2020 PROVIDER MANUAL

Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

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RENAISSANCE PHYSICIANS OVERVIEW

Renaissance Physicians is a physician-run organization with local groups of primary care physicians (PCPs) and a full specialist network. The goal is to grow and maintain a highly desired managed health care delivery system in which the IPA accepts responsibility for a wide range of medical services, including primary care, specialty care, laboratory, part B drugs, and diagnostic procedures.

Renaissance Physicians encourages the PCP to take the lead on coordinating care both of a preventive nature as well as chronic conditions with collaborative engagement from preferred specialist network. Due to the vast geography of the IPA, providers are grouped into a geographic networks called a POD (Physician Organized Delivery systems) centralized around a group of hospitals with full set of PCPs and Specialists who have enhanced relationships and aligned incentives. Providers work together to coordinate the care of the patient and make the navigation of healthcare easier.

This manual contains the operating policies and procedures of the IPA as well as health plan references as they relate to the day-to-day participating physicians and their patients. The IPA requires continual communication between the physicians and the management company, CareAllies, to ensure a consistent working relationship and timely notification of any and all practice related changes. You will receive updates to this manual as changes to the policies and procedures occur.

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 owned and led

Advantages of Renaissance

- One integrated contracting unit
- Physicians/providers set metrics and performance standards
- Ability to contract with PPOs through Clinically Integrated Network
- City-wide specialty network
- Superior physician satisfaction
- Greater physician-involvement and best practice sharing
- Aligned incentives with engaged management company

Renaissance Commitment

- Focus on greater Houston and Golden Triangle market
- Partnerships with health plans that benefit providers
- Point of service resources to supplement offices for quality
- Proactive provider education and process improvement strategies
- Robust group and physician level reporting
- Ongoing physician and staff education

Value Based Reimbursement

- Value based capitation rates for PCPs
- Competitive specialty capitation contracts
- Specialist True Ups
- Surplus funds distributed based on quality and total medical cost achievements to at risk providers
- Disciplined regular reimbursement review

Duties of Renaissance

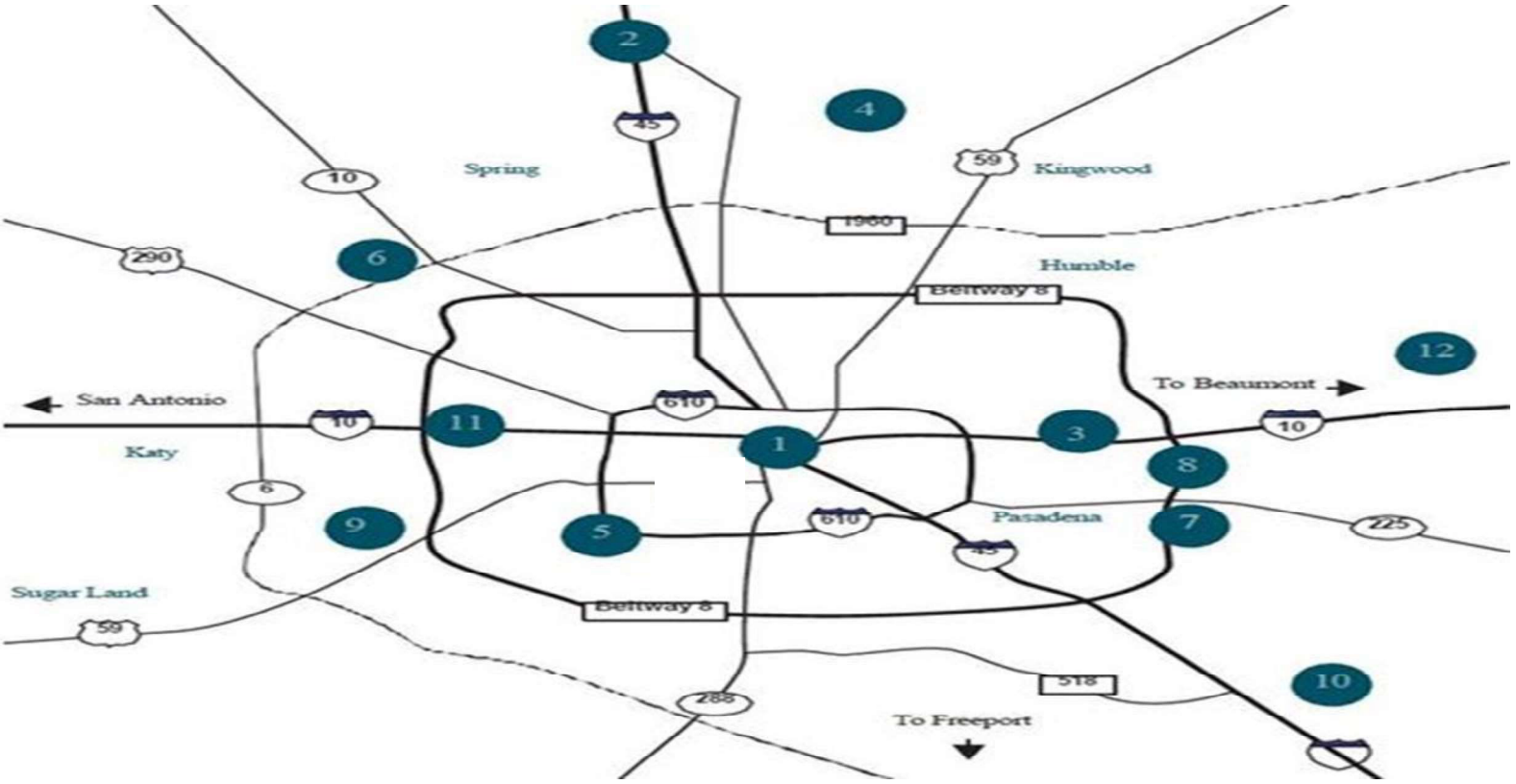
- Maintains Ultimate financial risk
- Credentialing
- Utilization/Quality management
- Creation of guiding principles
- Contracting and Physician reimbursement
- Financial reserve discipline

Duties of LLC

- Provider network development
- Management of LLC utilization
- Communication and engagement of network
- Provider and Patient Satisfaction
- Problem resolution

NETWORK MAP

1. Central Houston
2. Conroe
3. Eastside
4. Merit
5. Metropolitan
6. Northwest Suburban
7. Pasadena
8. Southeast Associates Baytown
9. Southwest
10. Space Center
11. West Houston
12. Eastex Physician Organization



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 patient who has selected you as his/her Primary Care Physician, you may request that IPA have that patient 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 all IPA patients 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 patients. 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 patients within three (3) months of enrollment with IPA.
- Primary Care Physicians shall use best efforts to provide follow-up patient care to patients 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 patient'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 all quality initiatives inclusive of any and all chart audits, patient preventive care, and patient 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 patient is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for patients.
- 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 patient 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 patient, 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 patients from you only, but submit an encounter to the IPA with proper notation for covering services.
- You have agreed to treat Participating Health 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 patients.
- 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 allow IPA Inpatient Managers to follow your patients in the hospital and other inpatient settings.
- You may not balance bill a patient for providing services that are covered by IPA. This excludes the collection of standard copays. You may bill a patient 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.

Patient Assignment to New PCP

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

- Fraudulent use of services or benefits
- The patient is disruptive, unruly, threatening, or uncooperative to the extent that patient seriously impairs IPA's or the provider's ability to provide services to the patient or to obtain new patients 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 patient 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 patient'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 patient's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP should complete the patient 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 patient education and counseling. An IPA PCP cannot request a disenrollment based on adverse change in a patient's health status or utilization of services medically necessary for treatment of a patient's condition.

Procedure

- Once the IPA Medical Director has reviewed the PCP's request and determined that the physician/patient relationship has been irreparably harmed, the patient 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 patient during the thirty (30) day period or until the patient selects or is assigned to another physician. The IPA will assist the patient in establishing a relationship with another physician.
- The physician will transfer, at no cost, a copy of the medical records of the patient to the new PCP and will cooperate with the patient's new PCP in regard to transitioning care and providing information regarding the patient's care needs.

A patient may also request a change in PCP for any reason. The PCP change that is requested by the patient 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 patients by closing their patient panels for IPA's patients only, nor may they discriminate among patients 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 60 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 patient medical records:

- Identifying information of the patient.
- Identification of all providers participating in the patient'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 patient 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 patients.

Access and Availability Standards for Providers

A Primary Care Physician (PCP) must have their primary office open to receive patients 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 patients 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*

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 patients, 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 patients 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) patients. Providers can call IPA customer service at 832-553-3300 to assist with translator to TTY services if these services are not available in their office location.

PROVIDER INFORMATION

The IPA recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs). Any employed mid-level practitioners rendering services must be listed on contracts and will not be assigned patients but will have data aggregated at their level for purposes of reporting.

The IPA may recognize Infectious Disease Physicians as PCPs for patients 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 patients and made available to the public.

The Role of the Primary Care Physician (PCP)

Each patient 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 patients as follows:

- Manage the health care needs of patients who have chosen the physician as their PCP.
- New Patients Initial visits should be scheduled with provider (physician) within 90 days of enrollment,
- On the Member's first visit to the provider office and within 60 days of enrollment, patient should be seen by the physician, if prior visits have been handled by PA or NP.
- Physician is to be available for questions at all scheduled visits when supervising a PA or NP and to review all referrals and coding and quality initiatives before submission to ensure accuracy and appropriateness.
- All visits and care should abide by CMS guidelines.
- Ensure that patients receive treatment as frequently as is necessary based on the patient's condition.
- Develop an individual treatment plan for each patient.

Inpatient Manager Program

IPA requires that in certain IPA PODs, patients 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 patients to the designated Inpatient Manager

Providers Designated as Primary Care Physicians (PCPs)

- Submit accurately and timely claims and encounter information for clinical care coordination.
- Comply with pre-authorization and referral procedures.
- Refer patients to designated IPA participating providers.
- Comply with Quality Management and Utilization Management programs.
- Participate in IPA directed Coding and Quality Initiatives.
- Use appropriate IPA designated ancillary and facility providers.
- 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, preferably 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 patient's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Comply with IPA Preventive Screening and Clinical Guidelines.
- Adhere to medical record standards as outlined in this manual.

The Role of the Specialist Physician

Each patient 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 Health Plan's patient as follows:

- Provide specialty health care services to patients as needed.
- Collaborate with the patient's Primary Care Physician to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician within 72 hours of encounter.
- 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 patient's condition and ensure that the codes submitted are supported by proper documentation in the medical record.

- Refer patients to designated IPA participating providers.
- Use appropriate IPA designated ancillary and facility 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 patient's care at the time of referral.
- The Specialist Physician must provide the PCP with information about his/her visit with the patient within 72 hours of encounter.
- The PCP must document in the patient'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 IPA 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 health plan, or limited number of health plans, offered either by the health plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting health 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 health 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 health plan. This letter may not quote specific health plan benefits without prior CMS approval and the agreement of all health 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 health 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 health 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 patients 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 IPAlogo.
- 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 health plan or limited set of health plans.
- Collect enrollment applications in physician offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular health plan or organization.
- Health Screen potential enrollees when distributing information to patients, as health screening is prohibited.
- Expect compensation directly or indirectly from the health plan for beneficiary enrollment activity.
- Call patients 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.
- Allow IPA to have room/space in provider's offices completely separate from where the patients have a prospect of receiving health care, to provide beneficiaries' access to IPA's sales representative.

PROVIDER REQUEST FOR PATIENT TO TRANSFER CARE TO ANOTHER PROVIDER

The providers in the IPA strive to promote the health and wellness of the patients 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 patient transfer to another provider. Having an expedient process for handling such requests, and effecting transfers when appropriate, should have a positive impact on both patient satisfaction and provider morale.

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

Procedure

A provider may request to have a patient 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 patient 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 patient regarding office procedures and treatment recommendations, should be carefully documented. A sample letter to address patient education is provided.

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

- Completed form: Physician Requests Transfer of Patient from Panel
- Attach all supporting documentation indicating efforts that have been made to counsel/educate the patient on the importance of being compliant (i.e., letter to patient, medical records, chart notes, documentation of missed appointments, and calls/reminders to the patient).
- 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 patient. 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 patient. 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 patient 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 patient 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 patient to select a new provider within thirty (30) days of

receiving the notice (transitional period).

The requesting physician must provide care to the patient during the thirty (30) day transitional period. When the patient 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 patient fails to pick a new provider after the thirty (30) day transitional period, the managed care plan will assign the patient 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

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. 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.

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.

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 health 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 IPA effective date. Providers are advised to not see IPA's patients 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.

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 IPA plan.

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) days 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.

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 patient 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 patient's name, patient'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 patient may or may not be billed for services denied by IPA.

The patient 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 patient, or the services are not covered, the EOP/RA will alert you to this and you may bill the patient.

Processing of Hospice Claims

When a Medicare Advantage (MA) patient elects hospice care, but chooses not to dis-enroll from the plan, the patient 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 patient is certified as hospice, the financial responsibility for that patient 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 patient chooses original Medicare for coverage of covered, non-hospice-care, original Medicare services and also follows MA plan requirements, then, the patient 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 patient who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; A PPO patient who receives services out of network has followed plan rules and is only responsible for plan cost-sharing. The patient need not communicate to the plan in advance his/her choice of where services are obtained.

When a patient revokes hospice care, financial responsibility for Medicare-covered services will return to the health plan on the first of the month following the revocation. The following are the submission guidelines for Medicare Advantage patients enrolled in Hospice:

Hospice-Related Services

- Submit the claim directly to CMS.

Medicare hospices bill the Medicare fee-for-service contractor for patients who have coverage through Medicare Advantage just as they do for patients, 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 patient 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 patient's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for patients 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 patients 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 patient's terminal condition, submit the claim to the fiscal intermediary using the condition code 07.
- For Part B services not related to the patient'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 patients 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.

Dual Eligible Patients

Many of your patients 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" patients by determining whether the patient 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 patients. Additional information concerning Medicaid provider participation is available at www.myrpo.com .

A patient's level of Medicaid eligibility can change due to their medical and financial needs. The IPA encourages you to verify patients' Medicaid eligibility when rendering services, which will help you determine if the patient 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): is the process of determining and reconciling individual payor liability for reimbursement when a patient is eligible for benefits coverage under more than one insurance company or other payor type (e.g., Medicare / Medicaid). Terms and conditions within the Summary of Benefits for each plan will generally dictate which payor is primary or secondary and any mathematical formula associated for calculating each payor's portion of 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 patient 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 patient. 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 patient'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 patients have the same date of birth, the plan which covered the patient the longest is considered primary.

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

If the Patient/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 patient'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 patients current employment	The employer has less than 20 employees	IPA /Medicare pays primary	Group Health Plan (GHP) 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 patients 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 patients 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)

If the Patient/Beneficiary	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
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 patient 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 patient 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 patient 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 patient 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 patient's plan.
- Submit the claim to the IPA first
- Be sure to have the patient 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 patients have an IPA.
- Medicaid will not pay the copay for the Participating Plan's patients.

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.

Patients 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 patient, 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 90 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.

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**

APPEALS AND RECONSIDERATION REQUEST FORM

Complete the top section of this form completely and legibly. Check the box that most closely describes your appeal or reconsideration reason. Be sure to include any supporting documentation, as indicated below. Requests received without required information cannot be processed.

Request for appeal or reconsideration

Customer first name: MI: Customer last name:
Customer ID #: Customer date of birth (MM/DD/YYYY):
Claim #: Date of service (MM/DD/YYYY):
Provider name/contact name: Provider NPI:
Provider phone #: Provider's contact email address:

Appeals

Reason for appeal:
__Medical necessity
__Notification/precertification
• Include precertification/prior authorization number
__Referral denial
__Payer policy

Submit Appeals to:
Renaissance Physicians
Attn: Appeals Unit
PO Box 2888
Houston, TX 77252-2888
Phone: **1-832-553-3300**
Fax: **1-832-553-3418**

Reconsiderations

Reason for reconsideration:
__Payment issue
__Duplicate claim
__Retraction of payment
__Request for medical records
• Include copy of letter/request received
__Request for additional information
• Include copy of letter/request received
• Provide missing or incomplete information
• Coding dispute
• Timely filing
• Remittance Advice (RA), Explanation of Benefits (EOB), or other documentation of filing original claim
__Coordination of Benefits

Submit reconsiderations to:
Renaissance Physicians
Attn: Reconsiderations
PO Box 2888
Houston, TX 77252-2888
Fax: **1-832-553-3418**

Note: If you have multiple reconsideration requests for the same health care professional and payment issue, please indicate this in the notes below and include a list of the following: Customer ID #, Claim #, and date of service. If the issue requires supporting documentation as noted above, it must be included for each individual claim. If no additional documentations required for your appeal or reconsideration request, fax in only this completed coversheet. You may use the space below to briefly describe your reason for appeal or reconsideration.

