



Chronic Condition Special Needs Plan



Provider Manual

**CommuniCare Advantage is the DBA for the legal entity OH CHS SNP, Inc.*

Chronic Condition Special Needs Plan: Contents

COMMUNICARE ADVANTAGE CONTACTS	3
ABOUT COMMUNICARE ADVANTAGE – WHO WE ARE, AND WHO WE SERVE	6
MISSION	6
MODEL OF CARE	6
MEMBER INFORMATION	10
Member Identification & Eligibility	10
Billing Members and Balance Billing	10
Benefits and Services	11
Emergent and Urgent Services	11
GRIEVANCE & APPEAL PROCESS	13
Utilization Management	13
Adverse Determinations	19
Clinical Practice Guidelines & Reference Material	20
Behavioral Health	21
PROVIDER INFORMATION	23
Administrative, Medical, and/or Reimbursement Policy Changes	23
Provider Marketing Guidelines	23
Member Assignment to New PCP	24
PROVIDER PARTICIPATION IN THE NETWORK	25
Notification Requirements for Data Changes	25
Closing Patient Panels	25

Access and Availability Standards for Providers	26
PROVIDER RIGHTS AND RESPONSIBILITIES	27
Provider Rights	27
Provider Responsibilities	27
Provider Contracting	28
Terminating Participation from the Provider Network	28
Credentialing and Recredentialing Process	29
Practitioner Rights in Credentialing	30
CLAIMS	34
Claims Submission	34
Coordination of Benefits and Subrogation Guidelines	38
Subrogation	40
Provider Appeals and Provider Dispute Resolution (PDR)	41
QUALITY PROGRAMS	41
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)	41
Stars Program	42
Program Evaluation	43
CORPORATE COMPLIANCE PROGRAM	46
APPENDIX A – FORMS	48
Prior Authorization Request Form	48
PCP Dismissal Form	50
APPENDIX B – QUALITY LINKS	51
APPENDIX C – SERVICES REQUIRING PRIOR AUTHORIZATION	52

CommuniCare Advantage Contacts

If you have questions about . . .	Contact
Behavioral Health Services	<p>Phone: 855-969-5869</p> <p>Hours: 8:00 a.m. to 8:00 p.m. M–F April 1–September 30; seven days per week October 1–March 31</p> <p>Fax: 855-969-5872</p>
Case Management Referrals	<p>Phone: 855-969-5870</p> <p>Fax: 877-478-5888</p> <p>Email: cm@communicare-advantage.com</p>
Claims: Payment Status, Refunds/Overpayments, Dispute Resolution, EDI	<p>Phone: 855-969-5869</p> <p>Hours: 8:00 a.m. to 8:00 p.m. M–F April 1–September 30; 7 days per week October 1–March 31</p> <p>CommuniCare Advantage Claims Department PO Box 21063 Eagan, MN 55121</p> <p>EDI Payer ID: 34525</p> <p>Website: www.communicare-advantage.com</p>
Claims: Paper Submissions	<p>CommuniCare Advantage Claims Department PO Box 21063 Eagan, MN 55121</p>
Credentialing and Recredentialing	<p>Phone: 855-969-5869</p> <p>Fax: 813-472-8962</p> <p>Email: providerrelations@communicare-advantage.com</p>
Dental Services (Extra Benefit)	<p>Phone: 855-535-8378</p> <p>Aflac Benefits Solutions PO Box 211276 Eagan, MN 55121-2776</p> <p>Payer ID Florida: ARGUS</p> <p>Payer ID Out of Florida: ARG01</p>

Fraud, Waste, and Abuse

Phone: 800-238-1770

Fax: 513-530-1378

Email: cca-compliance@communicare-advantage.com

CommuniCare Advantage

10123 Alliance Road

Blue Ash, OH 45242

Hospital/Facility Admission Notification

Phone: 855-969-5869

Fax: 888-300-9320

Member Services Call Center

Phone: 855-969-5869, TTY: 711

Fax: 855-969-5871

Hours: 8:00 a.m. to 8:00 p.m. M–F April 1–September 30; seven days per week October 1–March 31

Website: www.communicare-advantage.com

Nations Hearing (Extra Benefit)

866-951-4327

Pharmacy: Elixir

Phone: 833-685-5387

Fax: 877-503-7231

Pharmacy Claims Address:

Elixir

7835 Freedom Ave NW

North Canton, OH 44720

Prior Authorization - Medical

Phone: 855-969-5869

Fax: 888-300-9320

Provider Network Operations/Provider Relations

Phone: 855-969-5869

Fax: 513-605-6833

Email: Providerrelations@communicare-advantage.com

CommuniCare Advantage

Attn: Provider Relations

10123 Alliance Road

Blue Ash, OH 45242

Provider Services Call Center

Phone: 855-969-5869

Fax: 855-969-5872

Hours: 8:00 a.m. to 8:00 p.m. M–F April 1–September 30; seven days per week October 1–March 31

Quality Management

Phone: 855-969-5870

Fax: 877-508-8480

Email: qm@communicare-advantage.com

Vision Services (Extra Benefit)

Phone: 855-535-8378

Aflac Benefits Solutions

PO Box 211276

Eagan, MN 55121-2776

Payer ID Florida: ARGUS

Payer ID Out of Florida: ARG01

About CommuniCare Advantage – Who We Are, and Who We Serve

CommuniCare Advantage Chronic Condition Special Needs Plan (CSNP) is a Medicare Advantage plan designed to optimize the quality of care and services for individuals with chronic conditions. Specifically, CommuniCare Advantage CSNP serves Medicare Advantage and Part D-eligible individuals with diabetes mellitus, chronic heart failure, and/or cardiovascular disorders who live in one of the following areas across three states:

- Maryland: Anne Arundel, Baltimore, and Baltimore City Counties
- Ohio: Butler, Cuyahoga, Hamilton, Lorain, and Montgomery Counties
- Indiana: Hamilton, Hancock, Hendricks, Johnson, and Marion Counties

CCA also has a separate Medicare Advantage Institutional Special Needs Plan (ISNP). Please see the CCA ISNP Provider Manual for information specific to that plan and population.

The CommuniCare Family of Companies (CFC), founded in 1984, is one of the nation's largest providers of post-acute care, which includes skilled nursing rehabilitation centers, long-term care centers, independent living communities, and long-term acute care hospitals.

Mission

CommuniCare's commitment to "Serve with Pride" means a standard of operations founded on an unwavering commitment to Excellence. The mission to provide a superior customer experience to every patient served by the CommuniCare Family of Companies carries over to the CommuniCare Advantage Plan.

CommuniCare Advantage (CCA) provides a superior member experience in accordance with the CommuniCare Family of Companies True Blue Standards of Excellence:

- **Clinical Excellence.** CCA uses evidence-based guidelines to help members stay healthy and active. CCA engages with physicians and providers to understand the needs of the members and coordinate access to care.
- **Service Excellence.** CCA employees are unyielding in determination to deliver exceptional service that meets members' needs.
- **Satisfaction.** CCA listens to members and providers and strives to resolve challenges and anticipate needs.

Model of Care

The CommuniCare Advantage Model of Care establishes the quality framework guiding the delivery and coordination of care. It is tightly attuned to the needs of the population CCA serves. CCA's CSNP members are more vulnerable than most Medicare beneficiaries, with challenging chronic care needs and associated

comorbidities and difficulties with the activities of daily living. This may include functional impairment (hearing, vision, cognitive, ambulation, self-care, or independent living difficulty). Health literacy and language barriers may also complicate self-care, and members may be frail. Members' frailty may be complicated by age and socioeconomic factors in addition to the aforementioned challenges with multiple chronic conditions and comorbidities and cognitive or physical limitations. CCA assesses, and addresses, frailty according to psychological changes, physical decline, and social disruptions including isolation.

CommuniCare Advantage's Model of Care facilitates the early assessment and identification of health risks and major changes in the status of members to engage needed interventions at the earliest possible time. Our goal is to promote access to care and services important to each member's preferences and goals and consistent with best practices and guidelines.

CommuniCare Advantage's evidence-based Model of Care includes the following components:

- **Case Management.** Case managers play an important role in implementing the model of care. A case manager is assigned to every member to coordinate medical oversight and continuity of care across providers based on member preferences and goals. Case managers provide a range of services for CCA CSNP members, including health risk assessment, coordination of an interdisciplinary care team (ICT), and creation of an individualized care plan (ICP) driven by member care goals, needs, and preferences. They coordinate specialist services and community services outlined in the ICP, with comprehensive, continuous assessments including identifying physical, psychological, and spiritual aspects of care and member/caregiver/family preferences and goals. This includes culturally competent palliative care planning and coordination as well as advance directive discussions to facilitate coordination of services and to avoid unwanted treatments and hospital or emergency department admissions.
- **Health Risk Assessment.** CSNP members receive a health risk assessment after enrollment and at least annually thereafter to explore the member's goals, preferences, understanding of health conditions, barriers to care, functional and clinical status, and symptom management needs. The health risk assessment informs risk stratification and the creation of both an interdisciplinary care team (ICT) and individualized care plan (ICP).
- **Risk stratification.** CCA uses its healthcare analytics platform to stratify members related to clinical complexity and risk, informed by the health risk assessment. This stratification guides the intensity of service and care coordination provided and is also used to evaluate the provider network to ensure that the appropriate resources and specialties are available to address the needs of Plan members.
- **Interdisciplinary Care Team (ICT).** The ICT includes the primary care provider, member or legal representative, family members requested by the member or representative, the case manager, and practitioners of various disciplines and specialties based on the needs of the member.
- **Individualized Care Plan (ICP).** The ICP includes clinical, psychosocial, and pharmaceutical recommendations in addition to reflecting the goals and preferences of the member regarding interventions and advance care planning. The ICP is distributed to all members of the ICT and is

stored centrally so that it can be accessed or shared, as indicated. All providers are encouraged to participate in the interdisciplinary care teams as a way to support to member-focused model of care.

