2017

Provider Manual

PPO Service Area: Collin, Dallas, Denton, Johnson, Parker(zip codes 76008, 76020, 76108, 76126), Rockwall, and Tarrant

HMO Service Area: Collin, Denton, Tarrant

Welcome to Care N' Care!

Thank you for your participation in the Care N' Care network of physicians and providers. We are pleased to provide you with this edition of the Care N' Care Provider Manual. We hope this information will make it easier for you and your staff to find the information you need to provide service to your Care N' Care patients.

Please spend some time reviewing this manual. It is meant to supplement your Care N' Care network service agreement; nothing in this manual is intended to alter the terms and conditions of your Care N' Care network participation agreement.

From time to time, Care N' Care may revise the terms of this Provider Manual. You will be notified of any such changes and a current Provider Manual will also be available on the Care N' Care website at www.cnchealthplan . If you are contracted through a medical group or an IPA participation agreement, the medical group or IPA will notify you of changes to the Care N' Care Provider Manual.

If you have any questions regarding Care N' Care, please contact us at 817-687-4004. Also, feel free to share any specific suggestions for making the Care N' Care Provider Operations Manual a more useful tool. Thank you for your continued support of Care N' Care. We value your feedback and look forward to hearing from you.

Sincerely,

Wendy Karsten
Chief Executive Officer

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SECTION 1: IMPORTANT CONTACT INFORMATION

Care N' Care	8AM- 8PM CST 7 days a week
Phone	877-374-7993
Website	www.cnchealthplan.com
Address	Care N' Care Insurance Company, Inc. 1701 River Run, Ste. 402 Fort Worth, TX 76107
Concierge Services for Members (Claims, Billing, Appeals or Member Questions)	8AM-8PM CST 7 days a week
Phone	877-374-7993
TTY	711
Email Healthcare Concierge	concierge@cnchealthplan.com
Utilization Management (Silverback Care Management)	
Phone	855-359-9999
Fax	888-965-1964
Provider Eligibility Verification	
Interactive Voice Response (IVR) Eligibility Verification	888-965-1966
Eligibility Verification	817-529-9241
Provider Concierge	817-687-4004
Website	www.cnchealthplan.com
Email Provider Concierge	providerconcierge@cnchealthplan.com
Claims	
Claims Inquiry	877-569-6149
Fax	817-529-8302
Claims	Care N' Care Insurance Company, Inc. P. O. Box 961285 Fort Worth, TX 76161
Emdeon Clearing House	
Payer ID#	37228
Customer Service	888-363-3361
Pharmacy Services (Envision)	
Phone	855-791-5302
Fax	855-503-7231
Prior Authorizations	866-250-2005
Fax	877-503-7231
Pharmacy Appeals	855-791-5302

Website	www.envisionrx.com
Dental Services (Avesis)	
Phone	855-704-0436
Website	www.avesis.com
Vision Services (Avesis)	
Phone	855-704-0436
Website	www.avesis.com
Hearing (Avesis)	
Phone	855-704-0436
Website	www.avesis.com
Appeals & Grievances	
Appeals & Grievances	Care N' Care Insurance, Inc. Appeals & Grievances Department 1701 River Run, Ste. 402 Fort Worth, TX 76107
Fraud Waste Abuse Hotline	844-760-5838
Medicare (CMS) Contact Information	
Phone	800-MEDICARE or 800-633-4227
TTY	877-486-2048
Website	www.medicare.gov

Unless otherwise specified in your contract with Care N' Care, the information contained in this document will apply. We reserve the right to make changes to this manual as needed in order to remain compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. The most current version of our provider operations manual is available on our website www.cnchealthplan.com .

SECTION 2: CARE N' CARE PRODUCT LINES

Care N' Care offers North Texas residents affordable, flexible health coverage through a variety of Medicare Advantage plans. Care N' Care offers several PPO plans and HMO plan for its members and prospective members. The coverage service areas for our PPO product lines are: Collin, Dallas, Denton, Johnson, Parker (zip codes 76008, 76020, 76108 and 76126), Rockwall, and Tarrant counties. Care N' Care HMO product covered service areas are Collin, Denton and Tarrant County. Members have the option to obtain optional supplemental benefits which include dental, vision, and hearing benefits. Our plans also provide Fitness Services to our members. PPO and HMO Evidence of Coverage and Summary of Benefits can be found at www.cnchealthplan.com.

SECTION 3: NETWORK PROVIDER REQUIREMENTS

Care N' Care must follow certain regulations and requirements as mandated by the Centers for Medicare & Medicaid Services (CMS). As a contracted network provider, you must also follow certain regulations and requirements. These regulations and requirements are specifically outlined in this manual. Additional regulations and requirements may be described in your provider services agreement with Care N' Care, whether directly with Care N' Care or through an IPA or group agreement.

Some of the regulations you will need to be aware of are as follows:

- Care N' Care will assist providers with enhanced case management for their patients who have complex or serious medical conditions. Case managers will assist providers to assess conditions, establish and implement a treatment plan.
- Providers may not deny, limit or apply conditions to the coverage or furnishing of covered services to members enrolled in Care N' Care based on any condition related to the member's current health status.
- Not discriminate against Members as a result of their participation as Members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, disability or discriminate against dual eligible members.
- Providers may not impose any cost sharing to Care N' Care members for influenza or pneumococcal vaccine and any other preventative service as mandated by CMS.
- Providers agree to provide all claims encounter data necessary to characterize the context and purpose of each encounter with a Care N' Care member and a physician, other health care professionals or health care facility.
- Physicians, other health care professionals and facilities agree that all encounter data will be used by Care N' Care in validating its rates with CMS and that all encounter data and other information submitted to Care N' Care and ultimately CMS is accurate, complete, and truthful and is based on the physician's, other health care professional's or facility's best knowledge, information and belief.
- Physicians, other health care professionals and facilities acknowledge that misrepresentations about the accuracy of encounter data may result in federal/civil action and/or criminal prosecution.
- Providers agree not to bill Care N' Care members for covered services (except for applicable deductibles, copayments or coinsurance) if payment has been denied because the provider has failed to comply with the terms of this manual or the agreement between the provider and Care N' Care.

- Providers must notify all Care N' Care members of their financial obligation for non-covered services in writing.
- Physicians, other health care professionals and facilities and entities delegated by them to perform administrative services are covered entities under Federal and state privacy laws.
- To the extent required by law, providers and their contracted business associates will keep all medical records containing patient-identifiable information confidential and will not disclose any patient-identifiable information to any third party without the prior written consent of the member.
- Providers shall ensure services provided are documented and incorporated into the member's primary care medical record. It is important for specialty physicians and other providers to advise the referring physician when follow-up care is necessary.
- Providers are responsible for the education and training of all individuals working within their medical practice to ensure that procedures outlined in this provider manual are followed correctly. You may contact provider relations to request staff training that may include, but is not limited to, billing procedures and administrative policies.
- Physicians, other health care professionals and facilities will make individual medical records available to patients or their legally designated representative upon request.
- At all reasonable times, physicians, other health care professionals and facilities will provide Care N' Care, CMS, the Office of Inspector General, and their duly authorized representatives the right of access to its facilities and to its financial and medical records which are directly pertinent to Care N' Care members in order to monitor and evaluate cost, performance, compliance measures reporting, quality improvement activities, appropriateness, and timeliness of services provided.
- Physicians, other health care professionals and facilities may not give out or accept applications for enrollment. If an announcement is made to patients of their participation with Care N' Care, this may only be made one time without mentioning other Medicare health plans with which they participate.
- Provide timely notification to Provider Concierge Department of any changes, additions or terms.
- Providers are to verify their demographic information on the on-line Provider Directories on a quarterly basis and email providerconcierge@cnchealthplan.com confirming their information.
- Assure access and availability to Care N' Care members.
- Primary Care Provider's must be available to members 24 hours a day 7 days a week.
- After hour service providers must have an answering service or answering machine directing member with a phone number of how to reach their PCP or on-call provider.
- Members must be able to obtain an appointment for services:
    - Emergency Services such as life threatening or serious illness, must be provided upon member presentation at office or facility.
    - Urgent Care, requires prompt attention but isn't life threatening, including specialty urgent care must be provided within 24 hours of request.
    - Non-Urgent must be able to schedule appointment within a week's request.
    - Routine Primary Care is for new medical concern that is not considered urgent and must be provided within 30 days of requests.
    - Routine Specialty Care referrals must be provided within 30 days of requests. Preventative Health Services appointments for wellness check-ups must be provided within 90 days of requests.
    - Initial Outpatient Behavioral Health must be provided within 14 days of request.

Care N' Care appreciates your dedication to serving the Medicare Advantage population. If you have any questions above listed requirements, please contact your Provider Concierge Representative or Provider Concierge Department at 817-687-4004.

SECTION 4: PROVIDER CONCIERGE & PROVIDER CHANGES/UPDATES

Provider Concierge Department is the liaison between the community providers and health plan. Provider Concierge Department offers support, guidance, education, resources, training and conduct Provider site visits. Providers are encouraged to contact their assigned Provider Concierge Representative who will be their primary contact for any issues or concerns they may have regarding Care N' Care health plan. Issues or concerns can pertain to demographic updates/changes, claims, authorization, eligibility, contracting, and credentialing, etc. Providers can contact their assigned Provider Concierge Representative or Provider Concierge Department at 817-687-4004 or email providerconcierge@cnchealthplan.com.

Provider Additions, Changes, Terminations and Panel Closure

Care N' Care adheres to regulatory guidelines when evaluating requests to add, change or terminate providers and expects providers will provide accurate and timely provider data. Please send all provider adds, changes, and termination requests in writing to providerconcierge@cnchealthplan.com. Provider changes and updates include but are not limited to the following:

- Change in practice location;
- Change in practice affiliation;
- Change of address, phone or fax number;
- Change in hours of operation;
- Retirement or leave of absence exceeding 30 days;

Any change to a provider's status should be communicated immediately to Care N' Care Provider Concierge Department.

All provider profiles are reviewed for credentialing requirements, including but not limited to the following:

- Provider specialty (ies) and credentials (e.g., MD, DO, MFT, etc.);
- Medical license number and expiration date;
- DEA number and expiration date;
- NPI number;
- Board certification status;
- Professional liability insurance.

The following applies to all product lines HMO, PPO except Provider Sponsored Plans (PSPs). PSP provider termination timelines are documented in the Provider Agreement between Care N' Care and the physician group:

- Termination notice must be submitted to providerconcierge@cnchealthplan.com.
- Non-PCP provider add, change and termination requests received by the 10th of the current month are processed and will become effective by the 1st of the month.
- Non-PCP provider add, change and termination requests received after the 10th of the month are

processed and will become effective the 1st of the subsequent month.

- PCP terminations with effective dates of the 1st of the following month are processed as soon as possible, regardless of submission date. PCP terminations with effective dates after the 1st of the following month are processed within 30 days prior to the effective date of the termination.

Incomplete requests or those requiring further attention will be returned to senders with details regarding the issue(s) found and/or notice of action/ additional information needed.

To obtain provider ID#s, provider organizations are expected to check the Find a Doctor or Find a Specialist section of the Care N' Care website at www.cnchealthplan.com on or after the 1st of the appropriate month according to the timeline established above.

Care N' Care will notify members of PCP and/or hospital changes, using CMS approved member letters, samples are included at the end of this manual as **Attachment A**.

Corporate Information Changes
Corporate information includes but is not limited to organization name and/or dba, organization ownership, tax identification number (TIN), and payee name and address.

Changes to corporate information impact provider reimbursement and require a written letter on letterhead from the physician group that identifies the requested change and is signed by an administrator of the organization. In addition to the letter, a copy of the physician group's Articles of Incorporation, or Service Agreement must also be provided in order to verify administrators' names. If the request includes a TIN change, a W-9 must be provided. This information can be emailed to providerconcierge@cnchealthplan.com or you may contact your assigned Provider Concierge Representative.

Provider Directory
Care N' Care provider directory information is available online at the Care N' Care website at www.cnchealthplan.com . If a printed directory is required, please contact our Provider Concierge Department at 817-687-4004 or email providerconcierge@cnchealthpla.com and request a copy.

SECTION 5: MEMBER ELIGIBILITY

In order for an individual to enroll in Care N' Care Medicare Advantage Plan, the individual must be entitled to Medicare Parts A and B in addition to living within the service area the plan is offered. The Care N' Care service area for the PPO product lines are: Collin, Dallas, Denton, Johnson, Parker (zip codes 76008, 76020, 76108 and 76126), Rockwall, and Tarrant counties. The HMO product line covered service areas are Collin, Denton and Tarrant County. Medicare Advantage eligible beneficiaries who request enrollment with Care N' Care will be effective the first day of the month following the date a complete application for enrollment is accepted by the enrollment Department. Prospective members may not request future enrollment dates. Beneficiaries who are receiving services in a hospice facility are eligible to enroll with Care N' Care. Beneficiaries who have been medically determined to have End Stage Renal Disease (ESRD) are not eligible for enrollment into Care N' Care. An individual who receives a kidney

transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of eligibility and may enroll into Care N' Care.

SECTION 6: VERIFIYING ELIGIBILITY

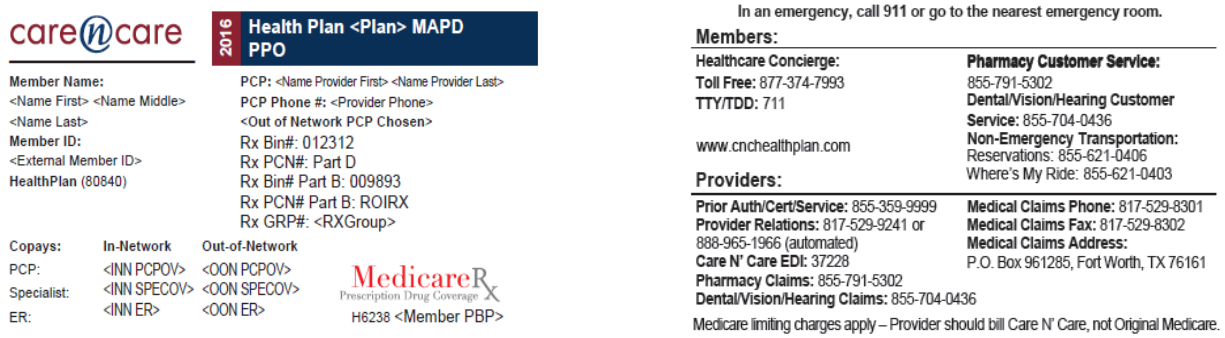
A member's eligibility status can change at any time during a plan year, all providers should consider verifying a member's eligibility upon each visit to your office or facility. There are several options to verify eligibility for Care N' Care members.

Interactive Voice Response (IVR) Eligibility Verification
Providers can verify member eligibility using our IVR system at 888-965-1966. Users have access to real-time eligibility data and have the option to listen to pending eligibility changes available 24 hours a day 7 days a week. IVR provides the following data:

- Member name and ID number;
- Member effective date;
- Member termination date;
- Benefit plan effective date;
- Benefit information;
- Co-payment amounts for the following: PCP visits, specialist visits, DME, hospital, emergency room, Home Health, Skilled Nursing Facility, Physical Therapy,

Provider Concierge Representative
To verify eligibility over the phone with a Provider Concierge Representative call 817-529-9241, Monday-Friday from 7:00AM-5:00PM CST. You will need your provider ID number.

Eligibility ID Cards
All members enrolled in Care N' Care's MAPD plans receive a member ID card. A sample of the ID cards are below:


care n care

2016 Health Plan <Plan> MAPD PPO

Member Name:
<Name First> <Name Middle>
<Name Last>
Member ID:
<External Member ID>
HealthPlan (80840)

PCP: <Name Provider First> <Name Provider Last>
PCP Phone #: <Provider Phone>
<Out of Network PCP Chosen>
Rx Bin#: 012312
Rx PCN#: Part D
Rx Bin# Part B: 009893
Rx PCN# Part B: ROIRX
Rx GRP#: <RXGroup>

Copays:	In-Network	Out-of-Network
PCP:	<INN PCPOV>	<OON PCPOV>
Specialist:	<INN SPECOV>	<OON SPECOV>
ER:	<INN ER>	<OON ER>

MedicareRx Prescription Drug Coverage

H6238 <Member PBP>

In an emergency, call 911 or go to the nearest emergency room.

Members:

Healthcare Concierge:
Toll Free: 877-374-7993
TTY/TDD: 711

www.cnchealthplan.com

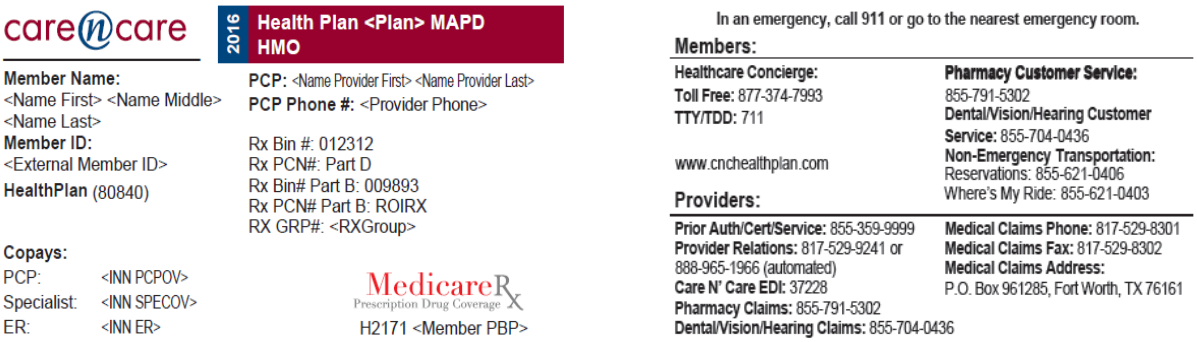
Pharmacy Customer Service:
855-791-5302
Dental/Vision/Hearing Customer Service: 855-704-0436
Non-Emergency Transportation:
Reservations: 855-621-0406
Where's My Ride: 855-621-0403

Providers:

Prior Auth/Cert/Service: 855-359-9999
Provider Relations: 817-529-9241 or 888-965-1966 (automated)
Care N' Care EDI: 37228
Pharmacy Claims: 855-791-5302
Dental/Vision/Hearing Claims: 855-704-0436

Medical Claims Phone: 817-529-8301
Medical Claims Fax: 817-529-8302
Medical Claims Address:
P.O. Box 961285, Fort Worth, TX 76161

Medicare limiting charges apply – Provider should bill Care N' Care, not Original Medicare.


care n care

2016 Health Plan <Plan> MAPD HMO

Member Name:
<Name First> <Name Middle>
<Name Last>
Member ID:
<External Member ID>
HealthPlan (80840)

PCP: <Name Provider First> <Name Provider Last>
PCP Phone #: <Provider Phone>

Rx Bin #: 012312
Rx PCN#: Part D
Rx Bin# Part B: 009893
Rx PCN# Part B: ROIRX
RX GRP#: <RXGroup>

Copays:

PCP:	<INN PCPOV>
Specialist:	<INN SPECOV>
ER:	<INN ER>

MedicareRx Prescription Drug Coverage

H2171 <Member PBP>

In an emergency, call 911 or go to the nearest emergency room.