Definitions

Payment issue: Was not paid in accordance with the negotiated terms
Coordination of benefits: Could not fully be processed until information from another insurer has been received
Duplicate claim: The original reason for denial was due to a duplicate claim
Medical necessity: Medical clinical review
Pre-certification/notification of prior-authorization or reduced payment: Failure to notify or pre-authorize services or exceeding authorized limits
Payer policy clinical: Incorrectly reimbursed because of the payers payment policy
Referral denial: Invalid or missing primary care physician (PCP) referral
Request for additional information: Missing or incomplete information *reply via sender*
Request for medical records: Please include copy of letter/request received
Retraction of payment: Retraction of full or partial payment
Timely filing: The claim whose original reason for denial was untimely filing

PATIENT INFORMATION

Eligibility Verification

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

You can verify patient eligibility the following ways:

Call the Health Plan – You must call the Health Plan to verify eligibility when the patient 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 patient eligibility online
- Ask to see the patient's Identification Card – Each patient is provided with an individual patient identification card. Noted on the ID card is the patient'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 patient 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 patients 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. For form myrpo.com/providers/provider-resources

Maximum Out-of-Pocket (MOOP)

The Maximum Out-of-Pocket (MOOP) benefit is now a part of all benefit plans. Patients 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 patient 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 patient's Medicare Part B premium and the IPA's plan premium).

Patient Hold Harmless

Participating providers are prohibited from balance billing the IPA's patients 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 patients or persons, other than the IPA, acting on behalf of patients 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 patient's Benefit Plan.

Patient Confidentiality

IPA knows that patients' 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 patients' personal information. IPA does not disclose patient 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 patients. This includes how we gather and use their personal information. The privacy practices apply to all of IPA's past, present, and future patients.

When a patient joins a Medicare Advantage plan, the patient 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 patients' 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 patients receive. This information also helps manage the treatment of diseases to improve our patients' quality of life.

Patients 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 patient 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 patient PHI. To discuss any breaches of the privacy of our patients, please contact the CareAllies Privacy Steward at **Patricia.Swan@CareAllies.com**.

Patient Rights and Responsibilities

Patients have the following rights:

The right to be treated with dignity and respect

Patients have the right to be treated with dignity, respect, and fairness at all times. IPA must obey laws against discrimination that protect patients from unfair treatment. These laws say that IPA cannot discriminate against patients (treat patients unfairly) because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If patients need help with communication, such as help from a language interpreter, they should be directed to call Customer Service. Customer Services can also help patients file complaints about access to facilities (such as wheelchair access). Patients can also call the U.S. Department of Health and Human Services' 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 see participating providers, get covered services, and get prescriptions filled within a reasonable period of time

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

Patients 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 patients can understand. Patients 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 patients may participate. Patients have the right to be told about any risks involved in their care. Patients 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. Patients have the right to receive a detailed explanation from IPA if they believe that a health 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, patients must request an initial decision. "Initial decisions" are discussed in the patients' Evidence of Coverage.

Patients 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 patients 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)

Patients have the right to ask someone such as a family member 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 illnesses. If a patient 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. Patients 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 patients 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 patients decide that they want to have an advance directive, there are several ways to get this type of legal form. Patients can get a form from their lawyer, from a social worker, from IPA, or from some office supply stores. Patients 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. Patients should consider having a lawyer help them prepare it. It is important for the patient to sign this form and keep a copy at home. Patients 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. Patients may want to give copies to close friends or family patients as well.

If patients 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 patients 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 a patient has 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 patient wants to sign one.

Remember, it is a patient'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 patients have signed an advance directive and they believe that a doctor or hospital has not followed the instructions, patients may file a complaint with their State Board of Medicine or appropriate state agency (this information can be found in the patient's Evidence of Coverage).

The right to make complaints

Patients have the right to make a complaint if they have concerns or problems related to their coverage or care. Patients or an appointed/authorized representative may file "Appeals," "grievances," concerns and Coverage Determinations. If patients 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, patients should be directed to call Customer Service.

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

The Evidence of Coverage tells patients what medical services are covered and what they have to pay. If they need more information, they should be directed to call Customer Service. Patients have the right to an explanation from IPA about any bills they may get for services not covered by IPA. The IPA must tell patients 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 patients on how to file an appeal, if asked, and should direct patients to review their Evidence of Coverage for more information about filing an appeal.

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

Patients 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. Patients have the right to find out from us how we pay our doctors. To get any of this information, patients should be directed to call Customer Service. Patients 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 patients to call Customer Service.

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

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

- If patients think they have been treated unfairly or their rights have not been respected, there are options for what they can do.
- If patients think they have been treated unfairly due to their race, color, national origin, disability, age, sexual orientation, 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, patients should be encouraged to call Customer Service.

Patients have the following responsibilities:

Along with certain rights, there are also responsibilities associated with being a patient of the IPA. Patients 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. Patients must be encouraged to ask questions of their doctors and other providers whenever the patient 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 health plan premiums and any copayments or coinsurances they may have for the Covered Services they receive. Patients 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 patient may inform all providers contracted directly or indirectly with IPA that the patient has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the patient 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 patient's written advance directive, he/she must advise the patient 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 patients 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 patients. Along with the patient's demographic information, the list includes the name of the health plan in which the patient enrolled. Please be aware that recently terminated patients may appear on the list. (See "Eligibility Verification" section of this manual).

- The IPA encourages its patients to call their Primary Care Physician and the rules they must follow to get care as a patient. Patients 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. Patients should always be encouraged to call Patient 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 health plan enrollment card to schedule appointments. However, if an IPA's patient calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the patient 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 patient may reasonably believe that the lack of immediate medical attention could result in:

- Permanently placing the patient'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, patients 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, or if they are unsure of the condition's severity, patients have been instructed to go immediately to the nearest emergency room facility. Patients 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 patient'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 patients needing emergency services. The hospital may attempt to contact the PCP for direction. Patients 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 patient is injured or becomes ill while temporarily outside the service area. Patients 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 patient 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 patient 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 patient'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.
- 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 health plan patients. Experimental procedures and items are those items and procedures determined 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 patient's room at a hospital or skilled nursing facility.
- Nursing care on a full-time basis in a patient'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 patients of the patient's household.
- Meals delivered to the patient'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 health 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 health 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 patient'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 health plan, the health plan will reimburse veterans for the difference. Patients are still responsible for our health 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 patient is not in agreement with the informal resolution, the patient 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.

Patients 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.

Patients 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 patient feels medically necessary.

In addition, a patient may appeal any decision related to a hospital discharge. In this case, a notice will be given to the patient with instructions for filing an appeal.

QUALITY 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 patients 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. Patient experience with health plan
4. Patient 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 (MA) 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 patients 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
Managing Urinary Incontinence	1
Plan All Cause Readmissions (HEDIS)	3
Medication Reconciliation Post Discharge (HEDIS)	1
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
Patients 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**
Patients 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**

POPULATION HEALTH TECHNOLOGY AND INTERGRATION

Information Protection Requirements and Guidance

IPA follows all applicable laws, rules, and regulations regarding the electronic transmittal and reception of Patient 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 patient 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 patient eligibility
- Create referrals and precertification
- 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**

ARCADIA

Arcadia is a population health management company, specializing in data aggregation, analytics, and workflow software for value-based care. Their customers achieve financial success in their risk-sharing contracts through Arcadia's focus on creating the highest quality data asset, pushing expertly derived insights to the point of care, and supporting administrative staff with data when and where they need it with applications including care management and referral management. Arcadia has off-the-shelf integration technology for more than 40 different physical and behavioral health EHR vendors, powered by machine learning that combs through variations in over 50 million longitudinal patient records across clinical, claims and operational data sources. Arcadia software and outsourced ACO services are trusted by some of the largest risk- bearing health systems and health plans in the country to improve the bottom line. Founded in 2002, Arcadia is headquartered outside Boston in Burlington, MA, with offices in Seattle, Pittsburgh, Chicago, and Rockford, IL.

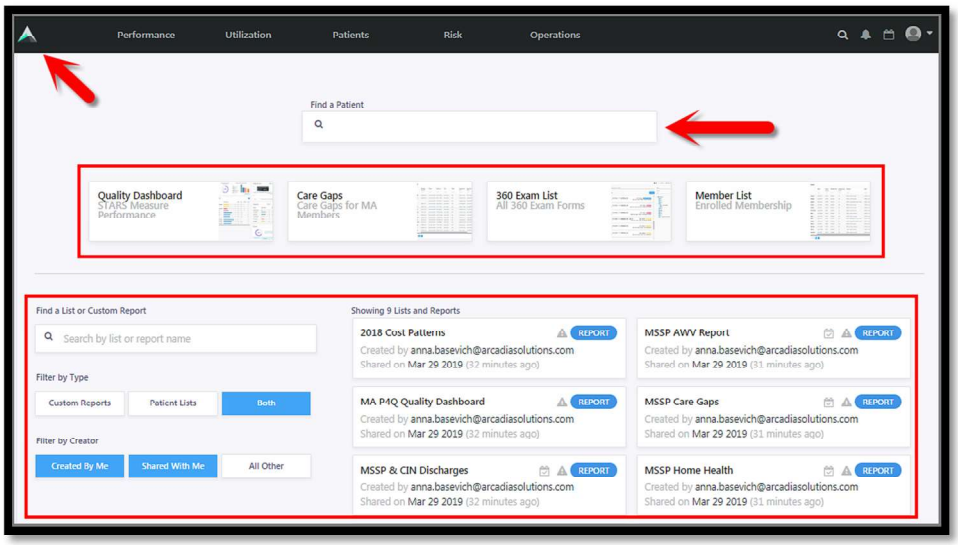
Home Page

The Home Page is the centralized location of the Arcadia platform where many essential components can be easily accessed. Returning to the Home Page can be easily done by selecting the Arcadia logo in the upper left corner from anywhere in the core platform. From this page the end user can quickly navigate to the following:

- Search Bar: allows users to find a specific patient by searching based on name, member ID or date of birth

- Custom Chips: globally filtered reports and lists that allow quick access to the Quality Dashboard, Care Gaps report, Arcadia 360 Exam List, and the Member List. Chips are consistent for all users

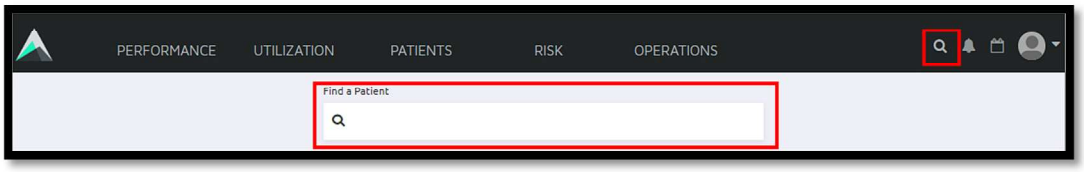
- Custom Reports and Lists: administrative or user created reports and lists customized to adapt to specific population needs



Patient Search

Users may search for a specific patient in the **Search Bar** near the top of the homepage or with the **Search Icon** in the upper right corner using the following:

- **Name** (Last Name, First Name)
- **Member Number**
- **Date of Birth** (MM-DD-YYYY or YYYY-MM-DD)



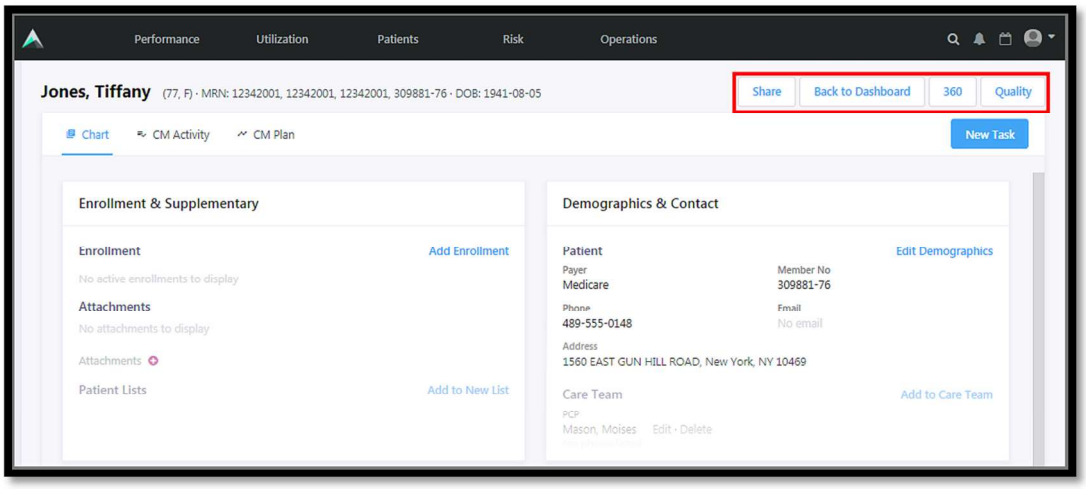
HELPFUL HINT!
The most accurate search results come from using the exact member number or full name.

Patient Chart

The **Patient Chart** is the **longitudinal health record of the patient**. Access to the Patient Chart may be done through a patient search or selecting a specific patient hyperlink within an Arcadia report. This chart will help orient the clinician to the following information:

- medications
- utilization history

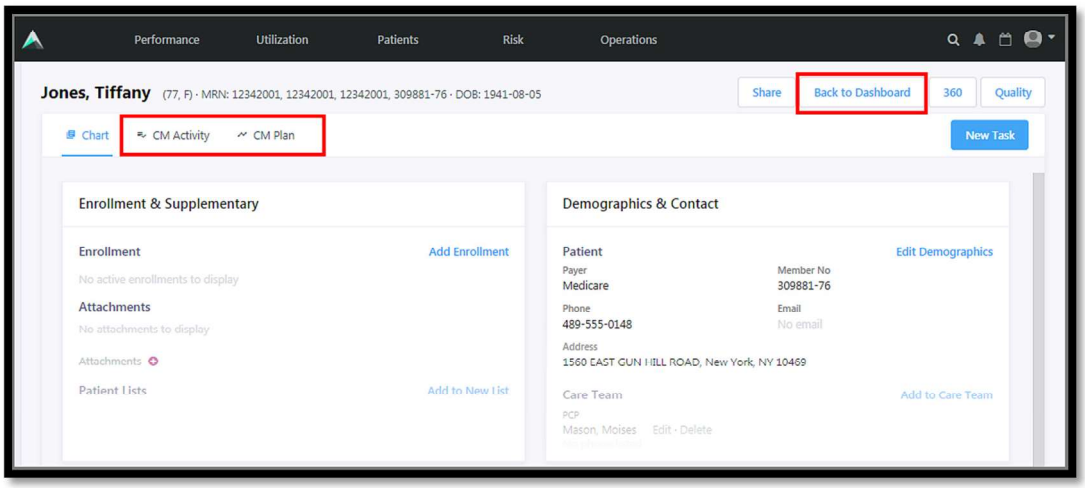
- eligible and outstanding quality measure gaps
- chronic condition history
- patient demographics
- care team (Care Management users only)



From the Patient Chart, end users will have access to the following buttons and functionality (based on individual user access rights):

- The **Share** button allows the patient chart to be **printed or downloaded as a PDF**
- The **Back** button returns the user to the **previous report or list**
- The **360** button directs the user to enter the **Arcadia 360** module
- The **Quality** button allows access to the **Hybrid Quality** module

Patient Chart: Care Management User

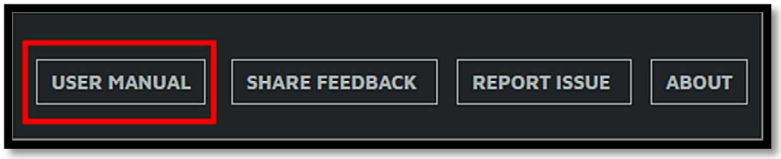


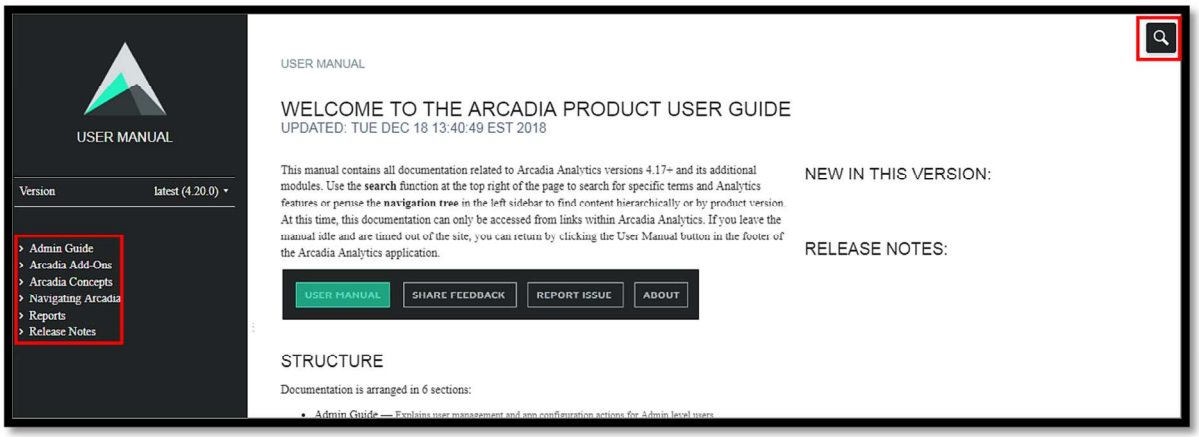
In addition, end users that leverage **care management** functionality, will have access to the following tabs and buttons:

- The **CM Activity** tab displays a **scorecard view** of scheduled tasks, activities and associated detail
- The **CM Plan** tab shows information around a **set of care plan goals and actionable interventions** to achieve those goals
- The **New Task** button allows the user to **schedule various different tasks**
- The **Back to Dashboard** button returns the user to the **CM Dashboard**

User Manual

- The **User Manual** contains all **documentation related to Arcadia Analytics and its additional modules**. Access the manual by navigating to the bottom of the page within the Arcadia platform and selecting the User Manual button. Once in the User Manual, use the search function at the top right of the page to **search for specific terms and features** or use the **navigation tree in the left sidebar to find content hierarchically**.