- **Coordination with PCP.** All members are required to choose or designate a PCP at enrollment from the directory of participating providers. Physicians contracted as PCPs and available to be chosen as a primary care physician with CCA are clearly identified in CCA's Provider Directory if credentialed at time of publication. Members can change their PCP at any time. The PCP change will become effective on the first day of the month following the change request.

Case managers partner with the PCPs to support the individualized care plan. The case manager works directly with the PCP to provide and oversee all aspects of member care including evaluating, recommending, or providing treatments to optimize health status. Information flow is critical to the CSNP model of care, and various platforms, processes, and professionals facilitate information exchange among the PCP or other relevant provider, CommuniCare Advantage, PHP where appropriate, and the member or representative. The CSNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Quality Improvement Program.

- **Advance Care Planning.** The Federal Patient Self-Determination Act 38 CFR § 17.32 ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining or withdrawing life-sustaining treatment. In accordance with guidelines established by the CMS, HEDIS requirements, and CommuniCare Advantage's own policies and procedures, CommuniCare Advantage requires all participating providers to have a process in place to support member decisions. To ensure providers maintain the required processes to advance directives, CommuniCare Advantage conducts periodic patient medical record reviews to confirm that required documentation exists.

All providers contracted directly or indirectly with CommuniCare Advantage may be informed by the member that the member has executed, changed, or revoked an advance directive. If the PCP or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must advise the member and CommuniCare Advantage. CommuniCare Advantage and the PCP or treating provider will arrange for a transfer of care.

Additionally, in the development of the ICP, the PHP or plan case manager will undertake a discussion with the member and family regarding advance care planning and include any applicable interventions in the ICP. If an advance directive has not already been executed, the PHP or plan case manager will provide education and encourage the member or responsible party to execute an advance directive to ensure that the member's wishes are supported.

- **Care Transitions.** Older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated. This is particularly true for CommuniCare Advantage's CSNP population with diabetes mellitus, chronic heart failure, and/or cardiovascular disease. Thus, CommuniCare Advantage actively works to coordinate transitions.

As a part of the care transition process, the case manager will be the primary advocate in ensuring the member's well-being across multiple care settings. The case manager will work with the PCP to ensure that the member receives the highest quality of health care in each health care setting. While the member is in an alternate care setting, CCA utilization management (UM) staff, the attending provider, and the member's PCP will coordinate and communicate to identify and facilitate provision of any needed services via the appropriate provider. While a member is inpatient in a hospital/care facility, UM staff will coordinate with the facility staff, attending provider, and PCP to ensure that the member will receive the necessary care and services upon discharge.

The CommuniCare Advantage transition team (case manager/care transition coach, nurse, and pharmacist) and UM coordinate with the PCP to smooth the transition and improve the health care of this vulnerable membership:

- Preparing for smooth transfer through communication of PCP and ICT contact information, member clinical condition (diagnoses, vital signs and clinical parameters, allergies), mental and functional status, current treatments and care plan, medications, and preferences as well as preferred language and hearing or visual limitations and advance care plans
- Providing members and caregivers/families one accountable point of contact
- Coordinating with the utilization manager for information during the member's transitions (i.e., after admission to a hospital) and communicating with the member, their caregiver/family, and medical providers during the care transition
- Ensuring transition of care protocols are followed
- Working with UM and hospital staff on discharge planning
- Providing coordination upon the member's discharge from the hospital or other facility with a prompt comprehensive assessment and medication review and subsequent updating of the HRA and individualized care plan with input from the ICT
- Initiating care transition coaching to ensure members understand their condition and red flags that the condition has declined, understand appropriate self-management, understand and can organize their medications, are able to schedule and complete follow-up appointments, and know how to ask healthcare professionals about their conditions

MEMBER INFORMATION

Member Identification & Eligibility

All participating providers are encouraged to verify eligibility prior to each encounter. It is important to note that membership data is subject to change; the Centers for Medicare and Medicaid Services (CMS) retroactively terminates members for various reasons from time to time. If this occurs, CommuniCare Advantage will initiate recoupments for any claims paid after loss of eligibility. The provider is encouraged to check CMS eligibility to see if there is any other coverage that replaced the CommuniCare Advantage CSNP coverage.

Each member receives an identification card with the member's identification number, the name of the PCP, and other helpful information such as important phone numbers. If the member does not have an ID card, you may verify member eligibility through the following methods:

- By contacting our Member and Provider Services Department at 855-969-5869
- By going to our website at www.communicare-advantage.com

ID Card:

Front and Back

 CommuniCare ADVANTAGE Printed Date: 6/29/2023	CommuniCare Advantage C-SNP Health Plan (80840) Member ID: A00007 Member Name: Test7 T Test7 CMS H3727 - 001	 RxBIN: 012312 RxPCN: PARTD RxGRP: CCAC																
<table border="1"><thead><tr><th colspan="2">For Members</th></tr></thead><tbody><tr><td>Member Services:</td><td>855-969-5869 (TTY/TDD: *711)</td></tr><tr><td>Pharmacy: Elixir</td><td>833-685-5387 (TTY/TDD: *711)</td></tr><tr><td>Dental and Vision: Aflac Benefits Solutions</td><td>855-535-8378 (TTY/TDD: *711)</td></tr><tr><td>Hearing: NationsHearing</td><td>866-951-4327 (TTY/TDD: *711)</td></tr></tbody></table> <table border="1"><thead><tr><th colspan="2">For Providers</th></tr></thead><tbody><tr><td>Provider Services: 855-969-5869</td><td>Pharmacists: 833-685-5387</td></tr><tr><td>Medical Claims: CommuniCare Advantage Claims Department PO BOX 21063 Eagan MN 55121-4328 EDI#: 34525</td><td>Pharmacy Claims: Elixir 7835 Freedom Ave NW North Canton, OH 44720</td></tr></tbody></table> <p>www.communicare-advantage.com</p>			For Members		Member Services:	855-969-5869 (TTY/TDD: *711)	Pharmacy: Elixir	833-685-5387 (TTY/TDD: *711)	Dental and Vision: Aflac Benefits Solutions	855-535-8378 (TTY/TDD: *711)	Hearing: NationsHearing	866-951-4327 (TTY/TDD: *711)	For Providers		Provider Services: 855-969-5869	Pharmacists: 833-685-5387	Medical Claims: CommuniCare Advantage Claims Department PO BOX 21063 Eagan MN 55121-4328 EDI#: 34525	Pharmacy Claims: Elixir 7835 Freedom Ave NW North Canton, OH 44720
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Billing Members and Balance Billing

Member Cost Sharing

CommuniCare Advantage members may have cost sharing requirements, which could include deductible, coinsurance, and copays. Providers should validate prior to rendering services. There is a possibility a member may have a primary or secondary payer, and providers should collect all health insurance information prior to rendering services.

Member Hold Harmless

Participating providers are prohibited from balance billing CommuniCare Advantage members including, but not limited to, situations involving nonpayment by CommuniCare Advantage, insolvency of CommuniCare Advantage, or CommuniCare Advantage's breach of its agreement. Providers may not charge, collect a deposit from, seek payment from, or have any recourse against members or their representatives, other than CommuniCare Advantage, for covered services provided based on the participating Provider's Agreement. The provider may, however, collect copayments, coinsurance, or deductibles for covered services in accordance with CommuniCare Advantage CSNP terms. If a member has both CommuniCare Advantage and Medicaid as a secondary payer, providers may not balance bill members.

Benefits and Services

A member's Evidence of Coverage letter outlines and defines the benefits and services they may receive. These services include Medicare Part A and Part B services consistent with original Medicare Parts A, B, and D, including primary and preventive services, hospitalization, nursing facility, emergency services, home health, DME, pharmacy, specialty care, lab work, and radiology.

Extra/value added benefits include preventive dental, routine vision, audiology with hearing aids, and a meal benefit for members discharging from an acute inpatient setting.

Emergent and Urgent Services

CommuniCare Advantage follows the Medicare definitions of "emergency medical condition," "emergency services," and "urgently-needed services" as defined in the Medicare Managed Care Manual Chapter 4 Section 20.2:

- **Emergency medical condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:
 - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
- **Emergency services:** Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or treat an emergency medical condition.
- **Urgently-needed services:** Covered services that are not emergency services as defined above but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition; are provided when the member is temporarily absent from CommuniCare

Advantage's service area; or under unusual and extraordinary circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible and it was not reasonable given the circumstances to wait to obtain the services through CommuniCare Advantage network.

The CommuniCare Advantage provider network includes hospitals, emergency rooms, and providers able to treat the emergent and urgent conditions of CommuniCare Advantage members 24 hours a day, 7 days a week. For urgent and emergent issues that occur in the member's service area, the PCP is responsible for providing, directing, or authorizing a member's urgent or emergent care. The PCP or his or her designee must be available 24 hours a day, 7 days a week to assist members needing emergent or urgent services.

For emergent or urgent issues, the PCP, working with the member's case manager, is responsible for coordinating the treatment of the member at the hospital or emergency room, including communicating with the hospital or emergency room about the member. Members have a copayment responsibility for outpatient emergency visits unless an admission results.