Members:

Healthcare Concierge:
Toll Free: 877-374-7993
TTY/TDD: 711

www.cnchealthplan.com

Pharmacy Customer Service:
855-791-5302
Dental/Vision/Hearing Customer Service: 855-704-0436
Non-Emergency Transportation:
Reservations: 855-621-0406
Where's My Ride: 855-621-0403

Providers:

Prior Auth/Cert/Service: 855-359-9999
Provider Relations: 817-529-9241 or 888-965-1966 (automated)
Care N' Care EDI: 37228
Pharmacy Claims: 855-791-5302
Dental/Vision/Hearing Claims: 855-704-0436

Medical Claims Phone: 817-529-8301
Medical Claims Fax: 817-529-8302
Medical Claims Address:
P.O. Box 961285, Fort Worth, TX 76161

A new identification (ID) card is automatically sent when:

- A new Medicare Advantage plan member enrolls
- A member changes his or her name
- A member changes his/her Primary Care Physician
- The member changes Medicare Advantage plans

Members enrolled in Care N' Care's Medicare Advantage Part D receive a member ID card that contains medical and prescription medication information:

Remember, eligibility data is based upon the best available data to the health plan and may not always be current at the time of request. Verification of eligibility does not guarantee payment.

SECTION 7: DUAL ELIGIBLE MEMBERS

Dually eligible members are those members who qualify for both Medicare and Medicaid. There are different types of eligibility as explained below.

Full Benefit Dual-Eligibles

Full benefit dual-eligible beneficiaries include those individuals who have coverage under both Medicare and Medicaid. In accordance with CMS guidelines, dual-eligible beneficiaries must enroll in a qualified

Medicare prescription drug program to receive prescription medication coverage. Dual-eligible beneficiaries automatically qualify for extra assistance and do not need to apply separately.

Beneficiaries who qualify for full dual benefit dual-eligible status may voluntarily choose to enroll in a Medicare Advantage plan, another Medicare health plan that offers prescription coverage or a stand-alone Prescription Drug Plan (PDP). Beneficiaries who do not enroll in a qualified Medicare Prescription Drug Program are automatically enrolled in one to ensure there is no loss of prescription medication coverage. Full benefit dual-eligible beneficiaries enrolled in a Medicare Advantage plan are enrolled into a Medicare Prescription Drug Program offered by the same Medicare Advantage organization. The Centers for Medicare and Medicaid services (CMS) facilitates the enrollment.

Other full subsidy eligible beneficiaries who may receive assistance include:

- Recipients of Medicare and Supplemental Security Income (SSI) only.
- Recipients of Medicare Savings Programs (MSPS), such as Qualified Medicare Beneficiaries (QMB only), Specified Low-Income Medicare Beneficiaries (SLMB only) or Qualifying Individuals (QI).

MSP recipients receive additional assistance from the beneficiary's state, paying for Medicare premiums and member cost sharing or copayments. The full subsidy eligible member listed above automatically qualifies for extra assistance and do not need to apply separately. These beneficiaries generally have slightly higher incomes than full benefit dual-eligible beneficiaries. Medicaid pays for cost sharing associated with Medicare, including member premiums.

Other Low Income Beneficiaries:
Beneficiaries with limited income and resources who do not fall into one of the subsidy programs discussed above may still qualify for assistance in paying for Medicare premiums and/or cost-sharing.

These beneficiaries must apply for the Low-Income Subsidy (LIS). Beneficiaries may apply for LIS by contacting the Social Security Administration or state of Texas Medicaid office. You may visit the website at: http://www.hhsc.state.tx.us/Medicaid/

Generally, the guidelines apply to beneficiaries with incomes less than 150 percent of federal poverty level and limited assets. The type of income considered is based on the rules of the SSI program. Monthly prescription medication plan premium, annual deductible and prescription medication copayments depend on the beneficiary's annual income and resources, in accordance with the United States Health and Human services (HHS) Poverty Guidelines.

For further information regarding Medicare savings Programs, you may visit:
http://www.cms.hhs.gov/center/ PeopleWithMedicareCenter.asp

SECTION 8: MEMBER RIGHTS AND RESPONSIBILITIES

Rights and responsibilities for Care N' Care members include:

- Choose a Primary Care Physician (PCP);
- A discussion of medically necessary treatment options for his or her condition, regardless of cost or benefit coverage;
- Timely access to Primary Care Providers (PCPs) and referrals to specialists when medically necessary;
- Timely access to all covered services, both clinical and non-clinical;

- Access to emergency services without prior authorization when the member, as a prudent layperson, acts reasonably, believing that an emergent medical condition exists;
- Actively participate in decisions regarding his or her health and treatment options;
- Receive urgently needed services when traveling out of his or her Medical Advantage plan service area, or within his or her Medical Advantage plan service area when unusual or extenuating circumstances prevent the member from obtaining care from his or her PCP, if applicable;
- Be treated with dignity and respect and to have his or her right to privacy recognized;
- Exercise these rights regardless of the member's race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care; and to expect these rights to be upheld by Care N' Care participating providers;
- Confidential treatment of all communications and records pertaining to his or her care. The member has the right to access his or her own medical records. Care N' Care and its participating providers must provide to members timely access to their medical records and any information that pertains to them. Except as authorized by state law, written permission from the member or the member's authorized representative must be obtained before medical records can be made available to any person not directly concerned with the member's care or responsible for making payments for the cost of such care;
- Extend these rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care;
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision);
- Be involved in decisions to withhold resuscitative service, or forego or withdraw life-sustaining treatment;
- Complete an advance directive, living will or other directive to his or her medical providers;
- Information about his or her Medical Advantage plan and covered services;
- Know the names and qualifications of physicians and health care professionals involved in the member's medical treatment;
- Receive information about an illness, the course of treatment and prospects for recovery in terms the member can understand;
- Information regarding how medical treatment decisions are made by the contracting medical group or Care N' Care, including payment structure;
- Information about his or her medications – what they are, how to take them and possible side effects;
- Receive as much information about any proposed treatment or procedure as he or she may need in order to give an informed consent or to refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment;
- Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the physician providing care;
- Be advised if a physician proposes to engage in experimentation affecting the member's care or treatment. The member has the right to refuse to participate in such research projects;
- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities;

- Examine and receive an explanation of any bills for non-covered services, regardless of payment source;
- General coverage and plan comparison information;
- Utilization of control procedures;
- Statistical data on grievances and appeals;
- The financial condition of Care N' Care;
- Summary of provider compensation agreement.

A Care N' Care member has the responsibility for:

- Providing his or her physicians or other care providers the information needed in order to care for him or her;
- Doing his or her part to improve his or her own health condition by following treatment plans, instructions and care that he or she has agreed on with his or her physician(s);
- Behaving in a manner that supports the care provided to other patients and the general functioning of the facility;
- Accepting the financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility;
- Accepting the financial responsibility for any premiums associated with membership in a Care N' Care Medicare advantage plan;
- Reviewing information regarding covered services, policies and procedures as stated in the member's Evidence of Coverage (EOC);
- Asking questions of his or her PCP or participating provider, as applicable, and/or Care N' Care Healthcare Concierge Department.

SECTION 9: BENEFITS

This Provider Manual provides participating providers necessary information to ensure members enrolled in Care N' Care's Medicare Advantage plan receive appropriate, timely covered services when needed.

The summary of benefits, which outlines in table format the benefits of the Care N' Care Medicare Advantage plan and all applicable copayments/cost sharing. The summary of benefits may be reviewed online at www.cnchealthplan.com . Benefits and policies listed in this provider manual apply to all providers, unless specified otherwise in the written Provider Agreement or the member's Evidence of Coverage (EOC).

As a Care N' Care participating provider, you are required to comply with applicable federal and state laws and all requirements set forth by the Centers for Medicare and Medicaid Services (CMS), which governs the Medicare Program. You are also required to comply with Care N' Care policies and procedures that may not be listed within this manual. Some services will require prior authorization/ precertification. Please refer to **Attachment B** for our prior authorization/ precertification list. Please contact your Provider Concierge Representative for further information or with any questions at 817-687-4004.

SECTION 10: PREVENTIVE SERVICES

In accordance with Medicare coverage guidelines, the following preventive services are covered as part of the Care N' Care Medicare Advantage Plans. Some preventive services are covered at 100% and do not have a copay or cost sharing for the member.

- Health facility membership program through Silver & Fit;
- "Welcome to Medicare" preventive visit, one time only within the first 12 months of Part B eligibility;
- Abdominal Aortic Aneurysm screening for people at risk so long as the member gets an in network referral for this test as a result of their "Welcome to Medicare visit";
- Annual wellness visit if the member has had Part B longer than 12 months. This visit cannot take place within 12 months of a "Welcome to Medicare" preventive visit;
- Annual glaucoma screening once per year, for Medicare beneficiaries who are at high risk, have a family history of the disease, or have diabetes;
- A baseline mammogram for female Medicare beneficiaries ages 35-40. One mammogram every twelve months for female Medicare beneficiaries over age 40; and a clinical breast exam once every 24 months;
- Medical nutrition therapy by registered dietitians or other qualified nutrition professionals for Medicare beneficiaries diagnosed with diabetes or chronic renal disease and for post-transplant patients;
- Bone mass measurements are covered for those at risk once every 24 months. Medicare covers procedures to identify bone mass, detect bone loss or determine bone quality, including a physician's interpretation of the results;
- Annual prostate cancer screening exams for male Medicare beneficiaries age 50 and over. These exams include a digital rectal exam and a Prostate Specific Antigen (PSA) test;
- HIV screening once every 12 months;
- Diabetes self-management, provides coverage for diabetes outpatient self-management training to include services furnished in non-hospital based programs. As the physician managing the member's condition, you must certify that the services are needed under a comprehensive plan of care. Services are covered with no copayment. This also provides coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics); Manufacture Freestyle, Precision and One-Touch devices.
- Prostate cancer screening one for men 50 and older, we cover a digital rectal exam and a PSA test once every 12 months;
- Pap test and pelvic exam is covered every 24 months with no copayment or deductible. For female Medicare beneficiaries at high risk for uterine or vaginal cancers, a pap test and pelvic exam is covered annually with no copayment or deductible;
- Colorectal cancer screening for people 50 and older, the following are covered:
  - Flexible sigmoidoscopy every 48 months;
  - Fecal occult blood test every 12 months;
  - Screening colonoscopy every 24 months for high risk members;
  - Screening colonoscopy every 10 years for members not at high risk.
- Limited preventive dental services. See our EOC for specific coverages;
- Depression screening once per year in a primary care setting;

- Screening and counseling to reduce alcohol misuse, up to 4 brief face to face counseling sessions per year provided by a qualified primary care doctor in a primary care setting;
- Screening for sexually transmitted infections and counseling to prevent sexually transmitted diseases when the tests are ordered by a primary care provider, once every 12 months;
- Obesity Screening and therapy to promote weight loss. If a member has a body mass index of 30+, this counseling is covered if it is given in a primary care setting where it is coordinated with a comprehensive care plan;
- For smoking and tobacco cessation, we cover two counseling quit attempts, each equaling four face to face visits, within a 12 month period;

Immunizations

Specified immunizations and adult boosters are covered as described below. Part B covered immunizations include:

- Pneumonia and Influenza Vaccine - In accordance with the federal regulations governing Medicare, members may self-refer for influenza and pneumococcal vaccines with no copayments. Participating providers who do not provide vaccines should provide the member with a list of affiliated clinics who can provide these vaccines;
- Hepatitis B if a member is at high risk and they meet Medicare Part B coverage rules. If the condition falls into one of the categories listed below, the vaccine is covered. No copayment applies if this is the only service provided;
  - End-stage renal disease (ESRD) members;
  - Hemophiliacs receiving Factor VIII or IX concentrates;
  - Mentally handicapped institutionalized residents;
  - Persons living in the same household as hepatitis B carriers;
  - Homosexual men;
  - IV drug abusers;
  - Staff in institutions for the mentally retarded;
  - Health care workers who have contact with blood or blood-derived body fluids.

Immunizations required for foreign travel are not covered. Immunizations fulfilling occupational-related requirements are not covered.

Part D covered vaccines are listed in our formulary's *List of Covered Drugs.* You can review this on our website at cnchealthplan.com.

SECTION 11: BEST AVAILABLE EVIDENCE

Best Available Evidence (BAE) policy is used when the low income subsidy information in CMS' systems is not correct. CMS relies on monthly files from the states and social security to establish an individual's low-income subsidy deemed eligibility and appropriate cost-sharing level. In certain cases, CMS systems do not reflect a beneficiary's correct low-income subsidy deemed status. This may occur, for example, because a state has been unable to successfully report the beneficiary as Medicaid eligible or is not reporting him/her as institutionalized.

Plans may initially rely on evidence presented at the pharmacy to provide a lower cost-sharing status at point of-sale, but must follow up with additional documentation within a specified period of time. We recommend that sponsors consider this approach to address urgent situations. The Best Available Evidence process will allow CMS and plan subsidy level records to be synchronized for those beneficiaries for whom Medicaid status has not been updated.

Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to make a change to a beneficiary's low-income status:

- A copy of the member's Medicaid card which includes the member's name and an eligibility date during the discrepant period;
- A report of contact including the date a verification call was made to the State Medicaid agency and the name, title and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.
- Other Medical provided by the State showing Medicaid status during the discrepant period.

In addition, Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

SECTION 12: PRESCRIPTION DRUG PROGRAM (PART D)

A formulary is a list of the drugs covered by Care N' Care. Care N' Care will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

To obtain a formulary list visit our website at www.cnchealthplan.com or refer to **Attachment C.**

**Not all Drugs are covered by our plan.*

Formulary Changes

Care N' Care may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much members will pay when filling a prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary;
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug;
- Moving a drug to a higher or lower cost-sharing tier;

If Care N' Care removes drugs from the formulary, or adds prior authorizations, quantity limits and/or step therapy restrictions on a drug or moves a drug to a higher cost-sharing tier and a member is taking the drug affected by the change, they will be permitted to continue taking that drug at the same level of cost sharing for the remainder of the plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed because of new information on a drug's safety or effectiveness, the member may be affected by this change. Care N' Care will notify the member of the change at least 60 days before the date that the change becomes effective or provide them with a 60-day supply at the pharmacy. This will give them an opportunity to work with their physician to switch to a different drug that Care N' Care covers or request an exception. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60-day notice before removing the drug from the formulary. Instead, Care N' Care will remove the drug immediately and notify members taking the drug about the change as soon as possible.

Non-Formulary and Prior Authorization/ Exception Requests

For certain prescription drugs and all non-formulary drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult the formulary for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Non-Formulary Drugs:

Sometimes a physician may determine a non-formulary drug is necessary to treat a member's medical condition. Care N' Care has established a process for the physician to request a non-formulary drug be eligible for coverage.

Prior Authorization:

Care N' Care requires prior authorization (prior approval) for certain drugs. This means that the physician must contact us before writing the prescription. If Care N' Care does not receive the necessary information to satisfy the prior authorization, we may not cover the drug.

NOTE: The prior authorization information for prescription drugs is located on the Care N' Care website at www.cnchealthplan.com

Quantity Limits:

For certain drugs, Care N' Care limits the amount of the drug that we will cover per prescription or for a defined period of time.

Step Therapy:

In some cases, Care N' Care requires the member to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may require the member's physician to prescribe Drug A first. If Drug A does not work for the member, then we will cover Drug B.

Generic Substitution:

When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/ or provide a member with the generic version, unless their physician has advised us that the member must take the brand-name drug and Care N' Care has approved this request.

If a physician determines that a member is not able to meet an additional restriction or limit for medical necessity reasons or a non-formulary drug is necessary to treat a member, the physician may request an exception (which is a type of coverage determination). For information on exceptions related to non-formulary drugs, prior authorization, quantity limits, step therapy and generic substitution please utilize the Prior Authorization/Exception Request form **Attachment I** or refer to the Care N' Care website at www.cnchealthplan.com . For additional questions or assistance, please contact the Prescription Drug Customer service Department at 1-855-791-5302.

Transition Policy

New members to Care N' Care may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Physicians should talk to the member to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. During the period of time a physician is talking to the member to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a physician with a current member affected by a formulary change from one year to the next, the physician should request a formulary exception.

Medication Therapy Management Program

Care N' Care offers medication management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs and who have high drug costs. These programs were developed for us by a team of pharmacists and physicians. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact your patient, we hope they will join so that we can help manage their medications. Remember, the patient will not need to pay anything extra to participate.

If they are selected to join a medication therapy management program, we will send them information about the specific program, including information about how to access the program.

Exclusions

Certain medications or medication categories are excluded from coverage for Medicare Part D members, including:

- Non-prescription medications, unless they are part of an approved step therapy;
- Medications when used for anorexia, weight loss, or weight gain;
- Medications when used to promote fertility;
- Experimental or investigational medications;
- Medications when used for cosmetic purposes or hair growth;
- Medications when used for the symptomatic relief of cough or colds;
- Be purchased exclusively from the manufacturer as a condition of sale;
- Barbiturates (except when used to treat epilepsy, cancer, or a chronic mental health diagnosis);
- Smoking cessation medications that do not require a prescription;
- Medications that are covered under Medicare Part A or Part B.