Contacting Production Support

- **Customer Portal:** “Report Issue” button in the Web Application
- **Email:** analyticssupport@arcadia.io
- **Phone:** 888.853.8095

Please remember to never send personal or patient sensitive information via unencrypted email. If you must provide PHI or PI, please use the customer portal or call the Production Support team for instructions on the best way to communicate sensitive information. Depending on how you created your request, you will receive an acknowledgement with a request number and possibly an estimated time of resolution for your request. Please make a note of and refer to this request number in future communications if you are not using the customer portal.

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 patients.

The Utilization Management staff base their utilization-related decisions on the clinical needs of patients, the patient'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 patient-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 patient's health plan benefits.
- To monitor utilization practice patterns of IPA's contracted physicians, hospitals, ancillary services, and specialty providers.
- To provide a system to identify high-risk patients and ensuring that appropriate care is accessed.
- To provide utilization management data for use in the process of re-credentialing providers.
- To educate patients, 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
- 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 patient for an elective admission, outpatient service, specialist referral 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 expeditiously as the patient's health condition requires. 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 patient 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 patient is eligible for services with IPA at the initial start of care
- Verification that the requested service is a covered benefit under the patient'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.

The Prior Authorization Department documents and evaluates requests utilizing CMS guidelines and nationally recognized 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:

- Patient name and identification number
- Location of service (e.g., hospital or surgi-center setting)
- Primary Care Physician name along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
- 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 patients 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 patient appears at an emergency room for care, which is non-emergent, the PCP should be contacted for

direction. The patient 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 patient's condition and treatment plan with our nurse coordinator.

Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status, and benefits at the time the service is rendered.

Outpatient Prior Authorization Department

Intake Unit:

- Consists of non-clinical personnel
- Receives faxes, provider portal submission 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
  - Creates and validates cases for services that must be forwarded to clinical personnel for medical necessity determination

Prior Authorization Unit:

- Consists of RN's and LPN's
- Performs medical necessity review of clinical requests for services such as:
  - Infusion
  - Outpatient Surgical Procedures
  - DME / O&P
  - Ambulance transports
  - Outpatient Diagnostic Testing
  - Outpatient Therapy
- Maintains clinical decision-making documentation
- Coordinates Medical Director Review of cases requiring secondary review
- Notifies customer and provider of Prior Authorization determination

Requests 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
- 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 patient'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 patient's health requires.

An expedited request may not be requested for cases in which the only issue involves a claim for payment for services that the patient has already received.

Routine:

A routine or standard Prior Authorization request will be determined as expeditiously as the health condition requires, but no later than 14 calendar days after receipt of the request.

Approval: 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. Approval notification is provided to the patient and the provider.

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 patients 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 patient.
- 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 patient'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 patient 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 patient'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 patient 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 patient interviews to identify patients 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 patients 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 patient 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 patient, 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 patient as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or patient 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 patients, 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 patient's representative. If the denial is either concurrent or post service (retrospective) and the patient is not at financial risk, the patient is not routinely notified.

An Advanced Beneficiary Notice (ABN) may not be used to hold patients liable for services unless a preservice organization determination has already been rendered.

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 patient. The patient must be aware that you are appealing on his or her behalf. Patient 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.

IPA CARE COORDINATION

The Primary Care Physician (PCP) is the patient'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 patients.

Referrals can be requested through several methods, such as:

- HSConnect
- Phone

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 CareAllies value the PCP's role in taking care of our IPA's patients and that the PCP has a very important role in directing the patient to the appropriate specialist based on your knowledge of the patient's condition and health history. It is also absolutely essential that patients 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:
  - Patient Name, Date of Birth, patient ID
  - PCP Name
  - Specialist Name
  - Date of Referral
  - Number of visits requested

If a patient 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

Patients 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 patient has a preference, the PCP should accommodate this request if possible. The only exceptions where the patient 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 patient.

Primary Care Physician's Referral Responsibilities

A PCP is responsible for ensuring a patient 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: **1-713-437-3060**
  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 patient if the patient's health plan requires a referral. Claims will be denied if a specialist sees a patient 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 patient'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 patient to another specialist with the following limits:

1. The PCP referred the patient 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 patient 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

HSConnect

2020

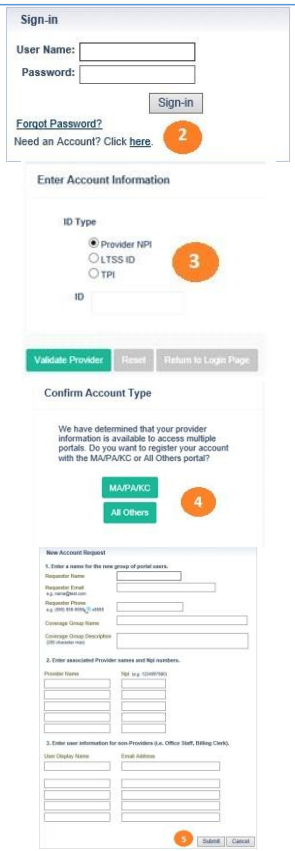
Welcome to HSConnect!

From the HSConnect Provider Portal you're able to:

- ☐ Submit Authorizations
- ☐ View Authorizations
- ☐ Check Member Eligibility & Copay Info
- ☐ Check Claim Status

Creating an Account:

1. Access HSConnect: https://www.hsconnectonline.com/login.aspx
2. In the "Sign in" Box click: "Need a new account click here"
3. Enter the requested provider information to correctly process the request.
4. If prompted, select the regional portal to access.
5. Enter the requested information and click submit.



Account Creation Definitions:

Requestor Name
Individual completing request. Preferrably office manager / administrator.

Requestor Email
Individual requestor email address.

Requestor Phone Number
Including area code & extension (if applicable).

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.

Providers
At least one provider is required (up to 5 can be entered in the initial request). Please supply both first and last name. NPI provided should be NPI used on claim submissions.
***Note** - both name and NPI are required.

Cigna.

PHARMACY QUALITY PROGRAMS

Narcotic Case Management

The Narcotic Case Management Program is designed to identify patterns of inappropriate opioid utilization with the goal to enhance patient safety through improved medication use. Monthly reports are generated using an algorithm that identifies customers at risk of potential opioid overutilization based on the number of prescribers, pharmacies, and calculated morphine milligram equivalent (MME) per day. Any individual with cancer or on hospice care is excluded from the program. The IPA clinical staff review claims data of all identified customers who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will send written notification by fax to the prescribers involved in the customer's care requesting information pertaining to the medical necessity and safety of the current opioid regimen. The IPA will reach out to discuss the case with the customer's opioid prescriber(s) in an attempt to reach a consensus regarding the customer's opioid regimen. If clinical staff is able to engage with prescribers, then action will be taken based on an agreed upon plan. In the most severe cases, clinical staff may collaborate with the prescriber(s) to implement customer-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may require customers to use only selected pharmacies or prescribers for opioid medications or limit the amount of opioid medication covered by the health plan. If the IPA does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multi-disciplinary team.

Medication Therapy Management

The Medication Therapy Management program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing medication adherence, and recognizing potential cost savings opportunities. The program is designed for customers that satisfy all three of the following criteria:

- Have at least three of the following conditions: Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, and Osteoporosis
- Take at least seven Part D prescription drugs from select classes; and
- Are likely to incur annual costs for covered drugs greater than or equal to $4,044

Eligible customers are automatically enrolled into the program and sent a welcome letter encouraging each customer to call to complete their Comprehensive Medication Review (CMR) before their annual wellness visit with their primary care provider, so the customer can take their medication list to the appointment. A comprehensive medication review is a personal review of prescriptions, OTC medications, herbal therapies, and dietary supplements with a clinical pharmacist. After the completion of the CMR, any potential drug therapy problems (DTPs) that were identified are sent to the prescribing provider and/or primary care provider by mail or fax. Along with DTPs, the provider also receives an updated list of the customer's medication history through the previous 4 months. Also, an individualized letter, which includes a personal medication record of all medications discussed and a medication action plan, is mailed to the customer. If the customer has any questions or comments about the medication action plan, a phone number is provided for follow up.

In addition to the CMR, customers also receive targeted medication reviews (TMRs) quarterly. The TMRs are automatically generated and completed electronically to review for specific DTPs. If any DTPs are identified, a letter may be mailed or faxed to the prescribing provider and/or primary care provider.

There is no additional cost for participation in the MTM program. Refer eligible customers to the MTM program at 1-800-625-9432 to complete their annual CMR.

Drug Utilization Review

The IPA completes a monthly review of prescription drug claims data to assess dispensing and use of medications for our customers. Drug Utilization Review (DUR) is a structured and systematic attempt to identify potential issues with drug therapy coordination among prescribers, unintentional adverse drug events (including drug interactions), and non-adherence with drug regimens among targeted classes of drugs. Retrospective Drug Utilization Review (rDUR) evaluates past prescription drug claims data, and concurrent Drug Utilization Review (cDUR) ensures that a review of the prescribed drug therapy is performed before each prescription is dispensed. cDUR is typically performed at the point-of-sale, or point of distribution, by both the dispensing pharmacist and/or through automated checks that are integrated in the pharmacy claims processing system. The IPA tracks and trends all drug utilization data on a regular basis to enable our clinical staff to determine when some type of intervention may be warranted, whether it is customer-specific or at a population level. Targeted providers and/or customers identified based on DUR activity will receive information regarding the quality initiative by mail or fax. rDUR studies that may be communicated to customers and/or providers include:

- Failure to refill prescribed medications
- Drug-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
- Use of multiple antidepressants, antipsychotics, or insomnia agents concurrently
- Multiple prescribers of the same class of psychotropic drug

Letters to customers will focus on topics such as the importance of appropriate medication adherence or safety issues. Letters to providers will include the rationale for any of the particular concerns listed above that are the subject of the initiative. Provider letters will also include drug claims data for the selected calendar period applicable to the initiative. If you (as a provider) receive a letter indicating that you prescribed a medication that you did not, in fact, prescribe, please notify the IPA using the contact information on the letter.

A multidisciplinary team determines the direction of pharmacy quality initiatives for the DUR program. The pharmacy quality initiative concepts originate from a variety of sources, including but not limited to, claims data analysis and trends, the Centers for Medicare and Medicaid Services (CMS) guidance, Pharmacy Quality Alliance (PQA) measures and initiatives, Food and Drug Administration (FDA) notifications, clinical trials or clinical practice guidelines, and other relevant healthcare quality publications.

Prescription Drug Monitoring Programs

Nearly all states currently require pharmacies and other dispensers to submit records of certain prescription drugs dispensed on a daily to monthly basis. These data are compiled into state-run databases, termed prescription drug monitoring programs (PDMPs), and made available in a searchable format to prescribers and pharmacists for use in monitoring drug utilization and abuse.

In their landmark 2016 Guideline for Prescribing Opioids for Chronic Pain, the CDC features PDMPs prominently in their final recommendations:

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

As part of our ongoing partnership with providers to decrease the unnecessary use and diversion of controlled substances, The IPA encourages prescribers and pharmacists to fully utilize their state's PDMP. You may find your state's PDMP at: http://www.pdmpassist.org/content/state-pdmp-websites.

MedWatch: The FDA Adverse Event Reporting Program

The Food & Drug Administration (FDA) MedWatch is a safety information and adverse event reporting program that allows both clinicians and consumers to report serious issues with human medical products and receive safety information updates. The FDA relies on clinicians to report medical adverse events after a drug product is marketed, as clinical trials may not elucidate all potential safety concerns for patients.

It is appropriate to report issues related to prescription and over-the-counter medications, biologics, medical devices, combination products, special nutritional products (infant formulas, medical foods), cosmetics, and foods/beverages to FDA's MedWatch Adverse Event Reporting Program. Types of events to report include: serious adverse events, product quality problems, product use/medication errors, therapeutic inequivalence/failure, and counterfeit medical products. Clinicians may submit a report using Form 3500, available online at www.fda.gov/medwatch/report.htm, or by downloading and mailing (5600 Fishers Lane, Rockville, MD 20852-9787) or faxing the form (fax number 1-800-332-0178). Questions about the form can be answered at 1-800-332-1088.

Safety problems with tobacco, vaccines, investigational study drugs, veterinary products, and dietary supplement problems should not be reported to FDA MedWatch. Adverse events with vaccines can be reported through the Vaccines Adverse Event Reporting System (VAERS) at https://vaers.hhs.gov/reportevent.html. For additional information on where to submit adverse event reports for the other product types, visit https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home.

Voluntary adverse event reporting is critical to maintain FDA surveillance of product safety. One single report could prompt a product safety investigation that could result in product label updates, Medication Guide inclusion criteria, product recalls, and/or product design, process, packaging, or distribution changes. Additionally, subscribing to MedWatch Safety Alerts via Email (MedWatch E-list), Twitter (@FDAMedWatch), or RSS provides a consumer-friendly platform by which to easily stay updated with recent alerts, and in turn, help improve the overall care and safety of patients.

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 patients' 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 patients 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 patient 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 their physical 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 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.
- 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, patient safety, case management, disease management, special needs, complaints, grievances and appeals, customer service, provider network, provider education, medical records, patient 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 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 patients 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 patients, through a comprehensive provider partnership.

Embedded Care Coordination

The CareAllies Embedded Care Coordination (ECC) Program provides onsite practice support to assist Physicians in providing quality care and achieving better clinical outcomes. The Embedded Care Coordinator (ECC) is typically a CareAllies employed RN or LVN. The ECC is a dedicated resource that is embedded in the IPA Physician's office. Responsibilities of the ECC include but are not limited to:

- Prompt Physician for standard of care alerts/ measures due for MA and Commercial patients
- Meet with Physician and office staff contact person on a routine basis to discuss STAR ratings, progress, opportunities, missed opportunities, and complex patients.
- Abstract data from medical records to close quality gaps
- HEDIS – gather and submit medical records to close open HEDIS chases MA and Commercial patients
- Communicate daily admits/discharges to ensure patient is seen for post discharge follow up and medication reconciliation
- Participate in Complete Health Team rounds and Interdisciplinary Care Team meetings as needed to discuss needs for identified patients.

10 FIVE-STAR STRATEGIES

Recommendations from Embedded Care Coordinators

Embedded Care Coordinators (ECCs) are nurses employed by the plan. ECCs are embedded in physician offices to help improve or maintain a physician's Part C and D Star ratings by helping to identify and close Star gaps. ECCs have identified 10 strategies PCPs can take to help improve our Drive To Five Star Quality Rating initiatives.