CommuniCare Advantage members may receive emergency services and urgently needed services from any provider, regardless of whether services are obtained within or outside the CommuniCare Advantage authorized service area and/or network and regardless of whether there is a prior authorization for the services. For emergency services outside the service area, CommuniCare Advantage will pay reasonable charges for emergency services received from nonparticipating providers, if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

CommuniCare Advantage's network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent and the ambulance provider is not contracted with CommuniCare Advantage, CommuniCare Advantage follows Medicare rules on coverage for ambulance services as set forth in 42 CFR 410.40.

Prior authorization is required for all non-emergent ambulance services. Claims for non-emergent ambulance transportation will be denied if prior authorization is not obtained. CCA follows CMS rules for coverage of non-emergent ambulance transportation. Per the Medicare Benefit Policy Manual, Chapter 10 for Ambulance Services, medical necessity must be established for all ambulance services. "Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary."

Grievance & Appeal Process

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of CommuniCare or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

An appeal is the procedure that deals with the review of adverse initial determinations made by CommuniCare Advantage on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive.

CommuniCare Advantage members or their appointed representative have the right to file a grievance about problems they observe or experience with CommuniCare Advantage or with any aspect of the care received from a provider. Situations for which a grievance may be filed include but are not limited to the following:

- Complaints regarding health plan services such as Member Services telephone hold times or responsiveness
- Complaints regarding the provider network such as issues such as waiting times, physician or office staff behavior, or lack of quality of the care received
- General issue about a drug not being on the formulary or listed as excluded

In addition, CommuniCare Advantage members and their appointed representatives may appeal any decision about CommuniCare Advantage's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide
- A bill that the member feels should be CommuniCare Advantage's responsibility, or a dispute regarding the calculation of the copay amount
- Services they have not received, but believe CommuniCare Advantage should pay for
- A reduction in or termination of service a member feels is medically necessary

Appealable issues will be placed in either the expedited or standard appeals process. An expedited appeal may be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.

Members or their appointed representatives may also appeal any hospital discharge decision. In this case, a notice will be given to the member or appointed representative with information about how to appeal, and the member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Members may refer to the CommuniCare Advantage Evidence of Coverage for additional information.

Utilization Management

CommuniCare Advantage's Utilization Management Department coordinates health care services with our provider network and case management teams to ensure appropriate utilization of health care

resources. This coordination ensures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the members.

CommuniCare Advantage Utilization Management staff base utilization-related decisions on the clinical needs of members, the member's benefit plan, InterQual Guidelines, the appropriateness of care, Medicare national coverage guidelines, CMS guidance, health care objectives, and scientifically based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other such relevant information.

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

Departmental Functions:

- Prior Authorization
- Concurrent and Retrospective Review
- Referrals
- Discharge Planning
- Continuity of Care
- Reporting and Monitoring

Prior Authorization

The PCP or specialist is responsible for requesting prior authorization of all scheduled admissions or services. CommuniCare Advantage recommends requesting prior authorization at least 14 days in advance of a scheduled/planned admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. For prior authorizations, providers may link to the Provider Portal by going to www.communicare-advantage.com, or fax requests to 888-300-9320.

Services Requiring Prior Authorization

Services requiring prior authorization are listed on CommuniCare Advantage's website and in Appendix C.

Services Requiring Notification Only

- ER
- Urgent admissions
- Observation status

Emergent or urgent admission notification must be received within 24 hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the member's condition is unstable and the facility is unable to determine coverage information, CommuniCare Advantage requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information

to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

The presence or absence of a service or procedure on the CommuniCare Advantage website list does not determine coverage or benefits. Call our Member Services Department to verify benefits, coverage, and member eligibility.

The Utilization Management Department, under the direction of licensed physicians and nurses, documents and evaluates requests for authorization. The requests are evaluated utilizing InterQual and CMS guidelines as well as nationally accepted criteria. Once a determination is made, the UM Department notifies the provider of the determination. Please see the Sample PA request form in the Appendix or online at www.communicare-advantage.com.

CommuniCare Advantage must be notified of emergency admissions within 24 hours of admission, or on the next business day, whichever is later.

Contracted hospitals and critical access hospitals (CAH) must comply with the provisions of the NOTICE Act (Notice of Observation Treatment and Implication for Care Eligibility Act) by delivering the Medicare Outpatient Observation Notice (MOON) to any CCA member who receives observation services as an outpatient for more than 24 hours.

Decisions and Time Frames

Emergency (see definition in the Emergent and Urgent Services section above): Authorization is not required.

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

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

Once the Utilization Management Department receives the request for authorization, CommuniCare Advantage will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, CommuniCare Advantage will assign an authorization number and enter the information in CommuniCare Advantage's medical management system. This authorization number can be used to reference the admission, service, or procedure.

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

Concurrent Review

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

- Covered services are being provided at the appropriate level of care
- Services are being administered according to the individual facility contract

CommuniCare Advantage's Utilization Management department complies with individual facility contract requirements for concurrent review decisions and timeframes. CommuniCare Advantage's nurses, utilizing CMS guidelines and InterQual Clinical Guidelines review criteria, will conduct medical necessity review.

CommuniCare Advantage's preferred method for concurrent review is a conversation between our Utilization Management staff and the facility UM staff within 24 hours of notification of an emergent admission or on the last covered day. If clinical information is not received within 72 hours of an emergency admission or last covered day, the case will be reviewed for medical necessity with the information CommuniCare Advantage has available. If the facility is unable to contact CommuniCare Advantage via phone, they may fax the member's clinical information within 24 hours of notification to 888-300-9320.

For planned admissions that have been prior authorized, CommuniCare Advantage will conduct concurrent review to support effective discharge planning services.

Review is not required for readmission to the referring SNF (the member's primary nursing facility) where applicable; however, if the patient is transitioning to an alternate or out-of-network SNF, prior authorization is required and reviews should be faxed to 888-300-9320. CommuniCare Advantage will render a determination within 24 hours of receipt of complete clinical information. The Utilization Management nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a favorable determination. Clinical update information should be received 24 hours prior to the next review date.

All acute, rehab, long-term acute care (LTAC), and SNF confinements that do not meet medical necessity criteria are reviewed by the CommuniCare Advantage Chief Medical Officer (CMO) and a determination is issued. The criteria used for the determination are available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact (855) 969-5870.

If the attending provider does not agree with the determination, the provider is encouraged to contact CommuniCare Advantage's CMO for peer-to-peer discussion at (833) 799-2273. Following the peer-to-peer discussion, the CMO will either reverse the original determination and authorize the confinement or uphold the adverse determination. If upheld, the member or member's representative may request a review with the Independent Review Organization contracted with CMS for an independent, second-level appeal reviewer.

in cases where the member disagrees with CommuniCare Advantage's first-level appeal decision. CommuniCare Advantage cooperates with the Independent Review Organization on all requests for information and will forward the full appeal case file when requested or required.

For members receiving hospital care and for those who transfer to a non-referring SNF or acute inpatient rehabilitation care, CommuniCare Advantage will approve the request or issue a denial if the request is not medically necessary. CommuniCare Advantage will also issue a denial if a member who is already receiving care in an acute inpatient rehabilitation facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

CommuniCare Advantage also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. This notice must be delivered to the member within 2 days prior to discharge. The facility is responsible for delivering the notice to the member or their authorized representative or individuals with power of attorney (POA) and for having the member, authorized representative, or person with POA sign the notice within the written time frame listed in the Adverse Determination section of this manual. The facility is requested and expected to fax a copy of the signed NOMNC back to Utilization Management department at the number provided. The NOMNC includes information on members' rights to file an expedited appeal.

Retrospective Review

In situations in which a member is affected by an eligibility error, a change in Medicare options or Plan, or other circumstances that prevent the provider from submitting a prior authorization request to the correct entity in a timely manner, retrospective review may be requested. Providers must submit the PA request form, in addition to a statement that explains why the request is being made retrospectively. The retrospective PA must be requested within 10 business days of the provider discovering that the member had retrospective eligibility or that the member's Medicare or Medicare Advantage plan has changed. When retrospective review is initiated by the provider, the provider should submit the request and all supporting documentation to the PA fax number, 888-300-9320. The request will be reviewed, and a decision will be rendered within the required timeframes.

Referral Process

CommuniCare Advantage does not require approved referrals to specialists and other in-network providers. However, all out-of-network providers and some outpatient procedures performed in the professional office, diagnostic radiology center, ambulatory surgery center, and other places of service as well as certain services such as diagnostic radiology, infusion, initiation of dialysis, DME and medical supplies over \$500.00 (except diabetic supplies), and home health require prior authorization. Please see the CommuniCare Advantage provider website at www.communicare-advantage.com for a complete listing, or contact Provider Services at

855-969-5869 for more information. Prior authorizations must be obtained prior to services being rendered. The requesting provider should notify the member that services are approved and document this in the medical record.

We value the PCP's role in taking care of CommuniCare Advantage members and recognize that the PCP has a very important role in directing the member to the appropriate specialist based on knowledge of the member's condition and health history. Members must be directed to participating providers. Please refer to CommuniCare Advantage's website to view the current provider directory for participating specialists. If a member has a preference for in-network services, it should always be accommodated.

Members may also self-refer for covered services; however, CommuniCare Advantage advises the members verbally if they call the Member Service line and in writing via the member handbook to consult with their PCP prior to accessing services. Members are also advised that services may require prior authorization, physician order, or both. Members may self-refer and access at will CommuniCare Advantage extra benefits including vision, dental, hearing benefits, OTC medications, and comfort items.

