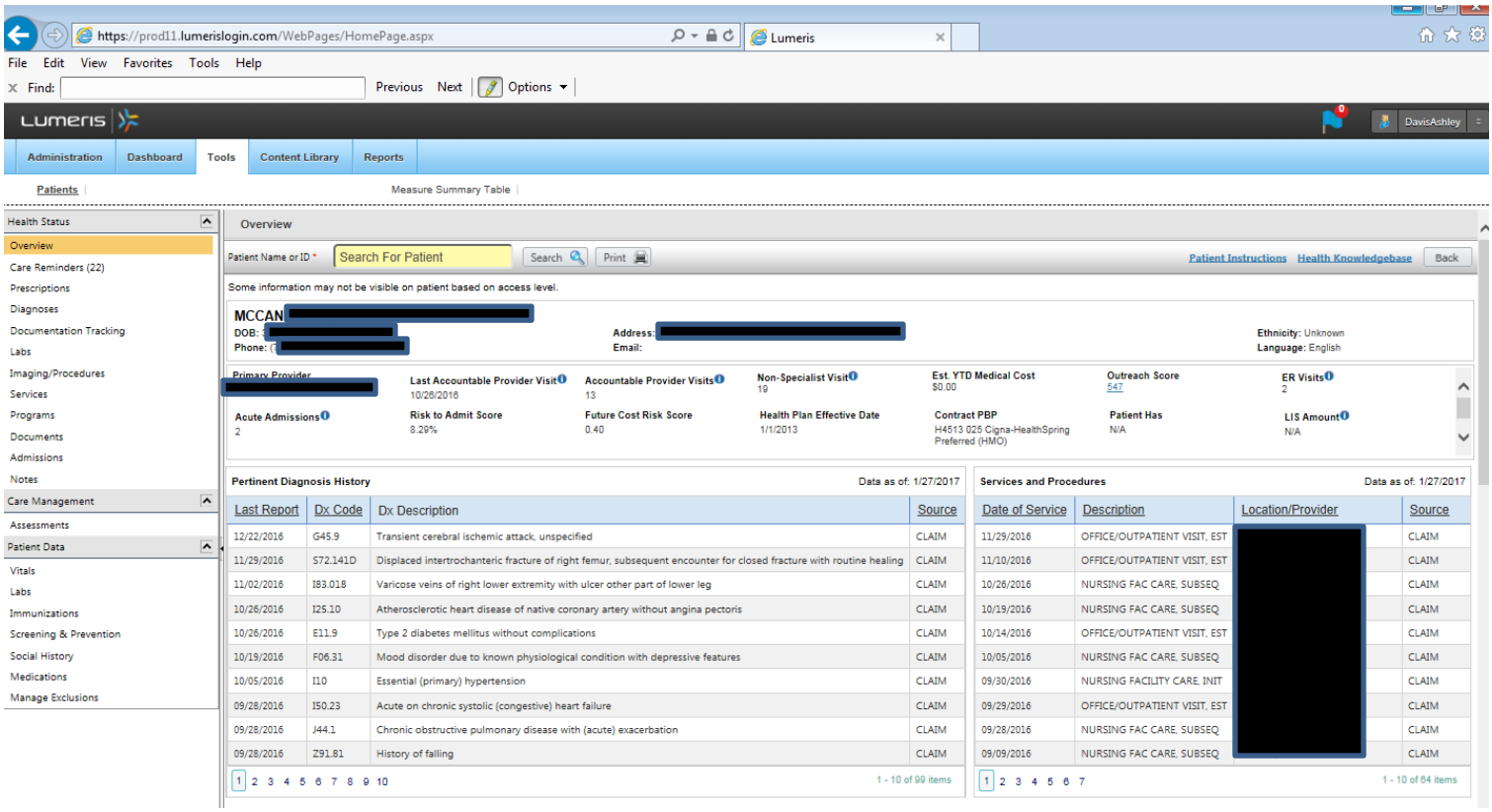
Review Membership Panel in Lumeris



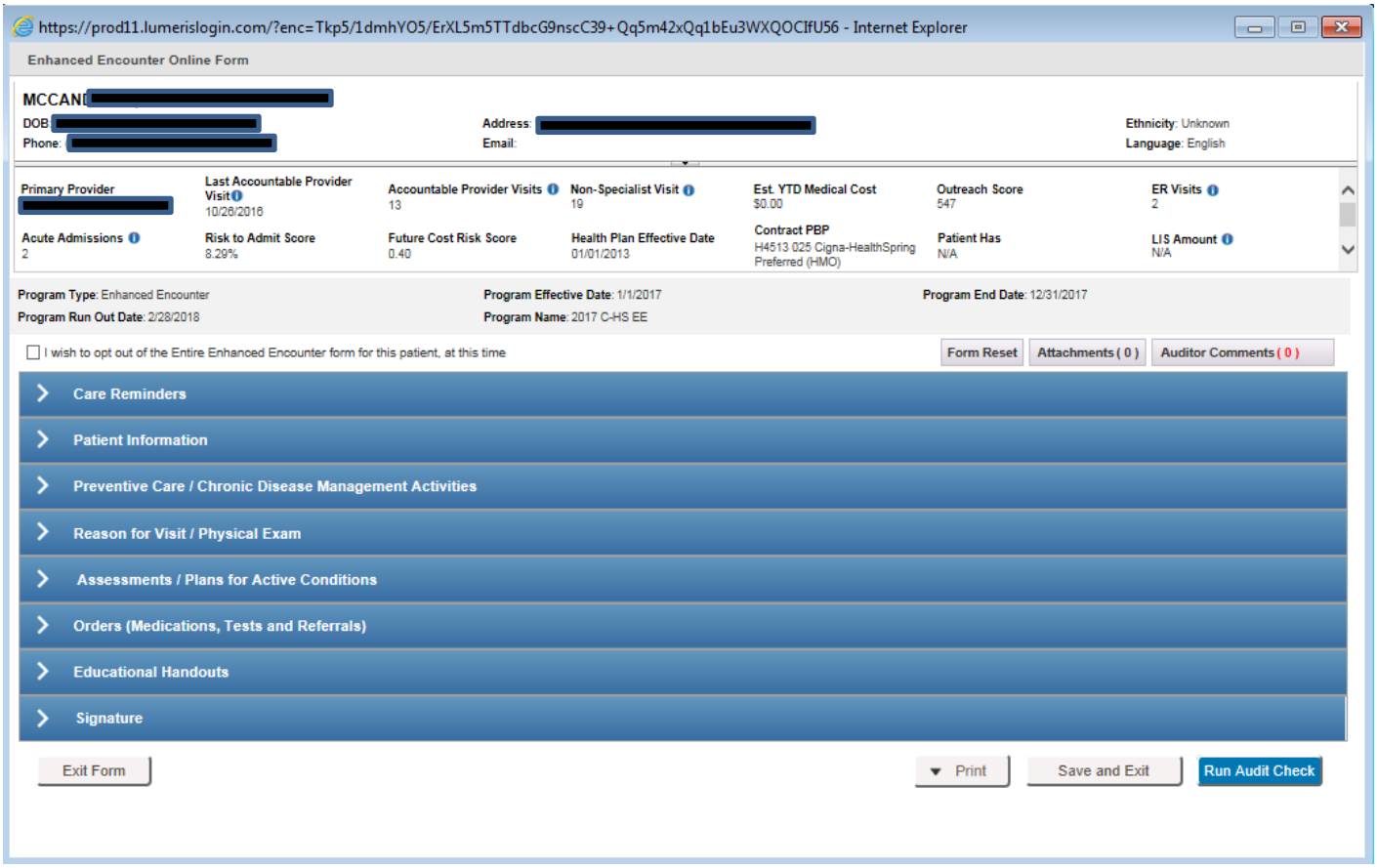
Review Patient History in Lumeris



Overview of Lumeris



Sample of EE (Enhance Encounter) in Lumeris



Cigna HealthSpring Care Management Referral Form

Cigna HealthSpring

MEMBER SUPPORT PROGRAMS & PHYSICIAN ORDER SHEET

Provider Name: **Provider Phone:**

Date: **Member Name:** **Member ID:**

Check the appropriate program(s) and fax this sheet to: 1-832-553-3423
If you have questions, please call Case Management at 1-888-501-1116

☐ **Comprehensive Case Management:**
(Episodic, Telephonic and Community): to support those members with chronic diseases that result in higher utilization. Member enrollment is based on identification through predictive modeling, prevalence rates and co-morbidities. Management and intervention is telephonic with home, office or hospital face- to-face visits when necessary. The focus is on those members with chronic diseases, three admissions in 6 months and a high risk score.