STRATEGY	TACTICS	OUTCOMES
1. Practice Coordinator (PC)	Appoint a PC to work with ECC staff on Stars tasks such as: delivering and reviewing discharge reports, discussing opportunities to improve medication adherence, and important documentation such as referral forms, list of covered Rheumatoid Arthritis (RA) approved medications with RA Trigger target lists, list of covered statin medications to address the Statin Use in Diabetes (SUPD) target lists, etc.	Helps ensure that Stars metrics are fully addressed.
2. Strategy sessions	Schedule planning sessions with PC, ECC and staffers to establish strategies to be executed throughout the year.	Helps meet short- and long-term goals, establish priorities and meet deadlines.
3. Empower PC	Empower PC to delegate certain Stars tasks to staffers.	Helps prioritize focus of the PC, meet deadlines and engage staff in fulfilling Stars tasks.
4. Individual education	Enable ECC to schedule regular 1:1 educational encounters to review best practices with all staff members.	Helps maintain workflow if a staff member is out, reduce discrepancies by establishing best practices and helps staff members feel important.
5. Tools and resources	Develop Stars related workflows, guides, and cheat sheets for current and new staff to reference.	Helps ensure all steps are followed to reach gap closure.
6. Timeliness	Establish deadlines that align with the ECC's routine needs and encourage staff to prioritize their work week to meet common goals.	Helps ECC provide progress updates and helps staff prioritize weekly goals.
7. Relatability	Increase PCP face-time with ECC and staffers by scheduling monthly 30-minute conversations to review reports and address outcomes.	In addition to improved outcomes, monthly face-time meetings make PCPs more relatable and help staffers stay present and engaged.
8. Communication technology	Empower ECC to send direct messages to PCP via EMR.	Helps reduce the amount of time it takes to close a gap.
9. Organization	Create an organization system to keep Star reports and important documents in a convenient place that can be easily accessed, reviewed and updated.	Helps create reminders of pending tasks and notation of completed tasks.
10. Proactive Engagement	Be proactive and engaged by moving through tasks early. For example, some offices schedule all labs and EE-focused appointments in Q4 to be completed in Q1.	Strong forward momentum and early resolutions are important in our Drive to 5 Stars Quality initiatives.

Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

What is the RPO CIN?
The RPO Clinically Integrated Network (CIN) is a network of Renaissance health care providers who seek to improve member care and reduce medical cost. A network that is clinically integrated allows the network's providers to collectively negotiate with the health plans, which may results in rates that are higher than what the providers would receive individually.

What requirements must I meet to join the RPO CIN?
Every provider who is part of the Tax ID number (TIN) with which you practice must join the RPO CIN. All providers must also utilize the ***Arcadia Platform*** to coordinate member care across the network.

How do I join the RPO CIN?
To join the RPO CIN, you must complete the RPO CIN Business Association Agreement signed by your provider group, CIN Participation Agreement signed by your provider group, CIN Acknowledgement Form, and the CIN Participation Exhibit D, one Exhibit D signed by each provider in the Tax ID Number. Providers must also complete the Election to Participate Form for each payer the TIN chooses to participate with.

Which health plans does RPO CIN currently have contracts with?
RPO CIN has an agreement with:

- **Cigna Commercial PPO Pay for Performance Program (P4P).** This program allows providers to start at a reimbursement rate of 105% of the current Cigna fee schedule with the potential to increase to 135% of the current Cigna fee schedule.
- **Humana Medicare Advantage PPO.** This program allows providers to receive 100% of Medicare and to be eligible for a shared savings STARS based quality bonus payment.
- **Aetna Medicare Advantage PPO/HMO.** This program allows providers to receive 100% of Medicare and to be eligible for a shared savings STARS based quality bonus payment.

CIN PCP offices will receive Embedded Care Coordinator (ECC) and pharmacist support.

Does the RPO CIN contract affect my current RPO contract?
No, the RPO CIN contract is a separate agreement apart from the RPO contract. The RPO CIN contract only applies to the health plans listed above.

If I join the RPO CIN, how does that affect my current direct health plan contracts?
If you elect to participate with the RPO CIN for a given line of business, your fee-for-service reimbursement rate will now be based off the RPO contract agreement with the health plan payer.

HEALTH PLANS

CIGNA

- Cigna-Medicare Advantage (Cigna MA)
- Cigna Collaborative Accountable Care Legacy
- Clinically Integrated Network (CIN) Cigna Collaborative Accountable Care
- Cigna HMO (City of Houston)

BLUE CROSS BLUE SHIELD TX

- Blue Advantage HMO (MAPD)
- Blue Value Based Incentive Plan (VBIP)

Cigna-Medicare Advantage (Cigna MA)

Transportation Benefit

Patients 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

Patient should call Access2Care:

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

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

From a doctor's visit

Patient 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

Patient should call Access2Care:

- Before the driver picks up patient 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 patient'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.
- Patient 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 patients with multiple comorbidities, complex care needs and/or short-term requirements for care. The program is designed to work as a partnership between patients, providers, and other health services staff. The goal is to provide the best clinical outcomes for patients. The central concept is early identification, education, and measurement of compliance with standards of care. The case management staff strives to enhance the patient's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. Staff patients 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. Health 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 patient 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 patients, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk

and diagnostic values are combined using proprietary rules, and used to identify and stratify patients for case management intervention. The plan uses a streamlined operational approach to identify and prioritize patient outreach, and focuses on working closely with patients 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 patient groups.

Patients 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, patient specific goals obtained; or the patient has been referred to Hospice. A patient'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

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

SPECIAL NEEDS PLAN

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 Patient Protection and Affordable Care Act reinforced the importance of the SNP Model of Care as a fundamental component by requiring NCQA review and approval.

Special Needs Plan Eligibility Criteria

Special Needs Plans (SNPs) are designed for specific groups of customers with special health care needs. Only customers meeting the following criteria may join the SNP plan. CMS defined these SNP types as follows.

The three SNP specific groups are:

- Dual eligible SNP (D-SNP): (for individuals who eligible for Medicaid and Medicare)
- Chronic conditions SNP (C-SNP): for individuals with chronic conditions that are substantially disabling or life-threatening
- Institutional SNP (I-SNP): for individuals who reside in a long-term care facility

CMS mandates that each SNP type have a Model of Care (MOC). The MOC is an evidenced-based care management program which facilitates the early and on-going assessments, the identification of health risks and major changes in the health status of SNP customers. The SNP MOC provides structure and describes the coordination of care and benefits and services targeted to improve the overall health of our SNP customers. The MOC also serves as also serves to ensure that the unique needs of our SNP customers are identified and appropriately addressed.

The SNP MOC identifies four key care management components:

- SNP population – provides a description of the unique characteristics of our overall and most vulnerable SNP customers.
- Care coordination – describes our SNP staff structure, the Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT) and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our SNP customers. The wide range of services is targeted to help our SNP customers achieve their optimal health and improve the connection to care.
- Provider Network – describes the Specialized Expertise providers who participate in our SNP program, Clinical Practices guidelines, and Care Transition protocols. The SNP MOC Training is also addressed this section.
- MOC Quality Measurement and Performance Improvement – this section describes the quality improvement plan and identifies goals for the SNP population; this section of the MOC includes clinical and customer satisfaction goals, as well as on-going performance evaluation of the SNP MOC.

SNP MOC Process

The SNP MOC care management process focuses on the unique needs of our SNP customers. The MOC includes key program components, including conducting an initial and/or annual HRA, the development of an ICP by the ICT team and with a change in the health status, performing Care Transition coordination. These benefits and services are provided to ensure appropriate care coordination and care management. The IPA also utilizes risk stratification methodology to identify our most vulnerable SNP customers. These members include those who are frail/disabled, customers with multiple chronic illnesses and those at the end of life. The risk stratification process includes input from the provider, customer, and data analysis. The goal is to

identify interventions, care coordination and care transitions needs, barriers to care, education, early detection, and symptom management.

- Health Risk Assessment (HRA) – Health plan will conduct an HRA to identify care needs. SNP customers will have a Health Risk Assessment (HRA) completed within 90 days of enrollment and then annually, within 365 days of the last HRA.
- Individualized Care Plan (ICP) – HRA results and evidence-based clinical protocols are utilized to develop an ICP. The Interdisciplinary Care Team is responsible for the development of an ICP.
- Interdisciplinary Care Team – An ICT is composed of key stakeholders, including the PCP and case managers. The ICT help to develop the ICP.
    - Primary Care Providers (PCPs) who treat SNP customers are core participants of the Interdisciplinary Care Team (ICT) as they are the primary care giver. However, ICT participants can also include practitioners of various disciplines and specialties, based on the customer's individual needs. The customer may participate in the ICT meetings, as may health care providers.
- Care Transition – a change in health status could result in new care management needs. As a result, our case management teams provide support to address the specific needs of our SNP population.
    - As a provider, your participation is required for the coordination of care, care plan management and in identifying additional health care needs for our Special Needs program customers.

PCP -

Your Participation is needed at the ICT meetings.

The IPA will invite you to participate in an ICT meeting when your SNP customer requires care management. We encourage you to participate in the ICT meeting and to collaborate in the care planning and identification of care plan goals for your SNP customer. SNP programs are geared support our customers and you by providing the benefits and services required and by supporting care management and customer goal self-management. Additionally, care transitions, whether planned or unplanned, are monitored, and PCPs are informed accordingly. PCP communication to promote continuity of care and ICT involvement is a critical aspect of care transitions protocols.

Implementation of the SNP Model of Care is supported through feedback from you, as well as systems and information sharing between the health plan, health care providers and the customer. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Stars & Quality department.

SNP Contact Information:

When a SNP customer completes a Health Risk Assessment (HRA), a care plan is generated. A copy of the HRA can be obtained by calling: our Health Risk Assessment department at **1-800-331-6769** based on the HRA responses. The customer and assigned PCP will receive a copy of the customer's care plan. A copy of the HRA can be obtained by calling: our Health Risk Assessment department at **1-800-331-6769** To discuss and/or request a copy of the care plan, refer an SNP customer for an Interdisciplinary Care Team meeting or to participate in an Interdisciplinary Care Team meeting at **1-888-501-1116**.

Behavioral Health

The Health plan provides comprehensive mental health and substance abuse coverage to its patients. Its goal is to treat the patient 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 patients 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. Patient follow-up is essential. High risk patients 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 patient'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 patient's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a patient 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.
- 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 patient.
- Direct patients to community resources as needed to maintain or increase patient'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 patient's behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues.
- Treating patients with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be patients with co-morbid physical and minor behavioral health problems or those patients 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.

Patients may access behavioral health services as needed:

- Patients may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Patients 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.
- Patients and providers can call the Participating Plan's Behavioral Health Patient 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 patient in treatment.

Continuity of Care

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

- Evaluate patient if he/she was hospitalized for a behavioral health condition within 7 days post-discharge.
- Provide patients receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the patient and the provider.
- Evaluate patient needs when the patient is in acute distress.
- Communicate with the patient's other health care providers.
- Identify those patients 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 patient 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 patients.

The Participating Plan's Utilization Management staff base their utilization-related decisions on the clinical needs of patients, the patient'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 patient-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 patient'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 patient'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 patients 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 patient 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 patients' or their Representatives' right to file an expedited appeal, as well as instructions on how to do so if the patient or patient'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 patient or their authorized representative/power of attorney (POA) and for having the patient, 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 patients' 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 patients.

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 patient.

The Acute Care Case Manager has two major functions:

- Ensure the patient 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 patients to Participating Plan's programs such as: CHF CCIP Program, Respiratory Care Program, and Fragile Fracture Program.
- Appropriate coordination of patient 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.
- Patients/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 patients (your patients).

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 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 patient or their physician to get approval for certain prescription drugs before the patient is able to have the prescription covered at their pharmacy.
- **Step Therapy (ST):** For a select group of drugs, the health plan requires the patient 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 patients 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 patient'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 patient'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 patient'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 patient 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 patient already received, an expedited appeal is not permitted.

Part D Appeals may be received orally or in writing from the patient'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.

BEHAVIORAL HEALTH SERVICES QUICK FACTS AND PHONE GUIDE

Cigna Medicare Advantage 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 Medicare Advantage the opportunity to demonstrate this commitment by recognizing overall needs and providing better care.

Cigna Medicare Advanatge 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)
Nursing Facility 99304-99306 99307-99310	New Patient Visit (10-45 min) Established Patient (10-35 min)	90833-30 min 90836-45 min 90838-60 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) *Physicians Office Only ~ Facilities Require Prior Authorization.*	
Q3014	Telehealth	

FUNCTION	PHONE/ADDRESS	DESCRIPTION OF SERVICES
Customer Eligibility/Benefits	800-230-6138	Verification of coverage and benefits; for facility admissions and other facility services, consult the Common Working File if customer 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 MA Claims Department P.O. Box 981706 El Paso, TX 79998-1706	
Claims Submission (electronic)	**Emdeon** Payer ID: 63092 or 52192 **SSIGroup** Payer ID: 63092 **Availity** Payer ID: 63092 or 52192 **Proxymed** Payer ID: 63092	

	Medassets Payer ID: 63092 **Zirmed** Payer ID: 63092 **OfficeAlly** Payer ID: 63092 **GatewayEDI** Payer ID: 63092 **Relay Health** Professional claims CPID: 2795 or 3839 Institutional claims CPID: 1556 or 1978	
Claim Status Inquires	800-230-6138	
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.
Demographic Updates	www.CignaforHCP.com	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926-2273
Medical Management Program (formerly referred to as: Provider Manual)	www.CignaforHCP.com	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926-2273
Contract Questions	www.CignaforHCP.com	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926-2273
Interested in Joining Cigna Behavioral Health Network	www.CignaforHCP.com	Follow: Join the Cigna Network > Behavioral > Cigna Behavioral Health Provider Application

Cigna Commercial

Cigna Local Access Plus

Access Standards

A physician group (hereinafter collectively "Provider") entering into a Collaborative Accountable Care (CAC) relationship with Cigna with their Local Access Plus product must meet the following, minimum standards when providing care:

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

Assignment of Aligned CAC Participants

Aligned CAC Participants will be identified at minimum every three (3) months using the methodology described below. A Participant becomes an Aligned CAC Participant once the Participant is listed on the Aligned CAC Participant list, except for purposes of determining Provider's TMC and the Market's TMC or TMC Performance Index, in which case when a Participant becomes an Aligned CAC Participant, the Participant is considered an Aligned CAC Participant for the entire Measurement Period or for the time during the Measurement Period in which the Aligned CAC Participant was a Participant, whichever is longer. Participants with Cigna Connect, Cigna Focus or Cigna SureFit networks, and Shared Administration, Strategic Alliances, patients under a capitation arrangement Payer Solutions, and Cigna International plans will not be included as CAC Participants. Also, excluded are Participants in Benefit Plans which have elected to not participate in the CAC program and when the Benefit Plan that is insured or administered by Cigna is not primary.

- Cigna uses twenty-four (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 primary care physician (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 twelve (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 twelve (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 twelve (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.

*Alignment to OB/GYN's, Nurse Practitioners (NP), and Physician Assistants (PA) will occur when Participants do not have a visit with one of the physician specialties described above. In order for this to occur, OB/GYNs, NPs, and PAs must be included in the CAC roster, and NPs and PAs must be credentialed to provide primary care services.

Patient Level Actionable Reports

The following reports will be provided to the group:

- **Monthly Report**: A combined report that includes Previse, Well Informed Gaps in Care and Monthly Closed Case Referral reports. It also includes pharmacy and other pertinent patient detail information helpful in managing

high risk patients. Please refer to the below descriptions for more detail on each section.

- **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 Aligned CAC 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.
- **Monthly Closed Case Referral Report:** This is a summary of all Aligned CAC Participants in which a case management case was closed during the past month.

- **Daily Report:** The daily report is a combined report that includes the inpatient daily census and case management referral report. It provides real time hospital admission information on Aligned CAC Participants to facilitate transition of care activities. It includes all reported admissions, at all types of inpatient facilities and provides discharge dates contingent on Cigna obtaining that information. The case management portion of the report provides the information on all Aligned CAC Participants referred into a case management program in the prior 24 hours.

Participant Communications

Cigna expects the Provider to issue the following communications to Aligned CAC Participants:

- Initial communication with Aligned CAC Participants describing the CAC Program, data that will be exchanged and that Provider will reach out to them periodically regarding the CAC Program and its services, and periodic communications to Aligned CAC Participants.
- The availability of comprehensive, coordinated care with the Provider every six months or as otherwise mutually agreed to.
- Furthermore, Provider will communicate information regarding availability of their services at the time of each visit.
- Provider will encourage Aligned CAC Participants to enroll in Cigna disease management and other programs where there is a likely benefit to the Aligned CAC Participant.
- Provider will implement annual patient satisfaction surveys and share results with Cigna. If patient satisfaction results deteriorate, Provider will develop and share improvement plans with Cigna.

Performance Reports

Cigna may provide the following reports on a quarterly basis:

- Advanced Imaging Summary
- Alignment Summary
- Episode Treatment Group Cost Summary
- Inpatient Facility Summary
- Out of Network Activities Summary
- Outpatient Emergency Department/Urgent Care Performance
- Pharmacy Utilization
- Provider Drilldown Report
- Quality Provider Drilldown Report
- Quality Summary
- Specialty Care Utilization Cost Summary
- Total Medical Cost Summary
- Trend Summary

The types of reports may change from time to time and Cigna will provide notice of any material changes to Provider. For additional information on the purpose and specifications of these reports, please contact your Cigna contracting representatives.