While referrals are not required for specialty office visits, the specialist is required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment, and the need for any ongoing care.

Continuity of Care

From time to time, a member may join the Plan in the middle of a course of treatment. CommuniCare Advantage will work with the rendering providers to ensure applicable authorizations are issued and that access to services is facilitated through the course of treatment. Services performed by non-participating providers require prior authorization, unless emergent or urgent. If the course of treatment is expected to last more than 90 days and if providers are non-participating providers, CommuniCare Advantage will offer providers the opportunity to participate in the network on a limited basis to streamline the care and efficiency of care for the member either through single case agreement or limited participation agreement. If a provider leaves CommuniCare Advantage's network and a member is in an active course of treatment, CommuniCare Advantage will attempt to minimize any disruption in care by offering continuity of care services with the current provider through the course of treatment or by working with the rendering provider to develop a transition plan to a participating provider as may be necessary if the provider is retiring, relocating, etc. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If an authorization was initiated or approved by another entity prior to a new member's enrollment with CommuniCare Advantage, this authorization will be honored for a period of up to 90 calendar days, or until the PCP evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Provider Services at 855-969-5869.

If CommuniCare Advantage terminates a participating provider, CommuniCare Advantage will work to transition a member into care with a participating physician or other provider within CommuniCare Advantage's network. CommuniCare Advantage will reimburse for the health care services provided by the terminated provider following the date of termination under such circumstances.

Utilization Reporting and Monitoring

CommuniCare Advantage pledges to members, providers, and employees that it does not use incentives to discourage access to care and service. CommuniCare Advantage carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members.

Both underutilization and overutilization may be harmful to the patient. Overutilization may indicate inadequate coordination of care or inappropriate utilization of services. By using data from provider and practitioner sites, individual product lines, and the system as a whole, CommuniCare Advantage monitors for under- and overutilization, analyzes data to identify the causes, and acts to correct any issues identified. CommuniCare Advantage then implements appropriate interventions whenever potential problems are identified and further monitors the effect of these interventions.

Adverse Determinations

Denials

The Utilization Management staff makes a determination (approval or denial) based on contract terms, benefits, or eligibility and using all available and applicable information. Only the CommuniCare Advantage CMO or Associate Medical Director may render a denial based on medical necessity, but the CMO or Associate Medical Director may also make a decision based on administrative guidelines. The CMO may suggest an alternative covered service. CommuniCare Advantage will notify the provider—and the member, when applicable—of a determination to deny or limit an admission, procedure, service, or extension of stay. Documentation will include the original request that was denied and the alternative approved service, along with the process for appeal.

CommuniCare Advantage employees are not compensated for denying services. The PCP or attending physician may contact the CMO or Associate Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

The written notification of denial includes the reason and is sent in accordance with CMS requirements. The timeframes for decisions are as follows:

- For non-urgent Part C pre-service decisions: within 14 calendar days of the request
- For non-urgent Part B drug pre-service decisions: within 72 hours of the request
- For urgent pre-service decisions: within 72 hours or three calendar days of the request

- For urgent pre-service Part B drug decisions: within 24 hours of the request
- For urgent concurrent decisions: within 24 hours of the request
- For post-service decisions: within 30 calendar days of the request
- For non-urgent Part D (pharmacy) pre-service decisions: within 72 hours of the request
- For urgent Part D (pharmacy) pre-service decisions: within 24 hours of request

Decisions for urgent and non-urgent Part C (excluding Part B drugs) may be extended for up to an additional 14 calendar days if necessary, if requested by the member or if CommuniCare Advantage justifies a need for additional information and the delay is in the best interest of the member. Part B drug decisions cannot be extended, per CMS guidelines.

Peer-to-Peer Information

CommuniCare Advantage complies with CMS requirements for written notifications to members, including rights to appeal and file grievances. For urgent care requests, CommuniCare Advantage notifies only the providers of the decision since the treating or attending practitioner is acting as the member's representative. If the denial is either concurrent or retrospective and the member is not at financial risk, the member is not routinely notified.

Clinical Practice Guidelines & Reference Material

CommuniCare Advantage has adopted evidence-based clinical practice guidelines (CPGs), which are nationally recognized guidelines based on available peer-reviewed clinical publications and medical professional societies that support adherence to evidence-based best practices for effective and efficient care. CommuniCare Advantage reviews, revises, and approves these guidelines, using nationally recognized, evidence-based literature.

Examples of sources of clinical practice guidelines:

- US Preventive Services Task Force
- AAFP – Preventing Falls in Older Persons
- ADA – Standards of Medical Care in Diabetes 2019, section on older adults
- Endocrine Society – Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline
- AAN – Practice Guideline Update Summary: Mild Cognitive Impairment
- 2018 – Alzheimer's Association Best Clinical Practices for the Evaluation of Neurodegenerative Cognitive Behavioral Syndromes, Alzheimer's Disease and Dementias in the United States
- The Society for Post-Acute and Long-Term Care Medicine – Depression CPG

Providers will be informed that adopted CPGs are available via various means, which could include newsletters, website, hard copies, or other communication methods.

CommuniCare Advantage will review medical and pharmacy claims, authorization data, member grievances, and as indicated medical records to monitor adherence to CPGs. Through prior authorization processes, the Director of Utilization Management and the CMO may become aware of opportunities to educate providers on the CPGs. Finally, Quality Operations will review provider medical records to monitor adherence to CPGs.

CPGs reflect current scientific research and evidence-based clinical standards for care appropriate to the CommuniCare Advantage CSNP population. Such guidance supports provider decision making but does not replace clinical decision making or medical judgment.

Behavioral Health

CommuniCare Advantage provides fully integrated behavioral and physical health care coordination through case managers who are trained in mental health first aid and integrated care.

Case managers will consider mental health in the health risk assessment and will incorporate behavioral health support in the development of the individualized care plan. Integration and communication among behavioral health and physical health providers is an important element of the plan. A member's interdisciplinary care team will accordingly include behavioral health service providers or will include input from behavioral health specialists based on member needs.

The most vulnerable among the CommuniCare Advantage population are likely to have mental illness, sometimes severe. Individuals living with mental health illness are at higher risk of experiencing chronic physical conditions, and people with chronic physical health conditions experience depression and anxiety at twice the rate of the general population. The combination of mental health and physical health issues can lead to worsening health outcomes. Thus, the model of care focuses on fully integrated behavioral and physical health care coordination.

Behavioral Health Services

CommuniCare Advantage members are supported by a robust network that incorporates medical and behavioral health needs. For behavioral health care, the network includes community mental health centers and psychiatric hospitals as well as psychiatrists, psychologists, social workers, certified therapists, and addiction support services.

CommuniCare Advantage encourages behavioral health providers to become part of the network and to participate in the integrated care approach based on the particular member's needs. In addition, PCPs are encouraged to participate in the identification and treatment of their member's behavioral health needs through screening and early identification of mental health and substance abuse issues, consultation or specialist referrals as needed, and regular communication with other physical and behavioral health providers.

Access to Care

CommuniCare Advantage's network includes mental health and substance abuse services and providers who identify and treat members with behavioral health care needs.

- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCPs' scope of practice.
- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation and ongoing outpatient treatment.
- Members and providers may call Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations at 855-969-5869.

Documentation

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

Additionally, case managers will document mental health in the health risk assessment and update the ICT on behavioral health providers' input or recommendations to ensure integrated care planning and management.

Provider Information

Administrative, Medical, and/or Reimbursement Policy Changes

There are times when CommuniCare Advantage may amend, alter, or clarify its policies based on, for example, regulatory changes, changes in medical standards, and modification of covered services. In accordance with the terms of the provider contract, CCA will notify providers of all material changes. In addition, CommuniCare Advantage policies and procedures may be obtained by accessing our website at www.communicare-advantage.com. It is the provider's responsibility to review and include policy updates and to comply with these changes upon receipt of these notices.

Provider Marketing Guidelines

The below information is a general guide to assist CommuniCare Advantage providers, who have contracted with multiple Medicare Advantage plans and are accepting Medicare fee-for-service patients, to understand which marketing and patient outreach activities are permissible under the CMS guidelines. Providers may not steer or attempt to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by CommuniCare Advantage sponsor or by another sponsor, based on the financial interest of the provider or agent. Providers must remain neutral in assisting plans to market to potential members or assisting in enrollment decisions.

Providers may (from Medicare Communications and Marketing Guidelines, MCMG)

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from <https://www.medicare.gov>) including in areas where care is delivered
- Provide the names of Plans/Part D sponsors with which they contract and/or participate
- Answer questions or discuss the merits of a Plan or Plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, Plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at <https://www.medicare.gov>, or 1-800-MEDICARE
- Refer patients to Plan marketing materials available in common areas
- Provide information and assistance in applying for the Low-Income Subsidy (LIS)
- Make available, distribute, and display communication materials, including in areas where care is being delivered
- Provide or make available Plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms)
- Announce new or continuing affiliations with specific Plans once a contractual agreement has been approved

Providers May Not:

- Accept/collect scope of appointment forms

- Accept Medicare enrollment applications
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific Plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Plans/Part D sponsors
- Offer inducements to persuade their patients to enroll in a particular Plan or organization
- Conduct health screenings as a marketing activity
- Distribute marketing materials/applications in areas where care is being delivered
- Offer anything of value to induce enrollees to select them as their provider
- Accept compensation from the Plan for any marketing or enrollment activities

Member Assignment to New PCP

CMS allows for a limited set of circumstances under which a provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits
- Disruptive, unruly, threatening or uncooperative behavior not caused by a physical or mental health condition but which seriously impairs CommuniCare Advantage's or the provider's ability to provide services to the member
- Threats of physical harm to a provider or his or her office staff
- Non-payment of required copayment for services rendered after multiple collection attempts
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary, rising to the level of fraud, waste, or abuse
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan

The provider is expected to make reasonable efforts to address the member's unacceptable behavior through education and counseling and, if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied and the provider feels the relationship has been irreparably harmed, the provider should complete the Member Dismissal form (see Appendix A) and fax it to CommuniCare Advantage using the fax number on the form. CommuniCare Advantage will research the concern and determine if the situation warrants requesting a new PCP assignment or other arrangement. A CommuniCare Advantage PCP may not request a disenrollment based on an adverse change in a member's health status or utilization of medically necessary services for treatment of a member's condition.