☐ **Aspire Palliative Care Program**:**
An innovative home and outpatient-based palliative care physician practice committed to providing an extra layer of support for patients with chronic conditions. The program supports members with serious and chronic illnesses including Advanced Cancer, CHF, COPD, ESRD, Advanced Dementia and many more illnesses. Aspire services include patient and family education, goals of care discussions, patient symptom management and the coordination of care with the patient's current provider

☐ **Respiratory Program:**
Designed to impact quality care and decrease utilization for members with respiratory conditions. Members with a diagnosis of COPD, Asthma, or Emphysema with home respiratory equipment and who had 2 or more admissions or with disease specific medications qualify for this program. These members have an initial home evaluation and respiratory assessment by a Registered Respiratory Therapist. They are then followed telephonically by a RRT Case Manager.

☐ **Transitional Care Clinic (TCC)**
Chronically ill patients needing complex care in an outpatient setting. Post Hospitalization Patients needing immediate follow-up that cannot be provided in the PCP's office because of complexity and time requirements

- Complex Case Patients having a history of repetitive ER or Hospital visits and multiple co-morbidities.
- Disease Management Patients with chronic unstable conditions ranging from CHF, COPD, Asthma, Diabetes Mellitus
- House Call visits

☐ **CHF Clinic:**
Members at highest risk for CHF exacerbation/hospitalization/frequent ER visit.

- NYHA level 3 or 4
- Telephonically unable to meet goals

☐ **Alegis**:**
Alegis is an in-home collaborative model of care designed to help improve quality of life in addition to decreasing inappropriate hospital utilization for patients with multiple, poorly controlled chronic conditions. This program is specifically designed to coordinate with, but not replace, the PCPs on a select subset of the patient population to realize optimal outcomes by year end.

☐ **Home Health Transition Program**:**
Addresses frequent re-admissions/frequent ER visits utilization by face to face encounters with members within 48 hours post discharge. Program Is a value add benefit without utilizing traditional home health benefits.

☐ **Depression Disease Management Program (DDM):**
Is a 12 week program to support and educate customers with depressive symptoms, new to a depression diagnosis or newly started on an antidepressant medication. Behavioral Health Contact # 1-866-780-8546.

☐ **Diabetes Empowerment and Education Program (DEEP)**
It is a 6 week program and it supports and educates customers with diabetes. The program is structured to meet in the community and designed to empower customers on strategies to help with diabetes self-management. The program is structured to be in a class setting for 6 weeks then customers who graduate from the program are enrolled in our comprehensive case management program.

****All programs may not be available in your demographic area. Medical Management will assist in coordinating these members to the most appropriate program available.**

Cigna-HealthSpring ID Card

Cigna Commercial Products

Cigna Products

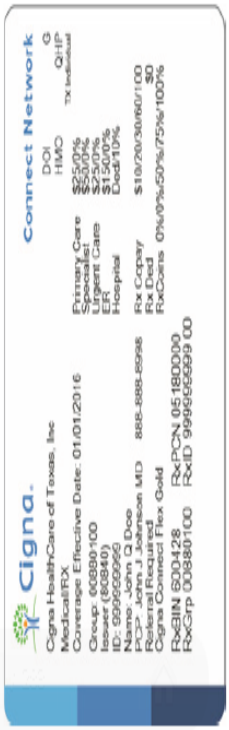
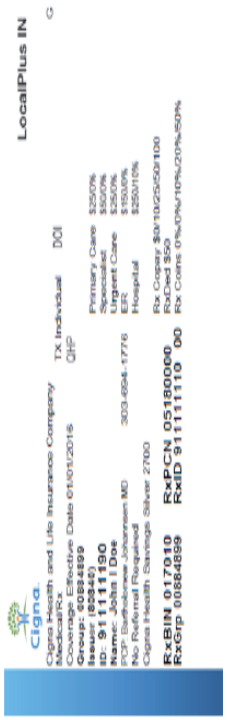
Renaissance Physician Organization (RPO)

Attributes	Products				
	Cigna SureFit™	City of Houston	Connect	LocalPlus® & LocalPlus IN	Open Access Plus (OAP)
PCP Selection Criteria	Optional - encouraged, but not required	Required	Required	Optional - encouraged, but not required	Optional - encouraged, but not required
Specialty Care Referral Requirements	No referral required*	Referral required	Referral required	No referral required*	No referral required*
Non-emergency Out-of-Network Benefits	No out-of-network benefits	No out-of-network benefits	No out-of-network benefits	Available for LocalPlus Not available for LocalPlus IN	Out-of-network available
Emergency	In- and out-of-network coverage**	In- and out-of-network coverage**	In- and out-of-network coverage**	In- and out-of-network coverage**	In- and out-of-network coverage**
Employer or Individual & Family Plan (IFP)	Employer	Employer: Client-specific network	IFP: Cigna Connect plans	Employer IFP: LocalPlus, Vantage plans	Employer IFP: Plans for existing customers only
Physician Network Composition	Three separate networks: RPO, Memorial Hermann and Health Care Alliance of Houston	One network: RPO, Kelsey Care, and Memorial Hermann Physician Network	RPO and directly contracted independent pediatricians and specialists. Refer to the health care professional directory on Cigna.com	Narrow physician network. Refer to the health care professional directory on Cigna.com	Open Access Plus network
Hospital Network Composition	All Cigna-contracted hospitals in the service area, except MD Anderson	All Cigna-contracted hospitals in the service area	Narrow hospital network. Refer to the health care professional directory on Cigna.com	Narrow hospital network. Refer to the health care professional directory on Cigna.com	All Cigna-contracted hospitals
Dedicated Phone Numbers	1.866.494.2111	Prior authorization: 1.713.437.3060 All other calls: 1.800.997.1406	1.866.494.2111	1.800.882.4462	1.800.882.4462

*Precertification may be required for hospital stays and some types of outpatient care.

**For emergency medical conditions as defined in the plan documents.

Example of CIGNA Commercial ID Cards

Attributes	Products				
	Cigna SureFit™	City of Houston	Connect	LocalPlus® & LocalPlus IN	Open Access Plus (OAP)
eServices: CignaforHCP.com	› NaviNet not available for precertification › Call Cigna Customer Service for pended claim status	All capabilities available	› NaviNet not available for precertification › Call Cigna Customer Service for pended claim status	All capabilities available	All capabilities available
eServices: Multipayer Vendors (EDI transactions via third party websites or practice management software)	All capabilities available (except precertification submissions through NaviNet)	All capabilities available	All capabilities available (except precertification submissions through NaviNet)	All capabilities available	All capabilities available
Service Area	*Partial counties:* Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, and Waller	*Full counties:* Harris, Fort Bend, Galveston, Montgomery *Partial Counties:* San Jacinto, Waller, Austin, Brazoria, Liberty, Walker, Grimes and Chambers	*Partial counties:* Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, and Montgomery	*Full counties:* Austin, Brazos, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, Waller, Washington *Partial counties:* Brazoria, Chambers, San Jacinto, Walker	Statewide
	Please refer to the health care professional directory on Cigna.com to determine the exact coverage area for a particular county.				
National Ancillary	All in-network	Not all national ancillaries are participating. Contact RPO.	All in-network	All in-network	All in-network
ID Card					