SECTION 13: COMPLIANCE

Compliance Program

Care N' Care has a commitment to compliance, integrity, and ethical values. This is demonstrated by Care N' Care compliance program and includes the following elements:

- Written policies, procedures, and standards of conduct;
- The designation of a Medicare Compliance officer or designee and compliance committee;
- Effective training and education;
- Effective lines of communication between the Medicare Compliance officer or designee, the organization's employees, contractors, subcontractors, agents, directors;
- Enforcement of standards;
- Provision for internal monitoring and auditing;
- Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives;
- Reporting of violations and potential violations;
- Fraud, waste, and abuse;

SECTION 14: MEDICAL SERVICES

All medical services provided under the Care N' Care Medicare Advantage plans are done so in accordance with Medicare Guidelines. It is always less costly for members to receive their care from an in-network provider; however, our PPO members may choose an out of network provider. Please note that due to Medicare Guidelines, Care N' Care is unable to pay for services from a non-Medicare out of network provider. While these services will be covered, so long as they meet Medicare's requirements, they will be more costly.

For our HMO plan, member must receive care from an in-network provider or the services will not be covered. Please note that HMO member referrals must come from the PCP. If you are unsure of the network status of a provider you may be referring to, please consult our provider directory at

www.cnchealthplan.com or contact our Provider Concierge Representatives or Provider Concierge Department at 817-687-4004 or email providerconcierge@cnchealthplan.com .

Pre-Authorization Request

Additionally, some of our services require prior authorization. Prior authorization is not a guarantee of payment. Prior authorizations are managed by our Utilization Management (UM) company, Silverback Care Management. Below is a list of the Prior Authorization forms available. Please refer to the end of the Provider Manual for each form attachment.

- **Attachment B** - Summary of Services Requiring Prior Authorization form;
- **Attachment C**-Specialty Drug Preauthorization List.
- **Attachment D** - Instructions on How to Submit a Prior Authorization form;
- **Attachment E** - Prior Authorization Request form;
- **Attachment F** - Home Health Prior Authorization Request form;
- **Attachment G** - DME Prior Authorization Request form;
- **Attachment H** - Skilled Nursing Facility and Long Term Acute Care Rehabilitation Prior Authorization request form;
- **Attachment I**- Pharmacy Authorization Exception Forms.

Failure to obtain the required authorization may result in a denied claim or reduction in payment.

SECTION 15: LABORATORY SERVICES

All laboratory services provided under the Care N' Care Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

Care N' Care Laboratory services may be obtained from a provider/facility of lab services that is contracted with Care N' Care or from a non-contracted provider/facility at a higher cost sharing for the member. When ordering laboratory services, please complete the entire laboratory referral form, including all patient information.

Some Care N' Care providers may do laboratory work in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

A copayment may be charged for laboratory services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits, laboratory services section.

SECTION 16: RADIOLOGY SERVICES

All radiology services provided under the Care N' Care Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

Care N' Care Radiology services may be obtained from a provider/facility of radiology services that is contracted with Care N' Care or from a non-contracted provider/facility at a higher cost sharing for the member. For a current listing of radiology service providers, please visit the Care N' Care website at www.cnchealthplan.com . When ordering radiology services, please complete the entire prior authorization form, including all patient information.

Some Care N' Care providers may perform radiology services work in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

A copayment may be charged for radiology services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits, Radiology services section.

Care N' Care requires prospective review of all outpatient Magnetic Resonance (MR), Computed Tomography (CT) and Positron Emission Tomography (PET) imaging procedures with the exception of:

- Inpatient radiology services;
- Emergency room radiology services;
- Outpatient radiology services other than MR, CT and PET imaging studies.

All outpatient MR, CT and PET imaging procedures require prior authorization/ precertification. The list of these services is provided on **Attachment B**. Physicians and specialty providers can request prior authorization/precertification by faxing a completed request form to 888-965-1964. A copy of the form may be obtained by calling 855-359-9999.

When a provider requests authorization of services, it is important to provide the following information:

- Member demographic information including the identification number and date of birth;
- Current diagnosis and clinical information including treatment history, treatment plan and medications;
- Member's chart and previous imaging study results if applicable.

Prior authorization requests are generally processed within 24 to 48 hours of the request by the delegated UM Department after the receipt of all necessary information. Failure to receive prior authorization for these services will result in a denial of payment and the member cannot be billed for the services. The provider may have appropriate appeal rights.

The notification process should be addressed by calling our delegated UM Department, at 855-359-9999 or faxing the prior authorization form to 888-965-1964. For urgent prior authorization or precertification requests, contact our delegated UM Department at 855-359-9999 by telephone and indicate that the prior authorization request is for medically urgent care. Care N' Care will render a decision no less than 24 hours after receipt of all necessary information.

SECTION 17: SKILLED NURSING

Coverage care and treatment in a Skilled Nursing Facility (SNF) is provided when medically necessary and approved through the prior authorization process by a Care N' Care delegated UM Department. Skilled nursing care in a sub-acute unit or facility is subject to a 100-day limit per benefit period. Custodial care in a skilled facility or any other facility is not a covered benefit by Medicare or Care N' Care. Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech - language pathologists or audiologists; and

- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Custodial care is defined as care that assists an individual with their daily activities of living, i.e., bathing, eating, dressing, using the rest room, etc. This also includes simple diets and medication routines. Even though Care N' Care's Medicare Advantage plans do not cover custodial care, services that fall under Medicare Part B will be covered. A copayment per day will be charged for skilled nursing facility care received from a Care N' Care network provider. For the most current cost share, please refer to the summary of benefits. For a current listing of skilled nursing care providers, visit the Care N' Care website at www.cnchealthplan.com.

SECTION 18: HOME HEALTH

Home Health services must receive prior authorization from Care N' Care. Providers requesting for Home Health Services for members are to fax the Home Health Pre-Certification form to 855-446-9982. The Care N' Care Home Health Prior Authorization form is available please see **Attachment F**. All Home Health care services provided under the Care N' Care Medicare Advantage plan are done so in accordance with Medicare coverage guidelines.

To qualify for the Medicare Home Health benefit, a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

Home Health services provided by a non-contracting provider or facility are covered at a higher cost sharing for PPO members only. Please refer to the summary of benefits for cost sharing information. For a current listing of Home Health care providers, please visit the Care N' Care website at www.cnchealthplan.com .

SECTION 19: DURABLE MEDICAL EQUIPMENT (DME)

All Durable Medical Equipment services provided under the Care N' Care Medicare Advantage plans are done so in accordance with Medicare coverage guidelines. Providers requesting Durable Medical Equipment for members are to fax the DME Prior Authorization form to 888-965-1964, please see **Attachment G.** Care N' Care will not cover Durable Medical Equipment unless criteria has been met. Durable Medical Equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and

- Is appropriate for use in the home;

Care N' Care requires prior authorization and shall cover Durable Medical Equipment when:

- The equipment meets the definition of Durable Medical Equipment as listed above;
- The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body part; and
- The equipment is used in the patient's home.

Care N' Care contracted providers are required to refer Durable Medical Equipment services to in-network Durable Medical Equipment providers. Durable Medical Equipment services provided by a non-contracting provider or facility are covered at a higher cost sharing for the PPO members only. Please refer to the summary of benefits for cost sharing information. For a current listing of DME providers, visit the Care N' Care website at www.cnchealthplan.

SECTION 20: OUTPATIENT SERVICES

Outpatient services include such services as physician office visits, and chiropractic services as well as outpatient hospital services, non-dental services and second opinions. Some of these services will require prior authorization.

All outpatient services provided under the Care N' Care Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

Care N' Care Outpatient services may be obtained from a provider/facility of outpatient services that is contracted with Care N' Care or from a non-contracted provider/facility at a higher cost sharing for PPO members only. For a current listing of outpatient specialty providers/hospital facility providers, please visit the Care N' Care website at www.cnchealthplan.com.

SECTION 21: EMERGENCY AND URGENT CARE

Care N' Care Medicare Advantage plans covers medical emergencies 24 hours a day, 7 days a week, from any provider in or out of network. Emergency Care can be defined as a condition that would lead a prudent lay-person possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the person's health in serious jeopardy; danger of serious impairment of the individual's bodily functions; serious dysfunction of any of the individual's bodily organs or parts; in the case of a pregnant woman, serious jeopardy to the health of the fetus; or serious disfigurement.

Care N' Care does not require prior authorization for emergency services to be covered. However, notification is requested.

Urgently needed care can be defined as non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. If the member is in the plan's service area and network providers are temporarily unavailable or inaccessible, urgent care services will be covered from an out-of-network

provider at the lower in-network cost sharing amount. If the member is outside of the plan's service area and cannot get urgent care from a network provider, the plan will cover such care at the lower in-network cost sharing amount.

For both emergency and urgently needed care, the hospital must provide notification to the Care N' Care delegated UM Department or the number located on the back of the Member ID card within 48 hours of providing services or as soon as reasonably possible. If a network Care N' Care facility fails to provide notification within 48 hours or the next business day, the emergency admission will not be covered and the member cannot be balanced billed.

SECTION 22: INPATIENT HOSPITAL SERVICES

Care N' Care Medicare Advantage plan provides coverage for inpatient hospital services in a network acute care facility. Inpatient hospital services require prior authorization/notification, from a provider or facility that a member of Care N' Care has been admitted or that services have been rendered. When planning an "elective" admission to a network facility, please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

When the Care N' Care delegated UM Department is notified of hospital admissions, the utilization management Department verifies eligibility, attending physician and assigns a concurrent nurse reviewer. The UM Department will enter the notification in the system to generate a case number and issues the number. The facility is responsible for obtaining the permanent authorization number by contacting the Care N' Care delegated UM Department prior to claim submission.

All elective, urgent and emergent, inpatient and skilled nursing admissions must be reported to Care N' Care's delegated UM Department by the next business day, unless otherwise stated in the facility contract. To notify Care N' Care delegated UM Department you may call 855-359-9999. Please have the following information ready to provide:

- Facility name;
- Name of caller reporting admission;
- Phone number of caller reporting admission;
- Member's full name;
- Member's identification (id) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room notifications there may not be a room number assigned, as these are potential admission and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay - elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;
- Type of admission (medical, surgical, telemetry, or intensive care);
- Admitting or attending physician;
- Other insurance if available;

- Status of admission (inpatient, skilled nursing or sub-acute rehabilitation) services may be reviewed after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate or not medically necessary.

Services denied for late or non-notification are considered non-reimbursable services and cannot be billed to the member.

SECTION 23: BEHAVIORAL HEALTH SERVICES

Care N' Care Medicare Advantage plans provide coverage for inpatient psychiatric care in a network acute care facility. When planning an "elective" admission to a network facility, when authorized by Care N' Care, for up to 190 days (lifetime benefit limit per member according to Medicare guidelines. Please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

If the member has used part of the 190-day Medicare lifetime benefit prior to enrolling in Medicare Advantage, the member is only entitled to receive coverage for the difference between the number of days already used and the Medicare Advantage authorized benefit.

Psychiatric care in a contracting hospital is subject to the benefits for hospital services. Please refer to the summary of benefits, Inpatient Psychiatric section.

When the Care N' Care UM Department is notified of hospital admission, the UM Department verifies eligibility, hospitalist or attending physician assignment, and assigns a concurrent nurse reviewer. The UM Department will enter the notification in the system to generate a case tracking number and issues the number to the caller. The facility is responsible for obtaining the permanent tracking number by contacting the Care N' Care UM Department prior to claim submission.

All elective, urgent and emergent care, inpatient admissions must be reported to Care N' Care's UM Department within 24 hours or the next business day, unless otherwise stated in the facility contract. To notify Care N' Care UM Department you may call 855-359-9999. Please have the following information ready:

- Facility name;
- Name of caller reporting admission;
- Phone number of caller reporting admission;
- Member's full name;
- Member's identification (ID) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room (ER) notifications there may not be a room number assigned, as these are potential admission and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay - elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;
- Type of admission (medical, surgical, telemetry, or intensive care);

- Admitting or attending physician;
- Other insurance, if available;
- Status of admission (inpatient, skilled nursing or sub-acute rehabilitation).

Services may be reviewed after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate or not medically necessary. Services denied for late or non-notification are considered non-reimbursable services and cannot be billed to the member.

Coverage for inpatient psychiatric care in a network psychiatric hospital is provided when authorized by Care N' Care UM Department for up to 190 days, which is the lifetime benefit limit per member according to Medicare guidelines.

Care N' Care does provide outpatient behavioral health service coverage for its members. These services may be obtained by contracted providers/facilities at a set cost sharing and at non-contracted providers/facilities at a higher cost sharing for PPO members only. Outpatient behavioral health services include those provided by a specialty provider, individual or group counseling sessions, visits to a clinical psychologist or social worker. Outpatient behavioral health also includes partial hospitalization program, which is defined as a structured program of active treatment that is more intense than the care received in your doctor or therapist's office and is an alternative to inpatient hospitalization. These services must be prior authorized.

A Care N' Care PPO members may self-refer to any of these behavioral health providers and will be charged the applicable cost sharing for the setting which care is rendered. For a further explanation of benefits, copayments and the most current directory of Outpatient Behavioral Health providers please visit the Care N' Care website at www.cnchealthplan.com.

NOTE: The coverage for mental health counseling does not include relationship or communication issues or behavioral problems not related to an illness or injury and are subject to payment under the Medicare coverage guidelines.

SECTION 24: CLAIMS

In order to be reimbursed for services rendered to a Care N' Care member, providers must submit a clean claim within the timely filing guidelines. All claims for medical services provided under the Care N' Care Medicare Advantage plans are processed in accordance with Medicare Guidelines by our third party administrator, Silverback Claims Management. Care N' Care requests that providers file claims electronically for faster service. When submitting claims, please include all required information. Care N' Care requires that all claims be submitted electronically on a UB-04 for facilities and a current CMS-1500 claim form for professional services. If you are filing claims manually, you must submit an original UB-04 or CMS-1500 claim form. Copies of claim forms are not accepted. All providers will receive an Explanation of Payment (EOP) each time a claim is processed that details the payment determinations along with any applicable reason codes.

Timely Filing

When Care N' Care is the primary payer, providers must submit claims within 60 calendar days from the date of service or date of payment received by primary payer unless it is otherwise stated in your contract with Care N' Care. When Care N' Care is the secondary payer, claims must be submitted within 60 days of the date on the primary payer's EOP receipt date. A copy of the primary carrier's EOP must be attached to the claim form in order to process the claim.

If payment is denied due to a provider's failure to comply with timely filing requirements, the claim is treated as a non-reimbursable service and cannot be balance billed to the member. You are allowed to appeal a decision of denial for timely filing.

If you believe you have filed a claim timely, you may request reconsideration for payment request in writing along with supporting proof of timely filing, these items may include:

- EOP from another insurance carrier dated within Care N' Care's timely filing limits for secondary payments only;
- If the claim was submitted to the incorrect payor the denial of payment letter from the insurance carrier, dated within Care N' Care's timely filing limits;
- Electronic Data Interchange (EDI) rejection letter, including batch number (showing date received versus date of service) that reflects the claim was submitted within Care N' Care's timely filing limits;

Unacceptable proof of timely filing includes:

- Screen-print of claim invoices;
- Copies of an original claim;
- Record of billing in an excel spreadsheet.

Clean Claims

Care N' Care follows all of the CMS claims policies for the Medicare program administration. A copy of the Medicare Claims Manual may be located at www.cms.hhs.gov.

A "clean claim" is defined as a claim that contains all necessary information and can be processed as submitted without requiring additional information from the submitting physician, practitioner or facility.

Submitted claims that do not meet the clean claims requirements may be pended for additional information or denied if the information submitted is invalid. Providers must submit only the missing information along with a copy of the notification letter, not a corrected claim. Submitting a corrected or second claim only creates duplicates and does not allow the original claim to be processed timely.

If Care N' Care determines that additional information is necessary to process the claim, the following steps may occur:

- The claim is pended and on the next business day, a notification letter requesting additional information is mailed to the provider.
- For all professional claims, if the requested information is not received within 30 days from the date the claim has been pended, a second notification letter is mailed to the provider.
- If the requested information is not received within 60 days from the claim-received date of the claim, the claim will be denied.
- For all inpatient and ancillary claims, if the requested information is not received within 60 days from the claim receipt date, the claim is denied.

If Care N' Care obtains the requested additional information within 60 days from the receipt of the claim and the information does not support payment or a favorable consideration, the claim is denied immediately. Providers are allowed to access the appropriate reconsideration process.

Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once Care N' Care receives the additional information requested, the original claim is processed.

All requested information must be received at the address indicated in the letter, which is:
Care N' Care
Claim Department
P.O. Box 961285
Fort Worth, TX
76161-0285

If payment is denied due to not complying with the clean claim requirements, the claim is treated as a non-reimbursable service and cannot be billed to the member; however, the provider can request a reconsideration.

Claims for Care N' Care members must comply with the clean claim requirements for fee-for-service Medicare (CFR 422.500).

The following information must be included on the claim:

- Provider identification (ID) number;
- Current Tax Identification Number (TIN);
- Current National Provider Identification Number (NPI);
- Member's name, address, telephone number, gender, and date of birth;
- Care N' Care member ID number;
- Care N' Care member group number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes. Bill to highest level of specificity;
- ICD-10 procedure and DRG codes for all UB-04 claims;
- Referral provider (indicate ordering provider on UB-04);
- Billing provider's name and remit address;
- Date of service;
- Current coordination of benefits (COB) information or other insurance information such as motor vehicle, workers' compensation or other third-party liability insurance information;
- If applicable: name and invoice of the chemotherapeutic agent and HCPCS code used for chemotherapy services.

Care N' Care network providers are required to submit claims for all services that are provided to Care N' Care members.

Electronic Claims Submission

Care N' Care has contracted with Emdeon (WebMD) to provide claims clearinghouse services for Care N' Care electronic claim submission. Care N' Care providers should file claims for Care N' Care members electronically whenever possible. Providers can contact Emdeon Customer Service at 888-363-3361.