Quality Multiplier

Definitions

Aligned National Participant(s) means a Participant(s) who resides in the United States and its territories that is aligned to a primary care physician using the same alignment process outlined in the section entitled "Assignment of Aligned CAC Participants".

Aligned Pharmacy Participant(s) means an Aligned CAC Participant(s) who has Prescription Drug Benefits under a Cigna insured or administered Benefit Plan at any time during the Measurement Period.

Generic Drug means each single source or multisource drug or supply generally accepted as therapeutically equivalent and/or interchangeable with drugs having identical amount of the same active ingredient and as further defined by the Aligned Pharmacy Participant's Benefit Plan.

Market EBM Rules Performance means the result of the sum of the successes divided by the number of opportunities incurred during that Measurement Period for every Market Aligned Participant as identified and calculated by Evidence-based medicine Connect using claims that were submitted and paid within or sixty (60) days after the Measurement Period, For purposes, of determining Market Performance, the Provider's opportunities and successes are excluded.

Market Pharmacy Participant(s) means Aligned Market Participant(s) who have Prescription Drug Benefits under a Cigna insured or administered Benefit Plan.

Market Pharmacy Performance means the result when 1) for each therapeutic class, 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 Market Pharmacy Participants divided by the number of days supply during the Measurement Period for all prescription drugs for which claims were submitted and paid within or sixty (60) days after the Measurement Period for Market Pharmacy Participants (Therapeutic Class generic dispensing rate GDR) and 2) the Therapeutic Class GDR is then multiplied by Provider's Weight for each class and summed across all therapeutic classes. The Provider's Weight is determined by number of days supply for which claims were submitted for each therapeutic class divided by total number of days supply for which claims were submitted for all the therapeutic classes. For purposes of determining Market Pharmacy Performance, the Provider's experience is excluded.

National EBM Rules Performance means the result of the sum of the successes divided by the number of opportunities incurred during a Measurement Period for every Aligned National Participant as identified and calculated by EBM Connect using claims that were submitted and paid within or sixty (60) days after the Measurement Period.

National Pharmacy Participant(s) means Aligned National Participant(s) who have Prescription Drug Benefits under Cigna insured or administered Benefit Plan.

National Pharmacy Performance means the result when 1) for each therapeutic class, 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 National Pharmacy Participants divided by the number of days supply during the Measurement Period all prescription drugs for which claims were submitted and paid within or sixty (60) days after the Measurement Period for National Pharmacy Participant (Therapeutic Class GDR) and 2) the Therapeutic Class GDR is then multiplied by Provider's Weight for each class and summed across all therapeutic classes. The Provider's Weight is determined by number of days supply for which claims were submitted for each therapeutic class divided by total number of days supply for which claims were submitted for all the therapeutic classes.

Quality Multiplier is determined by the Provider's performance relative to the 15 EBM Rules, the Generic Dispensing Rate, and Patient Experience Questions, collectively referred to as "Program Rules."

Success Rate means the number of times a Provider successfully complied with an EBM Rule divided by the number of opportunities to comply expressed as a percentage.

Program Rules

- **EBM Rules:** EBM Rules are 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. The EBM Rules that will be used in this evaluation are listed in Exhibit A. The opportunities and successes for each EBM Rule are identified using the OptumInsight (EBM Connect) version that is in use by Cigna at the end of a given Measurement Period, and the parties agree to abide by such calculations.

  Each opportunity and success will be attributed solely to the Represented Provider to which the Aligned CAC Participant is aligned and then included in the Providers results for the CAC program in which the Representative Provider participates.
- **Generic Dispensing Rate or 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 number 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 prescription drugs for CAC Pharmacy Participants.
- **Patient Experience.** Each Provider will be asked to respond to the following Patient Experience Questions:
  - Do you measure Patient Experience with at least seventy percent (70%) of physicians?
  - Have you identified three areas of opportunity for improvement of the Patient Experience?
  - 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?

Assessment Process

- **Earned Points**
  - **EBM:** For each Measurement Period, Provider will earn a maximum of one point for each Program Rule for which the Provider has at least twenty (20) opportunities during the Measurement Period and for which its Success Rate is at least ninety percent (90%) or for which the Provider's performance

exceeds one or more of the following by four percent (4%):

- National EBM Rules Performance during the same Measurement Period; or
- Market EBM Rules Performance during the same Measurement Period; or
- Provider's EBM Rules Performance for the Prior Measurement Period, or during the initial term of the Addendum, the twelve (12) months of the prior to the Effective Date. The Provider must have twenty (20) opportunities in both the above time periods for this provision to apply.

- **GDR:** For each Measurement Period during which the Provider had at least 1500 Aligned Pharmacy Participants the CAC will earn one point if the Provider's performance exceeds one or more of the following by three percent (3%):
  - National Pharmacy GDR Performance during the same Measurement Period, or
  - Market Pharmacy GDR Performance during the same Measurement Period, or
  - Providers GDR during the prior Measurement Period or during the initial term the twelve (12) months prior to the Effective Date of this Addendum.
- **Patient Experience** For each Measurement Period, the Provider will earn one point if the Provider responds "yes" to each of the Patient Experience Questions.

- **Maximum Points.** The Maximum Points will be the sum of all points available for the Program Rules.
  - EBM (Provider must have at least twenty (20) opportunities for each Rule to be included in the Maximum Points)
  - Generic Dispensing Rate (Provider must have at least fifteen hundred (1500) Aligned Pharmacy Participants)
  - Patient Experience.

Study Participation

Cigna encourages Provider to participate with Cigna in pilot studies as they become available. 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.

CCF and Performance Results

Provider acknowledges that its CCF and Performance Results may be shared with Cigna Affiliates, agents, subcontractors, and existing or potential Payors, or other patients of Cigna or Cigna Affiliates.

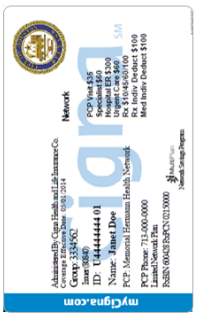
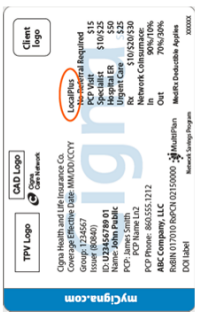
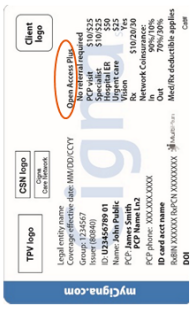
Cigna Commercial Products

Cigna Products

Renaissance Physician Organization (RPO)

	Plans			
Attributes	Cigna SureFit®	City of Houston	Local Plus® & LocalPlus IN	Open Access Plus (OAP)
PCP Selection Criteria	Required	Required	Encouraged	Encouraged
Specialty Care Referral Requirements	Referral required	Referral required	No referral required*	No referral required*
Out-of-Network Benefits	No out-of-network benefits	No out-of-network benefits	Out-of-network available†	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**
Employer plan	Employer	Client specific network	Employer	Employer
Physician Network Composition	4 separate healthcare organizations: RPO, Kelsey Care, Memorial Hermann and Health Care Alliance of Houston	RPO, Kelsey Care, and Memorial Hermann Physician Network	Narrow physician network. Refer to the health care professional directory on Cigna.com	Open Access Pus network
Hospital Network Composition	All Cigna-contracted hospitals in the service area	All Cigna-contracted hospitals in the service area	Narrow hospital network. Refer to the health care professional directory on Cigna.com	All Cigna-contracted hospitals
Dedicated Phone Numbers	1.800.882.4462	Prior authorization: 1.713.437.3060 All other calls: 1.800.997.1406	1.800.882.4462	1.800.882.4462

Example of CIGNA Commercial ID Cards

	Plans			
Attributes	Cigna SureFit®	City of Houston	LocalPlus & LocalPlus IN	Open Access Plus (OAP)
eServices Capability Differences	NaviNet not available for precertification	All capabilities available, when applicable	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	*Full counties:* Austin, Brazos, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, Waller, Washington *Partial counties:* Brazoria, Chambers, San Jacinto, Walker	Statewide
National Ancillary	Not all national ancillaries are participating. Contact RPO.	Not all national ancillaries are participating. Contact RPO.	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?

BLUE CROSS BLUE SHIELD OF TEXAS

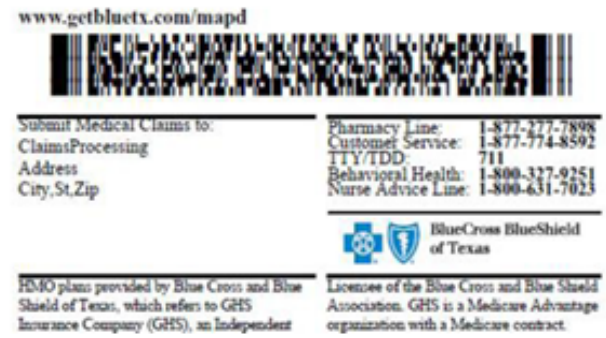
- **Blue Cross Blue Shield Medicare Advantage (MAPD)**

A Physician or Physician Group can elect to participate in the Blue Cross Blue Shield of Texas Health plans offered through Renaissance. A provider must complete an Election to Participate Form and submit the form to their designated Network Operations Representative.

The form can be found on http://www.myrpo.comunder the providers tab.

Blue Cross Blue Shield Medicare Advantage (MAPD)

Providers should be able to easily identify MAPD members by identifying plan type. Renaissance is the sole provider network for Blue Cross Medicare Advantage HMO.



Benefit Plan Overview:

Please visit our website or contact the Customer Service number for Blue Cross Medicare Advantage HMO members and/or providers **1-877-774-8592**. Customer Service numbers can also be found on the back of the Member's ID card.

Claims Submissions:

Certain types of services must be **submitted to Renaissance Physicians**, rather than to BCBSTX claims. When a claim is sent to Blue Cross Medicare Advantage HMO address that should have been sent to Renaissance, **the claim will be rejected** and you will receive notice to re-file it with the appropriate IPA or Medical Group.

Types of services that should be submitted to Renaissance:

- All Physician Services
- Outpatient diagnostic testing services

BCBS MA Professional Claims Should Be Submitted to RPO:
Billing Address
RPO Claims
PO Box 2888
Houston, TX 77252-2888

Electronic Payor ID
Availity: RENGQ (HCFA Only) or
Emdeon: 76066 (for HCFA and UB-04)

Provider Service
877-774-8592

Certain types of services must be **submitted to BCBSTX** rather than to Renaissance Physicians. When a claim is sent to Renaissance Physicians that should be sent to BCBSTX, **the claim will be rejected** and you will receive notice to re-file it with the appropriate IPA or Medical Group.

Types of services that should be submitted to BCBS MA:

- Institutional Claims

BCBS MA Institutional Claims Should Be Submitted to BCBS MA HMO:
Billing Address:
Blue Cross Medicare Advantage HMO c/o
Provider Services
PO Box 3686
Scranton, PA 18505 -9998

Electronic Payor ID
Availity 66006

Customer Service
1-877-774-8592

Annual Health Assessment:
Providers will be paid for performing annual health assessments on aligned patients. Payments will be made for one Annual Health Assessment per member per calendar year. Payments will be made on a quarterly basis to provider offices participating in the initiative.

BlueCross BlueShield of Texas

Blue Cross Medicare Advantage Provider Quick Reference Guide

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 CONTACT INFORMATION	
Blue Cross Medicare Advantage Customer Service *(also for Care Management & Part C & D Concerns)*	**Phone: 1-877-774-8592** *(for Provider & Member)*
PROVIDER DIRECTORY	
Online Provider Finder or Provider Status *(To verify a provider's status, access the Online Provider Directory)*	**Online Provider Directory** Blue Cross Medicare Advantage HMO Provider Finder Blue Cross Medicare Advantage PPO Provider Finder
Blue Cross Medicare Advantage (HMO)SM Renaissance Physician Organization (RPO) IPA Provider Finder *(To access the Online Provider Directory)*	Online Provider Directory Renaissance Physician Organization
Blue Cross Medicare Advantage HMO Valley Organized Physicians (VOP) IPA *(To access the Online Provider Directory)*	Online Provider Directory Valley Organized Physicians
Blue Cross Medicare Advantage HMO El Paso Integral Care (EPIC) IPA *(To access the Online Provider Directory)*	Online Provider Directory El Paso Integral Care (EPIC)
CLAIMS AND PAYMENT	
Electronic Medical Claim Submission	**BCBSTX Electronic Payor ID: 66006**
Eligibility, Benefit Information, Claims Status or Verification	Availity® or a web vendor of your choice **1-800-282-4548**
Paper Medical Claim Submission	**Blue Cross Medicare Advantage** Provider Services P.O. Box 3686 Scranton, PA 18505
All Other General Correspondence *(By Mail)*	**Blue Cross Medicare Advantage** P.O. Box 4555 Scranton, PA 18505 **Fax: 1-855-674-9192**
Medical Appeals & Disputes	**Blue Cross Medicare Advantage** Appeals & Disputes P.O. Box 4288 Scranton, PA 18505 **Fax (Appeals): 1-855-674-9185** **Fax (Disputes): 1-855-674-9189**

BlueCross BlueShield of Texas

Blue Cross Medicare Advantage Provider Quick Reference Guide

SUPPORTING DEPARTMENTS	
Blue Cross Medicare Advantage Marketing Department	**Phone: 1-866-292-6745**
Blue Cross Medicare Advantage Pharmacy Department	**Phone: 1-844-624-2549**

UTILIZATION MANAGEMENT/PRIOR AUTHORIZATION	
Blue Cross Medicare Advantage Utilization Management Department *(For Medical & Behavioral Health Services and Medical Coverage Determination, Medical Appeals, Medical Grievances)*	**Phone: 1-855-390-6573** **Fax: 1-855-874-4711** **Fax: 1-855-674-9185** **Fax: 1-855-674-9189**
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** -> iExchange information **iExchange Interactive Voice Response (IVR)** -> **Phone: 1-877-774-8592** (Mon – Fri, 8 a.m.–5 p.m.) **iExchange Help Desk** -> iexchangehelpdesk	
Blue Cross Medicare Advantage HMO eviCore® Preauthorization	eviCore Healthcare Web Portal **Phone: 1-855-252-1117**
Disease/Care Management Programs *(For Medical & Behavioral Health)*	**Phone: 1-855-390-6567**
Medical Care Management Department	**Phone: 1-877-774-8592**
Referral and Prior Authorization List	Referral and Preauthorization Lists
BLUE CROSS MEDICARE ADVANTAGE HMO/PPO/DSNP (Behavioral Health)	
Magellan - Behavioral Health Customer Service	**Phone: 1-800-327-9251**
Magellan Internal Number for Referrals	**Phone: 1-855-390-6573**
Magellan *(Electronic Claim Submission)*	**Magellan Electronic Payor ID: 01260**
Blue Cross Medicare Advantage PPO *(Behavioral Health Customer Service)*	**Phone: 1-877-774-8592**
Blue Cross Medicare Advantage DSNP	**Phone: 1-877-688-1813**
SUPPORTING VENDORS	
Dental Networks of America ®	**Phone: 1-800-972-7565**
TruHearing™	**Phone: 1-800-334-1807**
EyeMed	**Phone: 1-866 939-3633**
LogistiCare *(Transportation Services)*	**Phone: 1-844-452-9383**
Durable Medical Equipment / Home Health	**Online Provider Directory** Blue Cross Medicare Advantage HMO Provider Finder Blue Cross Medicare Advantage PPO Provider Finder
Blue Cross Medicare Advantage HMO *(Outpatient Clinical Reference Lab Services)*	**Quest Diagnostics, Inc.** questdiagnostics.com/home/physicians.html

BlueCross BlueShield of Texas

Blue Cross Medicare Advantage Provider Quick Reference Guide

Blue Cross Medicare Advantage PPO *(Outpatient Clinical Reference Lab Services)*	Quest Diagnostics **Phone: 1-888-277-8772** Clinical Pathology Laboratories **Phone: 1-800-595-1275** LabCorp **Phone: 1-800-845-6167**
Center for Medicare and Medicaid Website	www.cms.gov

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to Blue Cross and Blue Shield of Texas.

eviCore is a trademark of eviCore healthcare, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

Aerial, iExchange and Medecision® are trademarks of Medecision, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity or Medecision.

The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

Please note that verification of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

BCBS Commercial Plan

Blue Value Base Incentive Plan (VBIP)

Please note that we have two membership populations for Blue Cross Commercial:

- **Blue Advantage HMO℠**
- **Blue Choice PPO ℠**

Please note there are separate Quick Reference Guides for each population included at the end of this section.