CIGNA CAC Quality Measures

Cigna Domain	Case Description	Rule Description
At-Risk/Chronic Condition Population	Diabetes Care (NS)	Patient(s) 18-75 years of age that had an annual screening test for diabetic retinopathy.
	Diabetes Care (NS)	Patient(s) 18-75 years of age that had annual screening for nephropathy or evidence of nephropathy.
	Diabetes Care (NS)	Patient(s) 18-75 years of age with lab results that have evidence of poor diabetic control, defined as the most HbA1c result value greater than 9.0%.
	Diabetes Care (NS)	Patient(s) 18-75 years of age with lab results with most recent HbA1c result value less than 8.0%.
	CAD (NS)	Patient(s) currently taking a statin, All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefit and 4 months pharmacy benefit.
	Diabetes Mellitus	Patient(s) complaint with prescribed statin-containing medication (minimum compliance 80%). All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefits and 6 months pharmacy benefit.
Behavioral Health	Depression Med Mgmt (NS)	Patient(s) with a new episode of major depression that remained on an antidepressant medication during the 5 months acute treatment phase.
Child Health	Adolescent Well-Care	Patient(s) 12-21 years of age that had one comprehensive well0care visit with a PCP or an OB/GYN in the last 12 reported months.
	URI (NS)	All children that are 3 months to 18 years with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.
	Pharyngitis (NS)	All children that are 2 to 18 years treated with an antibiotic for pharyngitis that had a Group A streptococcus test.
	Well-Child 15 MO (NS)	Patient(s) that had six or more well0child visits with a PCP during the first 15 months of life.
Coordination/ Appropriate Utilization	LBP Imaging (NS)	Patient(s) with uncomplicated low back pain that did not have imaging studies.
	Bronchitis, Acute (NS)	Patient(s) with a diagnosis of acute bronchitis that did not have prescription for antibiotic on or three days after the initiating visit.
	GDR	Generic Dispensing Rate or GDR is the number of days supply during the Measurement Period for which Generic Drug claims were submitted and paid within or sixty (60) days after the Measurement Period for CAC Pharmacy Participants divided by the numbers of days supply during the Measurement Period using claims that were submitted and paid within or sixty (60) days after the Measurement Period for all prescriptions drugs for CAC Pharmacy Participants
Preventive Health	Breast Cancer Screening (NS)	Patient(s) 52-72 years of age that had a screening mammogram in last 27 reported months.
	Chlamydia Screening (NS)	Patient(s) 16-20 years of age that had a chlamydia screening test in the last 12 reported months.
Patient Experience	Patient Experience of Care	Each CAC will be asked to respond to the following Patient Experience Questions: 1. Do you/CAC measure Patient Experience with a least seventy percent (70%) of physicians? 2. Have you identified three areas of opportunity for improvement of the Patient Experience? 3. Do you have action plan for improvement in the three Patient Experience areas identified in the above question reflected in your Key Focus Action Plan?

Preventive Health	Breast Cancer Screening (NS) Chlamydia Screening (NS)	Patient(s) 52-72 years of age that had a screening mammogram Patient(s) 16-20 years of age that had a chlamydia screening te
Patient Experience	Patient Experience of Care	Each CAC will be asked to respond to the following Patient Exp 1. Do you/CAC measure Patient Experience with a least seventy 2. Have you identified three areas of opportunity for improvemer 3. Do you have action plan for improvement in the three Patient question reflected in your Key Focus Action Plan?

BLUE CROSS BLUE SHIELD OF TEXAS

- Blue Cross Blue Shield (MAPD)
- Blue Value Base Incentive Plan (VBIP)

A Physician Group can elect to participate in Blue Cross Blue Shield of Texas Health plan offered through IPA. A provider must complete an Election to Participate Form enclosed in the provider manual. You may contact your Network Operations Representative to obtain a form.

Important Information on Member/Subscriber ID Card:
Blue Shield of Texas (BCBSTX) offers a wide variety of health care products. Each member's/subscriber's identification (ID) card displays important information required for billing and determining benefits. When filing a BCBSTX claim, two of the most important elements are the member's/subscriber's ID number and group number.

Most members/subscribers with coverage through a Blue Cross Blue Shield Plan are assigned a three letter alpha prefix that appears at the beginning of their unique identification number. The alpha prefix is very important to the identification number as the prefix acts as a key element in confirming the member's eligibility and coverage information. Prefixes are also used to identify and correctly route claims to the appropriate Blue Cross Blue Shield Plan for processing.

- Support, tools and guidance are available to help our members make informed decisions and the best use of their benefits.

Blue Cross Blue Shield Medicare Advantage (MAPD)

Blue Cross Medicare Advantage covers the same things as Original Medicare, plus benefits not covered by Medicare or most Medicare Supplement insurance plans, including built-in prescription drug coverage.

*Blue Cross Medicare Advantage Basic (HMO)
(Houston, Austin, Valley and El Paso)
*Blue Cross Medicare Advantage Premier (HMO)
(Houston, Austin, Valley and El Paso)
Web: Please visit bcbstx.com/Medicare to view all plan documents.
Call: For more information about Blue Cross Medicare Advantage Benefits or formulary, please call 1-877-608-2698 (HMO Plans)

Blue Value Base Incentive Plan (VBIP)

VALUE-BASED CARE PROGRAMS
Value-based care (VBC) programs redefine how BCBSTX and its provider partners collaborate. These models introduce new performance measurements, as well as new compensation processes. The BCBSTX VBC model seeks to partner with providers that deliver sustainable improvements to member care while better managing health care costs. By shifting provider relationships towards VBC models, BCBSTX intends to increase the value of health care services. BCBSTX expects to achieve this through increased collaboration with its provider partners. The VBC programs are supported by:

• Defining financial incentive models that align the interests of all parties around improving patient care and population health, and,
• Improving coordination between providers and BCBSTX to reduce cost trends without reducing the level of benefit coverage or the options available to attributed members. Some VBC programs consist of attribution, financial performance targets, quality improvement targets, financial incentive reconciliation, data exchange and reporting. An ACO is a specific type of VBC program.

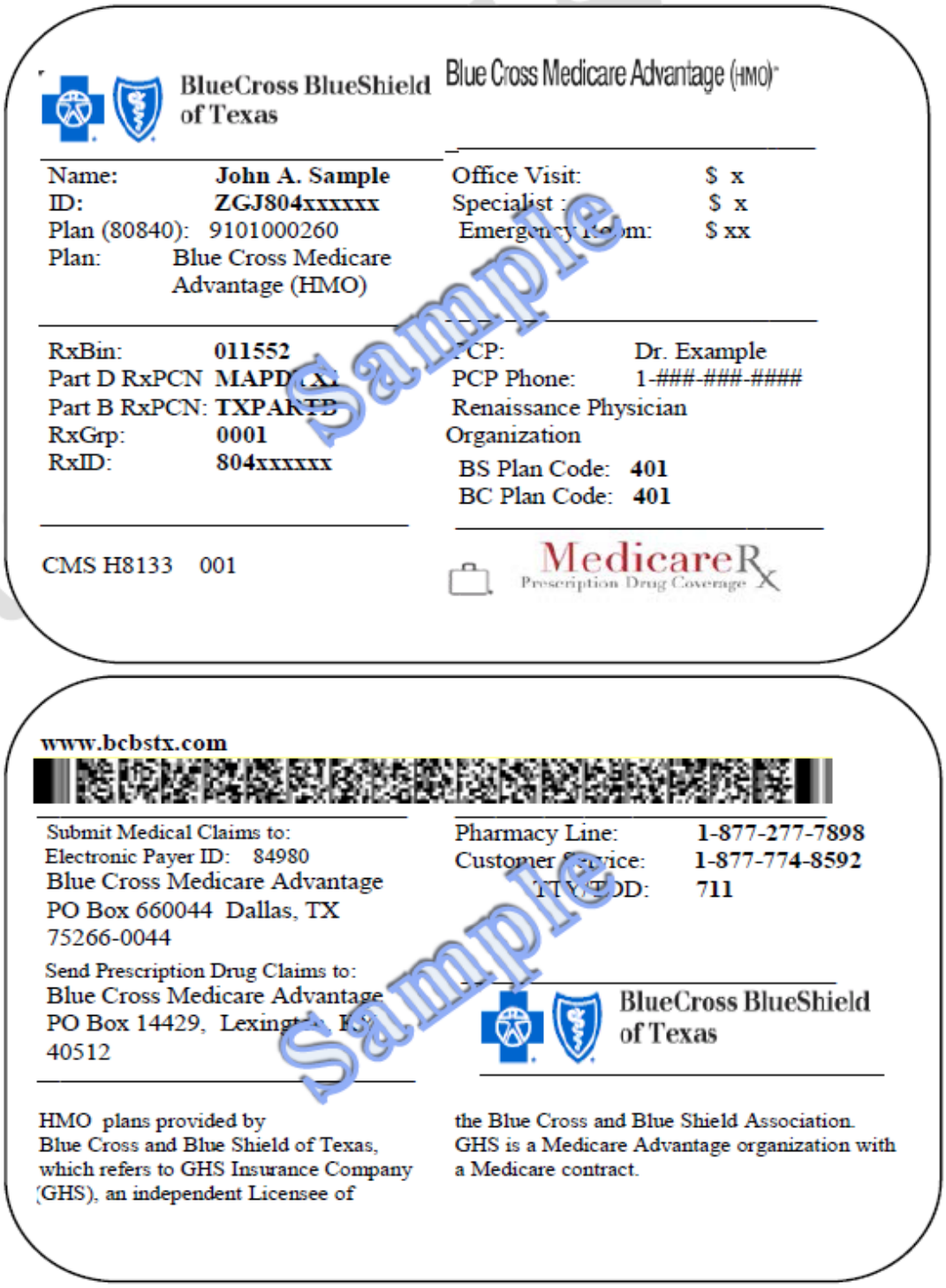
OVERVIEW
BCBSTX identifies members who qualify for inclusion in an ACO during a process called attribution. For purposes of this manual, Health Care Service Corporation (HCSC) includes BCBSTX. HCSC fully insured members, HCSC members from participating self-funded accounts, as well as participating BlueCard members are available for attribution. The BlueCard program enables our members to obtain health care services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area.