Payer Identification (ID) Number is:
EMDEON 37228

What are the advantages of submitting claims electronically?

- Reduction of costs associated with printing/mailing paper claims;
- Data integrity due to clearinghouse edits;
- Faster receipt of claims by Care N' Care, resulting in reduced processing time and faster payment;
- Confirmation of receipt of claims by the clearinghouse for your records;
- Availability of reports when electronic claims are rejected;
- Ability to track electronic claims, resulting in greater accountability.

EDI Reports

For successful EDI claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from EDI vendor;
- Confirmation/rejection reports from EDI clearinghouse;
- Confirmation/rejection reports from Care N' Care.

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/viewed or downloaded. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact Care N' Care Claims Department at 817-529-8301.

Paper Claims Submission

When electronic filing of claims is not possible, professional paper claims must be submitted on an original red CMS 1500 claim form and must be filled out appropriately to fulfill of the requirements necessary in submitting a clean claim. Facility paper claims must be submitted on an original UB-04 claim form and must be filled out appropriately to fulfill the requirements for submitting a clean claim. Copies of claim forms will not be accepted.

Paper claims can be mailed to:
Care N' Care
Claims Department
P.O. Box 961285
Fort Worth, TX 76161-0285

Corrected Claims

Corrected claims must be received by Care N' Care within 30 calendar days of the Explanation of Payment (EOP) issue date, unless otherwise stated in your contract or payment may be denied. If

payment is denied, the claim is treated as a non-reimbursable service and cannot be billed to the member.

Corrected claims must be appropriately marked on top of the claim "Corrected Claim" and submitted to:
Care N' Care
Claim Department
P.O. Box 961285
Fort Worth, TX 76161-0285

Corrected electronic claims when resubmitting a claim, enter the appropriate claim frequency code "Corrected Claims Process 2010"; Loop 2300; Segment CLM05-3; 7-replacement of prior claim; 8-void/cancel of prior claim.

Explanation of Payment (EOP)
Care N' Care's Explanation of Payment contains all of the information about claims submissions, denial or messaging codes and cash receipts for overpayments, if applicable. The Explanation of Payment should be reviewed when you receive it and reconciled against billing records. The Explanation of Payment includes Care N' Care member names and dollar amounts paid for all claims processed during the course of a week. Processing claims and adjustments results in one of the following remittance situations:

Positive remittance - A remittance that totals to a positive amount and results in a payment to the provider. The total at the bottom of the Remittance agrees with the check or electronic payment the provider receives.

Negative remittance - A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the remittance is negative, and does not result in a check or electronic payment to the provider.

Explanation of Payments and checks are mailed weekly. If you have not received payment or an Explanation of Payments after 60 days, please call us at 817-529-8301 to verify the status of your claim.

Refunds
Should an overpayment occur, Care N' Care will send a claim payment notification letter with detailed claim information about the payment error and request a return of the overpayment. If you do not dispute or return the requested payment within the specified period, the overpayment amount will be applied and subtracted from a future reimbursement as per the terms disclosed in the overpayment letter.

Care N' Care makes every attempt to identify claim overpayments and issue provider notices for overpayment refunds to be made within 30 days but in no case more than 12 months after the date of the original payment. If a provider receives an Overpayment Refund Request letter from Care N' Care, the provider should follow the instructions outlined in the letter for returning the overpayment or disputing the request. In the event that a provider independently identifies an overpayment from Care N' Care, the following steps should be taken:

Return a check made payable to Care N' Care to:
Care N' Care
Claims Department
P.O. Box 961285
Fort Worth, TX 76161-0285

Include a copy of the Explanation of Payment that accompanied the overpayment to expedite Care N' Care's adjustment of the provider's account. If the Explanation of Payment is not available, the following information must be provided:

- Care N' Care member name and ID number;
- Date of service;
- Payment amount;
- Vendor or provider name and number;
- Provider Tax Id number; and,
- Reason for the overpayment refund.

If you are contacted by a third-party overpayment recovery vendor acting on behalf of Care N' Care, please follow the overpayment refund instructions provided by the vendor. If you believe that you have received a Care N' Care check in error and have not cashed the check, return the check to the address above

If you believe that you have received a Care N' Care check in error and have not cashed the check, return the check to:
Care N' Care
Claims Department
P.O. Box 961285
Fort Worth, TX 76161-0285

Please include the applicable EOP and a cover letter indicating why the check is being returned.

Claim Payment Errors
Neither Care N' Care nor any contracted providers may request any claim payment adjustment more than nine (9) months after the date of original payment.

Coordination of Benefits
Providers should obtain all insurance information from their patients and verify the primary insurance. Care N' Care will also obtain all insurance information and load any other insurance other than Care N' Care for the member into the claims system.

Balance Billing
Balance billing is the practice of a contracted, network provider billing a member for the difference between the allowed amount and billed charges for covered services. When participating providers contract with Care N' Care, they agree to accept Care N' Care's contracted rate as payment in full. Balance billing members for any covered service is a violation of your Provider Agreement and CMS regulations. Contracted, network providers can only seek reimbursement from Care N' Care members for copayments and non-covered services.

Coding

Three major publications, the American Medical Association's Current Procedural Terminology (CPT-4) code book, the CMS Healthcare Common Procedural Coding System (HCPCS) code book and the International Classification of Diseases (ICD-10-CM Effective October 1, 2015) represent the basic standard of service code documentation and reference material as required by Care N' Care. Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers reflective of the date of service are required on all Care N' Care claims. These codes should be used in accordance with all applicable federal and state guidelines.

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Procedural Coding system (HCPCs) code book and the International Classification of Diseases (ICD-10-CM) represent the basic standard of service code documentation and reference material as required by Care N' Care.

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the prima Code each diagnosis to the highest level of specificity (4th or 5th digit when available).

Valid AMA CPT-10 and Level II HCPCs procedure codes are required on all claims.

Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

All providers must bill claims according to CMS guidelines. Some services may be subject to reduction by the multiple procedure reduction rule.

Services and supplies that are covered but considered included in a related service will be denied or bundled into the payment for the related service. Care N' Care follows the CMS bundled services policy with few exceptions.

Care N' Care considers other services that are not part of the CMS bundled services policy as always included in a more primary procedure.

Care N' Care does not require documentation at the time of claim submission. Note that in the event the claim is audited, documentation may be required.

SECTION 25: MEMBER APPEALS & GRIEVANCES

Care N' Care follows the requirements as set forth by CMS for the rights of a Medicare Advantage member for Appeals and Grievances. This information may be located in the Medicare Managed Care

Manual, Chapter 13 on the CMS website at: http:// www.cms.hhs.gov/manuals/downloads/mc86c13.pdf

Care N' Care is responsible for processing all Medicare Advantage member grievances and appeals as outlined in the Code of Federal Regulations (CFR) 422.562(a). Care N' Care has an internal Appeals and Grievances Department, which is responsible for the processing of all member and provider appeals and grievances. This enables Care N' Care to receive process and resolve the member's issue quickly in accordance with the CMS timeliness requirements.

Federal regulations require certain procedures are followed for members enrolled in the Medicare Advantage program.

What is an Appeal?

An appeal is a request for reconsideration of a denied prior authorization request (also known as an adverse determination) that the member believes is a Medicare covered service.
If a member wants to appeal an adverse determination, the following steps must occur:

- Members must file a written request for reconsideration within 60 days of a denial;
- The member may also contact our Healthcare Concierge Department and have a Healthcare Concierge Representative take the information over the phone at 877-374-7993 from 8:00 AM – 8:00 PM CST, Monday thru Friday. Care N' Care is responsible for making a reconsideration decision within 30 days of the request. This means upholding the denial and forwarding the file to an independent review entity (Centers for Health Dispute Resolution (CHDR) for final review, or overturning the original denial and approving the service within 30 days from the member's original request.
- Due to the time frames CMS mandates for Medicare advantage plans to process appeals, plan physicians will receive requests for medical records to assist in the resolution of an appeal;
- Physicians are allowed seven days to forward medical records to the Medicare Appeals and Grievance department. When contacted for medical records or other case documentation, the requested information must be furnished as soon as possible;
- If an appeal is urgent or needs to be expedited through our normal process - please clearly state "expedite" on the appeal documentation;

Care N' Care Medicare Advantage members have a right to appeal any decision about payment of, or failure to arrange or continue to arrange for, what the member believes are covered services (including non-Medicare covered benefits) under the Care N' Care plan.

Commonly appealed decisions may include:

- Payment for emergency services, out-of-area urgently needed services, renal dialysis, or post-stabilization services.
- Payment for health services furnished by a non-contracting practitioner or facility that the member believes should have been arranged for, furnished or reimbursed by Care N' Care.
- Services that the member has not received, but which the member believes Care N' Care should pay for or arrange.
- Care N' Care's discontinuation of services, or refusal to pay for or provide services, that the member believes are medically necessary covered services.

There are standard and expedited organization determinations and appeals for the Medicare Advantage member and they are defined as follows:

A standard appeal is processed by the organization within a 30-day time frame. A standard organization determination is processed in 14 days and expedited organization determination is processed in a 72-hour time frame.

There are two different expedited review processes that are performed by Care N' Care:

Expedited organization determination - An expedited organization determination is a decision to authorize or deny a time-sensitive service that meets the criteria for an expedited review of 72 hours.

Expedited appeal - An expedited appeal is a time sensitive service appeal that meets the criteria for an expedited review in a 72-hour time frame.

Criteria for Expedited Review
Here are some examples of what may be considered for an expedited review:

- Requests by a physician/provider;
- Requests for continued skilled nursing facility (SNF) stay;
- Requests for continued Home Health services;
- Requests concerning a refusal by the provider to proceed with a scheduled service or test because the contracting provider failed to give an authorization for a service that has been scheduled.

Other requests for expedited services that can be considered for expedited organization determination are if the member complains of severe pain (consider whether delaying care could seriously jeopardize the life or health of the member or the member's ability to regain maximum function).

An expedited review for organization determination must be provided when a physician or provider (network or non-network) and indicates that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Grievances
A grievance is a written or verbal expression of dissatisfaction with any service aspect of the delivery system other than one involving an organization determination.
Member grievances pertain to issues such as:

- Office waiting times;
- Physician demeanor and behavior;
- Office staff demeanor and behavior;
- Adequacy of facilities;
- Quality of care;
- Billing inquiries

Members can file a grievance at any time in writing or by telephone. Care N' Care's Appeals and Grievances staff must respond to a member's grievance within 45 days of the date it is received at the plan.

Members may send a written grievance to the:
Care N' Care
Appeals and Grievances Department

1701 River Run, Ste. 402
Fort Worth, TX 76107

Members who want to file a verbal grievance must contact a Care N' Care Healthcare Concierge Representative at 877-374-7993.

SECTION 26: QUALITY IMPROVEMENT

Care N' Care promotes quality care and service excellence for its members. The organization's Quality Management (QM) program provides the framework and structure within which the health plan pursues this commitment. A framework in which the health plan consults with network physicians in selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying and proposing solutions to problems and aiding in communication of program activities with other providers.

The program promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality management activities based upon findings. It is established at the direction of and approved by the Board of Directors, the governing body for Care N' Care.

The Chief Executive Officer is designated the authority and responsibility for the overall operation of the Program. The Medical Director, the senior clinical staff member, is responsible for all clinical aspects of the Program and works closely with the Director of Quality to carry out those responsibilities. All senior and department leadership are responsible for implementing the Program throughout the organization. The Plan committee structure has an important role in implementing the Program and includes network providers in their membership.

The Program is designed to comply with regulatory requirements. It is evaluated and updated on an annual basis.

The overall goal of the Quality Management Program is to achieve quality care and services for members through the development, implementation and ongoing improvement of organizational systems.

Consistent with its emphasis on quality, Care N' Care maintains the Quality Management Program with goals to:

- Promote physical and mental health for Care N' Care members;
- Promote evidence-based medicine;
- Promote healthy lifestyles, risk identification, and early intervention;
- Promote active involvement by the member in health care planning and decision-making;
- Promote and coordinate efficient and effective resource utilization;
- Facilitate timely access and availability to care and services;
- Facilitate communication regarding performance improvement initiatives;
- Promote consumer safety.

Confidentiality

All records and proceedings of the Quality Management Program and the Quality Council as well as the subcommittees, related to member or practitioner specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information. All member or provider information is maintained in confidential files. The health care providers hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement" annually. This agreement requires the members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues Quality Management reports when required by law.

Due to the nature of routine Quality Management operations, Care N' Care has implemented policies and procedures to protect and ensure proper handling of confidential and privileged medical record information. Upon employment, all Care N' Care employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

Conflict of Interest

Care N' Care maintains a Conflict of Interest policy to ensure potential conflicts are avoided by staff and members of committees. This policy precludes using proprietary or confidential Care N' Care information for personal gain or the gain or others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. No person may participate in the review, evaluation or final disposition of any case in which that person has been professionally involved of where judgment may be comprised.

Fiscal and clinical interests are separated. Care N' Care and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in underutilization.

Quality Management Scope

The scope of the Quality Management program encompasses both clinical and non-clinical care and services conducted at Care N' Care and by its providers. Inherent in its structure is ongoing education to integrate the continuous quality management model across all Care N' Care functions and its delegated entities. Under the direction of the plan Medical Director Care N' Care coordinates and facilitates ongoing monitoring and improvement of activities outlined in its Quality Management Program Description and Work Plan.

Health promotion and health management activities are integral part of the Quality Management program. Particular attention is given to high volume, high risk areas of care and services of the populations Care N' Care serves.

Care N' Care has integrated quality management activities into all health plan functional areas. These include, but are not limited to, the following functional areas and departments:

- Medical Health Services including: Complex Care Management, Disease Management, Care Coordination, and Care Transitions;
- Operations, including member and provider services;
- Network Management;
- Compliance;

- Member Services;
- Appeals and Grievances;
- Claims;
- Medicare;
- Delegation Oversight;
- Credentialing Oversight;
- Pharmacy;
- Utilization Management – as described in Utilization Program.

The Quality Management program description and evaluation are reviewed and approved not less than annually by the Quality Council.

Ultimate review and approval of the Quality Management program description, annual evaluation and work plan, rests with the Board of Directors.

Goals and Objectives

Quality Improve the health status of members through high quality, well-coordinated care;

- Deliver exceptional performance as demonstrated by internal measures and the Centers for Medicare and Medicaid Services (CMS) 5-star rating system;
- Promote use of evidence-based medicine by the health plan and by network providers;
- Facilitate early risk identification and interventions;
- Involve members in health care planning and decision-making, promote healthy lifestyles;
- Coordinate utilization of medical technology and other medical resources efficiently and effectively for member welfare;
- Facilitate effective organizational communication of performance improvement initiatives and priorities;
- Establish an environment responsive to member concerns and grievances;
- Facilitate timely access and availability to care; and
- Promote consumer safety.

Quality Management Activities

Integration is a vital component of successful quality management. Departments involved in quality management activities are integrated through coordinated referral processes and systems for quality/risk/utilization issues, care management, and member complaints/grievances. As the central area for receiving potential quality/risk management issues and coordination of Quality Management activity, the Quality department acts as a critical interface between Care N' Care departments, Centers for Medicare and Medicaid Services (CMS), and other regulatory agencies.

Care N' Care does delegate Quality Improvement activities, however does collaborate with the network to ensure quality initiatives and goals are met.

The Quality Management program uses a variety of mechanisms to continuously measure, evaluate, and improve the care and services provided to members. Care N' Care has adopted a uniform approach to quality and the processes for addressing quality issues. Process steps include designing, measuring, assessing and improving processes utilizing the Plan-Do-Study-Act (PDSA) cycle as a means to meet or exceed the minimum performance standards established by the organizations.

The following activities are included in the Quality Management program and reflect important aspects of care and service:

Clinical Practice and Preventative Health Guidelines:
Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating practitioners. Care N' Care evaluates the most current medical evidence including but not limited to, the U.S. Preventative Services Task Force, the Centers for Disease Control and Preventative specialty organizations. Care N' Care measures population-based performance against preventative health and clinical guidelines annually, primarily through HEDIS measurement.

Complaints/Grievances
Member complaints/grievances are tracked and trended through the QM program to:

- Monitor effective and timely resolution of member concerns.
- Identify opportunities for improvement in the quality of care and service provided to members.

Complaints/grievances can be made by the member, on behalf of the member by their representative, as well as identified by an internal department, member, provider, or regulatory agency. Member grievances are also identified through escalation by the Member Services department. The Grievance and Appeal Coordinator reviews member complaints/grievances related to potential quality of care/service issues and forwards potential cases to the Quality Department for the investigation and resolution process. Data for quality of care/service issues are collected, reviewed and trended to identify opportunities for improvement through the Quality Council.

Disease Management
Disease Management services are available to Care N' Care members at no cost. Silverback Care Management provides disease and care management activities for congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), hypertension (HTN) and major depression for plan members and beneficiaries that meet the program's eligibility criteria. Disease Management is a program of coordinated health care interventions and communications for members with conditions in which patient self-care efforts are significant to outcomes.

The Disease Management Program Goals:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies;
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.
- Enhance member self-management skills
- Reduce intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve member adherence to the Physician/Practitioner and health care
- Facilitate appropriate health care resource utilization
- Reduce avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and medical claim costs.
- Physicians can make referrals for Disease Management by sending a referral request or calling Silverback at 855-359-9999.

Complex Case Management
Complex Case Management is available to members identified as high risk for adverse health outcomes. The goal of Complex Case Management is to facilitate appropriate care and services for plan members who have experienced a significant health event or illness. Complex Case Management Program is a more intense case management approach and utilizes a multidisciplinary team of registered nurses, social workers, pharmacists, dieticians and physicians. Evidence-based guidelines for complex case management focused standard assessment and screening tools, condition-specific clinical guidelines and case management specific assessments targeted to at-risk populations. The goal is to help members achieve optimal health outcomes in balance with available resources. Additionally, the complex case management community-based program facilitates access to community resources through social work support to patient and caregivers across the care continuum. Members are identified through various avenues including predictive modeling, discharge planning activities, and/or physician referrals. These services are offered to plan members at no cost; if applicable to their individual needs. Referrals for complex case management can be made to 1-855-359-9999.