A member may request a change in PCP at any time and for any reason. The PCP change that is requested by the member will be effective the first of the month following the receipt of the request, unless circumstances require an immediate change.

Provider Participation in the Network

Providers must be contracted with and credentialed by CommuniCare Advantage or the entity under contract to perform credentialing services. CommuniCare Advantage's credentialing program is compliant with all CMS guidelines and state regulations as applicable. CommuniCare Advantage is ultimately responsible for all services provided by contracted entities, terms of the contract, and fulfillment of all terms and conditions of its contract. CommuniCare Advantage may agree to delegate credentialing to a provider organization so long as a Delegation Agreement is signed by both parties, and a pre-delegation audit is conducted and found to be satisfactory, with ongoing annual audits being conducted for the duration of the Agreement.

Notification Requirements for Data Changes

For any changes to a provider's practice, participating providers must provide written notice to CommuniCare Advantage at least 10 days in advance of the change(s), or as soon as possible after the change, if advance notice is not possible. The following is a list of changes that must be reported to CommuniCare Advantage by contacting your Provider Network Representative:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations, if required
- Practice name
- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers or acquisitions
- Addition or closing of a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

Updating information in a timely fashion ensures that the practice is listed accurately in the Provider Directory and that claims adjudicate correctly and promptly.

Closing Patient Panels

When a participating PCP elects to stop accepting new patients, the patient panel is considered closed. If a participating PCP closes his or her panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against CommuniCare Advantage members by closing their patient panels for CommuniCare Advantage members only, nor may they discriminate among CommuniCare Advantage members by closing their panel to certain product lines.

Providers who elect to stop accepting new patients must notify CommuniCare Advantage's Provider Contracting and Network Operations Department, in writing, at least 60 days prior to the date the patient panel will be closed.

Access and Availability Standards for Providers

CommuniCare Advantage has established written standards to ensure timeliness of access to care that meet or exceed the standards established by CMS, to ensure that all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. CommuniCare Advantage requires that all providers offer standard hours of operation that do not discriminate against Medicare enrollees and are convenient for CommuniCare Advantage members, the facilities where members reside, and facility staff who aid in member care.

Timeliness of Access to Care

CommuniCare Advantage members should have access to care 24 hours a day, 7 days a week as medically necessary. Timely access requirements for routine, preventive, and urgent care services are listed below.

Primary care physicians are required to provide:

- Routine and preventive care within 30 days
- Routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within 1 week (7 days) of onset
- Immediate urgent and emergent care in the physician's office or telephonically, in coordination with a case manager
- 24 hour a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician call coverage during time off, with immediate response to emergency care calls, 30-minute response to weekday and after-hours urgent care calls, and end-of-day return or routine care calls. It is not permissible to pre-record direction for members to utilize the Emergency Department for after-hours needs.

Specialists are required to be available for a consult or new patient appointment within 21 days of initial request and to be immediately available to primary care physicians for an urgent or emergent consult regarding a member.

Telephone access (applicable to all contracted providers regarding calls from members, members' caregivers, CommuniCare Advantage Nurse Practitioners, CommuniCare Advantage CMO, and Utilization Management staff):

- Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately.
- Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
- Routine care calls, both weekdays and after-hours calls, will be returned by the end of the day or the following morning.

- All calls are answered promptly by the provider, provider staff, and/or a reliable paging service or answering service.

Monitoring of Network Access

CommuniCare Advantage will use valid methodology and data sources to continually collect and perform analysis of provider data to measure performance against CommuniCare Advantage's written standards and against CMS requirements. In addition to regularly scheduled performance measurement, CommuniCare Advantage will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access of care are collected through the CommuniCare Advantage Member Services department line or through submissions to the Quality Improvement Committee. Complaints related to access to care are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Practitioners or sites identified for access improvement opportunities will be contacted in a timely manner regarding survey or measurement results, and follow-up inquiries and measurements may be scheduled.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Provider Rights and Responsibilities

Provider Rights

CommuniCare Advantage would like your suggestions and feedback on how service may be improved within the organization.

If a contacted provider feels he/she has not been paid according to policy, he/she may dispute the payment. See Provider Appeals and Provider Dispute Resolution section of this manual for details.

Provider Responsibilities

- Each provider has agreed to treat CommuniCare Advantage members with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Providers are required to provide services that do not discriminate against any patient in any manner including but not limited to source of payment, race, ethnicity, national origin, sex, sexual orientation, gender identity, age, religion, place of residence, health status, mental or physical disability, medical history, evidence of insurability, or genetic information.
- Each provider has agreed to provide continuing care to participating members.

- Each provider has agreed to utilize CommuniCare Advantage's participating physicians/facilities when services are available and can meet the patient's needs. Approval prior to referring outside of the contracted network of providers may be required.
- Each provider has agreed to follow CommuniCare Advantage's policies and procedures including but not limited to Utilization Management, Case Management, Quality Management processes.
- All providers are invited and encouraged to participate in CommuniCare Advantage provider committees that include Provider Council, Credentialing, and Medical Policy.
- A provider may not balance bill a member for providing services that are covered by CommuniCare Advantage. This excludes the collection of standard copays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.
- Providers may not charge the Medicare cost share to dually eligible members (members with both Medicare and Medicaid) for covered Part A, B, or D services

Provider Contracting

CommuniCare Advantage maintains an open network and encourages providers to contract to become participating providers. Providers may request a provider agreement and credentialing application through the following means:

- Provider Network Operations Phone: 855-969-5869
- Provider Relations email address: providerrelations@communicare-advantage.com

A provider is considered fully participating and may render services to CommuniCare Advantage members once all of the following have occurred:

- The provider has received correspondence confirming that the Credentialing Committee has approved the application and providing the applicable effective date
- The provider has returned a fully executed and complete Provider Agreement and W9
- The provider has been fully configured in the CommuniCare Advantage system

Terminating Participation from the Provider Network

A 90-day notification is required if a provider wishes to terminate his or her participation in either of the CommuniCare Advantage networks or CommuniCare Advantage terminates a provider for reasons other than cause. Please refer to your contract for specific termination requirements.

Termination of a Provider Contract with Cause

If CommuniCare Advantage suspends or terminates an agreement, CommuniCare Advantage must give the affected provider written notice of the following:

- Reason for the action
- Standards and data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable

Affected health care professionals have the right to appeal the action and request a hearing. The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional.

If CommuniCare Advantage suspends or terminates a contract with a health care professional due to deficiencies in the quality of care, CommuniCare Advantage must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should send a written notification to the CommuniCare Advantage Network Operations Management email at providerrelations@communicare-advantage.com. Upon receipt of the termination request, CommuniCare Advantage will send notification of the termination to all affected members at least 30 calendar days before the effective date of termination and will assist members to select alternative providers as applicable.

Credentialing and Recredentialing Process

The credentialing program ensures that the CommuniCare Advantage network consists of quality providers who meet clearly defined criteria and standards. The credentialing policy and procedure can be requested by contacting your provider services representative.

The decision to approve or deny credentialing is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law. The credentialing program has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The credentialing program is reviewed annually, revised, and updated as needed.

While specific to each practitioner type, facility, or ancillary provider, the credentialing process validates licensure, clinical privileges, malpractice insurance, and Medicare participation and screens for OIG and other applicable exclusions, licensure restrictions or recent actions, and other regulatory or business requirements.

Once a complete application is received and processed, a recommendation to approve, deny, or pend for additional information will be forwarded to the credentialing committee, along with the applicable

information from the file to support the recommendation. The credentialing committee will review the information and recommendations from the credentialing department and render a determination. A decision letter will be mailed to the provider within 30 days of the determination decision. The credentialing process generally takes up to 90 days to complete but in some instances may take longer.

To maintain participating status, all practitioners are required to recredential at least every 3 years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information four months in advance of their three-year anniversary date. Three good faith attempts will be made to obtain the required information via mail, email, or telephonic request. If no response is received, the credentialing department will submit a notice to the provider that failure to apply for re-credentialing is interpreted as voluntarily relinquishing credentialed status, and the provider will be terminated in accordance with contractual requirements.

Application Process

Individual practitioners

- If participating in Council for Affordable Quality Healthcare (CAQH), complete and return the Provider Profile Sheet
- If not participating in CAQH, complete and return the Provider Profile Sheet and the full Provider Credentialing Application

Facility or ancillary providers

- Complete and return the Provider Profile Sheet and the full Ancillary/Facility Credentialing Application

Practitioner Rights in Credentialing

Right to Be Informed of Your Credentialing Application Status upon Request: Upon receipt of a written request, CommuniCare Advantage will provide written information to the applicant of the status of the credentialing application within 15 business days. CommuniCare Advantage will advise the provider of any items still needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared to information provided by the applicant.