The attribution process runs monthly and includes the following steps:
1. Develop and maintain ACO information used to drive the attribution steps.
2. Identify the provider entity with the strongest relationship to a member.
3. Apply member eligibility requirements.
4. Establish the ACO's reference population.
The ACO is measured for quality performance using a maximum of 18 metrics from National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®) survey. BCBSTX contracts with NCQA-certified vendors to calculate and audit the ACO's performance results for HEDIS and AHRQ metrics. Note: Results for ACOs with a July 1 effective date cannot be audited because the measurement year is not a calendar year as required by HEDIS and AHRQ.

If an agency discontinues any metric, BCBSTX discusses replacement options with the ACO. Also, BCBSTX can take into account extenuating circumstances beyond the ACO's control that result in a decline in the results for a particular metric, e.g., vaccine shortage.

Blue Cross Medicare Advantage HMO Comprehensive Contact List	
Note: If your request is for a service covered under a capitated independent physician association (IPA), medical group, or other delegated entity responsible for claim payment, please make your request for verification directly to the appropriate IPA or entity.	
Provider and Member Customer Service	1-877-774-8592
Utilization Management Department (For Medical & Behavioral Health Services and Medical Coverage Determination, Medical Appeals, Medical Grievances)	Call 855-930-6573 Fax 800-639-6703 Fax 855-874-4711 Fax 855-674-9185 Fax 855-674-9189
Utilization for Renaissance Physicians	713-437-3060
iExchange (Web-based application used to submit transaction requests for inpatient admissions and extensions, treatment searches, provider/member searches, referral authorizations and select outpatient services and extensions.)	iExchange Web Application – https://www.bcbstx.com/provider/tools/iexchange.html iExchange IVR -> 877-774-8592 (Mon – Fri, 8am–5pm) iExchange Help Desk – iExchangeHelpDesk@bcbstx.com
Renaissance Physicians Provider Finder	Renaissance Physician Attn: Claims PO Box 2888 Houston, TX 77252-2888 Availity - RENGQ (all caps) - as payor ID for HCFA only Emdeon - 76066 - payor ID for HCFA and UB-04
Renaissance (RP) Provider Finders (To access the Online Provider Directory)	myrpo.com
Medical Coverage Determinations	Fax 855-874-4711 mail to: Blue Cross Medicare Advantage HMO Attn: Appeals & Grievances P.O. Box 4288 Scranton, PA 18505
Medical Appeals Expedited Appeal Only	Fax 855-674-9185 Call 877-774-8592
Magellan Internal Number for Referral from RP/Magellan to HCM Care Management	1-855-390-6573
Magellan Mental Health and Chemical Dependency Behavioral Health Customer Service (Note: Telephonic access is available 24 hours a day, 7 days a week)	1-800-327-9251 Note: The required call to precertify can be made by the member, the behavioral health professional, physician or a member's family member.
Magellan Provider Finder (To access the Online Provider Directory)	Magellanhealth.com/provider
Disease/Care Management Programs	855-390-6567
Eye Med (EyeMed Vision Member Services)	1-844-684-2255
Pharmacy	Mail Order Pharmacy PrimeMail 877-277-7895 www.MyPrime.com Pharmacy Directory https://www.bcbstx.com/medicare/pdf/mapd-pharmacy-tx-2017.pdf
Quest Diagnostics (Outpatient Clinical Reference Lab)	Quest Diagnostics, Inc. is the contracted lab for Blue Cross Medicare Advantage for all outpatient clinical reference laboratory services. For locations or questions, contact Quest at 1-888-277-8772, or visit Quest's website at QuestDiagnostics.com/patient
Dental Networks of America	877-774-8592
Durable Medical/Home Health Provider Finder	https://www.bcbstx.com/provider/network/bma_hmo.html

Example of Blue Cross Medicare Advantage HMO ID Card



Blue Medicare Advantage HMO Star Measures	Star Weight	4-Star Cut Points
Part C Measures		
Breast Cancer Screening in members aged 50-74	1	≥74%
Colorectal Cancer Screening in members aged 50-75	1	≥71%
Annual Flu Vaccine (member survey)	1	≥75%
Improving or Maintaining Physical Health (member survey)	3	≥69%
Improving or Maintaining Mental Health (member survey)	3	≥80%
Monitoring Physical Activity for members aged 65 or older (member survey)	1	≥55%
Adult BMI Assessment for members aged 18-74	1	≥90%
Osteoporosis Management in female members aged 67 - 85 years within 6 months of a fracture	1	≥51%
Diabetes Care – Eye Exam (members aged 18-75)	1	≥75%
Diabetes Care – Kidney Disease Monitoring (members aged 18-75)	1	≥93%
Diabetes Care – Blood Sugar Controlled for members aged 18-75 (HbA1C ≤ 9 %)	3	≥71%
Controlling High Blood Pressure • Aged 18-59 with or without diabetes: <140/90 mmHg • Aged 60-85 with diabetes: <140/90 mmHg • Aged 60-85 without diabetes: <150/90 mmHg	3	≥75%
Rheumatoid Arthritis Management	1	≥82%
Reducing Risk of Falling (member survey)	1	≥67%
All-Cause Hospital Readmissions	3	≤9%
Ease of Getting Needed Care and Seeing Specialist (member survey)	1.5	≥84%
Getting Appointments and Care Quickly (member survey)	1.5	≥77%
Rating of Health Care Quality (member survey)	1.5	≥86%
Coordination of Health Care Services (member survey)	1.5	≥86%
Part D Measures		
High Risk Medication in members ≥ 65 years	3	≤8%
Medication Adherence for Diabetes Medications	3	≥75%
Medication Adherence for Hypertension (RAS antagonists)	3	≥77%
Medication Adherence for Cholesterol (Statins)	3	≥73%
Medication Therapy Management (MTM) Program – Comprehensive Medication Review (CMR) Completion Rate	1	≥48.6%

Authorization Contacts

Service Type	Phone	Fax
Pre-Certification & Referrals	800-441-9188	800-252-8815
Diagnostic Imaging (AIM Specialty Health)	800-859-5299	

Key Contacts

Department	Phone
Provider Services	800-451-0287
Behavioral Health	800-451-0287
Pharmacy Therapeutics	888-229-2812
iExchange Helpdesk	800-746-4614
AIM Specialty Health	800-859-5299
Davis Vision	800-501-1459

Useful Links

BCBSTX Website	https://www.bcbstx.com/provider/contact_us.html
Availity	https://www.availity.com/
iExchange	https://www.bcbstx.com/provider/tools/iexchange.html
Aim Specialty Health	https://www.providerportal.com/
Davis Vision	http://www.davisvision.com/