Medical Record Review (MRR)
The objective of Medical Record Review activities are to:
- Evaluate compliance with medical record documentation requirements.
- Document the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.
- Evaluate compliance with medical record confidentiality policies.

Care N' Care's MRR for Primary Care Providers (PCPs) are conducted in accordance to state, CMS and quality requirements at least every three years by the Medical Management department. Overall results and opportunities for improvement are reported to the Delegation Oversight Review Committee (DORC). Improvement action plans as recommended by the DORC, are implemented and monitored by the Medical Management department.

Member Satisfaction
Member satisfaction is assessed through annual member satisfaction surveys such as the Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcomes Survey (HOS), as well as member complaint/grievance and disenrollment data, Member survey results are used to:
- Measure Care N' Care performance and identify opportunities for improvement.
- Measure the effectiveness of previously implemented improvement interventions.
- Establish benchmarks and monitor Care N' Care performance against national CAHPS performance data.
- Assess overall levels of satisfaction to determine if Care N' Care is meeting member expectations.

Action plans to address opportunities for improvement, based on member satisfaction results, are reviewed and approved by the Quality Council.

Monitoring of Performance Indicators
Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations, National standard indicators, e.g. Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and systems (CAHPS), Health Outcomes Survey (HOS) are used to continuously measure Care N' Care performance.

Results are used to identify current gaps in care of service and are integrated in quality improvement projects for Care N' Care.

Practitioner Accessibility and Availability Monitoring

Practitioner accessibility and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of practitioners, number and type of practitioners, appointment availability, provision for emergency care, and after hours service are measured. The cultural, ethnic, racial, linguistic needs of Care N' Care's members are assessed on an ongoing basis and formally evaluated at least annually. Monitoring activities may include practitioner surveys, onsite visits, evaluation of member satisfaction, and evaluation of complaints/grievances, geo-access surveys, and when applicable, monitoring of closed primary physician panels. For more information regarding access and availability monitoring, please contact your assigned Provider Concierge Representative.

Specific deficiencies are addressed with a CAP, and follow-up activity is conducted to reassess compliance. Practitioner accessibility and availability activities are reported to an overseen by the Quality Management Committee.

Monitoring/Improvement of Quality Indicators

Selection of objective and measurable indicators for programs and interventions impacting effectiveness of care and services, are based on industry-wide specifications used to assess quality of care pertaining to functional status, access, satisfaction and outcomes (e.g. HEDIS, CAHPS, HOS). Data is retrieved from the Care N' Care data tables, a central repository of all transaction systems, including but not limited to: member demographics, claims and encounters; pharmacy, and laboratory data. Supplemental data sources, such as medical records, case management, and member reported health assessment data, are used to support reporting, validation, and analyses, Quality Improvement Projects (QIPs) specifically address the unique characteristics and special needs of the Care N' Care population, hence they are stratified by plan type, age, disease categories, and risk status. Care and services are evaluated in a variety of settings that include institutional and ambulatory. Also, evaluated is the coordination among contracted providers and with outside agencies. Inherent in the structure is ongoing, continuous education to integrate the quality management process model across all Care N' Care functions and delegated entities.

Outcomes are assessed by the annual HEDIS report, comprised of a comprehensive description and assessment of the Care N' Care transaction systems and internal audit processes (Roadmap), data integration and rate generation, collection and review of medical records, management and coordination of the HEDIS audit by outside certified audit agency, and a final report to CMS. The project involves an organization-wide effort to ensure data accuracy and completeness.

HOS and CAHPS results are reviewed to assess member health status and satisfaction with plan services and care received.

CMS issues the annual CAHPS and HOS baseline and associated reports. An analysis of Care N' Care's results are presented to the Quality Council as an attachment to the annual Quality Program Evaluation. The analysis includes recommendations for process improvements and quality initiatives.

Care N' Care collects, analyzes and reports Part C reporting data elements to CMS as defined by regulatory and technical specification outlines from CMS. The data are collected both internally and externally from our delegated entities.

Quality Improvement Projects (QIPs)

QIPs are studies designed to include measurement of performance, Care N' Care interventions, improving performance, and systematic and periodic follow up on the effect of the interventions. Quality indicators are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status, and member satisfaction. The Quality Management department is responsible for the implementation of one or more Quality Improvement Projects (QIP) to enhance effectiveness established by the centers for Medicare and Medicaid Services (CMS). Interventions are evaluated and refined to achieve demonstrable improvement. Care N' Care relies on its delegated entities to provide data necessary for evaluating the effectiveness of each of the interventions. Results of evaluations and recommendations are reviewed and approved by the Quality Council. Current QIPs are defined in detail as part of Care N' Care's annual Quality Management Work Plan.

Chronic Care Improvement Program (CCIP)

The Chronic Care Improvement Program (CCIP) integrates both quality and chronic care management programs. These programs involve care coordination, interventions, and ongoing monitoring of progress in accordance with Care N' Care and CMS guidelines and requirements. The goal of the CCIP program involves education and outreach to members and providers to promote health, manage symptoms, and assure timely access. Care N' Care relies on its delegated entities to provide data necessary for evaluating the effectiveness of each of the selected interventions. All aspects of CCIP activities, coordination, progress, results, and evaluation are overseen by the Quality Council.

Patient Safety

Care N' Care supports the prevention and elimination of healthcare errors by our commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to, processes to report identified adverse events, Medication Therapy Management Program (MTM), and potential quality of care referrals. In addition, Care N' Care provides education to members to promote patient awareness, encouraging health care advocacy, and facilitate decision-making through the Care N' Care newsletter and other program-specific materials.

Never Events Policy

Care N' Care has determined that if a healthcare service is deemed a "never event" or a "hospital acquired condition" as defined by CMS, that neither Care N' Care nor the member will be responsible for payments for said services. Healthcare facilities and providers are prohibited to collect and/or bill members for co-payments, coinsurance, deductible charges, or balance bill Care N' Care or its members for events which are designated as ineligible for payment.

Examples of additional charges directly resulting from the occurrence of such a "never event" include:

- The event results in an increased length of stay, level of care or significant intervention.
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service.
- An unintended procedure is performed.

• Readmission is required as a result of an adverse event that occurred in the same facility.
• These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

Some examples of Surgical Events
Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:
• Surgery performed on the wrong body part.
• Surgery performed on the wrong patient.
• Wrong surgical procedure on a patient.
• Retention of a foreign object in a patient after surgery or other procedure.
• Intraoperative or immediately post-operative death in an otherwise healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologist patient safety initiative).
- Surgical Site infections following orthopedic, CABG, and bariatric procedures

Medication Therapy Management Program (MTMP)
Care N' Care participates in Medication Therapy Management Program (MTM). The program is based on CMS requirements/guidelines for MTM development. Members identified for the Medication Therapy Management Program (MTMP) program are believed to be at increased risk of experiencing morbidity and mortality due to the loss of the physiologic reserve. Care N' Care works in conjunction with their Pharmacy Benefits Manager (PBM) to conduct the MTM program.

Potential Quality Issues
Care N' Care maintains a system of trended quality issues identified over time, using the Quality Management process. Potential quality issues may be referred from a variety of internal and external sources. All quality issues identified by Care N' Care staff or providers will be investigated and assigned a quality determination through the reportable events policy and procedures. The Quality Department's clinical staff conducts the preliminary review and investigation, with a subsequent review by a physician and/or referral for physician peer review. Cases are referred to the Quality Council if further review is needed.

Over-utilization or Under-Utilization of Services
Care N' Care has established a methodology for monitoring over- and under-utilization of services. Using data submitted by the provider organizations, Care N' Care compares the utilization on several key indicators to specific performance standards. Key indicators may include, but are not limited to, Bed Days/1000; Average Length of Stay (LOS) for Acute, Skilled Nursing and Behavioral Health care; ER Visits/1000, and member appeals.

CMS Star Rating
Care N' Care has a comprehensive CMS 5 Star program aimed at increasing its star rating to 5. Strategies to achieve this goal include, but are not limited to:
- Obtain executive leadership buy-in and promotion of quality
- Educate all staff members on their impact on the CMS 5 star rating for Care N' Care
- Integrate quality initiatives across the organization
- Promote a culture that is integrated/cooperative, nimble, flexible and accountable.

- Data Collection and identification of opportunities for improvement (HEDIS, CAHPS, Provider Reporting)
- Develop unique initiatives aimed at both providers and members

Quality Management Outcome and Evaluation

The Quality Management Program description and the Work Plan govern the program structure and activities for a period of one year. No less than annually, the Quality Department in cooperation with key departments throughout Care N' Care complete a formal evaluation to include:

- Completed and ongoing activities that address quality and safety of clinical care and services.
- Trending of performance measures related to quality and safety of clinical care and service.
- Analysis of results, including barrier analysis and opportunities for improvement.
- Evaluation of overall effectiveness and progress towards network-wide safe clinical practices.

The Board of Directors approves the Quality Improvement Program Annually.

SECTION 27: CREDENTIALING

Prior to consideration for acceptance into the Care N' Care network, all providers must submit a completed application including a signed and dated attestation and meet the established criteria outlined in the credentialing policies and procedures. Once the credentialing staff receives the application, it is sent to a Credentialing Verification Organization (CVO). The CVO performs primary source verifications relating to the provider's credentials to include, but not limited to, education, licensure, board certification, and malpractice claims history. If any issues or concerns are identified during the credentialing process, the credentialing staff will present the information to the Credentials Committee Chair for review.

All provider files will be presented to the Credentials Committee who will determine credentialing status. The Credentials Committee will be provided a list of "clean files" for approval. A "clean file" is defined as one which the provider has met all established criteria and has no issues. For files that do not meet the established criteria, the Credentials Committee will take the issue into consideration, as well as results of the primary source verification, malpractice history, sanction history, disciplinary actions, or other information deemed relevant by Care N' Care.

Providers having any questions regarding credentialing you may contact the Credentialing department at credentialing@cnchealthplan.com.

SECTION 28: FRAUD, WASTE AND ABUSE (FWA)

Eliminating Fraud, Waste, and Abuse (FWA) in the delivery of health care is an obligation, responsibility and legal requirement of all Care N' Care employees and our contracted providers and their employees. This section provides important requirements and expectations in delivering service to members while minimizing risks to yourself and Care N' Care.

Medicare Advantage/Part D FWA Education and Training Requirements
The Centers for Medicare & Medicaid Services (CMS) require Medical Advantage and Prescription Drug Plans (MAPD) to provide effective training to all employees, first tier and downstream, and related entities upon initial hire and annually thereafter.

First tier entities are those who have contracted with Care N' Care to provide administrative or prescription drug services to our members. Downstream entities are companies that first-tier entities subcontract with to provide these services.

Medicare Providers and Suppliers Deemed Compliant
Under CMS regulations, effective June 2010, providers and suppliers who are enrolled in the Medicare program and "deemed" to have satisfied any FWA training requirements by virtue of their Medicare participation. That is, if you hold a valid Medicare provider agreement or supplier approval and can bill Medicare directly and receive payment, you are deemed compliance with the above training requirement. You are, of course, still free to participate in any health care FWA training you wish, and are still required to take compliance training.

As a Care N' Care contracted provider, if you are not "deemed" compliant as indicated above, you are required to meet CMS FWA training requirements.

First Tier, Downstream and Related entities will have three (3) options for ensuring for satisfying the general compliance and FWA training requirement that must be completed 90 days after initial hire/contracting and annually thereafter:
Complete the general compliance and/or FWA training modules through the CMS Medicare Learning Network (MLN) and retain the system-generated certificate of completion as proof of completion; download and incorporate the content of the CMS standard training modules from the CMS website to include in existing compliance training materials and systems; or incorporate the content of the CMS training modules into written documents for providers (e.g., Provider Guides, Participation Manuals, Business Associate Agreements, etc.).

You must also maintain training records or logs of FWA training participants from your organization for 10 years. These logs are subject to Care N' Care and government audit upon request.

FWA Government Regulations
Deficit Reduction Act: The Deficit Reduction Act (DRA) of 2005 is intended to reduce federal expenditures and, in turn, reduce federal deficits. DRA requirements are applicable to Care N' Care as a Medicare Advantage organization and apply to our contracted providers by virtue of contracting with Care N' Care for the provision of Medicare Services.

False Claims Act (FCA): As health care providers furnishing services under government programs, you and Care N' Care are vulnerable to substantial legal risk under the FCA. The FCA prohibits the submission of false or fraudulent claims to the government. For example:

- Knowingly presenting a false record or statement to get a false claim paid or approved by the government;

- Conspiring to defraud the government by getting a false claims allowed or paid;
- Knowingly retaining any government overpayment. The can now be pursued by the government, even if initial receipt of the overpayment or the submission that caused the overpayment were not at the time knowingly false;
- Concealing, improperly avoiding, or decreasing an obligation to pay money to the government. Liability attaches regardless of whether the provider ever submitted a false claims to get government money or used a false statement to hide it.

Fraud Enforcement and Recovery Act (FERA): Signed into law in 2009, FERA boosts the federal government's power to investigate and prosecute any financial fraud against the government and expands liability under the FCA. Under Section 4 of FERA, liability may attach whether or not there is intent to defraud the government. Therefore, many types of innocuous overpayments could now potentially lead to liability under the FCA.

Office of the Investigator General (OIG): The OIG has targeted Medicare Advantage plans for investigations to ensure compliance with all the rules and regulations that govern managed care organizations. OIG civil and monetary penalties codified in the Social Security Act adopt by reference many of the provisions of Civil Monetary Penalties Law (CMPL). For more information about criminal and civil enforcement actions is the OIG website at www.oig.hhsc.gov.

Anti-Kickback Statute: It is a felony to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referral of items or services paid in whole or in part by a federal health care program. Remuneration includes transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Physician Self-Referral Prohibition Statue: The "stark law" prohibits a physician from making a referral for certain designated health services to an entity in which the physicians (or member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies (for example, bona fide employment, FMV compensation arrangement, etc.)

Health Insurance Portability and Accountability Act (HIPAA): HIPAA established health care fraud as a federal criminal offense and increased the penalties. HIPAA 203(b)(1) created the Medicare Incentive Reward Program (IRP) to encourage reporting of sanction able activities. IRP will pay a reward for information that leads to a minimum recovery of $100 from a party determined by CMS to have committed sanction able offenses.

Patient Protection and Affordable Care Act and Health Care & Education Reconciliation Act: Adds funding to the health care Fraud and Abuse Control Funds and integrity programs to fight FWA. Among the other integrity efforts the reform laws:

- Create a data repository for CMS to match claims with agencies such as the Social Security Administration and Veteran's Affairs to identify FWA;
- Require that overpayments be reported and returned 60 days after they are identified;
- Withhold deferral Medicaid matching payments for states that fail to report enrollee encounter data; Require that orders for items or services be prescribed by a Medicare enrolled physician or other eligible professional for goods or services on or after 7/1/2010;
- Require physicians to maintain and provide upon request documentation for certification for DME and Home Health services for orders made on or after January 1, 2010;

- Require physicians to have a face-to-face encounter with a patient before prescribing DME or home health services for those prescribed after January 1, 2010;
- Increase civil monetary penalties for making false statements to federal health care programs or for delaying inspections ($50,000 for each false record or statement);
- Suspend payment during fraud investigations;
- Allow the U.S. Department of Health & Human Services secretary to place a temporary moratorium on enrollment of new providers or suppliers if it is determined that this will prevent or combat FWA.

Balanced Budget Act of 1997: Mandated a risk adjustment payment methodology for what is now the Medicare Advantage program, to increase payment accuracy. Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage organizations based on the health status of their enrolled beneficiaries. Accurate payments to Medicare Advantage organizations help ensure that providers are paid appropriately for the services they provide to Medicare Advantage beneficiaries.

Risk Adjustment Data validation (RADV): Utilizes coding and documentation audits to ensure Care N' Care's risk adjustment payment integrity and accuracy. The RADV audit occurs after final risk adjustment data submission deadline for the Medicare Advantage contract year. Therefore, proper medical record documentation is key to accurate payment and successful data validation.

Penalties

Penalties for violating FWA laws include:

- Denial of payment: You will not be paid for un-allowed services provided;
- Monetary penalties for violating the FCA include three times the amount of damages which the government sustained plus civil penalties between $5,500 and $11,000 per claim. Each separate bill, voucher or other false payment demand constitutes a separate claims;
- Exclusion: Excluded individuals or entities cannot be paid, directly or indirectly, by the federal health care programs, for any items or services they provide.

Expectations

- Take the Care N' Care FWA training or CMS approved training;
- Document patient's medical records properly and accurately. A claim for services must be supported by proper documentation in the medical record;
- Do not falsify or misrepresent information on prescription;
- Do not dispense expired or altered prescription drugs;
- Know and abide by all applicable laws and regulations;
- Have appropriate policies and procedures to address FWA in your organization;
- Educate yourself and attend scheduled FWA and compliance training opportunities;
- Provide general compliance, FWA and HIPAA training to your staff upon hire or contracting with the first 30 days and annually as well as upon discovery of non-compliance;
- Require attendance in training programs as a condition of employment/contracting;
- Provide specialized compliance training at least annually and that meets CMS training guidelines to employees that have specific responsibilities in Medicare business areas;
- Protect patient information;
- Retain adequate records of employee training for 10 years;
- Strive for accuracy and excellence in service, coding and billing:
    - Do not up-code;

  - Do not unbundle services;
  - Provide only medically necessary services;
  - Do not bill for services not rendered;
  - Do not bill for worthless services;
  - Do not submit duplicate billing.
- Always use your NPI number. Protect your information;
- Watch for suspicious activity and red flags;
- Do not retaliate against your own employees who report FWA concerns in good faith.
- Screen all employees and Downstream Entities against federal government exclusion lists, including the Office of Inspector General ("OIG") list of Excluded Individuals and Entities and the General Services Administration ("GSA") Excluded Parties Lists System. (Anyone listed on one or both of these lists is not eligible to support Care N' Care's Medicare Advantage and Prescription Drug Plans, must be removed immediately from providing services or support to Care N' Care, and Care N' Care must be notified upon such identification).