Right to Review Information Submitted to Support Your Credentialing Application: The applicant may review any documentation he or she submitted in support of the application, together with any discrepant information received from a professional liability insurance carrier, state licensing agencies, and certification boards.

Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe: If discrepancies are found between information submitted by the applicant and information obtained by CommuniCare Advantage during the primary source verification process, CommuniCare Advantage will

notify the applicant. The applicant may submit corrections for the discrepant information or provide a written explanation within 30 calendar days of the request.

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required for all PCPs and OB/GYNs. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within 30 days and may be re-audited, at a minimum within 60 days, to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards, even after re-auditing, will not be eligible for participation.

Credentialing Committee / Peer Review Process

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or reapproval as a participating provider. Providers who meet all of the acceptance criteria may be approved by the CommuniCare Advantage Chief Medical Officer. Provider applications that require review or discussion are presented to the credentialing committee for consideration. The credentialing committee is composed of contracted primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and recredentialing process must be obtained and verified within 160 days prior to presentation to the Chief Medical Officer or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discriminatory Credentialing and Recredentialing

CommuniCare Advantage's Credentialing Program is compliant with all guidelines from CMS and state regulations as applicable. CommuniCare Advantage does not discriminate, in terms of participation, reimbursement, or indemnification, against any healthcare professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

CommuniCare Advantage will not consider a practitioner's gender, race, religion, creed, national origin, age, sexual orientation, types of procedure, or types of patients the practitioner specializes in or any other criteria lacking professional or business justification in determining whether the practitioner may participate in the CommuniCare Advantage provider network, except for those regarding conflict of interest (COI) following both local and federal regulations. This does not preclude the credentialing committee from including in its network providers who meet certain demographic or specialty needs such as cultural needs of its covered persons. CommuniCare Advantage does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers may not render services to CommuniCare Advantage members until the notification of successful credentialing is received except in the case of urgently needed care or emergency care and treatment, or unless prior authorization has been obtained. Applicants who are denied by the Credentialing Committee will be notified via letter within thirty 30 days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Credentialing and Participation Appeals Process & Notification of Authorities

Practitioners who receive an adverse participation decision receive written notification of the reasons for the decision, and appeal rights will be included with the determination letter.

Credentialed providers who receive a corrective action plan or admonition receive written notification of the reasons for the decision, including appeal rights. For decisions to recommend limitation or loss of privileges, the notification will include the reasons for the action, outline the appeals process or options available to the provider, and provide the time limits for submitting an appeal. Such recommendations are placed in the provider's credentialing file and may be reported to the applicable state oversight agency and National Practitioner Data Bank if they involve continuing medical education, proctoring, a written admonition, relicensing or accreditation efforts, or other applicable activity. If the Peer Review or Credentialing Committee learns that a provider has experienced termination or suspension of privileges, CCA notifies the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB).

Confidentiality of Credentialing Information

Information and documentation obtained in the credentialing process is confidential. Only employees of CommuniCare Advantage or persons with authority to act in the committee peer review/approval process, or agents of CommuniCare Advantage performing in a legal capacity of reviewers of the Plan, or agents of accreditation, federal or state regulatory agencies, acting in the capacity of reviewers of CommuniCare Advantage, or others as provided by law may have access to credentialing files.

Ongoing Monitoring

CommuniCare Advantage credentialing department performs ongoing review of licensure and OIG sanction websites on a regular monthly or quarterly basis as applicable. Participating providers who are identified as having been sanctioned are subject to review by CommuniCare Advantage CMO or the Credentialing Committee who may elect to limit, restrict, or terminate participation. Any provider whose license has been revoked or has been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid

or any other government health related program or who has opted out of Medicare will be automatically terminated from the CommuniCare Advantage provider network.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and contracted. Directory specialty designations must be commensurate with the licensure, education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by Credentialing and Re-credentialing Process of CommuniCare Advantage.

CLAIMS

Claims Submission

CommuniCare Advantage encourages providers to submit claims electronically via a clearinghouse and to check the status of claims electronically. Paper claims are also accepted; however, electronic claims are highly encouraged to promote more accurate, efficient, and secure processing and payment of claims.

EDI PAYER ID NUMBER: 34525

CLEARINGHOUSE: SSI Claimsnet

Paper claims may be sent to:

CommuniCare Advantage Claims Department
PO Box 21063
Eagan, MN 55121

Timely Filing

In order for reimbursement consideration, claims must be filed within the 180-day timely filing period. If there is a third-party payer or other health insurance, timely filing starts on the day of the other payer's adjudication.

Claim Format Standards

Standard CMS-required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html>

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

Corrected Claims

A corrected claim is used to update a previously processed claim with new or additional information. A corrected claim is member and claim specific and should only be submitted if the original claim information was incomplete or inaccurate. A corrected claim does not constitute an appeal. Corrected claims may be sent electronically or on paper and should be received within 365 days of the original determination.

To submit a corrected claim, the appropriate resubmission code or type of bill must be used per CMS guidelines. Frequency codes for CMS-1500 Form box 22 (Resubmission Code) or UB04 Form box 4 (Type of

Bill) should contain a **7** to replace the frequency billing code (corrected or replacement claim), or an **8** (Void Billing Code). All corrected claim submissions should contain the original claim number. Electronic replacement claims submitted with claim frequency code **7** or **8** with the original claim number must be submitted in Loop 2300 REF02- Payer Claim Control Number with qualifier F8 in REF01. See the table below for frequency code details.

FREQUENCY CODE	DESCRIPTION
5 - Late Charge(s) (Institutional Providers Only)	Use to submit additional charges for the same date(s) of service on a previous claim.
7 - Replacement of Prior Claim	Use when replacing the entire claim (all but identity information
8 - Void/Cancellation of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."

Claim Payment

CommuniCare Advantage pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a covered service that has no defect or impropriety. A defect or impropriety may include lack of data fields required by CommuniCare Advantage or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term will be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. Claims are paid once per week.

CommuniCare utilizes VPay to distribute all claim payments. The default method of payment is by VCard, which is an expedited method of payment via Mastercard, and is processed through a merchant terminal. Instructions for processing these payments are included on each EOP. For a different form of payment such as paper check or electronic funds transfer (EFT), please contact the VPay Customer Service Center at 1-888-920-0581 or by emailing support@vpayusa.com to discuss your payment preference.

Pricing

Original Medicare typically has market-adjusted prices by code (i.e., CPT or HCPCS) for services that traditional Medicare covers. However, there may be circumstances under which CommuniCare Advantage offers a

covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, CommuniCare Advantage will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid.

CommuniCare Advantage applies National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE) in claims processing. CommuniCare Advantage follows guidelines put forth by the AMA CPT and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may affect contracted allowances. All editing applied by CommuniCare Advantage is subject to the grievance, appeals, and clinical review policies and procedures outlined in this manual.

New or Non-listed Codes and Not Otherwise Classified Codes

CommuniCare Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code during the annual or quarterly code reviews or at any other point during the year, CommuniCare Advantage will make every effort to load the new code at the Medicare pricing level, subject to all applicable copayments, deductibles, and cost-sharing amounts. If a provider submits a code, or the code is an unlisted/not otherwise classified (NOC) code, or does not have a contracted allowance, the following process will occur:

1. CommuniCare Advantage retains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system.
2. An unlisted procedure or NOC code must have a concise description of the service or procedure rendered in Item 19 on the CMS-1500 claim form or electronic equivalent. In the concise description of the procedure, it is helpful to include how the procedure was performed (e.g. laparoscopic, transnasal, infusion, with clip, type of graft, etc.), the body area treated and why it was performed.
The electronic equivalent for Item 19 holds up to 80 characters for the concise statement. If the description does not fit in Item 19, providers who submit paper claims should include an attachment to describe the service or procedure.
3. For claims over \$100.00 in billed charges, supporting documentation must be included with the claim in order to determine allowance basis, and to make a coverage determination. This would include, but is not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS.
4. If a claim is denied, Provider may dispute the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare
5. CommuniCare Advantage will pay for any such services that include proof of payment by Original Medicare within the past 6 months at 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing. CommuniCare Advantage will also consider paying per invoice (if applicable) when submitted.
6. If no proof of Original Medicare payment or invoice are submitted, then CommuniCare Advantage will default to paying such services at 40% of billed charge.
7. Authorization guidelines apply to unlisted codes.

All codes/services submitted for payment and not recognized by the claims system are subject to verification of medical necessity. If there are questions or concerns about coverage, Providers should call for pre-certification or pre-determination.

Explanation of Payment (EOP)

The EOP is sent to the provider after adjudication of the claim. The statement provides a detailed description of how the claim was processed.

Non-Payment / Claim Denial

Any denials of coverage or nonpayment for services by CommuniCare Advantage will be addressed on the Explanation of Payment (EOP). All applicable adjustment codes per claim will be listed on the EOP. Per your contract, the member may or may not be billed for services denied by CommuniCare Advantage. The member may not be billed for a covered service when the provider has not followed appropriate procedures. If the benefits are exhausted or not covered, the EOP will indicate when the member may be billed.