Claims

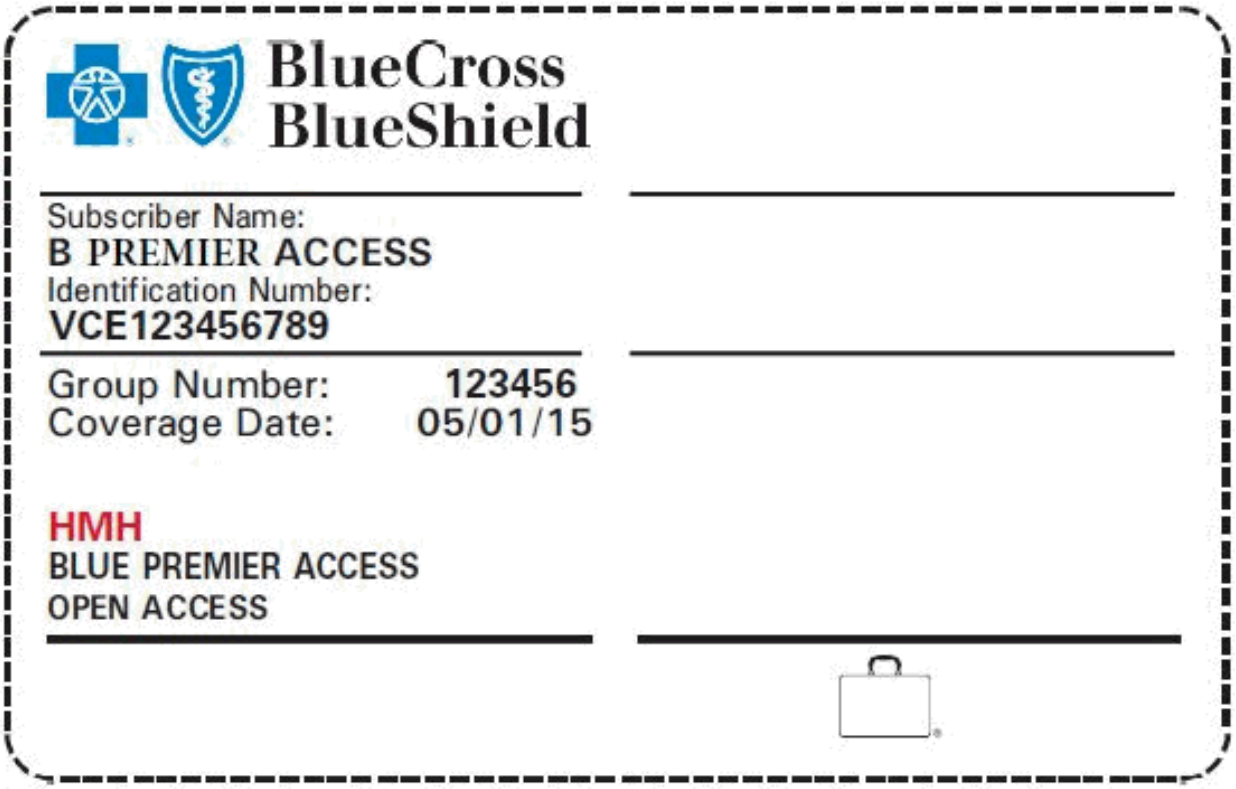
Electronic payer ID: 84980 (Availity)	
Address	Phone
Blue Cross and Blue Shield of Texas P O Box 660044 Dallas, TX 75266-0044	800-282-4548

Local Network Management Office Location

Region	Address	Phone	Fax
Houston	1800 West Loop South, Suite 600 Houston, TX 77027-3279	713-663-1149	713-663-1227
Golden Triangle (Beaumont, Orange, Port Arthur)	2615 Calder, Suite 700 Beaumont, TX 77702	713-663-1149	713-663-1227

Email: ProfessionalProviderNetworkDept@bcbstx.com

Example of Blue VBIP ID Card



BLUE VBIP QUALITY METRICS

#	QUALITY METRICS
	PREVENTIVE MEDICINE SERVICES (HEDIS)
1	Breast Cancer Screening
2	Cervical Cancer Screening
3	Colorectal Cancer Screening
4	Childhood Immunization Status (MMR only)
	COMPREHENSIVE DIABETES CARE (HEDIS)
5	Comprehensive Diabetes Care - HbA1c Test (Annual)
6	Comprehensive Diabetes Care - HbA1c Control (<8.0%)
7	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)
	ASTHMA (HEDIS)
8	Medication Management for People with Asthma (75%)
	INPATIENT UTILIZATION (HEDIS)
9	Plan All-Cause Readmissions (Actual to Expected)
	OTHER QUALITY METRICS (HEDIS)
10	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
11	Use of Imaging Studies for Low Back Pain
12	Appropriate Treatment for Children with Upper Respiratory Infection
13	Appropriate Testing for Children with Pharyngitis
	AMBULATORY SENSITIVE ADMISSIONS (AHRQ)
14	Prevention Quality Acute Composite (AHRQ 91)
15	Prevention Quality Chronic Composite (AHRQ 92)
	MEMBER EXPERIENCE (CG-CAHPS®)
16	Follow-Up on Test Results
17	Getting Timely Appointments, Care and Information (composite)
18	How Well Providers Communicate with Members (composite)

Add Amerigroup contact sheet here

Example of Amerigroup (Amerivantage) ID Card

Amerigroup RealSolutions
Medicare Advantage Plans
www.myamerigroup.com/medicare

Amerivantage Select (HMO)
Amerigroup Texas, Inc.

Member ID:
Member Name:
PCP Effective Date:
Primary Care Physician (PCP):
PCP Phone:
Clinic Name/IPA:
Renaissance Physician Organization
Issuer ID: 80840
Copays may apply for certain services

Rx GROUP: WM2A
Rx BIN: 003858
Rx PCN: MD
CMS Contract/PBP/Segment
-018-

MedicareRx
Prescription Drug Coverage

Members: Call your PCP or 24-hour Nurse HelpLine for nonemergency care. You need to show this card for medical care, but not for emergency care. In an emergency, call 911 or go to the nearest ER.

Customer Service:	**1-866-805-4589**
TTY:	**711**
Providers:	**1-800-220-1378**
Pharmacy:	**1-866-630-3820**
Vision:	**1-800-879-6901**
Dental:	**1-855-418-1621**
24/7 Nurse Line:	**1-855-658-9249**
SilverSneakers:	**1-855-741-4985**

Providers and Hospitals: Prior authorization is required for all non-emergency admissions and certain services. For emergency admissions, please call 800-220-1378 within 24 hours of treatment.

Claims: Amerigroup, P.O. Box 61010 Virginia Beach, VA 23466-1010. EDI Information : Payer ID - Emdeon: 27514; Caparo: 28804; Availity: 26375
Pharmacy Claims: P.O. Box 14718 Lexington, KY 40512-4718

Use of this card by any person other than the member is fraud
05/30/2017

APPENDIX

Renaissance Physicians
CARE THAT REVOLVES AROUND YOU.

PRIOR AUTHORIZATION LIST- When performed in-network*

FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2017

IPA Prior Authorization (PA) Requirements

This Prior Authorization list supersedes any lists that have been previously distributed or published–older lists are to be replaced with the latest version.

IPA Prior Authorization (PA) Policy

PCP's or referring health care professionals should OBTAIN Prior Authorization BEFORE services requiring Prior Authorizations are rendered. Prior Authorizations may be obtained via HSConnect or as otherwise indicated in the Health Services section of the 2017 Provider Manual. Please see the HSConnect section of the provider manual for an overview of the HSConnect portal capabilities and instructions for obtaining access.

Rendering providers should VERIFY that a Prior Authorization has been granted BEFORE any service requiring a Prior Authorization is rendered. Prior Authorizations may be verified via HSConnect or as otherwise indicated in the Health Services section of the Provider Manual.

IMPORTANT – Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service. Remember, benefits will vary between plans, so always verify benefits.

IPA Referral Policy

RP values the PCP's role in directing the care of customers to the appropriate, participating health care professionals. Participating specialists are contracted to work closely with our referring PCPs to enhance the quality and continuity of care provided to customers.

Although a Prior Authorization may not be required for certain services, a REFERRAL from a PCP to a Specialist MUST BE in place. The Referral should indicate PCP approved for a consultation only or for consultation and treatment, including the number of PCP approved visits.

Refer to your roster within HSConnect to locate an in-network health care professional or facility.