Reporting FWA Concerns

Report concerns of suspected FWA in a timely manner. When in doubt, report it. Reporting potential FWA may be done through the compliance hotline, email, or letter via fax or mail at:

- Hotline: 844-760-5838
- Fax: 817-810-5214
- Email: CNCCompliance@cnchealthplan.com
- Address: Care N' Care Insurance Company
  Attention: Compliance Office
  1701 River Run, Suite 402
  Fort Worth, TX 76107

Whistleblower Protection

Care N' Care policies and procedures include the following protections for reporters of FWA:

- Confidentiality
- Anonymity
- Non-retaliation

Monitoring FWA Prevention Practices

As part of the annual delegation oversight audit, all delegated entities will present evidence of up-to-date FWA prevention practices, including but not limited to:

- Updated policies and procedures meeting federal and state requirements;
- Updated staff training logs and sign-in sheets.

SECTION 29: ADVANCED DIRECTIVES

Living Will Declaration and Advance Directives

The Omni Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as Patient self-Determination Act and which largely became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, and providers of home health care or personal care services, hospice programs and Medicare Advantage health plans (Care N' Care) that receive Medicare or Medicaid funds. The primary purpose of the act is to ensure that members of Care N' Care are made aware of advance directives and are given the opportunity to execute them if they so desire. This act also prevents discrimination in care if the member chooses not to execute advance directives.

What is a Health Care Advance Directive?

A health care advance directive is the primary legal tool for any health care decision made when you cannot speak for yourself. "Health Care Advance Directive" is the general term for any written statement you make while competent concerning your future health care wishes. Formal advance directives include the living will and the health care power of attorney.

What Does CMS Require of Care N' Care?

Care N' Care is required to include a description of our written policies on advance directives to our members including an explanation of the following:

- Care N' Care cannot refuse care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- Each member has the right to file a complaint if the member believes Care N' Care is noncompliant with advance directive requirements, as well as the information of where to file the complaint;
- Care N' Care requires that all providers document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;
- Care N' Care is required to comply with Texas State law (See http://www.caringinfo.org/userfiles/File/Texas.pdf. for information regarding forms, terminology. You may also share this website with your Care n' Care members);
- Care N' Care must provide for community education regarding advance directives.

SECTION 30: DELEGATED ACTIVITIES

Medicare Advantage Organizations commonly contract with delegated entities to perform certain functions that otherwise would be the responsibility of the organization to perform, including management and provision of services.

The Medicare Advantage Organization, however, remains ultimately responsible for all services provided and otherwise fulfilling all terms and conditions of its contract with CMS regardless of any relationships that the organization may have with other entities.

Medicare Advantage Organizations must oversee and be accountable for any functions or responsibilities that are delegated to other entities. It is the sole responsibility of the Medicare Advantage Organization to ensure that the function is performed in accordance with all applicable standards.

Care N' Care has the sole discretion to allow the delegation of activities to providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities without prior written consent from Care N' Care

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, in accordance with all applicable law, this manual, and other administrative policies and procedures of Care N' Care as may be amended from time to time. Care N' Care will provide delegated entities with Care N' Care's standards and requirements applicable to the delegated activities and will notify delegated entities of any substantive changes to these standards and requirements.

Delegated entities may utilize their own policies and procedures for the delegated activities, provided that and only to the extent such policies and procedures are consistent with Care N' Care's delegation policies. If the delegated entity's policies and procedures are inconsistent with Care N' Care's delegation policies, Care N' Care's delegation policies will apply.

The contract between Care N' Care and the delegated entity specifies the activities that have been delegated, if any, and reporting responsibilities. Delegated entities should refer to their contract with Care N' Care for additional information.

This is an overview of delegation. For additional details related to a particular delegated function, please refer to that section of this Manual as follows:

- Claims Adjudication, see Section 23.
- Credentialing and Site Reviews, see Section 26.
- Medical Services, see Section 13.
- Case Management/Disease Management, see Section 25.
- Medical Records Review, see Section 25.
- Monitoring for Fraud, Waste, and Abuse, see Section 27.
- Quality Improvement Program – see Section 25.

Delegation Determinations and Monitoring/Auditing

Prior to the delegation of any activity, Care N' Care evaluates the entity's ability to perform the delegated activity and documents that it has approved the entity's policies and procedures with respect to the delegated activity. Care N' Care also verifies that the contractor has devoted sufficient resources and appropriately qualified staff to performing the function.

Care N' Care monitors the performance of the delegated entity on an ongoing basis and formally reviews the performance of the entity at least annually. Care N' Care has established a multi-disciplinary Delegation Oversight Review Committee that is ultimately responsible for maintaining a comprehensive oversight program for the routine monitoring of delegated activities performed on behalf of Care N' Care by delegated entities.

Care N' Care has written procedures for monitoring and review of delegated activities. Care N' Care uses Delegation Oversight Audit tools to conduct pre- delegation due-diligence as well as focused and annual audits of delegated entities.

The Delegation Oversight Audit includes, but is not limited to, a review of all applicable policies and procedures and the evidence demonstrating the implementation of the processes, a file review as applicable, a review of applicable committee minutes, and any additional documentation required to demonstrate the performance of the delegated activities.

A Care N' Care representative will work collaboratively with the delegated entity to schedule and perform the audit. Care N' Care may also, at its discretion, perform unscheduled audits as it deems

necessary. Results of the audit and any requirements for corrective action will be returned to the delegated entity within 30 days of the date of Care N' Care's recommendation/determination. Care N' Care will also send a confirmation letter to the delegated entity designating the functions that have been delegated.

Depending on the results of pre-delegation review or on-going auditing and monitoring, Care N' Care will assign one of the following delegation statuses to the entity:

- Full Delegation: The delegated entity is authorized to perform delegated activities with ongoing monitoring and, at a minimum, annual oversight audits performed by Care N' Care.
- Conditional Delegation with a Corrective Action Plan (CAP): If the delegated entity fails to meet standards required to maintain or be granted "Full Delegation" status a CAP is required with Conditional Delegation status which may include more frequent and/or focused audits. All CAP activity and submissions are reviewed by the Delegation Oversight Review Committee for determination of delegated status.

Revocation and Resumption of Delegated Activities

Per CMS regulations, Care N' Care or CMS may revoke delegated activities and reporting requirements, or specify other remedies, in instances where CMS or Care N' Care determine that delegated entity has not performed satisfactorily.

Delegated entities should refer to their contract with Care N' Care for specific details regarding how deficiencies and de-delegation will be handled.

Should an entity request to be considered for re-delegation of activities, the Delegation Oversight Review Committee will review any request for re- delegation.

Compliance Requirements

In order to meet CMS requirements, all delegated entities are also required to complete an annual Compliance Attestation Process.

SECTION 31: DELEGATED CREDENTIALING

Care N' Care may delegate credentialing activities to Provider Organizations (PO) who have demonstrated the ability to conduct the delegated functions and associated responsibilities in compliance with CMS, and Care N' Care requirements. The following table outlines the PO and Care N' Care activities and responsibilities as well as the Care N' Care requirements relative to the delegated functions.

Provider Organization (PO) Activities and Responsibilities	Frequency of PO Reporting (*Refer to Care N' Care Reporting & Attestation Due Dates document)	Care N' Care Activities and Responsibilities
• Develop, implement and submit to Care N' Care PO Credentialing Program; • Maintain Credentialing / Re-Credentialing Policies and Procedures outlining structure, accountability, scope, criteria, decision-making process, processes of all credentialing / re-credentialing activities; • Establish and maintain a credentialing decision-making process; • Establish and maintain a functioning Credentialing Committee and/or other peer review committees; • Collect and evaluate ongoing monitoring information; • Make credentialing decisions • Maintain network management/specialty services; • Conduct organizational provider quality assessment, accreditation, certification, and licensure; • Maintain practitioner files in accordance with CMS. Including: Hospital admitting privileges Performance monitoring **Sanction Monitoring: State & Federal** Direct Vendor Contractual Agreements Terminations & Appeals Office Site Quality Assessment	Immediately • Changes to credentialing/Re-credentialing Application;	• Monitor and oversee credentialing/re-credentialing functions to ensure standards are met – not less than annually; Note: A contracted PO may not delegate credentialing and/or re-credentialing activities to another organization without the prior written notification and approval by the Care N' Care Delegation Oversight Review Committee.

Corrective Action Plans
Refer to Section 29 – Delegated Functions.

Sub-Delegation of Credentialing
A contracted PO may not delegate credentialing and/or re-credentialing activities to another organization without the prior written notification and approval by the Care N' Care Delegation Oversight Review Committee.

SECTION 32: DELEGATED CLAIMS

Confidentiality
Claim employees should be instructed not to disclose any proprietary or confidential information to any person or organization except as specifically authorized in the course of employment as required for carrying out his/her job duties.

Claim employees should also maintain the confidentiality of all patient and provider information. Claim employees should not discuss patient diagnoses, medical information or treatment plans with any other individual, except as specifically authorized in the course of employment as required for carrying out his/her job duties.

Confidential patient/member medical information should not be discussed in public areas such as elevators, rest rooms, lunchrooms or restaurants where individuals who should not have access to this information could overhear the information. Such behavior could pose a potential serious breach of patient confidentiality and could be considered a violation of law.

Corrections or Other Revisions
Claim personnel should never alter information on claim documents or computer reports unless the changes are obvious and the original data remains visible. Single line strikeouts should be used in lieu of correction fluid or heavy obliteration and a note of explanation should be made and attached to the document being revised. All such changes should be initialed and dated.

Reporting
All automated reports should be reviewed and tested to assure accuracy. Always provide a clear, written warning to report recipients whenever you know that some problem exists in the quality or accuracy of report data. Claim personnel should ensure the accuracy of all data contained in reports submitted to Care N' Care.

Claims Handling
Claims are legal documents, which regulations stipulate must be handled expeditiously. Care must be taken to avoid damaging, destroying, shredding, discarding, misplacing or sorting them apart from working inventory. All Delegated Administrators (DA's) are expected to have written policies and procedures regarding the proper handling of claim documents.

Stamp claims only with the date that accurately indicates the day on which they were received.

Check Handling
When measuring claims for compliance with timeliness requirements mandated by state and federal regulations, the date the claim payment check is placed in the U.S. Mail or equivalent for delivery defines the end of the measurement of time. Care should be taken to ensure the following processes are considered when measuring timeliness:

The number of days required to mail checks after they are printed should be documented in DA policies and procedures. Care N' Care requests an attestation as part of all Claim Audits that verifies the DA's check mailing lag time. An intentional delay before mailing checks beyond the routine number of days it takes your organization to audit or sign them is a non-compliant process unless you're reporting and timeliness compliance measurement have been adjusted to allow for the delay.

Computer Systems
Claim personnel should always enter true dates, status codes or classification codes (such as contracted provider status, type of service coding, "clean" or "non-clean" identifiers, etc.). Authority to directly delete or alter claim records should be carefully restricted to maintain system integrity, and all such transactions should be included in an audit trail.

Conflicts of Interest
Claim employees should refuse to accept favors or benefits under circumstances which might be construed by a reasonable person as influencing the performance of their job (e.g. accepting inappropriate gifts, gratuities or favors). Claim employees should refrain from using any information gained confidentially in the performance of their job as a means of making private profit. Claim employees should refrain from other employment that would pose a conflict of interest with their regular claim processing responsibilities.

Fraud Waste and Abuse
Delegated Administrators (DAs) are required by CMS to develop and maintain a program to identify, and eliminate Fraud, Waste and Abuse please refer to Section 27 of this Manual for more details about the CMS requirements for a compliant Fraud, Waste and Abuse program.

Corrective Action
Claim management should institute oversight programs to ensure that staff members refrain from repeated acts or practices once such practices are deemed inappropriate or non-compliant by the employer, a health plan, CMS or other regulators. Claim management should act promptly on verbal or written instructions from health plans, CMS or other regulators to correct deficiencies found in audits.

Policies and Procedures
All claims policies and procedures should be developed to comply with regulatory requirements and all claim-processing personnel should adhere to the policy and procedure guidelines once they are established.

Claim Date-Stamping

Each claim should be date-stamped with the date the claim is received by the payer. If it is necessary to change a date stamp because a wrong date was stamped it should be done in accordance with the industry best practice. The industry best practice recommends that a line be drawn through the incorrect stamp, that the employee making the correction initials the correction, and that the correction be dated. The claim should then be stamped with the correct date received. Except for a situation where a date was stamped wrong accidentally, claims personnel should not alter or change date stamps.

Payment of Interest

Federal Interest

All Medicare Advantage Organizations must pay interest on clean claims from non-contracted providers that have not been paid within 30 calendar days of the earliest relevant date stamp received date. Interest must be paid at the current rate beginning the 31st day from the receipt of the claim up until the date that the payment is placed in the U.S. Mail or equivalent for delivery. The Federal interest rates change every six (6) months on January 1, and July 1.

Care N' Care routinely notifies DA's of the current federal interest rate once it is published and available. However, lack of notice from Care N' Care is not sufficient cause to pay interest at an incorrect rate.

The current interest rate is set by the federal government. Current and historical interest rates can be found on the internet at: http://www.treasurydirect.gov

Interest Calculation

When determining the interest penalty payment, the measurement of time during which interest should be paid must include the date the check is to be placed in the U.S. mail or equivalent. To calculate the daily federal interest rate for senior claims, divide the current approved interest rate by 365 (366 for leap years). The daily interest rate is then multiplied by the total days beyond the 30th and the total amount of the claim payment that is due.

The current interest rate is set by the federal government. Current and historical interest rates can be found on the internet at: http://www.treasurydirect.gov

Example 1 - How to Calculate Interest on a Claim

The payment due on a clean claim is $1,200. It is being processed 53 days after receipt. It will take an additional three days to verify, sign and mail the check.

The interest payment, which would be calculated on the basis of 26 delayed days (23+3 for check issuance, processing and mailing), is 26 x $1,200 x (the current annual interest rate)/365 days = interest due.

Example 2 - How to Calculate Interest on a Claim

The amount to be paid is $220. Today is the 32nd day after the receipt of the claim. The checks will not be printed, signed and mailed until next week, 6 days from today. Based on the delay of 8 days (2 + 6 for check processing), the interest payment is 8 x $220 x (the current annual interest rate)/365 days = interest due

Always ensure that you are using the correct interest rate when paying prompt payment interest. The rate changes semi-annually every January 1 and July 1. You can verify the rate at their convenience at http://www.treasurydirect.gov., which is maintained by the Federal Treasury of the U.S. government.

Misdirected Claims
All DA's should have a process for forwarding misdirected claims received by the Claims department that are not their responsibility. It is recommended that triage and sorting processes be developed so that misdirected claims can be identified and forwarded within eight (8) calendar days of receipt in order to assure that the payer has the necessary time required to adjudicate and pay the claim in a timely manner.

Claims Turnaround Time Requirements

Clean Claims
At least 95% of "clean" Medicare Advantage claims from unaffiliated (non- contracted) providers are to be paid within 30 calendar days of the earliest date received.

"60-Day" Claims
All other Medicare Advantage claims are to be paid or denied within 60 calendar days of the earliest date received.

Denials
Claim denials with member liability and provider denials must be issued and mailed within 60 calendar days of the earliest date received.

Claims Compliance Audits
Care N' Care will conduct a claims compliance audit of each DA at least once per year. DA's that are not compliant with CMS requirements will be audited more frequently. The type of audit performed will be based on the reason for the audit, which may be:

- A pre-scheduled annual audit;
- A re-audit scheduled due to documented non-compliance with CMS or contractual requirements discovered during the annual audit or a focused audit;
- A focused audit scheduled due to documented non-compliance with CMS or contractual requirements during an annual audit or a re-audit;
- A follow-up to receipt of claims timeliness reports or other information received from internal or external sources that document or allege non-compliance with CMS or contractual requirements;
- An unscheduled exigent audit to check on serious operational deficiencies or other concerns brought to the attention of Care N' Care.

Under most circumstances a representative from the Care N' Care Delegated Compliance will contact the DA to schedule a mutually agreeable date for performing the audit. It may be necessary, however, under certain circumstances for Care N' Care to conduct an unscheduled exigent audit. Under these circumstances no contact will be made by Care N' Care with the audit subject until the Care N' Care auditor arrives at the site of the DA.

With the exception of an unscheduled exigent audit, once a date is set for the audit the DA will receive an audit confirmation letter that includes detailed information about the audit scope.

As part of the compliance audit, Care N' Care will randomly select claims from a claim universe provided by the DA and may review the following: (This list is not meant to be all inclusive. The Care N' Care Claim Compliance Auditor may request information that does not appear on this list or in the Scope of Audit document.)

- Inventory management reports;
- Reports of pended claims (claims being developed);
- Claims processing policies and procedures;
- Training materials;
- Organizational structure;
- Information systems (IS);
- Claim, and claim supporting areas of DA offices;
- Testing of contracted provider status;
- Claim adjudication review, which may include a review of:
  - Clean and un-clean non-contracted provider paid claims;
  - Contracted provider paid claims;
  - Denied claims with member liability;
  - 1st Level provider dispute resolution claims.
- Attestations and supporting copies;
- Excluded providers;
- Progress related to corrective action plans (if applicable);
- Additional information that may be required.

Care N' Care maintains the right to expand the audit scope.

Reporting the Audit Universe

Based upon the audit scope, Care N' Care will require that the DA generate reports that identify:

- Clean and unclean non-contracted provider paid claims;
- Contracted provider claims;
- Denials with member liability;
- 1st level PDR claims.

These reports should be run for the agreed upon audit period. The Care N' Care auditor will request that the DA complete and sign an attestation that these reports represent the entire universe, as defined by CMS, of claims processed during the audit period. The reports should include the following data elements:

- Member Last Name;
- Provider Name;
- Claim Number;
- Date of Service;
- Initial Date Received (Date stamp);
- 2nd Date Received (If Available);
- Date Check/Denial Letter Mailed;

- Check Numbers;
- Sufficient information for the DA to identify and prepare the selected claim for audit.