Some common claim denial examples:

- Duplicate claim submission
- Member not eligible at time of service
- Non-covered service
- Service requires prior authorization
- Service requires specific modifiers
- Invalid procedure code
- Invalid diagnosis code
- Unbundled procedure
- Incidental procedure
- Exclusive procedure
- New patient code billed for established patient
- New patient code billed within 3 years of previously billed code by same provider
- Global pre/post code billed within the global period

Processing of Hospice Claims

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a CommuniCare Advantage member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services

rendered during the election period. CommuniCare Advantage is responsible for extra services covered under the member's MA plan (e.g. dental, vision) and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. If a member revokes the hospice election, the hospice or original Medicare continues to cover the expenses until the first day of the month following the revocation. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of hospice election.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 — Special Rules for Hospice Care. Section C outlines the Medicare payment rules for members who have elected hospice coverage. The Medicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and Beneficiary Protections Sections 10.22 – 10.4 and the CMS Change Request 8727 dated May 1, 2014, all outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: <http://cms.gov>.

Effective and Termination Dates Coinciding with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, CommuniCare Advantage is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a skilled nursing facility.) However, CommuniCare Advantage is responsible for Part B services rendered as of the effective date of coverage.

CommuniCare Advantage is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered by CommuniCare Advantage beginning on the effective date of enrollment.

If CommuniCare Advantage coverage terminates while the members is hospitalized, CommuniCare Advantage is responsible for the facility charges until discharge regardless of the reason for the coverage termination. Part B services rendered during the confinement will be the responsibility of the new payer, original Medicare or the new Medicare Advantage, employer, or other coverage as of the effective date of the termination.

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding 100 percent of the allowable amount.

Order of Benefit Determination Rule: Rules which, when applied to a particular member covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in

providing benefits for that member. A plan will be determined to have primary or secondary responsibility for a person's coverage with respect to other plans by applying the NAIC (National Association of Insurance Commissioners) rules.

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

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

Allowable Expense: Any expense customary or necessary for health care services provided as well as covered by the member's Health Care Plan.

CommuniCare Advantage is the secondary payer to the following plans:

1. Group health plans ("GHP") of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 and older who are covered under the plan by virtue of the individual's current employment status with the employer, or the current employment status of a spouse of any age
2. Large group health plans ("LGHP") (employers with at least 100 employees) that cover Medicare beneficiaries who are under age 65, entitled to Medicare due to disability, and are covered under the group plan by virtue of the individual's or a family Member's current employment status with an employer
3. Workers compensation plans
4. Automobile medical (Med-Pay) or no-fault plans. If it can be determined that the insured waived Med-Pay coverage prior to processing the claim, the Medicare Advantage Plan would be primary for injuries related to a motor vehicle accident. If the Plan is unable to easily determine this information, the Plan will request for claim to be submitted to the automobile carrier first and require notification of either payment or denial from the automobile carrier.
5. Liability plans of all types (automobile, malpractice, etc... except as noted above)
6. Veteran's Administration or TriCare plans

CommuniCare Advantage is primary to the following plans:

1. Group Health Plans that employ fewer than 20 employees
2. Group Health Plans that insure the enrollee, or the spouse of an enrollee, by virtue of retirement
3. Individual health plans that are purchased by the enrollee privately and not as a member of a group, and for which payment is not made through an employer
4. State Medicaid plans

Basic Processing Guidelines for COB

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

When CommuniCare Advantage is the secondary payer:

- All CommuniCare Advantage guidelines must be met in order to reimburse the provider (i.e., precertification, referral forms, etc.).
- The provider collects only the copayments required.
- Once payment and/or EOB are received from the other carriers, submit a claim with the other carrier's EOB for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

Secondary benefits are not payable in the following circumstances:

1. When the primary carrier pays the provider's charges in full
2. When the Provider is either obligated to accept or voluntarily accepts a third-party payment as payment in full
3. When the third-party payment is equal to or greater than the gross amount (including copayment/coinsurance) by CommuniCare Advantage

When CommuniCare Advantage is the primary insurance carrier:

- The provider collects the copayment required under the member's CommuniCare Advantage Plan.
- The provider submits the claim to CommuniCare Advantage first.
- Providers should be sure to have the member sign the "assignment of benefits" sections of the claim form.
- Once payment and/or remittance advice (RA) has been received from CommuniCare Advantage, providers should submit a copy of the claim with the RA to the secondary carrier for adjudication.

Please note that CommuniCare Advantage is a total replacement for Medicare. Medicare cannot be secondary when members have CommuniCare Advantage.

Subrogation

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

Claims involving subrogation or third-party recovery (TPR) will be processed internally by the CommuniCare Advantage Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to CommuniCare Advantage with any information regarding the third-party carrier. All claims will be processed per the usual claim's procedures.

For claims-related questions, please contact Provider Services at 855-969-5869.

Provider Appeals and Provider Dispute Resolution (PDR)

Non-Participating providers: A non-participating provider appeal (dispute) is a reconsideration of the original organizational determination not to approve or pay for a service, including a level of care decision (including not just outright denials, but also partial denials). All non-participating providers are required to submit a Waiver of Liability form (WOL) with all appeal requests for claim appeals.

An appeal must be submitted to the address listed below within 60 calendar days from the original adverse determination. You must include the following with your appeal request: a copy of your denial, any medical records that would support why the service is needed, and the Waiver of Liability form.

Appeal Request Address:

CommuniCare Advantage Appeals and Grievance Department
10123 Alliance Road
Blue Ash, OH 45242
FAX: 513-605-6830

Participating providers: Provider Dispute Resolution (PDR) is a claim payment dispute related to a claim that a provider feels did not process or pay correctly. PDRs may be requested by either calling Provider Services at 855-969-5869, or by mailing a request to the Claims address within 60 calendar days of the original payment determination.

In the event that a dispute, breach, or other controversy remains unresolved to the provider's satisfaction, a provider should notify the CommuniCare Advantage Provider Network Operations representative, and refer to the Dispute Resolution section of the provider contract.

QUALITY PROGRAMS

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

CommuniCare utilizes the NCQA® HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical records review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to ensure continuity and comparability of results. The HEDIS measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease. HEDIS results are used in a variety of ways. They are the measurement standard for many of CCA's clinical quality activities and health improvement programs.

The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs. Selected HEDIS results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks. HEDIS results are available upon request. Contact the Quality Department to request information regarding the results.

Plan-wide HEDIS measures are reported annually as mandated for health plans contracting with CMS. Each spring, CommuniCare Advantage representatives will be required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections. Providers can improve their HEDIS scores and reduce their administrative burden with the following actions:

- Submit claims/ encounter data for each and every service rendered
- Consider including CPT II codes to provide additional detail and reduce medical record requests

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

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are a set of surveys sponsored by CMS. The survey provides valuable information regarding patient's experience that cannot be assessed by other means. The CAHPS® survey score makes up over thirty-four percent of the Stars Score.

The Medicare (CAHPS®) surveys produce data on the member's experience of care that allow comparisons between MA and PDP contracts on domains that are important to consumers. The survey data are publicly reported by contract. The results from the Medicare (CAHPS®) survey are published on the Medicare Options Compare Web site (www.medicare.gov). CommuniCare Advantage will administer the CAHPS survey when all requirements are met.

Stars Program

The Medicare star rating program was created by CMS. It evaluates the relative quality of private health plans that offer services to Medicare beneficiaries. CMS scores health plans on a one- to five-star rating system. Five stars represents the highest quality a plan can achieve. Members can use this rating system to gauge a plan's quality rating, ease of access to care, provider responsiveness and members' satisfaction with the health plan.

The CMS Medicare Star Rating system rates the quality and performance of Medicare Advantage plans to help consumers and their families compare plans. Medicare Advantage plans are rated on their ability to:

- Help members stay healthy
- Assist members in managing chronic conditions

- Ensure positive member experiences with their health plan
- Achieve member satisfaction
- Provide effective customer service

Additionally, Medicare Advantage and Medicare Prescription Drug Plans that provide drug services are rated on how well they provide prescription-related coverage as well as customer service, member complaints, member experience with drug plan, and drug safety. Star ratings are calculated may change from year to year. The annual Medicare Star Ratings are posted online at www.medicare.gov.

Program Evaluation

CommuniCare Advantage continually monitors its quality program and makes changes as needed to its structure, content, methods, and staffing. Changes to the program are made under two conditions: (1) changes must benefit members; and (2) changes must comply with applicable regulations and guidance. Changes to the program are accompanied by policy and procedure revisions and staff training as required. The program operates under the umbrella of CommuniCare Advantage's Quality Improvement Committee which reports to the Joint Board of Directors. It is reviewed and updated annually in collaboration with the quality improvement department.

Quality Improvement Program Overview

CommuniCare Advantage's Quality Improvement Program (QIP) takes a proactive approach to improve the way care is provided and the way the health plan engages with members, providers, and other stakeholders so that its vision, mission, and commitment to member care is fully realized. The QIP provides a comprehensive structure to identify, monitor and evaluate, and continually improve care delivery, member satisfaction and member safety, implementing corrective actions and interventions when necessary to address opportunities for improvement. The QIP is designed to monitor performance in key areas and identify opportunities to improve clinical care, care delivery, service and member satisfaction and safety.

Quality Improvement Committee

The Quality Improvement Committee (QIC) reviews data at least quarterly to ensure systems are being monitored and maintained to achieve the highest quality for the organization. The Board will delegate the day-to-day oversight of the Quality Improvement Program (QIP) to the QIC. The QIC is composed of leaders from diverse areas of the Plan to bring a variety of skills and perspectives to the oversight of the QIP. The QIC will have the authority to develop subcommittees, workgroups, and operational teams focused on specific initiatives.