Procedures/Services	PA Required	PA Not Required	Comments
Admissions	✓		Admissions include: Inpatient Medical and Behavioral Health Admissions Inpatient Observation Inpatient Rehabilitaiton Skilled Nursing Facility LTAC Intermediate Care Facility/Assisted Living *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Allergy Injections without a MD visit		X	
Allergy Serum and Testing		X	No authorization required with a specialist referral
Ambulance (Air)*	✓		
Ambulance (Ground)		X	**Facility to Facility Transports**: Prior authorization not required **Emergent Transports**: Prior authorization not required
Ambulance (Ground)*	✓		**Non-Emergent Transports** and Facility to Home Transports: Prior authorization required **Facility to Facility Transports**: Prior authorization required for transports over 75 miles

Procedures/Services	PA Required	PA Not Required	Comments
Amniocentesis		X	
Angioplasty/Cardiac Catheterization/Stents (cardiac and renal)	✓		
Arteriogram/Angiogram	✓		
Audiogram		X	
Biopsy		X	No prior authorization required for all procedures in any contracted locations
Blood Services (Outpatient)		X	
Bone Density Study		X	
Breast Prosthesis (inserts)		X	CMS limits coverage to one prostheses every other year with appropriate coding *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Bronchoscopy		X	
Cardiac Monitoring		X	Any duration; placed on patient in any contracted location (non-invasive in office, hospital, outpatient, etc.). *Implantable cardiac monitors require prior authorization*
Cardiac Rehab		X	Only covered for specific conditions under Medicare guidelines *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Cardiac Testing All Stress Testing Myocardial Perfusion Imaging (SPECT) Cardiac CT Cardiac Nuclear Studies	✓		Non-imaging cardiac stress test (Treadmill EKG) does not require prior-authorization.
Cardioversion		X	
Chemotherapy	✓		Initial treatment only
Chiropractic	✓		Only covered for specific conditions under Medicare guidelines
Colonoscopy		X	
Corticosteroid Injections		X	
CT Scans Fast (EBCT) 64 Slice CTA Scans – all modalities	✓		No prior authorization required for standard CT scans
Diabetic Shoes and Inserts		X	CMS payment guidelines dictate the number of shoes/inserts covered by diagnosis/condition *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Diabetic Supplies and Monitors	✓		Prior authorization required under Part B benefit for non-preferred products or when quantity limits are exceeded for preferred products. *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Doppler/Duplex Studies		X	

Durable Medical Equipment (DME)	See Comments ➡	Prior Authorization is required for: • All rental DME • Purchased DME per contract rates, per line item greater than $500; certain items require prior authorization regardless of price [1] • All supplies per contract rates, per line item greater than $500 • All repairs to DME

Procedures/Services	PA Required	PA Not Required	Comments
Electrocardiogram (EKG)		X	
Echocardiogram (ECHO): Stress ECHO and Transesophageal ECHO (TEE)*	✓		No prior authorization required for routine Transthoracic (TTE) ECHO only*
Electroencephalogram (EEG)		X	
Electromyography (EMG) & Nerve Conduction Studies	✓		No Medical Director review required if Miliman's Criteria is met.
Electrophysiology (EP)		X	
Education		X	Includes diabetic education, nutritional counseling, and smoking cessation-please refer to EOC for limitations
Endoscopy		X	
Genetic Testing/Molecular Diagnostics/Pharmocogenetic Testing	✓		Only covered under certain conditions under Medicare guidelines. Health Plan Medical Director review required
Hearing Aid		X	Some plans provide limited hearing aid benefit; see Customer Evidence of Coverage (EOC) *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Hemodialysis		X	*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Home Health Services	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Home Infusion	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Interventional Radiology	✓		
Lab work		X	Must use contracted provider, Quest Diagnostics
MRA (all modalities)	✓		
MRI (all modalities)	✓		
Myelogram		X	
Nuclear Cardiac Studies	✓		
Nuclear Radiology Studies	✓		Prior Authorization is required for all Nuclear Studies Except: • Whole body nuclear bone scans • Thyroid Uptake Studies • Gastric Emptying Study • HIDA Scan • DEXA Scan • VQ Scan

			• Parathyroid Scan
Occupational Therapy	✓		
Orthotics- New or Repairs	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Outpatient Observation	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Outpatient Surgical Procedures	✓		All outpatient hospital and ambulatory surgical centers procedures require prior authorization Except: those specifically addressed in this document as not requiring PA.
Procedures/Services	**PA Required**	**PA Not Required**	**Comments**
Oxygen Equipment	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Part B - Outpatient Biologicals/Drugs	See Comments ➡		Part B prior authorization list and request form is available on the Cigna-HealthSpring health care professional website. Medicare Part B drugs may be administered and a backdated prior authorization obtained in cases of emergency. Definition of emergency services is in accordance with the provider manual *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Pain Management	See Comments ➡		Prior Authorization required for all procedures except: Trigger Point injections, joint injections and ESI- Epidural Steroid Injections
Peritoneal/Home Dialysis		X	*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Physical Therapy	✓		
Podiatry	✓		Only covered for specific conditions under Medicare guidelines
Positron Emission Tomography (PET)	✓		Note-CMS allows up to three PET/CTs for initial staging and restaging purposes. Additional PET/CT request require Medical Director review.
Preventive Screenings		X	Include mammogram, pap test, colonoscopy, flu and pneumonia vaccines, bone density, glaucoma screening
Prosthetics- New or Repairs	✓		*For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Pulmonary Rehab		X	Only covered for specific conditions under Medicare guidelines *For Blue Cross or Cigna City of Houston members, please contact Blue Cross or Cigna directly to obtain authorization*
Radiation Therapy	✓		Prior authorization only required for IMRT, Gamma knife, Cyber knife, and Selective Internal Radiation Therapy (SIRT)

RENAISSANCE PHYSICIANS CASE MANAGEMENT PROGRAMS

Aspire Palliative Care Program**:
An innovative home and outpatient-based palliative care physician practice committed to providing an extra layer of support for patients with chronic conditions. The program supports members with serious and chronic illnesses including Advanced Cancer, CHF, COPD, ESRD, Advanced Dementia and many more illnesses. Aspire services include patient and family education, goals of care discussions, patient symptom management and the coordination of care with the patient's current provider

Transitional Care Clinic (TCC)
Chronically ill patients needing complex care in an outpatient setting. Post Hospitalization Patients needing immediate follow-up that cannot be provided in the PCP's office because of complexity and time requirements

- Complex Case Patients having a history of repetitive ER or Hospital visits and multiple co-morbidities.
- Disease Management Patients with chronic unstable conditions ranging from CHF, COPD, Asthma, Diabetes Mellitus
- House Call visits

Alegis**:
Alegis is an in-home collaborative model of care designed to help improve quality of life in addition to decreasing inappropriate hospital utilization for patients with multiple, poorly controlled chronic conditions. This program is specifically designed to coordinate with, but not replace, the PCPs on a select subset of the patient population to realize optimal outcomes by year end.

RENAISSANCE PHYSICIANS CASE MANAGEMENT REFERRAL FORM

Renaissance Physicians
CARE THAT REVOLVES AROUND YOU.

Member Support Programs
&
Physician Order Sheet

Provider Name: _____ Provider Phone: _____

Date: _____ Member: _____ Member ID: _____

Check the appropriate program(s) and fax this sheet to: 832 553-3423

☐ **Aspire Palliative Care Program:**

An innovative home and outpatient-based palliative care physician practice committed to providing an extra layer of support for patients with chronic conditions. The program supports members with serious and chronic illnesses including Advanced Cancer, CHF, COPD, ESRD, Advanced Dementia and many more illnesses. Aspire services include patient and family education, goals of care discussions, patient symptom management and the coordination of care with the patient's current provider. Aspire is a skilled team of doctors, nurse practitioners, social workers and other specialists who work together in conjunction with a patient's current physician to develop a plan of care that best fits the needs of the patient and their family.

☐ **Transitional Care Clinic (TCC)**

Chronically ill patients needing complex care in an outpatient setting.
Post Hospitalization Patients needing immediate follow-up that cannot be provided in the PCP's office because of complexity and time requirements

- Complex Case Patients having a history of repetitive ER or Hospital visits and multiple co-morbidities.
- Disease Management Patients with chronic unstable conditions ranging from CHF, COPD, Asthma, Diabetes Mellitus, Coronary Artery Disease and Lipid Management
- House Call visits

For Additional Cigna Healthspring Programs, contact Case Management *888-501-1116*

For Additional Blue Cross Programs, contact *877-774-8592*

All programs may not be available in your demographic area. Medical Management will assist in coordinating these members to the most appropriate program available.

Advance Directive: Texas

Directive to Physicians and Family or Surrogates

Advance Directives Act (see §166.033, Health and Safety Code)

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I _____ , recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)

Additional Requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:
1.

2.

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me, following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed_____Date_____

City, County and State of Residence_____

Two witnesses must sign in the spaces below.

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness (1) may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness (1)_____Witness (2)

Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
a. that may be treated, but is never cured;
b. that leaves a person unable to care for or make decisions for the person's own self; and
c. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

Directiva a los médicos y a familiares o substitutos

Ley de Directivas Anticipadas (ver §166.033, del Código de Salud y Seguridad)

Éste es un documento legal importante conocido como Directiva Anticipada.
Su función es ayudar a comunicar sus deseos relacionados con el tratamiento médico para un momento futuro cuando no esté en capacidad de hacer conocer sus deseos debido a una enfermedad o lesión. Estos deseos se basan generalmente en sus valores personales. En particular, querrá considerar qué nivel o dificultades de tratamiento está dispuesto a soportar a cambio del beneficio que obtendría en caso de estar gravemente enfermo.