Care N' Care will make the selection of claims to be audited and provide the DA with a report of the claims selected following the timeframe as outlined in the most recent CMS Audit Protocols.

Information and Documents
Care N' Care requires that DA's provide the following (note that this list is not all inclusive and the Auditor may request information about any claim that is not listed here):

- The original claim. Care N' Care will accept microfilmed/scanned copies of claims or electronically submitted claims. Otherwise, if a claim is not available at the time of the audit, the claim may not be considered as processed within the regulatory guidelines for denials and payments and will be reported as non-compliant;
- Explanation of Benefits (EOB) or Explanation of Payment (EOP);
- Canceled check (front and back) or bank statements that correspond to the period being audited; Originals, copies and supporting documentation must be presented in the order of selection of each type of claim (30-day, 60-day, etc.);
- In the case of 1st Level PDR claims, the data provided should include the appeal by the provider, the notice of payment or denial and sufficient information to support the decision to uphold or overturn the appeal.

All documents are to be prepared and ready for the Care N' Care auditor to retain them following the audit. The Care N' Care will decide at the time of the audit what records will be retained by Care N' Care as documentation for the audit.

All information regarding Claims Compliance issues should be sent to:
Care N' Care
Compliance Department
1701 River Run, Suite 402
Fort Worth, TX 76107

Audit findings will determine whether a re-audit will be scheduled. The levels of compliance achieved by the DA will determine the timing of subsequent audits and any additional actions to be taken by Care N' Care until compliance is achieved. At the completion of the audit, a closing interview will be held with the appropriate management staff of the DA. During that meeting, the auditor will discuss briefly the audit findings and schedule a follow-up audit if one is required.

A final report will be issued within 30 calendar days of the audit date. The report will be sent to the claims management staff and the main administrator of the DA. It will include the audit report, details of any findings, a request for a Corrective Action Plan (CAP) if one is required, and a reminder of the follow up audit date, if required. Also attached to this report will be paid claim worksheets for each claim category audited. The data on these worksheets documents the audit result for each claim sampled and, therefore, may help prepare a CAP, if one is required.

Corrective Action Plan (CAP)
A CAP will be required if a situation of non-compliance is documented during the audit. Care N' Care requests that the CAP include:

- A root cause analysis designed to correct the underlying problem that results in program violations and to prevent future noncompliance;
- The expected actions the DA will take to remediate;
- The date(s) the Corrective Action is expected to be completed and timeframes for specific achievements;
- The ramifications for failure to implement the Corrective Action successfully;
- Must include a signature evidencing acceptance by the FDR.

Care N' Care allows 30 calendar days from the time that a CAP is requested to the date that it is due to be returned to Care N' Care.

All audit results are reported to the Care N' Care Delegation Oversight Review Committee. The Committee is responsible for, among other things, assuring that all DA's are in compliance with CMS and applicable state regulations and for authorizing the continued delegation of claims activities to the DA.

Delegation of Claim Processing Responsibilities

Should it be necessary for Care N' Care to de-delegate claim processing responsibilities, Care N' Care will send a formal de-delegation notification letter to the administrator or senior management of the DA. If the DA does not pay its own claims but has an MSO or TPA contracted to handle claims, then a copy is sent to the MSO or TPA as well.

If a DA is de-delegated for all claim adjudication responsibilities, Care N' Care will contact the DA that is being de-delegated to go over operational and logistical issues and requirements. The following issues will be covered:

- Discussion of specific service dates for claims, i.e. where the de- delegation starts, so this is clear to all parties;
- Clarification of who will handle denials, the DA or Care N' Care;
- Explanation that monthly timeliness reports are still required for dates of service prior to de-delegation;
- Clarification of who will handle claims status calls for dates of service after a certain date, the DA or Care N' Care;
- Directions as to how authorizations will be communicated to Care N' Care for delegated claims (if the DA will no longer provide the UM function, there will be a discussion of transition issues with Care N' Care UM);
- Claims forwarding instructions for sending claims to Care N' Care and how frequently (i.e. mail within one working day of receipt), the address to send them to and to whose attention;
- Procuring of contract information and arranging for copies of contracts so Care N' Care can process/pay at the rates negotiated by the DA;
- Reviewing contract provisions regarding the capitation withhold required to fund the payment of claims by Care N' Care for the DA;
- Explanation that Care N' Care has the right to continue auditing those claims which remain the responsibility of the DA;
- Explanation of any further penalties which might apply if the DA does not comply;
- Explanation of any administrative fee(s) for de-delegation;
- Explanation of how capitation deductions for dates of service prior to de- delegated status will be

handled.

If it is not possible to schedule an in-person meeting for all parties to meet and discuss the above issues, a conference call may be set up instead. If there are any bankruptcy issues surrounding the de-delegation there may be special instructions from a court or from attorneys, including Care N' Care General Counsel.

See the Delegated Claims Denial Process below, for details about the Care N' Care process when a DA has been de-delegated for claim denials with member liability only.

Delegated Claims Denial Audit Process

All DA's must comply with CMS requirements for claim denials with member liability. Care N' Care reviews a sample of denied claims with member liability as part of the annual claim audit process. The sample is reviewed for compliance with all aspects of the CMS requirements for this formal notice.

CMS also requires that the formal correspondence to a member concerning a denial of a claim with member liability be sent to the member in an envelope that states, on the outside, in a pre-printed format: "Important Plan Information"

Care N' Care requests a sample envelope and an affidavit of compliance at each annual claim audit to verify that a DA is prepared to and does use a compliant envelope when sending a notice of a denial with member liability to a Care N' Care member. If a DA cannot document their compliance with a sample envelope and an executed attestation of compliance, a CAP will be requested by the Auditor.

If a DA is found to be non-compliant with CMS requirements for denials, they may be subject to a re-audit, a retrospective audit of 100% of the denials issued or they may be de-delegated for the claim denial process. If a DA is placed in retrospective review status for claim denials, copies of one hundred percent (100%) of Medicare Advantage claim denials with member liability issued by the DA must be submitted weekly to Care N' Care.

Denials may be submitted by mail to Care N' Care, Attention Claims, P.O. Box 961285, Ft. Worth, Tx 76161.

Each denial should be accompanied by sufficient data to allow Care N' Care to verify that the decision to deny the claim and hold the member liable is correct, such as:

- A dated copy of the claim denial notice sent to the member and any attachments;
- A copy of the claim, including received date stamp(s);
- A copy of all supporting information necessary to substantiate the denial. This may include copies of an emergency room record, a print out of notes from your computer screen that documents information, or a basic explanation of circumstances pertinent to the denial decision. Full medical records are not necessary; submit enough to justify the denial decision.

Care N' Care will review all of the denials submitted by you and may overturn your decision to deny. If we overturn your decision we will return the claim to you within five (5) days of receipt. We expect that you will then pay the claim promptly. If you do not, it may be necessary for Care N' Care to pay the claim on your behalf and deduct the payment proceeds from future capitation funds.

Care N' Care expects to receive a copy of the check and EOB representing payment within ten (10) working days of the date that you were notified that your decision to deny was overturned by Care N' Care. If Care N' Care does not receive the check and EOB within the required time, Care N' Care will pay the claim on your behalf and deduct the payment amount from future capitation payments.

DA's who do not consistently meet denial accuracy requirements will be required to submit a CAP or may be de-delegated for claims adjudication involving claim denials with member liability.

If you have been de-delegated, prospective denials will need to be faxed for approval prior to issuance.

Each denial should be accompanied by sufficient data to allow Care N' Care to verify that the decision to deny the claim and hold the member liable is correct, such as:

- A dated copy of the claim denial notice to be sent to the member and any attachments;
- A copy of the claim, including received date stamp(s);
- A copy of all supporting information necessary to substantiate the denial. This may include copies of an emergency room record, a print out of notes from your computer screen that documents information, or a basic explanation of circumstances pertinent to the denial decision. Full medical records are not necessary; submit enough to justify the denial decision.

The denials and all supporting documentation should be faxed to Care N' Care for review on or before the 55th day of claim aging. Care N' Care will review the denial(s) and approve, request additional information, or overturn the decision to deny within 2 business days of receipt.

Prospective denials may be overturned by Care N' Care. If Care N' Care overturns your decision we will return the claim to you within two (2) business days of receipt. We expect that you will then promptly pay the claim.

Care N' Care expects to receive a copy of the check and Explanation of Payment representing payment within ten (10) working days of the date that the claim was returned to you. If Care N' Care does not receive the check and Explanation of Payment within the required time, Care N' Care will pay the claim on your behalf and deduct the payment amount from future capitation payments.

Medicare Advantage claim denials with member liability issued by a DA may/will be requested by Care N' Care at the following times:

- Annual claims audits;
- Random focused audits for denials;
- Focused reviews based on appeals and grievance results.

Failure by a DA to submit denials for review by Care N' Care when requested will result in increased oversight activities regarding the level of compliance achieved by the DAs claim adjudication process and could be considered a breach of the Agreement with Care N' Care. This increased oversight does not preclude Care N' Care from imposing additional sanctions that may be available in the agreement with Care N' Care. Compliance with CMS requirements and Care N' Care policies and procedures is mandatory in order to retain delegated status.

Monthly Reporting Of Claims Processing Timeliness

In order to oversee the compliance level achieved, Care N' Care requires all DA's to report claims processing compliance on a monthly basis.

This timeliness data is reported to CMS on a quarterly basis. If a DA does not submit monthly timeliness

reports as required, they are in breach of their agreement with Care N' Care. In that case Care N' Care may take action against the DA including but not limited to increased oversight of the DA claim adjudication process or other sanctions identified in the agreement or this Manual.

This report should be faxed/mailed/e-mailed in time to be received at Care N' Care by the 15th of the month following the month being reported. Talk to your Care N' Care Claims Compliance Auditor about the various methods of reporting that are available to you.

Maximum Out Of Pocket (MOOP)
CMS requires that all MAO plans have a Maximum Out Of Pocket Limit (MOOP). This limit is accumulated based upon claims paid by Care N' Care and encounters reported to Care N' Care by DA's who process claims on our behalf. Correct accumulation of the MOOP and timely implementation of the limit will improve member satisfaction.

Every agreement between a DA and Care N' Care requires the DA to report accurate data, including encounter data that is used to accumulate the MOOP. Encounter data accuracy means data which is complete, truthful and includes any member out of pocket contribution and in compliance with CMS requirements.

Member Balance Billing Restrictions
The Social Security Act requires that Medicare Advantage Organizations provide covered medical services to plan enrollees through written contracts with physician and other health care providers. Pursuant to the terms of your contract, you may only bill Care N' Care members for (1) copayments and other cost sharing that is outlined in the Members Explanation of Coverage or (2) non-covered services that the member has agreed, in writing in a manner consistent with CMS requirements, to receive prior to their delivery. In billing for such non-covered services, a contracted provider may only bill up to the Medicare allowable amount, if one is defined for the service otherwise the charge should be limited to their usual and customary fee.

For non-contracting providers, Section 1852(k)(1) of the Social Security Act states that a physician who does not have a contract establishing payment amounts for services furnished to an individual enrolled with a Medicare Advantage organization shall accept as payment-in-full for covered services from the organization the amounts that the physician could collect under the original Medicare fee-for-service program. For Medicare participating physicians, this amount is limited to the Medicare physician fee schedule amount. For non- participating physicians, this amount is limited to 109.25% of the Medicare physician fee schedule amount, including applicable deductibles and co-pays.

Non-contracting Medicare-participating physicians cannot bill Care N' Care members for covered medical services, except for any appropriate coinsurance or deductible amounts. The failure to adhere to this Medicare assignment rule could result in the physician incurring civil monetary penalties, criminal penalties or exclusion from the Medicare program. You should immediately direct any such non-contracting physician to cease all efforts to bill and collect from a Care N' Care member.

Care N' Care expects all delegated entities to enforce these laws and contract provisions that prohibit inappropriate member billing. When we receive notice that a member is being billed we consider the membership of that member as being in jeopardy as a result of the receipt of the bill. We triage the issue so that within 48 working hours we know if the bill is for a copayment or if it is a balance billing issue as well as the identity of the responsible party.

In order to maintain the confidence of the member in Care N' Care we are dedicated to resolving member billing issues within 7 working days of the day we first become aware of the issue. To resolve member billing issues within 7 working days, we need your cooperation, including a quick investigation and response to our inquiry so that we can move forward to resolution. The Member Balance Billing Team at Care N' Care will fax to your appointed representative sufficient information for you to search your records and determine the current status of the claim. If we have it, our fax will include the CMS-1500 or UB-04 form. We expect to receive a complete reply from you within 3 working days of the day that you receive the fax regarding whether the claim has been paid or denied or if it will be paid or denied by a certain date. If the claim has been denied we will determine if there is potential member liability and will require your assistance to explain and support the reason for the denial to the member.

If the provider is billing the member inappropriately we will expect you to remind the provider of the laws that prohibit this, and, if they are contracted with you, the contract provisions that prohibit them from billing the member for any amount other than copayments and coinsurance.

If we do not receive your cooperation in this regard; if we do not receive proof of payment and/or denial with appropriate documentation; if you are unable to stop a provider for which you are financially responsible from inappropriately billing the member; if you are unable to convince us that the provider is billing the member appropriately, Care N' Care will pay the claim and deduct the payment from future capitation.

Please ensure that you have designated someone on your staff, as our primary contact, who understands the importance of these issues and who has the authority and the time to respond within the time frames mentioned above. If you would like to ensure that you do have the right staff designated as the contact for this process, please contact your Provider Concierge Representative.

SECTION 33: ATTACHMENTS

Attachment A: Member Letter Examples

<Date>

«First_Name» «Last_Name»
«Member_Mailing_Addr1» «Member_Mailing_Addr2»
«City», «State» «Zip_Code»

Dear «First_Name» «Last_Name»,

Care N' Care is committed to keeping you informed about matters affecting your health care. Care N' Care was recently notified by your <Medical Group/IPA> that your physician, <Provider name>, has relocated. The new office is located at <New address>. The phone number of the office is <New phone number>.

If this office is inconvenient and you would like to select another provider or if you have any questions, please call Care N' Care Healthcare Concierge at 877-374-7993 (TTY users: 711) between the hours of 8:00 a.m. to 8:00 p.m. CST, seven days a week. Requests to change providers that are received on or before the 25th of the month will be effective the 1st of the following month.

Si usted desea que un representante le llame y le explique en Español el contenido de esta carta, por favor llame 877-374-7993.

Sincerely,
Bridjit Campbell
Director, Healthcare Concierge Services

Care N' Care 101504IA

<Date>

«First_Name» «Last_Name»
«Member_Mailing_Addr1» «Member_Mailing_Addr2»
«City», «State» «Zip_Code»

Dear «First_Name» «Last_Name»,

Care N' Care is committed to keeping you informed about matters affecting your health care. Care N' Care was recently notified <Medical Group/IPA> that your physician,

<Name>, has changed phone numbers. The new phone number of the office is

<Number>.

If you have any questions, please call Care N' Care Healthcare Concierge at 877-374-7993 (TTY users: 711) between the hours of 8:00 a.m. to 8:00 p.m. CST, seven days a week. Requests to change providers that are received on or before the 25th of the month will be effective the 1st of the following month.

Si usted desea que un representante le llame y le explique en Español el contenido de esta carta, por favor llame 877-374-7993.

Sincerely,
Bridjit Campbell
Director, Healthcare Concierge Services

Care N' Care 101504IA

<Date>

«FirstName» «LastName»
«CurrMailAddr1» «CurrMailAddr2»
«CurrMailCity», «CurrMailState» «CurrMailZip»

Dear Valued Member:

We understand that matters affecting your health care are important to you. With this in mind, we wish to notify you that your physician, <Name> will no longer be associated with <Medical Group/IPA> effective <Date>. We want to reassure you that all of your benefits and copayments through Care N' Care will remain intact and we will work with you to arrange for your medical services with minimal disruption.

In order to assure the uninterrupted availability of health care services, we have updated our records to reflect that <Name> is your new personal care physician. <Name> office is located at <Address>. The phone number at this office is <Number>. You will receive a new ID that will reflect this change of PCP assignment.

We understand that continuity of care is important to you. Please call your current doctor and ask for your medical records to be transferred to your new doctor. You will need to sign a medical records release and they will instruct you on this process. If you are currently receiving inpatient hospital care, under the care of a specialist, receiving treatment/therapy, have a scheduled surgery/procedure, currently in a hospital/skilled nursing facility, use medical equipment (wheelchair, oxygen, hospital bed, etc.) or have any other concerns regarding continuation of a medical service, please call the Care N' Care Healthcare Concierge Department at 877-374-7993 (TTY: 711). We will work with our Utilization Management Department to coordinate any future care.

If during this transition period you receive a bill in error from a provider for a covered medical service, do not pay the bill. Instead, please retain a copy of the bill for your files, and then forward the bill to:

Care N' Care Claims Department
P.O. Box 961285
Fort Worth, TX 76161-0285

You may be eligible to disenroll from Care N' Care and return to Original Medicare or to enroll with another Medicare Advantage or Prescription Drug Plan. Beginning in <year>, you can make plan changes only at certain times during the year unless you qualify for a "Special Election". For more details, please call your Care N' Care Healthcare Concierge .

<Your current primary care physician is also available with another contracted medical group. If you would prefer to stay with this doctor or choose another doctor as your personal care physician, or would prefer to utilize a specific hospital, please contact your Healthcare Concierge at 877-374-7993 (TTY users: 711), Monday through Friday, 8:00 am to 8:00 pm CST, seven days a week. Your Healthcare Concierge will be happy to assist you with selecting another doctor.

Si usted desea que un representante le llame y le explique en Español el contenido de esta carta, por favor llame 877-374-7993.

Sincerely,
Bridjit Campbell

Director, Healthcare Concierge Services

CMS# 061802

Care N' Care 01-2002d

<Date>

«First_Name» «Last_Name»
«Member_Mailing_Addr1» «Member_Mailing_Addr2»
«City», «State» «Zip_Code»

Dear Valued Member:

We understand that matters affecting your health care are important to you. With this in mind, we wish to notify you that your physician, < Name> will no longer be associated with <Medical Group/IPA> effective <Date>. We want to reassure you that all of your benefits and copayments through Care N' Care will remain intact and we will work with you to arrange for your medical services with minimal disruption.