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.

What is an ACO?

An ACO is a collection of providers that agree to coordinate care across a continuum of health care settings to improve quality outcomes and cost efficiencies. The ACO model is intended to improve members' health and experience of care while reducing costs by avoiding unnecessary hospital admissions, readmissions, emergency room visits and duplication of services.

ACOs center on addressing the health needs of broad member populations while holding providers within the ACO accountable for quality and cost efficiencies delivered for their members – the attributed cohort. BCBSTX supports the ACO by providing information about the attributed cohort that gives providers a more comprehensive profile of the members' care.

To achieve its goals, the ACO model uses a multidisciplinary approach to better coordinate care, improve quality and reduce costs, which involves provider leadership, primary and specialty care providers, clinical teams, and the member and his or her family.

ACO Attribution Logic and Methodology

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.

ACO Financial Performance Measurement and Reports

The ACO is measured for financial performance against a BCBSTX-established methodology to compare the actual cost-of-care changes during the performance period against the baseline period in order to determine the earned incentive in accordance with the terms of the Agreement. BCBSTX refers to this methodology as the Adjusted Provider Performance Measurement (APPM).

The APPM Model

APPM uses statistical regression calculations to create a risk-adjusted performance target for the ACO financial performance. It is designed to measure the cost trends in an ACO attributed cohort over time relative to cost trends that would be expected for the ACO cohort if it were not attributed to the ACO.

Establishing an expected cost is critical to setting a benchmark for ACO performance. APPM involves a statistical regression formula that generates an expected medical cost for the ACO attributed cohort based on age, gender and medical conditions. APPM uses the reference population to generate the coefficients for age, gender and medical conditions. These coefficients are then applied to each ACO member based on that member's specific age, gender and medical condition information to create a cost prediction for each member.

The ACO population's expected cost is the average expected cost of the ACO attributed cohort. This is the same type of predictive modeling technique used to set expected costs in government risk adjustment programs such as Medicare Advantage, the Medicaid Chronic Illness and Disability Payment System model, and the Affordable Care Act risk adjustment model.

Expected values are not deemed as reliable as individual person predictions but, rather, they produce reliable population cost predictions as the measured population grows larger.

The APPM groups age and gender information into categories and diagnosis information into medical condition categories using AHRQ Clinical Classification System (CCS) diagnosis grouper - level 2.
These categories are established in advance by AHRQ and are not subject to manipulation by BCBSTX when calculating performance. The categorization is necessary for the statistical technique to function properly.

The benchmark value represents what the ACO attributed cohort would be expected to cost based on age, gender and medical condition information.

ACO Inbound Data
In order to support the ACO's success with population health management activities, BCBSTX shares its confidential and proprietary attributed membership information, medical and pharmacy claims, and pre-authorization information with the ACO on a limited-use basis subject to restrictions, terms and conditions set forth in the Confidential Data Release Agreement (CDRA) between the ACO and BCBSTX. A standard CDRA form is provided by BCBSTX. The CDRA must be executed prior to the exchange of any data associated with the attributed population.

ACO Outbound Data
The ACO is required to electronically submit and share data, including supplemental clinical data as shown below:

- File Type: Supplemental File (Quality Data)
- Description of File: The supplemental file contains clinical data not available in claims data. This data allows BCBSTX to provide quality metric reporting to ACOs on those measures that require clinical-type data.

A complete set of technical specifications, including data dictionaries that define the data elements for each file, is provided to the ACO by BCBSTX.

Supplemental Clinical Data

BCBSTX uses medical claims data, along with supplemental data. If no medical claims data is available, BCBSTX uses only supplemental data provided by the ACO.

BCBSTX requires the ACO to electronically submit supplemental clinical data for the following quality metrics no later than 60 days after the performance period ends:

- Quality Metrics:
  - Comprehensive Diabetes Care - HbA1c Control (<8.0%)
  - Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)

Member Experience Data
In most instances BCBSTX selects and pays for a vendor to administer and report results from the CG- CAHPS® member experience survey in the fourth quarter of each calendar year. BCBSTX uses the results for the three quality metrics below:

- Follow-Up on Test Results
- Getting Timely Appointments, Care and Information (composite)
- How Well Providers Communicate with Members (composite)

ACO Quality Performance Measurement and Reports
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.

VBIP Quality and Member Experience Metrics Summary
See table on following page for quality metrics.

Care Management Programs

- **Complex & Comprehensive Case Management:** For members who have complex medical needs and require a wide variety of resources to manage health and improve quality of life
- **Condition Management:** Disease specific case management
- **Lifestyle management:** Weight management and smoking cessation
- **Special Beginnings and High Risk Pregnancy:** Uncomplicated and high risk pregnancy support

BlueCross BlueShield of Texas

Blue Advantage HMO℠ Quick Reference Guide----VBIP COMMERCIAL MEMBERSHIP

Major Characteristics	Benefits, Eligibility, Claims Status or Verification	Claim Reviews, All Correspon	Preauths, Online Approval of Benefits for Select Outpatient Services and Inpatient Admissions	Laboratory Services	Behavioral Health Services (Mental Health and Chemical Dependency)
• **Blue Advantage HMO** members must select a **Blue Advantage HMO** Primary Care Physician (PCP). • Blue Advantage providers may only bill for copayments, cost share (coinsurance) and deductibles, where applicable. • **Some services may be self-referred to a Blue Advantage HMO** physician or professional provider (i.e. annual well woman exam, annual routine eye exam) as indicated by the member's benefit plan. • To receive benefits, all medical care must be directed by the selected **Blue Advantage HMO** PCP. A PCP referral is required to all **Blue Advantage HMO** Specialist Physicians, Professional Providers, Facility or Ancillary Providers. • To receive benefits, referrals to out-of-network physicians, professional providers, facility or ancillary providers must be authorized by the Utilization Management Dept. • As of 1/1/17, Blue Advantage HMO members 19 and younger will receive their annual eye exam and eye wear from **EyeMed Vision Care** providers. **Blue Advantage HMO** members will continue to use **Blue Advantage HMO** contracted providers for medical eye care. Please include all appropriate diagnosis codes on your claims in order to accurately represent the services provided. To request network participation with **EyeMed Vision Care**, please call (888) 581-3648. For all other **Blue Advantage HMO** members, providers for vision care could vary. Contact the customer service number on the member's ID card to verify the member's vision benefits. • **Blue Advantage HMO** members under age 20 have an included dental benefit. For more information, refer to the member's **Blue Advantage HMO** ID card or call **Dental Network of America** at **800-820-9994**.	• Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call **Blue Advantage HMO** Provider Customer Service: **800-451-0287*** • Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice. • To adjust a claim, call **Blue Advantage HMO** Provider Customer Service: **800-451-0287**** • **Verification does not apply to administrative services only (ASO) plans.** • **All claims should be submitted electronically. Blue Advantage HMO** Electronic Payor ID: **84980** • If the physician, professional provider, facility or ancillary provider must file a paper claim, mail claim to: **Blue Advantage HMO** P.O. Box 660044 Dallas, TX 75266-0044 • Claims must be submitted within **180** days of the date of service. Claims that are not submitted within **180** days from the date of service are not eligible for reimbursement. Physicians, professional providers, facility or ancillary providers must submit a complete claim for any services provided to a member. **Blue Advantage HMO** physicians, professional providers, facility or ancillary providers may not seek payment from the member for claims submitted after the **180** day filing deadline. ** To access eligibility and benefits, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.* *** To adjust a claim, you must have a document control number (claim number).*	• Claim Reviews and Correspondence should be sent to: **Blue Advantage HMO** P.O. Box 660044 Dallas, TX 75266-0044 • The Claim Review form with instructions is located on the BCBSTX website: bcbstx.com/ provider click on the Education and Reference tab, then click on Forms	• Access the iExchange Web application through the BCBSTX website at http://www.bcbstx.com/provider/tools/iexchange.html **or** call the iExchange Interactive Voice Response (IVR) System at **800-451-0287**. • Current listings of providers and their NPI numbers are available online through the iExchange Web application or Provider Finder®. • For questions or problems, call the iExchange Support Desk at **800-746-4614**. • For case management or to contact the Medical Care Management Dept., call **855-896-2701**. • For referrals, approval of benefits for select outpatient preauthorizations and inpatient admissions, refer to the iExchange webpage at http://www.bcbstx.com/provider/tools/iexchange.html *(Note: A link to the Preauthorization/ Notification/Referral Requirements List is located in the left-side navigation under Related Resources)* **or** refer to the Blue Essentials (formerly HMO Blue Texas℠), Blue Advantage HMO and Blue Premier Provider Manual sections D and E. • For preauthorization for outpatient molecular and genome testing and outpatient radiation therapy, contact eviCore at www.evicore.com or 1(855)252-1117.	**Laboratory Services** • Quest Diagnostics, Inc. is the **exclusive** lab for **Blue Advantage HMO** for all outpatient clinical reference laboratory services. For locations or questions, contact Quest at **888-277-8772, or** visit Quest's website at: QuestDiagnostics.com/patient	• Magellan Behavioral Health Providers of Texas, Inc. (Magellan) coordinates all behavioral health (mental health and chemical dependency) services for **Blue Advantage HMO** members. • To obtain preauthorization, check benefits, eligibility, claims status/problems or verification, call Magellan at **800-729-2422.** • The patient, Primary Care Physician (PCP) or behavioral health professional must contact Magellan to preauthorize all inpatient, partial hospitalization and outpatient behavioral health services. • Preauthorization must be obtained ***prior*** to the delivery of care for behavioral health services. • The physician or professional provider is responsible for filing claims. Mail claims to: Magellan Behavioral Health Providers of Texas, Inc. Attn: Claims P.O. Box 1659 Maryland Heights, MO 63043 ***Note**: Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice.*

BlueCross BlueShield of Texas

Blue Advantage HMO Quick Reference Guide Additional Information Page, cont'd

For Blue Advantage HMO, BCBSTX encourages the provider's office to:

- Ask for the member's ID card at the time of a visit;
- Copy both sides of the member's ID card and keep the copy with the patient'sfile;
- Eligibility, benefits and/or verification requests, contact availity.com, or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.
- Utilize the iExchange Web application at http://www.bcbstx.com/provider/tools/iexchange.html to obtain approval of: referrals, select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at **855-896-2701**.

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is **84980**.
  - For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at **800-AVAILITY (282-4546)**.
  - For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at **800-AVAILITY (282-4546).**
  - For information on electronic filing, access the Availity website atavaility.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insured's complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Note**: This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional

Provider Record ID and Network Effective Dates:

- A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
  - Physical address (primary, secondary, tertiary); (2) Billing address; (3) NPI and Provider Record ID changes; (4) Moving from Group to Solo practice; (5) Moving from Solo to Group practice; (6) Moving from Group to Group practice; and (7) Backup/covering providers.
- ***New*** Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at **800-AVAILITY (282-4546)** to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at **972-996-9610**, *press 3*.

BlueCard (Out-of-State Claims):

- To check benefits or eligibility, call **800-676-BLUE** (2583);
- File all that include a 3-digit alpha prefix on the member's ID card to BCBSTX (***Note**: The member's unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix);*
- File all other claims directly to the Home Plan's address as it appears on the back of the member's IDcard;
- For status of claims filed to BCBSTX, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the member's ID card.

Blue Advantage HMO – Outpatient Clinical Reference Lab Services

All outpatient clinical reference lab services must be referred to **Blue Advantage HMO**'s exclusive lab provider - **Quest Diagnostics, Inc**.

The **Affordable Care Act (ACA)** includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC)** also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the **APTC**.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn't pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member's coverage.
  - For additional details, go to www.Healthcare.gov.
- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    1. Electronic and/or clearinghouse compliant with the HIPAA 270/271
    2. Interactive Voice Response (IVR) / automated telephonesystem
    3. Provider Customer Service
  - Reminders to check for grace period status will be included on correspondence related to:
    1. Pre-determinations, Preauthorizations, Referrals

** To access eligibility and benefits, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc. ** To adjust a claim, you must have a document control number (claim number).*

Updated December 22, 2016

BlueCross BlueShield of Texas

Blue Choice PPO℠ Quick Reference Guide -----VBIP COMMERCIAL MEMBERSHIP

Major Characteristics	Benefits, Eligibility, Claims Status or Verification	Claim Reviews, All Correspondence	Preauthorization, Online Approval of Benefits for Selected Outpatient Services and Inpatient Admissions	Laboratory and Radiology Services	Behavioral Health Services (Mental Health and Chemical Dependency)
• **Blue Choice PPO** physicians and professional providers may only bill for copayments, cost share (coinsurance) and deductibles, where applicable. • To receive Network benefits, **Blue Choice PPO** subscribers must receive medical care from **Blue Choice PPO** physicians and professional providers. **No referrals are required.** • To receive Network benefits, referrals to out-of-network physicians and professional providers must be authorized by the Medical Care Management (UM) Dept. • Some services may be self- referred to a **Blue Choice PPO** physician or professional provider (i.e. annual well woman exam, annual routine eye exam) as indicated by the subscriber's benefit plan.	1. Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call BCBSTX Provider Customer Service : **800-451-0287*** 2. Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice. 3. To adjust a claim, call BCBSTX Provider Customer Service: **800-451-0287*** 4. **Verification does not apply to administrative services only (ASO) plans.** 5. **All claims should be submitted electronically**. BCBSTX Electronic Payor ID: **84980** 6. If the physician or professional provider must file a paper claim, mail claim to: **BCBSTX** **P.O. Box 660044** **Dallas, TX 75266-0044** • **Blue Choice PPO** claims must be submitted within **365** days of the date of service. Claims that are not submitted within **365** days from the date of service are not eligible for reimbursement. Physicians and professional providers must submit a complete claim for any services provided to a member. **Blue Choice PPO** physicians or professional providers may not seek payment from the member for claims submitted after the **365** day filing deadline. ** Interactive Voice Response (IVR) system. To access, you must have full subscriber's information, i.e.subscriber's ID, patient date of*	• Claim Reviews/ Correspondence should be sent to: BCBSTX P.O. Box 660044 Dallas, TX 75266-0044 • The Claim Review form with instructions is located on the BCBSTX website: bcbstx.com/provider click on the Education and Reference tab, then click on Forms	• Access the iExchange Web application through the BCBSTX website at http://www.bcbstx.com/provider/tools/iexchange.html • Current listings of providers and their NPI numbers are available online through the iExchange Web application or *Provider Finder*®. • For questions or problems, call the iExchange Support Desk at **800-746-4614.** • For case management or to contact the Medical Care Mgmt Dept., call**855-896-2701.** • For approval of select outpatient services and inpatient admissions, refer to the iExchange webpage at http://www.bcbstx.com/provider/tools/iexchange.html • Refer to the Preauthorization / Notification/Referral Requirements List under Clinical Resources on bcbstx.com/ provider to determine the services that require preauthorization or referrals or call the iExchange interactive Voice Response (IVR) at **877-774-8592.** • Effective 8/1/17 **eviCore** will manage preauthorization for certain specialized clinical services. Refer to the Preauthorization/ Notification/ Referral Requirements List under Clinical Resources on bcbstx.com/provider for eviCore preauthorization requirements. To authorize **eviCore** services contact the eviCore Healthcare Web Portal at https:// www.evicore.com or call 855-252-1117.	**Laboratory Services** • Quest Diagnostics, Inc. is the ***preferred statewide*** outpatient clinical reference laboratory. To schedule a Patient Service Center (PSC) appointment, log onto QuestDiagnostics.com/patient or call **888-277-8772.** • To locate other participating labs in the **Blue Choice PPO** network, visit the Online Provider Directory *(Provider Finder)*. **Radiology Services** • Ordering physicians and professional providers (PCPs and specialists) must contact AIM Specialty Health® (AIM) to obtain a **Radiology Quality Initiative** (RQI) for the following services when performed in a physician's or professional provider's office, outpatient department of a hospital or a freestanding imaging center: • CT/CTA scans • MRI/MRA scans • SPECT/Nuclear Cardiology studies • PET scans • To obtain a RQI, contact AIM as follows: **Call Center: 800-859-5299 Internet:** aimspecialtyhealth.com **Fax: 800-610-0050** ***Note:*** *Fax option is available only for physicians or professional providers who are submitting clinical information for existing requests.* • For routine radiology services not part of the RQI, refer to the Blue Choice PPO Physicians, Professional Provider, Facility and Ancillary Provider Manual (Section B)	**Important: Not all plans include Behavioral Health benefits** • Blue Cross and Blue Shield of Texas (BCBSTX) manages all behavioral health services (mental health and chemical dependency). • Subscribers are responsible for requesting preauthorization, although behavioral health professionals and physicians or a family member may request preauthorization on behalf of the subscriber. All services must be medically necessary. Preauthorization is required from BCBSTX for all inpatient, partial hospitalization and outpatient behavioral health services. • To obtain preauthorization, call: **BCBSTX** **800-528-7264** • Preauthorization must be obtained ***prior*** to the delivery of behavioral health services. • Refer to the online Blue Choice PPO Physicians, Professional Provider, Facility and Ancillary Provider Manual (Section I) • **All claims should be submitted electronically.** BCBSTX Electronic Payor ID: **84980** • If the provider must file a paper claim, mail claim to: BCBSTX P.O. Box 660044 Dallas, TX 75266-0044 • For claims status inquiries, contact your electronic connectivity vendor, i.e. Availity or other electronic connectivity vendor or call Provider Customer Service: **800-451-0287*** **Interactive Voice Response (IVR) system. To access, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.)*

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Blue Choice PPO Physician and Professional Provider – Provider Manual online at bcbstx.com/provider**. Updated June 5, 2017**

BlueCross BlueShield of Texas

Blue Choice PPO℠ Additional Information Page

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is **84980**.
  - For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at **800-AVAILITY (282-4546)**.
  - For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at **800-AVAILITY (282-4546)**.
  - For information on electronic filing, access the Availity website at availity.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB04 claim form.
- All claims must be filed with the insured's complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Note**: This does not apply to services provided by an employee of a physician and professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

ParPlan is a Blue Cross and Blue Shield of Texas (BCBSTX) payment plan under which health care professionals agree to:

- File all claims electronically for BCBSTX patients;
- Accept the BCBSTX allowable amount;
- Bill subscribers only for deductibles, cost-share (coinsurance) and medically necessary services which are limited or not covered; either at the time of service or after BCBSTX has reimbursed the provider;
- Not bill BCBSTX for experimental, investigative or otherwise unproven or excluded services; and
- Not bill either BCBSTX or subscribers for covered services which are not medically necessary.