Se le sugiere que hable sobre sus valores y deseos con su familia y con la persona escogida como su agente, lo mismo que con su doctor. El doctor, otro proveedor médico o una institución médica pueden ofrecerle algunos recursos para ayudarle a completar la directiva anticipada. A continuación se dan unas definiciones breves que le podrán ayudar en sus discusiones y en la planeación. Escriba sus iniciales al lado de las opciones de tratamiento que mejor reflejen sus preferencias personales. Deles una copia de su directiva a su doctor, a su hospital de costumbre, a sus parientes y a su agente. Haga una revisión periódica del documento. Mediante la revisión periódica, puede asegurar que la directiva refleje sus preferencias.

Además de esta directiva anticipada, la ley de Texas estipula otros dos tipos de directivas que pueden ser importantes en caso de una enfermedad grave. Estas son: el Poder médico y la Orden de no revivir fuera del hospital. Debe hablar sobre estos con el doctor, su familia, un representante del hospital o con otros consejeros. También es posible que desee llenar una directiva relacionada con la donación de órganos y tejidos.

Directiva

Yo, reconozco que la mejor atención médica se basa en una relación de confianza y comunicación con mi doctor. Juntos, mi doctor y yo tomaremos las decisiones médicas mientras yo esté en condiciones mentales de hacer conocer mis deseos. Si en algún momento yo no estoy en capacidad de tomar decisiones médicas respecto a mi salud debido a una enfermedad o lesión, ordeno que se respeten las siguientes preferencias respecto al tratamiento:

Si, a juicio de mi doctor, estoy padeciendo de una enfermedad terminal de la que se espera moriré dentro de los seis meses, incluso con tratamientos disponibles para prolongar la vida, suministrado de acuerdo con las normas actuales de atención médica:

_____Yo pido que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo, y que mi doctor me deje morir tan dignamente como sea posible; O

_____Yo pido que me mantengan con vida en esta situación terminal usando los tratamientos disponibles para prolongar la vida. (Esta preferencia no se aplica al cuidado de hospicio).

Si, a juicio de mi doctor, estoy sufriendo de un padecimiento irreversible, que no permitirá que me atienda yo mismo ni que tome decisiones por mí mismo y se espera que moriré si no me suministran tratamientos para prolongar la vida de acuerdo con las normas actuales de atención médica:

____Yo pido que no me den o me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo, y que mi doctor me deje morir tan dignamente como sea posible; O

____Yo pido que me mantengan con vida en esta situación irreversible usando tratamientos disponibles para prolongar la vida. (Esta preferencia no se aplica al cuidado de hospicio).

Peticiones adicionales: (Después de consultarle al doctor, usted querrá escribir algunos tratamientos en el espacio disponible que usted quiera o no quiera que se le den bajo circunstancias específicas, como la nutrición artificial y los líquidos, los antibióticos por vía intravenosa, etc. Asegúrese de anotar si quiere o no quiere el tratamiento en particular).

Después de firmar esta directiva, si mi representante o yo elegimos cuidado de hospicio, entiendo y estoy de acuerdo en que me den solamente aquellos tratamientos para mantenerme cómodo y que no me den los tratamientos disponibles para prolongar la vida.

Si no tengo un poder para la atención médica, y no puedo dar a conocer mis deseos, designo a las siguientes personas para que tomen decisiones con mi doctor que sean compatibles con mis valores personales:

1.

2. _____

(Si usted ya ha firmado un poder médico, entonces ya habrá nombrado a un agente y no deberá anotar otros nombres en este documento).

Si las personas nombradas antes no están disponibles, o si no hay un vocero designado, comprendo que se escogerá un vocero para mí, siguiendo las pautas especificadas por la ley de Texas.

Si, a juicio de mi doctor, mi muerte es inminente dentro de minutos u horas, a pesar de que me den todo tratamiento médico disponible suministrado dentro de las pautas de atención actuales, autorizo que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo. Comprendo que bajo la ley de Texas esta directiva no tiene efecto si se ha diagnosticado que estoy embarazada. Esta directiva seguirá en efecto hasta que yo la revoque. Nadie más puede hacerlo.

Firmado_____ Fecha

Ciudad, condado y estado de domicilio

_____

Dos testigos tienen que firmar en los espacios siguientes.

Dos testigos adultos hábiles tienen que firmar a continuación, reconociendo la firma del declarante. El testigo designado Testigo (1) no puede ser una de las personas designadas para tomar decisiones relacionadas con el tratamiento para el paciente y no puede estar relacionado con el declarante por sangre o por matrimonio. Este testigo no puede tener derecho a ninguna parte de la sucesión y no puede tener un reclamo en contra de la sucesión del paciente. Este

testigo no puede ser el médico que lo atiende ni un empleado del médico que lo atiende. Si el testigo es empleado del centro de salud en el cual se cuida al paciente, este testigo no puede estar directamente involucrado en el suministro de atención al paciente. Este testigo no puede ser funcionario, director, socio o empleado de la oficina del centro de atención médica donde se atiende al paciente o de ninguna organización matriz del centro de atención médica.

Testigo (1)

Testigo (2)_____

Definiciones:
"Nutrición e hidratación artificial" quiere decir el suministro de nutrientes o líquidos mediante una sonda puesta en una vena, bajo la piel en los tejidos subcutáneos o en el estómago (tracto gastrointestinal).

"Padecimiento irreversible" quiere decir un padecimiento, lesión o enfermedad:
a. que se puede tratar, pero que nunca sana;
b. que deja a la persona incapaz de cuidarse o tomar decisiones por ella misma, y
c. que sin el tratamiento para prolongar la vida, suministrado conforme con las normas actuales de atención médica, podría ser fatal.

Explicación: muchas enfermedades graves como el cáncer, la insuficiencia de cualquier órgano vital (el riñón, el corazón, el hígado o el pulmón) y una enfermedad del cerebro grave, como la demencia de Alzheimer, se pueden considerar irreversibles desde muy temprano. No hay curación, pero el paciente puede mantenerse con vida por periodos prolongados de tiempo si recibe tratamientos para prolongar la vida. Más tarde durante la misma enfermedad, ésta se puede considerar terminal cuando, incluso con tratamiento, se espera que el paciente muera. Usted deberá considerar qué niveles de tratamiento está dispuesto a soportar para lograr un resultado particular. Ésta es una decisión muy personal que usted deberá discutir con el doctor, la familia u otras personas importantes en su vida.

*Tratamiento para prolongar la vida" quiere decir un tratamiento que, a juicio médico, preserva la vida de un paciente y sin el cual el paciente moriría. El término se refiere a medicamentos para preservar la vida y a medios artificiales para mantener la vida como los respiradores mecánicos, el tratamiento de diálisis del riñón, la hidratación y la nutrición artificial. El término no se refiere a la administración de medicamentos para el dolor, la ejecución de un procedimiento quirúrgico necesario para suministrar comodidad ni ningún otro servicio médico ofrecido para aliviar el dolor del paciente.

"Padecimiento terminal" quiere decir una enfermedad incurable causada por lesión, enfermedad o dolencia que a juicio médico produciría la muerte dentro de unos seis meses, incluso con el tratamiento disponible para prolongar la vida suministrado de acuerdo con las normas de atención médica actuales.

Explicación: muchas enfermedades graves se pueden considerar irreversibles desde muy temprano en la evolución de la enfermedad, pero no se considera terminal hasta que la enfermedad ha avanzado bastante. Al pensar en una enfermedad terminal y su tratamiento, deberá considerar los beneficios y las dificultades relacionados con el tratamiento y discutirlos con el doctor, la familia u otras personas importantes en su vida.

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

STOP DO NOT RESUSCITATE

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physicians signature _____ Date _____ Printed name _____ Lic# _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____.

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. **Section C** - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses.

Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state**.** [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority:
1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

Disclosure Statement for Medical Power of Attorney

Advance Directives Act (see §166.163, Health and Safety Code)

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility; or
- a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

Medical Power Of Attorney

Advance Directives Act (see §166.164, Health and Safety Code)

Designation of Health Care Agent:

I, _____ (insert your name) appoint:

Name:

Address:

_____ Phone:

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision Making Authority Of My Agent Are As Follows:

_____

_____

_____

_____

Designation of an Alternate Agent:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

<u>First Alternate Agent</u>

Name:

Address:

_____ Phone:

<u>Second Alternate Agent</u>

Name:

Address:

_____ Phone:

The original of the document is kept at

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Name: _____

Address: : _____

_____

(continued on reverse)

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date:

Prior Designations Revoked

I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

(You Must Date and Sign This Power of Attorney)

I sign my name to this medical power of attorney on _____ day of _____ (month, year)
at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

Statement of First Witness

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature:

Print Name: _____ Date: _____ Address:

_____

Signature of Second Witness

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

version 10/25/99

Declaración referente al poder médico

Ley de Directivas Anticipadas (ver §166.163, del Código de Salud y Seguridad)

Éste es un documento legal importante. Antes de firmar este documento debe saber esta información importante:

Salvo los límites que usted imponga, este documento le da a la persona que usted nombre como su agente la autoridad de tomar, en su nombre, y cuando usted ya no esté en capacidad de tomarlas por su propia cuenta, todas y cada una de las decisiones referentes a la atención médica conforme con sus deseos y teniendo en cuenta sus creencias morales y religiosas. Puesto que "atención médica" se refiere a cualquier tratamiento, servicio o procedimiento para controlar, diagnosticar o tratar cualquier padecimiento físico o mental, su agente tiene el poder de tomar, en su nombre, decisiones sobre una amplia gama de opciones médicas. Su agente puede dar consentimiento, negar consentimiento o retirar el consentimiento para recibir tratamiento médico y puede decidir si suspender o no dar tratamiento para prolongar la vida. Su agente no puede autorizar su ingreso voluntario a un hospital para recibir servicios de salud mental, ni que le den tratamiento convulsivo, psicocirugía o un aborto. El doctor deberá seguir las instrucciones de su agente o permitir que se le cambie a usted de doctor.

La autoridad de su agente comenzará cuando su doctor certifique que usted no está en capacidad de tomar decisiones de carácter médico.

Su agente tiene la obligación de seguir sus instrucciones cuando tome decisiones en su nombre. A menos que usted especifique lo contrario, su agente tiene la misma autoridad que usted tendría para tomar decisiones sobre su atención médica.

Antes de firmar este documento, es muy importante que hable sobre éste con el doctor o con cualquier proveedor médico para asegurarse de que entienda la naturaleza y los límites de las decisiones que se tomarán en su nombre. Si no tiene un doctor, debe hablar con alguien más que sepa de estos asuntos y pueda contestar sus preguntas. No necesita la ayuda de un abogado para hacer este documento, pero si hay algo en este documento que usted no entienda, debe pedirle a un abogado que se lo explique.

La persona que usted nombre como su agente debe ser alguien conocido y de su confianza. Debe ser mayor de 18 años, o puede ser menor de 18 años si se le ha retirado la incapacidad de minoría de edad. Si usted nombra al proveedor de atención médica o terapeuta (por ejemplo, su doctor o un empleado del centro de salud, hospital, casa para convalecientes o centro de tratamiento terapéutico, que no sea un pariente) esa persona tiene que escoger entre ser su agente o ser su proveedor de atención médica o terapeuta; conforme con la ley, una misma persona no puede desempeñar las dos funciones a la vez.

Debe informarle a la persona que usted escoja que quiere que ella sea su agente de atención médica. Usted debe hablar sobre este documento con su agente y con su doctor y darle a cada uno de ellos una copia firmada. Usted debe escribir en el documento el nombre de las personas e instituciones a quienes ha dado copias firmadas. Su agente no puede ser enjuiciado por las decisiones sobre atención médica tomadas de buena fe en su nombre.

Aun después de firmar este documento, usted tiene el derecho de tomar decisiones de atención médica mientras esté en capacidad de hacerlo y no se le puede administrar o detener un tratamiento si usted se opone. Tiene derecho de revocar la autoridad otorgada a su agente informándole a su agente o a su proveedor de atención médica o terapeuta, oralmente o por

escrito, y firmando un nuevo poder médico. A menos que indique lo contrario, el nombramiento de su cónyuge como su agente se disuelve en el caso de que usted se divorcie.

Este documento no se puede modificar o cambiar. Si quiere hacer algún cambio, tiene que hacer un documento nuevo.

Es aconsejable que nombre a un tercer agente en caso de que su agente no quiera, no pueda o esté incapacitado para actuar como su agente. Cualquier agente alterno que usted nombre tendrá la misma autoridad de tomar decisiones de atención médica en su nombre.

Este poder no tiene validez a menos que se firme en presencia de dos testigos adultos hábiles. Las

siguientes personas no pueden actuar como UNO de los testigos:

- la persona que usted ha nombrado como su agente;
- una persona que es su pariente por sangre o matrimonio;
- una persona que, después de su muerte, tenga derecho a cualquier porción de su sucesión de acuerdo con su testamento o con una adición a su testamento firmado por usted o que tenga derecho a ésta por efecto legal;
- el doctor que lo atiende;
- un empleado del doctor que lo atiende;
- un empleado de un centro de atención médica del cual usted es paciente si el empleado le está prestando servicios directamente a usted o es un funcionario, director, socio o empleado de las oficinas del centro de atención médica o de cualquier organización matriz del centro de atención médica; o
- una persona que, en el momento de firmar este poder, pueda reclamar cualquier porción de su sucesión después de su muerte.

Poder médico

Ley de Directivas Anticipadas (ver §166. 164, del Código de Salud y Seguridad)

Nombramiento de un agente de atención médica:

Yo, _____(escriba su nombre) nombro a:

Nombre:_____

Dirección:_____

Teléfono: _____

como mi agente para que tome todas y cada una de las decisiones sobre atención médica por mí, a menos que yo diga lo contrario en este documento. Este poder médico entra en vigor si yo no tengo capacidad para tomar mis propias decisiones sobre la atención médica y mi doctor certifica este hecho por escrito.

La autoridad de mi agente médico para tomar decisiones tendrá las siguientes limitaciones:

_____

_____

_____

Nombramiento de un agente alterno:

(Usted no tiene que nombrar a un agente alterno, pero si quiere puede hacerlo. Un agente alterno puede tomar las mismas decisiones médicas que tomaría el agente designado si el agente designado no puede o no quiere hacer las veces de agente. Si el agente designado es su cónyuge, el nombramiento se revoca automáticamente por ley si su matrimonio se disuelve).

Si la persona designada como mi agente no es capaz o no está dispuesta a tomar decisiones médicas por mí, nombro a las siguientes personas, para que hagan las veces de agente para tomar decisiones de tipo médico conforme yo las autorice por medio de este documento. Lo harán en el siguiente orden:

Primer Agente Alterno

Nombre:

Dirección:

Teléfono: _____

Segundo Agente Alterno

Nombre:_____

Dirección:_____

Teléfono: _____

El original de este documento se mantendrá en:

_____

Las siguientes personas o instituciones tienen copias firmadas: Nombre:

Dirección:_____

_____

Nombre: _____

Dirección:_____

_____

Duración

Comprendo que este poder existirá indefinidamente a partir de la fecha en que se firma el documento a menos que yo establezca un término más corto o lo revoque. Si no estoy en capacidad de tomar decisiones médicas por mi propia cuenta cuando este poder se venza, la autoridad que le he dado a mi agente seguirá en vigor hasta que yo pueda volver a tomar decisiones por mí mismo.
(Si aplica) Este poder se vencerá en la siguiente fecha:

Revocación de nombramientos anteriores

Revoco cualquier poder médico anterior.

Acuse de recibo de la Declaración

Me dieron la declaración en la que se explica las consecuencias de este documento. La leí y la entiendo.

(Tiene que escribir la fecha y firmar este poder)

Firmo mi nombre en este poder médico el _____de _____(mes) de _____ (año) en

_____

(Ciudad y Estado)

_____

(Firma)

_____

(Nombre en letra de molde)

Declaración del primer testigo

No soy la persona designada como agente por medio de este documento. No soy pariente del poderante ni por sangre ni por matrimonio. No tendré derecho a ninguna parte de la sucesión del poderante después de su fallecimiento. No soy el médico tratante del poderante ni estoy empleado por el médico tratante. No tengo ningún derecho sobre ninguna porción de la sucesión del poderante después de su fallecimiento. Además, si trabajo en el centro de atención médica donde es paciente el poderante, no tengo que ver con el cuidado directo del poderante y no soy funcionario, director, socio, ni empleado de la oficina del centro de atención médica ni de ninguna organización matriz del centro de atención médica.

Firma:

Nombre en letra de molde: _____Fecha: _____

Dirección: _____

Firma del segundo testigo

Firma:

_____

Nombre en letra de molde: _____ Fecha: _____

Dirección: _____

versión 10/25/99