We are pleased to notify you, however, that there will be no disruption in your current personal care physician relationship. < Name>, your personal care physician, is currently affiliated with <Medical Group/IPA>. In order to assure the uninterrupted availability of health care services, we have transferred you to this medical group effective <Date>. <Name) office is located at <Address>. The phone number of the office is <Number>. The affiliated hospital is <Name>. You will receive a new ID card within a week that will reflect these changes.

If you are currently receiving inpatient hospital care, under the care of a specialist, receiving treatment/therapy, have a scheduled surgery/procedure, currently in a hospital/skilled nursing facility, use medical equipment (wheelchair, oxygen, hospital bed, etc.) or have any other concerns regarding continuation of a medical service, please call your Care N' Care Healthcare Concierge at 877-374-7993. We will work with our Utilization Management Department to coordinate any future care.

If during this transition period you receive a bill in error from a provider for a covered medical service, do not pay the bill. Instead, please retain a copy of the bill for your files, and then forward the bill to:
Care N' Care
Claims Department
P.O. Box 961285
Fort Worth, TX 76161-0285

You may have the right to disenroll from Care N' Care and return to Original Medicare or to enroll with another Medicare Advantage or Prescription Drug Plan. You can make plan changes only at certain times during the year unless you qualify for a "Special Election". For more details, please call your Care N' Care Healthcare Concierge.

If you would prefer a different doctor as your personal care physician, or would prefer to utilize a specific hospital, please contact your Healthcare Concierge at 877-374-7993 (TTY Users: 711), seven days a week, 8:00 am to 8:00 pm CST, seven days a week. Your Healthcare Concierge will be happy to assist you with selecting another doctor.

Si usted desea que un representante le llame y le explique en Español el contenido de esta carta, por favor llame 877-374-7993.

Sincerely,
Bridjit Campbell
Director, Healthcare Concierge Services

CMS# 041802
Care N' Care 01-2002

Attachment B: Pre-Authorization Guidelines and Summary

care n care
Insurance Company, Inc.

CARE N' CARE PREAUTHORIZATION GUIDELINES AND SUMMARY

The following services REQUIRE preauthorization for Inpatient and Outpatient.

Inpatient
Elective Surgery and Medical Admissions
Emergency Admissions
Acute Rehabilitation Admissions
LTAC Admissions
Skilled Nursing Facility (SNF) Admissions
Behavioral Health

Outpatient Services
Bariatric Surgery - and specific obesity related services (IP and OP)
Bone Growth Stimulator
Breast Reconstruction
Cardiology Services:
Cardiac Resynchronization Therapy (CRT)
Defibrillator (AICD) Implant
Diagnostic Catherization
Echo
Stress Echo
Electrophysiology Implant
Chemotherapy Injectable Drugs
Cochlear & Auditory Implants
Cosmetic & Reconstructive
DME (greater than $1000)
End Stage Renal Disease/Dialysis Services
Home Health
Hysterectomy
Hyperbaric Therapy
Infusions and Injections
Non-Emergency Air Transportation
Orthognathic Surgery
Orthotics (greater than $1000)
Orthopedic Surgery
Potentially Unproven Services, including Experimental / Investigational Services
Prosthetics
Proton Beam Therapy
Radiology Services:
CT
MRI
MRA
Spect Scans
PET Scan
Nuclear Medicine
Nuclear Cardiology Studies
Therapeutic Radiation (IMRT, SRS, SBRT)
Rhinoplasty
Sleep Apnea Procedures & Surgeries
Sleep Study - Facility Based
Spinal Stimulator for Pain Management
Vagus Nerve Stimulation
Vein Procedures
Transplant Work-Up
Wound Care

Out of Network Services
Any out-of-preferred or out-of network requests for HMO plans (referrals and preauthorizations) will require preauth.

Specialty Drugs
For a list of medications that require preauthorization when delivered in the physician office, clinic, outpatient or home setting, please refer the Specialty Drug Preauth List

Preauthorization Guidelines and Summary

Last Approved December 2015

Attachment C: Specialty Drug Preauthorization List

care n care
Insurance Company, Inc.

CARE N' CARE

Specialty Drug Preauthorization List

2016

The medications listed below require preauthorization when delivered in the physician office, clinic, outpatient or home setting

Preauthorization is NOT required when administered as an Inpatient or in the ED or Urgent Care Clinic

Brand Name	Generic Name
Abraxane®	Paclitaxel Protein-bound, paclitaxel-nab
Actemra	tocilizumab
Acthar Gel	corticotropin
Adcetris	brentuximab vedotin
Aldurazyme	laronidase
Alimta®	Pemetrexed
Aloxi	palonosetron HCl
Aralast NP	alpha 1-proteinase inhibitor
Aranesp	darbepoetin alfa
Arcalyst	rilonacept
Arranon	nelarabine
Arzerra	ofatumumab
Atgam	lymphocyte immune globulin
Avastin®	Bevacizumab
Aveed	testosterone undecanoate
Beleodaq	belinostat
Benlysta	belimumab
Berinert	c1 esterase inhibitor
Blincyto	blinatumomab
Boniva	ibandronate sodium
Botox	onabotulinumtoxinA
Brovana	arformoterol
Carimune NF®, Panglobulin NF® and Gammagard SD®	Immune Globulin, Intravenous
Cerezyme	imiglucerase
Chemotherapy Chemotherapy Agents Supportive and Drugs Symptom Management Drugs	Chemotherapy Chemotherapy Agents Supportive and Drugs Symptom Management Drugs
Cimzia	certolizumab pegol
Cinryze	c1 esterase inhibitor
Cyklokapron	tranexamic acid
Cyramza	ramucirumab
CytoGam	cytomegalovirus immune globulin
Dacogen	decitabine
Duopa	carbidopa / levodopa
Dysport	abobotulinumtoxin A

Elaprase	idursulfase
Elelyso	taliglucerase alfa
Elitek	rasburicase
Eloxatin	oxaliplatin
Emend IV	aprepitant
Entyvio	vedolizumab
Epogen	epoetin alfa
Erbitux®	Cetuximab
Erwinaze	asparaginase Erwinia chrysanthemi
Eylea	aflibercept
Fabrazyme	agalsidase beta
Firazyr	icatibant
Flebogamma®	Immune Globulin, Intravenous
Flolan	epoprostenol (injection)
Folotyn	pralatrexate
Fusilev	levoleucovorin
Gammagard®	Immune Globulin, Intravenous
Gammaplex®	Immune Globulin, Intravenous
Gamunex®	Immune Globulin, Intravenous
Gattex	teduglutide
Gazyva	obinutuzumab
Gel-One	sodium hyaluronate
Gemzar®	Gemcitabine HCl
Gilenya	fingolimod
Glassia	alpha 1-proteinase inhibitor
Growth Hormones: Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive	somatropin
Halaven	eribulin mesylate
Herceptin®	Trastuzumab
Hyalgan1	sodium hyaluronate1
IImmune Globulin, Intravenous	Immune Globulin, Intravenous
Ilaris	canakinumab
Iluvien	fluocinolone acetonide
Immune Globulin: Carimune NF, Flebogamma 5%, Gamastan, Gammagard S/D, Gammagard Liquid, Gamunex, Hizentra, Octagam, Privigen, Vivaglobin	immune globulin
Istodax	romidepsin
Ixempra	ixabepilone
Jetrea	ocriplasmin
Jevtana	cabazitaxel
Kadcyla	ado-trastuzumab emtansine
Kalbitor	ecallantide

CARE N' CARE

Specialty Drug Preauthorization List

2016

The medications listed below require preauthorization when delivered in the physician office, clinic, outpatient or home setting

Preauthorization is NOT required when administered as an Inpatient or in the ED or Urgent Care Clinic

Brand Name	Generic Name
Kineret	anakinra
Krystexxa	pegloticase
Kynamro	mipomersen sodium
Kyprolis	carfilzomib
Lemtrada	alemtuzumab
Lucentis	ranibizumab
Lumizyme	alglucosidase alfa
Macugen	pegaptanib sodium
Makena	hydroxyprogesterone caproate
Marqibo	vincristine sulfate
Monovisc	sodium hyaluronate
Mozobil	plerixafor
Myobloc	rimabotulinumtoxinB
Myozyme	alglucosidase alfa
Naglazyme	galsulfase
Neupogen	filgrastim
Neulasta	pegfilgrastim
Nplate	romiplostim
Nulojix	belatacept
Opdivo	nivolumab
Octagam®	Immune Globulin, Intravenous
Omontys	peginesatide
Ontak	denileukin diftitox
Orencia	abatacept
Orthovisc	hyaluronan
Ozurdex	dexamethasone intravitreal implant
Perjeta	pertuzumab
Prialt	ziconotide
Privigen®	Immune Globulin, Intravenous
Procrit	epoetin alfa
Prolastin-C	alpha 1-proteinase inhibitor
Prolia	denosumab
Provenge®	Sipuleucel -T
Provenge®	Sipuleucel -T
Qutenza	capsaicin/skin cleanser
Reclast	zoledronic acid
Remicade	infliximab
Remodulin	treprostinil (injection)
Revatio	sildenafil citrate (injection)
Rituxan®	Rituximab
Ruconest	c1 esterase inhibitor

Sandostatin LAR	octreotide
Signifor LAR	pasireotide
Simponi	golimumab
Simponi ARIA	golimumab
Soliris	eculizumab
Somatuline Depot	lanreotide
Stelara	ustekinumab
Supartz1	sodium hyaluronate1
Sylatron	peginterferon alfa-2b
Sylvant	siltuximab
Synagis	palivizumab
Synribo	omacetaxine mepesuccinate
Synvisc	hylan G-F 20
Temodar	temozolomide
Testopel	testosterone pellet
Torisel	temsirolimus
Treanda	bendamustine HCl
Tysabri	natalizumab
Tyvaso	treprostinil (inhaled)
Unituxin	dinutuximab
Valstar	valrubicin
Varizig	varicella zoster immune globulin
Vectibix®	Panitumumab
Velcade®	Bortezomib
Veletri	epoprostenol
Ventavis	iloprost (inhaled)
Vidaza®	Azacitidine
Vimizim	elosulfase alfa
Visudyne	verteporfin
Vpriv	velaglucerase alfa
Xeomin	incobotulinumtoxin A
Xgeva®	Denosumab
Xofigo	radium Ra 223 dichloride
Xolair	omalizumab
Yervoy®	Ipilimumab
Zaltrap	ziv-aflibercept
Zemaira	alpha 1-proteinase inhibitor
Zevalin	ibritumomab tiuxetan
Zometa	zoledronic acid
Zyprexa Relprevv	olanzapine

Attachment D: Referral/Pre-Authorization Submission

SILVERBACK

CONTACT US:
PHONE: 1-855-359-9999 • FAX: 1-888-965-1964 • myNTSP.com/search

Provider Portal

- Auto approval for in-network referrals
- Easier submission process for both referrals and preauthorization eliminating the need for faxing or call-in requests
- Ease of authorization look up, including status of request
- Training or Access: 844-632-2095 or email help@ntsp.com

REFERRAL/PRECERT SUBMISSIONS

- If unable to utilize the Provider Portal, please **fax** in your request to Silverback Care Management at 1-888-965-1964
- Referrals must come from PCP. Specialists needing referrals, please request the referral from the PCP to initiate
- Allow **two business days turn-around time** for processing.
- If authorization is **not** received within two business days:
  - **CONTACT** us at **1-855-359-9999**
- **Remember:**
  - HMO health plan referrals must come from PCP. Specialists needing referrals, please request the referral from the PCP to initiate
  - HMO health plan referrals must be on file in order for precert to be processed
  - HMO health plan referrals and precert requests must be submitted prior to date of service (DOS).
  - PPO referrals are not required, but are a courtesy notification and can be submitted by PCP or Specialist
    - PPO referrals are not required in order for precerts to be processed

NON-STANDARD SUBMISSION

- **OUT OF NETWORK REFERRALS**: While every effort is taken to process out of network referrals in a timely manner, please allow **a turn-around time of 14 calendar days.**
- **EXPEDITED PRECERTS:** Please mark expedited **only IF** it meets CMS definition:
  - CMS defines this as a determination that **"could seriously jeopardize the life or health of the enrollee** or the enrollee's ability to regain maximum function"
  - **Clinical information** supporting the urgent need **must be submitted.**
- **CHANGES TO ORIGINAL REQUEST:** Contact us at **1-855-359-9999.**

We thank you for the opportunity to serve you and your patients.

Attachment E: Authorization Request Form

CARE N' CARE

Phone: 855-359-9999 **Fax:** 888-965-1964

❑ Pre-Certification ❑ Referral/Notification

Health Plan/Payor:

❑ Care N' Care PPO ❑ Care N' Care HMO

Submitted by:(select one) ❑ PCP Office ❑ Specialist Office		Today's Date: / /
Patient's Name:	DOB / /	Member ID:
Patient PCP:		NPI:
Contact Name:		
Contact Phone:		FAX:

Proposed Date of Service: / /	
Treating Provider:	NPI:
Other Provider Name: (i.e. Facility, DME)	NPI:
Phone:	FAX:

❑ Outpatient ❑ Office ❑ Inpatient ❑ DME ❑ Ambulatory Surgery Center

Health-e-Care: ❑ Clinic Visit (All) ❑ Clinical Pharmacist ❑ Social Services ❑ Advance Care Planning (MOST)

ICD-10 CM Diagnosis Description	ICD-10 CM Code
Procedure: CPT/HCPCS Exact Description	**CPT/HCPC Code**
Describe any special circumstances which should be considered when authorizing services:	
Clinical Information: (You may attach additional clinical)	

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____

_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.

3/7/2016

Attachment F: Home Health Pre-Authorization Form

care n care
Insurance Company, Inc.

CARE N' CARE

Phone: 855-359-9999 | **Fax:** 855-446-9982

Home Health Pre-certification Form

ONLY COMPLETED FORMS WILL BE PROCESSED

HOME HEALTH AGENCY NPI#_____ **PCP NPI#** _____
REQUESTING PROVIDER NPI#_____

Eval____ **Initial**____ **Recert**____ **Resumption of Care**____

REQUESTOR AND PATIENT INFORMATION

Agency Name: _____ Contact Person: _____
Phone: _____ Fax: _____
Patient: _____ Patient ID#/DOB: _____
PCP: _____ Ordering Physician: _____
Diagnosis Related to HH need: _____

SKILLED NURSING SERVICES | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

PT | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

OT | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

SPEECH THERAPY | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

MSW | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

HHA | CODE:

# of visits requested: _____ 485 Dates of Service: _____ - _____

485 and orders are required for all initial SOC requests.

page 1 of 2

A **SN summary** documenting current clinical status with skilled need is required for **all SN recert** requests. Please do not send the Oasis.
Examples of acceptable SN summary documentation:

- Change in condition – describe what changes in patient's condition have occurred
- Unstable condition – describe unstable condition and attach supporting documentation; examples include vital signs log, PT/INR log, blood sugar log, other abnormal labs that require SN intervention
- New and changed meds within 14 days – describe what meds have changed or been added
- Wound clinical with photo; new photo required every 30 days to show progression

Submit therapy evaluations and notes for all therapy services being requested.

Describe circumstances that require skilled services:

Attachment G: DME Pre-Authorization F

care n care
Insurance Company, Inc.

CARE N' CARE

DME Pre-Authorization Request Form

Phone: 855-359-9999
Faxes: 888-965-1964

Today's Date: _____

Health Plan/Payor:

❑ Care N' Care PPO ❑ Care N' Care HMO

Patient's Name:	Birth Date: / /
Member ID#:	
DME Provider:	DME NPI:
DME Contact Person:	
DME Phone:	DME Fax:
Requesting Physician:	NPI:
PCP:	NPI:
Proposed Date of Service: / /	

RENTAL	PURCHASE

ICD-10 CM Diagnosis Description	ICD-10 CM Code
Procedure: CPT/HCPCS Exact Description (one per line please)	CPT/HCPC Code (one per line please)
Describe any special circumstances which should be considered when authorizing services:	
Clinical Information/Comments: (You may attach additional clinical)	

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____
_____
_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.

Attachment H: SNF LTAC Rehab Pre-Authorization Form

CARE N' CARE

SNF, LTAC, REHAB Request

Phone: 855-359-9999 **Fax:** 855-446-9981

Health Plan/Payor:

❑ Care N' Care PPO ❑ Care N' Care HMO

Patient's Current Location (If Facility, name of Facility is Needed):

❑ ER: _____ ❑ Acute: _____ ❑ LTAC/REHAB: _____
❑ Office ❑ Home ❑ Other: _____

Request for:	❑ SNF	❑ LTAC	❑ REHAB	Today's Date: / /

Patient's Name:	DOB / /	Member ID:
Patient PCP:		NPI:
Requestor Name:		
Requestor Phone:		FAX:

Expected Admit Date: / /	
Ordering Physician:	Ordering Physician NPI:
Facility:	Facility NPI:
Treating Physician:	Treating Physician NPI:

ICD-10 CM Diagnosis Description	ICD-10 CM Code
Describe any special circumstances which should be considered when authorizing services:	
Clinical Information: ****Clinical Information MUST be included with Request including eval and clinical notes from referring facility****	

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____
_____
_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.

3/7/2016

Attachment I: Authorization/ Exception Request

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:	Fax Number:
2181 E. Aurora Rd, Suite 201 Twinsburg, OH 44087	877-503-7231

You may also ask us for a coverage determination by phone at 855-791-5302 or through our website at https://www.cnchealthplan.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State_____ Zip Code _____

Phone _____ Enrollee's Member ID # _____

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

H6328_AG4167CV 12/2011

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

_____

_____

_____

_____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature of person requesting the coverage determination (the enrollee, or the enrollee's prescriber or representative):

_____ **Date:** _____

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Prescriber's Signature _____ **Date** _____

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

- ☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]
- ☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]
- ☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]
- ☐ **Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]
- ☐ **Other** (explain below)

Required Explanation: _____