For All Blue Choice PPO Products, BCBSTX encourages the provider's office to:

- Ask for the subscriber's ID card at the time of a visit;
- Copy both sides of the subscriber ID card and keep the copy with the patient's file;
- Eligibility, benefits, and/or verification requests, contact your availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the subscriber's ID card.
- Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice.
- For Claim Adjustments, call BCBSTX Provider Customer Service at 800-451-0287*.
- Utilize the iExchange Web application at http://www.bcbstx.com/provider/tools/iexchange.html to obtain: approval of benefits for select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at **855-896-2701**.

Provider Record ID and Network Effective Dates:

- A minimum of 30 days advance notice is required when making changes affecting the provider's BCBSTX status, especially in the following areas:
  (1) Physical address (primary, secondary, tertiary); (2) Billing address; (3) NPI and Provider Record ID changes; (4) Moving from Group to Solo practice; (5) Moving from Solo to Group practice;
  (6) Moving from Group to Group practice; and (7) Backup/covering providers.
- ***New*** Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claims electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at **800-AVAILITY (282-4546)** to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at **972-996-9610**, *press 3*.

BlueCard (Out-of-State Claims):

- To check benefits or eligibility, call 800-676-BLUE (2583)*;
- File all claims that include a 3-digit alpha prefix on the subscriber's ID card to BCBSTX (**Note**: The subscriber's unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix);
- File all other claims directly to the Home Plan's address as it appears on the back of the subscriber's ID card;
- For status of claims filed to BCBSTX, contact your electronic connectivity vendor, i.e. Availity or other electronic connectivity vendor or call the toll-free Provider Customer Service number indicated on the subscriber's ID card or as listed on the previous pages for the appropriate plan type.

Blue Choice PPO - Outpatient, Non-Emergency Diagnostic Imaging Services (Statewide):

- AIM Specialty Health® (AIM) will be responsible for managing outpatient, non-emergency diagnostic imaging services for **Blue Choice PPO** subscribers.
- Ordering physicians or providers (PCPs & specialists) must contact AIM to obtain a **Radiology Quality Initiative** (RQI) for the following services when performed in a physician's or professional provider's office, outpatient department of a hospital or a freestanding imaging center: CT/CTA scans, MRI/MRA scans, SPECT/Nuclear Cardiology studies and PET scans.
- To obtain a RQI, contact AIM as follows: Call Center: **800-859-5299**, Internet: aimspecialtyhealth.com
  or by Fax: **800-610-0050** ***(Note:*** *Fax option is available only for physicians or professional providers who are submitting clinical information for existing requests.)*
- For routine radiology services not part of the RQI, refer to the Blue Choice PPO Physicians, Professional Providers, Facility and Ancillary Provider Manual (Section B) for more details.

** Interactive Voice Response (IVR) system. To access, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.) ** To adjust a claim, you must have a document control number (claim number).*

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Blue Choice PPO[SM] Additional Information Page, continued

The **Affordable Care Act (ACA)** includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC)** also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the **APTC**.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn't pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member's coverage.
  - For additional details, go to www.Healthcare.gov.
- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    - Electronic and/or clearinghouse compliant with the HIPAA 270/271
    - Interactive Voice Response (IVR) / automated telephone system
    - Provider Customer Service
  - Reminders to check for grace period status will be included on correspondence related to:
    - Pre-determinations
    - Preauthorizations
    - Referrals

** Interactive Voice Response (IVR) system. To access, you must have full subscriber's information, i.e. subscriber's ID, patient date of birth, etc.)*

*** To adjust a claim, you must have a document control number (claim number).*

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Blue Choice PPO Physician and Professional Provider – Provider Manual online at bcbstx.com/provider.

BlueCross BlueShield of Texas

Standard Group ID Card Elements Quick Reference Guide

VBIP Commercial Membership

Blue Cross and 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 with coverage through a Blue Cross Blue Shield Plan are assigned a three letter **alpha prefix** that appears at the beginning of their 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.

There are two types of alpha prefixes: plan-specific and account-specific. The plan-specific alpha prefixes are assigned to every Blue Cross Blue Shield plan and start with **X, Y, Z or Q**. The first two positions indicate the Plan to which the member/subscriber belongs while the third position identifies the product in which the member/subscriber is enrolled. **Note: ZG identifies the Texas Plan**

The account-specific alpha prefixes are assigned to national accounts; national accounts are employer groups that have offices across multiple states and offer uniform coverage benefits to their employees and the alpha prefix assigned to the national account will associate to the employer's name.

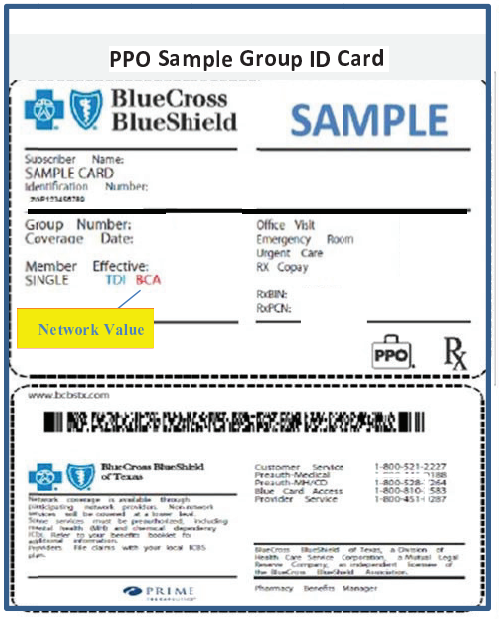
Identifying the **network** that a member is a part of is now easier with the addition of the three (3) character network value that will be displayed in a red font. The network value will appear on Medical Identification cards where network benefits may apply.

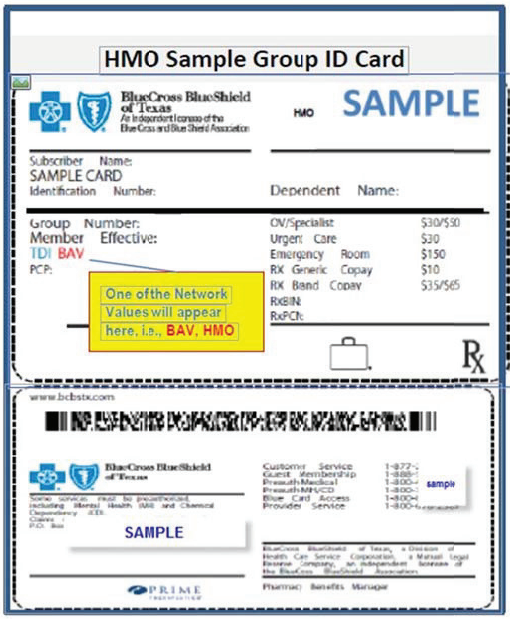
PPO Network Value:
BCA = Blue Choice PPO Network

HMO Network Values:
HMO = Blue Essentials
BAV = Blue Advantage HMO Network

If TDI is present, subject to TDI rules & regulations

August 1, 2017





A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

Date: January 2020

To: Renaissance Physicians

From: CareAllies, Provider Relations

Re: **Blue Cross Blue Shield: VBIP: Commercial Members Care Management**

Blue Cross Blue Shield offers a variety of care management programs for its members. Please see the listing of programs below and consider utilizing them for your BCBS Commercial members (Blue Choice PPO, Blue Premier, and Blue Advantage HMO).

- **Complex & Comprehensive Case Management**
  - For members who have complex medical needs and require a wide variety of resources to manage health and improve quality of life;
  - Including, but not limited to: member involved in MVA, multiple injuries, Transplants, High Risk OB members, multi-chronic conditions leading to high cost/high utilization
- **Condition Management**
  - Disease specific case management with a focus on the 5 core conditions of Asthma, Diabetes, CAD, CHF, and COPD but may also engage with members diagnosed with chronic lower back pain
- **Lifestyle management**
  - Weight management and smoking cessation
- **Special Beginnings and High Risk Pregnancy**
  - Uncomplicated and high risk pregnancy support

If you believe one of your members could benefit from case management programs, please reach out to this secure email box at **ACOProviderCollaboration@bcbstx.com**. You will be contacted by a BCBS clinician who will work with you to assess the member and coordinate care.

To validate member benefits, call **1-888-796-8468** (or the number listed on the back of the member's card) and provide the following:

General member information: Member Name, DOB, Subscriber ID

Prescription drug coverage information: Member information as above, drug name, NDC code, Amount, Days

DME Equipment benefit: Member information as above, DME description, DX code, CPT Code, and NPI number for prescriber and/or vendor

Please contact your Provider Engagement representative with any questions.

As always, thank you for your hard work and dedication to Renaissance and its members.

2020 BCBS VBIP QUALITY METRICS

Updated, as of January 1, 2020

#	QUALITY METRICS
	PREVENTIVE MEDICINE SERVICES (HEDIS)
1	Breast Cancer Screening
2	Cervical Cancer Screening
3	Colorectal Cancer Screening
	COMPREHENSIVE DIABETES CARE (HEDIS)
4	HbA1c Testing (Annual)
	ASTHMA (HEDIS)
5	Medication Management for People with Asthma (75%)
	INPATIENT UTILIZATION (HEDIS)
6	Plan All-Cause Readmissions (Actual to Expected)
	OTHER QUALITY METRICS (HEDIS)
7	Appropriate Use of Imaging Studies for Low Back Pain Assessment
8	Acute Bronchitis Treatment in Adults without Antibiotic
9	Appropriate Testing for Children with Pharyngitis
	MEMBER EXPERIENCE (CG-CAHPS®)
10	Follow-Up on Test Results
11	Getting timely appointments, care, and information
12	How well providers communicate with members

Renaissance Physicians
CARE THAT REVOLVES AROUND YOU.

Blue Cross VBIP Quality Measures
Coding Quick Reference Guide

Metric	Criteria	Codes to Identify Screenings
Breast Cancer Screening	Age 40-69 ♀ Exclude: History of bilateral mastectomy or two unilateral mastectomies.	CPT: 77055-77057 HCPCS: G0202, G0204, G0206 UB Revenue: 0401, 0403
Cervical Cancer Screening One or more pap tests during the measurement year or the two years prior	Age 21-64♀	CPT: 88141-88143, 88147-88148, 88150-88155, 88164-88167, 88174, 88175
Colorectal Cancer Screening Annual FOBT Flex Sig within 5 years Colonoscopy within 10 years	Age 50-75	CPT: G0104-G0106, G0120- G0122, G0328, 82270,82274, 45330, 45331, 45333, 45338, 45339, 45378, 45380-45385
Diabetes Care: HbA1C testing	Age 18-75 Two lab tests separated by 3 months	CPT:83036, 83037 CPT II:3044F, 3045F, 3046F
Diabetes Control HbA1c < 8%	Age 18-75 Most recent lab value during the year will be the representative value.	CPT II:3044F, 3045F, 3046F
Diabetes Care: Blood Pressure Control < 140/90	Age 18-75 Last BP of year is in control as defined as < 140/90	**Documented in chart** CPTII: 3044F, 3045F
Appropriate use of Imaging Low Back Pain Assessment	Assesses adults 18–50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance) - See more at: http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents/low-back-pain#sthash.m1SLJ7vd.dpuf	
Medication Management Asthma	Assesses adults and children 5–85 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period. - See more at: http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents/asthma#sthash.YLiue5l6.dpuf	

All Cause Readmission (Actual to Expected)	This measure is used to assess the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for members 18 years of age and older. Discharge from a hospital is a critical transition point in a patient's care. Poor care coordination at discharge can lead to adverse events for patients and avoidable rehospitalization. Hospitalization readmissions may indicate poor care or missed opportunities to coordinate care better. Research shows that specific hospital-based initiatives to improve communication with beneficiaries and their caregivers, coordinate care after discharge and improve the quality of care during the initial admission can avert many readmissions.	

Appendix: Exhibit 2

QUALITY AND MEMBER EXPERIENCE METRICS SUMMARY

The information below is provided at a summary level. For more details, please refer to AHRQ and NCQA specifications.

For ACOs with a July 1 effective date, all of the dates shown below will be adjusted forward by 6 months (i.e., December 31 = June 30).

#1: BREAST CANCER SCREENING

DESCRIPTION: The percentage of women 50 to 74 years old who had a mammogram to screen for breast cancer

RATIONALE:

- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
One or more mammograms during the 27 months prior to the end of the measurement year	Women 52 to 74 years old as of December 31 of the measurement year

BCBSTX ENROLLMENT CRITERIA

October 1 two years prior to the measurement year through December 31 of the measurement year with an allowed gap up to 45 days per calendar year

EXCLUSIONS

Women who had a bilateral mastectomy; women who had a unilateral mastectomy with a bilateral modifier; women who had two unilateral mastectomies with service dates 14 days or more apart; members with at least one hospice claim or encounter during the measurement year

#2: CERVICAL CANCER SCREENING

DESCRIPTION: The percentage of women 21 to 64 years old who were screened for cervical cancer

RATIONALE:
- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
Women 24 to 64 years old who had cervical cytology performed in the three years prior to the end of the measurement year *OR* Women 30 to 64 years old who had cervical cytology/human papillomavirus (HPV) co-testing performed in the five years prior to the end of the measurement year	Women 24 to 64 years old as of December 31 of the measurement year

BCBSTX ENROLLMENT CRITERIA

The measurement year and two years prior to the measurement year with no more than one gap of up to 45 days during each year of continuous enrollment

EXCLUSIONS

Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix; members with at least one hospice claim or encounter during the measurement year

#3: COLORECTAL CANCER SCREENING

DESCRIPTION: The percentage of members 50 to 75 years old who had appropriate screening for colorectal cancer

RATIONALE:
- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
One or more screenings for colorectal cancer: • Fecal occult blood test (FOBT) during the measurement year or FIT-DNA test • Flexible sigmoidoscopy or CT colonography during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year	Members 51 to 75 years old as of December 31 of the measurement year

BCBSTX ENROLLMENT CRITERIA

The measurement year and the year prior to the measurement year with no gaps more than 45 days during each year

EXCLUSIONS

Members with a diagnosis of colorectal cancer or total colectomy; members with at least one hospice claim or encounter during the measurement year

#4: COMPREHENSIVE DIABETES CARE – HbA1c TEST (ANNUAL)

DESCRIPTION: Percentage of members 18 to 75 years old with diabetes mellitus who had an HbA1c test

RATIONALE:
- HEDIS
- High prevalence of diabetes in population

RATE CALCULATION

NUMERATOR	DENOMINATOR
HbA1C test during measurement year	Number of eligible members 18 to 75 years old as December 31 of the measurement year with diagnosis of type 1 or type 2 diabetes based on claims or pharmacy data BCBSTX receives from its pharmacy benefit manager

INCLUSION CRITERIA

Members who meet the age requirement in the measurement year and meet at least one of the following during the measurement year or the year prior to the measurement year:
- At least one ambulatory prescription for insulin or an oral hypoglycemic/ anti-hyperglycemic drug
- At least two face-to-face encounters with different dates of service in an ambulatory setting, emergency room, observation setting or non-acute inpatient setting with a diagnosis of diabetes
- At least one face-to-face encounter in an nt setting with a diagnosis of diabetes

SIONS

Members who do not have a diagnosis of di in any setting during the measurement year or year prior *and* who had a diagnosis of gesta r steroid-induced diabetes in any setting, during the measurement year, or the year prior to t surement year; members with at least one hospice claim or encounter during the meas t year

#5: MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (75%)

DESCRIPTION: The percentage of members, 5 to 85 years old during the measurement year, who were identified as having persistent asthma and who were dispensed appropriate medications they remained on during the treatment period

RATIONALE:

- HEDIS
- For persistent asthmatics, consistent use of asthma controller medications may improve asthma control

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of members who filled prescriptions for asthma controller medication that covered at least 75 percent of the days from the first controller medication prescription during the measurement year through the last day of the measurement year	Members with persistent asthma who are 5 to 85 years old as of December 31 of the measurement year

BCBSTX ENROLLMENT CRITERIA

The measurement year and the year prior to the measurement year with no more than one 45-day gap in coverage each year; must have pharmacy benefit during the measurement year

EXCLUSIONS

Members who had a diagnosis from any of the following at any time during the member's history through December 31 of the measurement year:

- Emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes/vapors
- Cystic fibrosis
- Acute respiratory failure
- Members who had no asthma controller medications dispensed during the measurement year
- Members with at least one hospice claim or encounter during the measurement year

#6: PLAN ALL-CAUSE READMISSIONS (ACTUAL TO EXPECTED)

DESCRIPTION: For members 18 to 64 years old, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days of the member's discharge and the predicted probability of an acute readmission

RATIONALE:

- Readmissions are costly and sometimes preventable
- Readmissions can indicate quality concerns or opportunities for improved coordination of post discharge care

RATE CALCULATION

NUMERATOR	DENOMINATOR
Number of HEDIS-defined Index Hospital Admissions with a readmission within 30 days of the index discharge date	All acute inpatient stays for members 18 to 64 years old (as of the discharge date) with a discharge date on or between January 1 and December 1 of the measurement year; include acute admissions to behavioral health care facilities

BCBSTX ENROLLMENT CRITERIA

365 days prior to the index discharge date through 30 days after the index discharge date with no more than 45 days gap in coverage

EXCLUSIONS

- Planned re-admissions within 30 days (maintenance chemotherapy, principal diagnosis of rehabilitation, organ transplant, potentially planned procedure without an principal acute diagnosis)
- Stays for the following reasons:
    - Inpatient stays with discharges for death
    - Acute inpatient discharge with a principal diagnosis for pregnancy

ADDITIONAL INFORMATION

Data are reported for the following indicators:

1. Count of index hospital stays (denominator)
2. Count of 30-day readmissions (numerator)
3. Average adjusted probability of readmission

From this data, the ratio of the actual readmission rate to the average adjusted probability of readmission is calculated

#7: USE OF IMAGING STUDIES FOR LOW BACK PAIN

DESCRIPTION: The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

RATIONALE:

- HEDIS
- Imaging for low back is high utilization/high cost factor
- Unnecessary imaging exposes members to unnecessary radiation

RATE CALCULATION

NUMERATOR	DENOMINATOR
An imaging study with a diagnosis of low back pain conducted on the index episode start date or in 28 days following the index episode start date	All members, 18 years old as of January 1 of the measurement period to 50 years old as of December 31 of the measurement period, who had an outpatient or emergency department encounter with a principal diagnosis of low back pain

BCBSTX ENROLLMENT CRITERIA

180 days (six months) prior to the index episode start date through 28 days after the index episode start date without gaps

INCLUSION CRITERIA

Members, 18 years old as of the beginning of the measurement year to 50 years as of the end of the measurement year, who had:

- At least one outpatient or emergency department encounter with a principal diagnosis of low back pain during the intake period
- No low back pain diagnosis during the six-month (180-day) period prior to the first low back pain encounter
- Had no diagnosis for which an imaging study in the presence of low back pain is clinically indicated

The intake period is from the beginning of the measurement year to 28 days prior to the end of the measurement year

EXCLUSIONS

Members who had a diagnosis of cancer at any time during the member's history through 28 days after the episode start date; recent trauma, intravenous drug abuse or neurologic impairment; any trauma during the 3 months prior to the episode start date through 28 days after the episode start date; diagnosis of HIV, spinal infection, or neurologic impairment; kidney or other organ transplant; members with at least one hospice claim or encounter during the measurement year

#8: APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

DESCRIPTION: The percentage of children 3 months to 18 years old who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription

RATIONALE:

- HEDIS
- Acute care measure
- Measure for pediatric population
- Antibiotic overuse

RATE CALCULATION

NUMERATOR	DENOMINATOR
Dispensed a prescription for antibiotic medication on or three days after the index episode start date	All children 3 months to 18 years old as of July 1 of the year prior to the measurement year to 18 years old of June 30 of the measurement year with a URI

BCBSTX ENROLLMENT CRITERIA

30 days prior to the index episode start date through three days after the index episode start date

INCLUSION CRITERIA

Children, 3 months to 18 years old during the intake period, who had a URI encounter with:

- No other diagnosis present
- No antibiotic medication prescribed or refilled within 30 days prior to the encounter or still active on the date of the encounter
- No specified competing diagnosis on or within three days following the encounter

The intake period is from six months prior to the beginning of the measurement year to six months prior to the end of the measurement year. The earliest episode during the intake period is the index episode start date.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#9: APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

DESCRIPTION: The percentage of children 3 to 18 years old who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode

RATIONALE:

- HEDIS
- Acute care measure
- Measure for pediatric population
- Antibiotic overuse

RATE CALCULATION

NUMERATOR	DENOMINATOR
A group A streptococcus test in the seven-day period from three days prior to the index episode start date through three days after the index episode start date	Children 2 years old as of July 1 of the year prior to the measurement year to 18 years old as of June 30 of the measurement year who were diagnosed with pharyngitis and dispensed an antibiotic

BCBSTX ENROLLMENT CRITERIA

30 days prior to the index episode start date through 3 days after the index episode start date

INCLUSION

Children, 2 to 18 years old during the intake period, who had a pharyngitis encounter with:

- No other diagnosis present
- An antibiotic prescribed within three days of the encounter
- No antibiotic medication prescribed or refilled within 30 days prior to the encounter or still active on the date of the encounter

The intake period is from six months **prior** to the beginning of the measurement year to six months **prior** to the end of the measurement year. The earliest episode during the intake period is the index episode start date.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

Accountable Care Organization – Quality Reports
Frequently Asked Questions

GENERAL QUESTIONS

1. **Question**: Where can I find the latest source specifications for the ACO quality metrics?

   Answer: The latest set of HEDIS specifications can be found at the NCQA website: http://www.ncqa.org/hedis-quality-measurement/hedis-measures. Although the AHRQ specifications do not require purchases of licenses, Health Care Service Corporation (HCSC) still recommends that an ACO obtains specifications directly from the source. The AHRQ website contains both information for AHRQ measure specifications http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx) and CAHPS surveys (http://www.ahrq.gov/cahps/index.html).

2. **Question:** In the context of the ACO Quality Reports, what does a "HEDIS-like" engine mean?

   Answer: A certified HEDIS engine is designed to run the prior calendar year of claims against the most current year engine available. (Example: HEDIS 2018 would be run using 2017 claims.) The engine undergoes NCQA certification, and the results are audited. For the monthly Gaps in Care reports, these reports use current year claims measured against a copy of the current year certified, audited HEDIS engine. The intent of these reports is to give each ACO an earlier view of quality activity. Again, because of the alternate timeframes involved, this is considered an "off-label" use of HEDIS, and so these reports are considered run against a "HEDIS-like" engine.

BREAST CANCER SCREENING, CERVICAL CANCER SCREENING, COLORECTAL CANCER SCREENING

3. **Question**: Patients appear in the monthly Gaps in Care report who have had a mastectomy, or hysterectomy, or colectomy, or prior cancer diagnosis. How can an ACO provide the information needed to exclude a patient from the denominator?

   Answer: The HEDIS engine calculates these gaps based on claims data. When a patient first sees a provider within the ACO for a checkup, the provider should indicate this previous medical history by adding the appropriate diagnosis code(s) to the claim.

4. **Question:** Patients appear in the monthly Gaps in Care report who had a cancer screening not submitted via a claim, or while covered by another health plan. (Examples could include a free cancer screening through a public health department or workplace event, or any screening where a claim was not submitted to HCSC for any reason.) How can an ACO provide the information needed to include that patient in the numerator?

   Answer: The HEDIS engine calculates these gaps based on claims data. Since HCSC is contractually obligated to have the quality measures audited for most ACOs, the data tied to these measures needs to originate from an auditable source. HCSC is working on an enhancement to allow *expanded*

supplemental data for ACOs using standard (automated) electronic files, as defined in the HEDIS Roadmap document provided by HCSC which would provide a mechanism to enable ACOs to submit this screening data while fulfilling audit requirements.

An ACO could improve their scores for this measure by reviewing the Gaps in Care reports early and reaching out to patients who are eligible for screening. Another action an ACO could take is to review the Gaps in Care reports and identify providers who have larger lists of patients with a gap, and coach the providers as appropriate.

5. **Question:** Why is the numerator so high in my March 2018 Gaps in Care reports for my breast cancer screening, cervical cancer screening and colorectal cancer screening measures using only one month of claims data: claims incurred/paid for 1/1/2018 – 1/31/2018?

   Answer: Some measures define the performance year as the current measurement year, while other measures such as the breast cancer screening, cervical cancer screening and colorectal cancer screening also include claims for time periods prior to the performance period. These time periods are outlined in the HEDIS specifications.

   For example, for the breast cancer screening measure, 27 months of claims prior to the end of the measurement year is used. If the patient had a mammogram in December 2017 for the 2018 calendar year performance period, they will still meet the numerator criteria.

   An example of a measure that defines the performance year as the current measurement year are the comprehensive diabetes care measures. The comprehensive diabetes care measures require more frequent monitoring and screening so the HEDIS timeline looks for claims within the current performance year only.

COMPREHENSIVE DIABETES CARE – HBA1C TEST (ANNUAL)

7. **Question**: Why do patients appear in the monthly Gaps in Care report who do not have diabetes?

   Answer: For this measure, the HEDIS engine is triggered by activities in either the measurement year OR the year prior. The trigger could be from a diagnosis code on claims, or from prescription data. An example scenario would be a patient who had been diagnosed with diabetes several years ago, but instead of seeing a primary care physician for a checkup (where presumably an HbA1c test would be conducted), the patient simply continued to have prescriptions refilled. Therefore, the patient will continue to be included in the denominator.

   <u>Diabetes member identification criteria (as of HEDIS 2018)</u>
   Members age 18-75 years of age meeting any of the following criteria:

   - two face-to-face claims or encounters on different dates of service in an outpatient setting, emergency room setting or non-acute inpatient setting with a diagnosis of diabetes
   - one face-to-face claim or encounter in an acute inpatient setting with a diagnosis of diabetes
   - members who were dispensed insulin or oral hypoglycemics and/or antihyperglycemics on an ambulatory basis. Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis coding only.

An ACO could improve their scores for this measure by reviewing the Gaps in Care reports early and reaching out to patients who have not had an HbA1c test. Another action an ACO could take is to review the Gaps in Care reports and identify providers who have larger lists of patients with a gap, and coach the providers as appropriate.

MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (75%)

9. **Question**: Why are there so few members in the numerator and/or denominator?

   Answer: This measure is designed to count the number of patients diagnosed with asthma who fill their controller medication for 75% of the measurement year. The HEDIS engine is designed to count for the full measurement year, not for 75% of the year to date. Therefore, the Gaps in Care reports will not have any patients in the numerator until after six months into the measurement year, when claims from patients filling prescriptions via mail order and have ordered a third 90-day supply will start to filter through the HEDIS engine. The numerator should then increase exponentially through the remainder of the year.

   An ACO can proactively improve scores for this measure by reaching out to patients as a reminder to refill controller medications.

PLAN ALL-CAUSE READMISSIONS (ACTUAL TO EXPECTED)

10. **Question**: How is the expected rate calculated?

    Answer: The expected rate is calculated by the HEDIS engine, using criteria set forth by NCQA based on the ACO's population demographics and risk.

    Expected Readmission Rate= Average Adjusted Probability of Readmission, calculated using risk adjustment based on age, gender, comorbidities, presence of surgeries and discharge condition. Please refer to NCQA for the full specifications.

11. **Question:** How can an ACO improve the actual to expected ratio of readmissions?

    Answer: Unlike other HEDIS measures, readmissions is not really a gap that can be closed. An ACO can improve its ratio of actual to expected readmissions by coaching its facilities to coordinate patient care and discharges with a goal of reducing readmissions.

    We understand that every admission cannot be prevented but every admission can be targeted with proper discharge planning, follow up and care coordination efforts to prevent a 30-day readmission. The measure fosters joint accountability across entities such as hospitals, home care, primary care and specialists in order to prevent avoidable readmissions.

USE OF IMAGING STUDIES FOR LOW BACK PAIN

This measure is designed to assess how many patients were not given an imaging study for an initial diagnosis of low back pain (without clinical indications of necessity). You can calculate this measure by taking the result of dividing the numerator by the denominator, and subtracting the result from 1.

Example: an ACO had 500 patients who met the denominator criteria. One hundred of them, or 20%, received imaging studies without clinical indications of necessity. This means that 80% of the patients did not receive unnecessary imaging which would be the calculated rate for this population.

An ACO can proactively improve future scores for this measure by educating providers in order to reduce unnecessary patient exposure to imaging studies.

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

15. This measure is designed to assess how many patients were not prescribed antibiotics. This rate is known as an inverse rate. You can calculate this measure by taking the result of dividing the numerator by the denominator, and subtracting the result from 1.

    Example: an ACO had 400 patients who met the denominator criteria. One hundred of them, or 25%, received antibiotics. This means that 75% of the patients did not receive antibiotics which would be the calculated rate for this population.

16. **Question**: The intake period for this measure occurs six months prior to the beginning of the measurement year, and ends six months prior to the end of the measurement year. How can an ACO close gaps if the claims have already occurred?

    Answer: Instead of measuring a calendar year, this measure looks at claims six months prior to the start of the measurement year through the sixth month of the measurement year. (Example: HEDIS 2018 will look at claims beginning 7/1/2016 through 6/30/2017, instead of 1/1/2017 through 12/31/2017 as most other measures.)

This measure is designed to help prevent overuse of antibiotics. Once a provider has prescribed antibiotics for a child with a diagnosis of an upper respiratory infection, it cannot be undone. Most parents taking a sick child to the doctor will fill the prescription as soon as possible. An example of how an ACO can use these Gaps in Care reports as a tool to improve quality performance is to identify which providers have a high number of patients that meet the criteria for this measure. The ACO could then work with any applicable providers to determine whether more education or coaching is needed.

This is an optional metric for Year 1. ACOs can use the Caps in Care reports starting in month 9 of Year 1 to identify the opportunities for Year 2 performance and so forth for Year 3.

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

17. **Question**: The intake period for this measure occurs six months prior to the beginning of the measurement year, and ends six months prior to the end of the measurement year. How can an ACO close gaps if the claims have already occurred?

    Answer: Instead of measuring a calendar year, this measure looks at claims six months prior to the start of the measurement year through the sixth month of the measurement year. (Example: HEDIS 2018 will look at claims beginning 7/1/2016 through 6/30/2017, instead of 1/1/2017 through 12/31/2017 as most other measures.)

    Once a patient has been prescribed antibiotics by a physician, most patients will immediately have the prescription filled. There is not much that an ACO can do to correct this once it has happened. Also, a strep test will only be clinically meaningful during a short period of time. Unlike a cancer screening, this is not a gap that can be closed by calling patients listed in the detail report and having them take a strep test later. However, an ACO can proactively improve scores for this measure by educating providers and patients. An ACO could use the patient detail reports to identify providers who might need coaching to ensure they are ordering strep tests for these patients and waiting for positive results before prescribing antibiotics.

    This is an optional metric for Year 1. ACOs can use the Gaps in Care reports starting in month 9 of Year 1 to identify the opportunities for Year 2 performance and so forth for Year 3.

APPENDIX

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

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Disclosure Statement for Medical Power of Attorney

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

This is an important legal document.
Before signing this document, you should know these important facts:

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:

First Alternate Agent

Name:

Address:

_____ Phone:

Second Alternate Agent

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