Medical Policy Committee

The Medical Policy Committee (MPC) reviews policies and provides guidance related to the clinical operations of the health plan and to the provider network. Medical policies are intended to have the impact of guiding care decisions rendered by the health plan or its participating providers and may include, for example, CDC guidance, prior authorization criteria sets, and clinical guidelines. They reflect current scientific research and evidence-based clinical standards for care appropriate to the CommuniCare Advantage CSNP population. Such guidance supports provider decision making but does not replace clinical decision making or medical judgment.

Continuous Quality Improvement Process

The QIP will be designed to monitor performance in key areas and identify opportunities to improve clinical care, care delivery, service, and member satisfaction and safety. The QIP will incorporate an iterative process of continuous assessment and monitoring to enhance members' care and service.

Quality Improvement Projects

The QI program is broad in scope to monitor and evaluate the quality of care and service received by members. Data are tracked and trended monthly, quarterly, and annually as delineated in the QI Work Plan, and baseline measurements are established. Opportunities for improvement and barriers are identified, and root-cause analysis is conducted as needed. Interventions are selected and implemented as appropriate. Written Instructive Communications (WIC) and Quality Improvement Plans (QIP) are initiated as indicated, and re-measurement is conducted in accordance with the Work Plan calendar.

Annual Quality Evaluation

An evaluation of the previous year's QI program is completed annually. The written evaluation is an assessment of the effectiveness of the QI program. The evaluation outlines accomplishments, includes limitations or barriers to meeting objectives, and states conclusions and recommendations for the upcoming year. The evaluation addresses the structure and functioning of the QI program, processes in place, and the outcome or results of QI activities. The evaluation is approved by the QIC. Results of the formal evaluation will be available on the CommuniCare Advantage provider website.

Quality of Care Issues

Quality of care issues include clinical quality indicators and quality of care concerns. The utilization management staff typically identify clinical quality indicators and refer them to the Quality department for review. Clinical quality indicators may be defined as an adverse outcome occurring in the inpatient or

ambulatory care setting that could be indicative of potential inappropriate or incomplete medical care.

Quality of care complaints are those concerns reported by members, families, or providers that could indicate a potential problem in the provision of quality care and services.

All quality of care issues will be reviewed and investigated. As part of the investigation, the Quality department may request records from providers and facilities. If action is taken it will be documented in the provider's record and reviewed by the credentialing committee at the time of recredentialing. Quality of care issues may be mailed to our Grievance and Appeals address, or reported verbally to our Member and Provider Customer Service department.

CORPORATE COMPLIANCE PROGRAM

Overview

CommuniCare Advantage has developed a vigorous compliance program to help oversee and enforce the policies and promote business integrity. CommuniCare Advantage's corporate compliance program ensures that all practices and programs are conducted in full compliance with federal and state regulatory requirements applicable to Medicare Advantage and Medicare Part D plans.

CommuniCare Advantage and its employees are committed to meeting all contractual obligations set forth in CommuniCare Advantage's contracts with CMS.

The purpose of the corporate compliance program is to prevent violations of federal and state laws governing CommuniCare Advantage's lines of business, including but not limited to health care fraud and abuse laws. In the event such violations occur, the corporate compliance program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

Confidentiality

CommuniCare Advantage is committed to preserving the confidentiality of its members and practitioners. To ensure the confidentiality of member information, written policies and procedures have been developed. . Patient data gathered during the case management process are available for the purposes of review only and are maintained in a confidential manner. Employees are required to complete annual confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of hire. As part of the provider contract, providers are expected to comply with the confidentiality and enrollee record accuracy requirements, including: (a) safeguarding the privacy of any information that identifies a member; (b) releasing medical records and information only in accordance with federal and state laws, court orders, or subpoenas; (c) maintaining the records and information in an accurate and timely manner; (d) ensuring timely access by members to the records and information that pertain to them; and (e) abiding by all state and federal laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. [42 C.F.R. §§ 422.504(a)(13) and 422.118].

Fraud, Waste, and Abuse

CommuniCare Advantage is committed to detecting and preventing fraud and financial waste and abuse. Therefore, policies and procedures have been developed to ensure compliance with the laws that govern our operations as a healthcare provider. The policies are comprehensive and include requirements for background checks to promote quality of hiring; clinical policies to ensure quality of care; financial policies to ensure accurate billing; billing policies to discourage fraud waste and abuse; and conflicts of interest policies to ensure the CommuniCare Advantage patient, residents, and customers receive uncompromised service.

The federal FCA, 31 U.S.C. Sections 3729-3733 and similar state laws assist the federal and state government programs, purchases and/or contracts. These laws prohibit the knowing and/or intentional use of false of

fraudulent claims, records or statements for the purpose of obtaining payment from the government. These laws prohibit, among other things, billing for service not rendered; billing for undocumented services; falsifying cost reports, billing for medically necessary services, assigning improper codes to secure reimbursement or higher reimbursement; participating in kickbacks and retaining an overpayment for services or items. A violation of these laws may result in civil, criminal and/or administrative penalties, including monetary penalties, imprisonments, exclusion from participation in Medicare and Medicaid and loss of licensure status.

The evaluation and detection of fraudulent and abusive practices includes all aspects of CommuniCare Advantage's business and its business relationship with third parties, including health care providers and members. All employees, vendors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at 800-238-1770. The compliance hotline is a confidential resource that can be used by employees, contractors, agents, members, or other parties to voice concerns about any issue that may affect CommuniCare Advantage's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at cca-compliance@communicare-advantage.com
- By mail to Corporate Compliance Officer, 10123 Alliance Road, Blue Ash, OH 45242
- Directly by phone at 800-238-1770

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

CommuniCare Advantage conducts periodic analysis of all levels of CPT, ICD-9/ICD-10, and HCPCS codes billed by our providers. The analysis allows CommuniCare Advantage to comply with its regulatory requirements for the prevention of fraud, waste, and abuse and to supply our providers with useful information to meet their own compliance needs in this area.

In order to meet your fraud, waste, and abuse obligations, please take the following steps:


- Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.
- Complete the mandatory online training at www.communicare-advantage.com.

APPENDIX A – FORMS

Prior Authorization Request Form

Form is downloadable from www.communicare-advantage.com under Resources

AUTHORIZATION SUBMISSION FAX: 888-300-9320



REQUEST FOR AUTHORIZATION OF SERVICES

PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization.
NON-PARTICIPATING PROVIDERS: Prior authorization is required for all services with exception of emergent, urgent care, and observation. Payment is only for the medical services noted below and is subject to the limitations and exclusions in the Member Handbook/Certificate of Coverage.

Section I: Member Information

Member Name: _____ Date of Birth: _____ Member ID: _____
Ordering Provider: _____ Phone No.: _____ Fax No.: _____
Primary Diagnosis (ICD-10 and Description): _____
Reason for Service Request: _____

Section II: Requesting Provider/Requesting Facility Information

Facility Name	Street Address
Facility Phone	City, ST ZIP
Facility Fax	Facility NPI
Facility Tax ID	
Provider Name	Street Address
Provider Phone	City, ST ZIP
Provider NPI	Provider Tax ID

Section III: Services Requested (include copy of order or clinical note)

Start Date: _____ End Date: _____

<input type="checkbox"/> Abortion	<input type="checkbox"/> Infusion Therapy
<input type="checkbox"/> Acute Rehabilitation Facility	<input type="checkbox"/> Medical Nutrition Education
<input type="checkbox"/> Air Ambulance	<input type="checkbox"/> Medical supplies >\$250 (except diabetic supplies)
<input type="checkbox"/> Ambulance (for non-emergency transport)	<input type="checkbox"/> MOHS Procedure (Dermatology)
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Non-Participating Provider
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Obstetrical Care
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Opioid Treatment
<input type="checkbox"/> Outpatient and Partial Hospital	<input type="checkbox"/> Orthotics >\$250
<input type="checkbox"/> Neurological Testing	<input type="checkbox"/> Outpatient Hospital (excludes labs, ultrasounds, x-rays)
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Prosthetics
<input type="checkbox"/> Clinical Trials (not approved by Medicare)	<input type="checkbox"/> Radiation Therapy/Radiation Oncology
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Radiology/Diagnostic Test: Barium Enema, Cardiac, CT, CTA, Echo, MRA, MRI, Nuclear Med, PET, PII, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasounds
<input type="checkbox"/> Diabetic Shoes	<input type="checkbox"/> Rehab Therapy: PT, OT, ST, Outpatient and Office
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Rehab: Cardiac/Pulmonary/Respiratory
<input type="checkbox"/> DME (ISNP – all; CSNP >\$250)	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Enteral Feeding	<input type="checkbox"/> Sleep Study
<input type="checkbox"/> Experimental/Investigational Procedures	<input type="checkbox"/> Sterilization
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> TMJ Treatment
<input type="checkbox"/> Home Health Services	<input type="checkbox"/> Transplant
<input type="checkbox"/> Hospice (Notification Only)	<input type="checkbox"/> Wound Care (outpatient hospital only)
<input type="checkbox"/> Hospital – Inpatient	
<input type="checkbox"/> Hospital – Long-Term Acute Care	
<input type="checkbox"/> Hyperbaric Oxygen Therapy	
<input type="checkbox"/> Implantable Pump, Device, Stimulator	

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CONTINUED
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REQUEST FOR AUTHORIZATION OF SERVICES, continued

CPT or HCPC Code(s)	Description	# of Visits/Injections

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

- ☐ **Standard Authorization:** Authorizations will be processed within 14 days of receipt.
- ☐ **Expedited Authorization (Must Read and SIGN):** By signing below I certify that waiting for a decision under the standard timeframe could place the Member's life or health in serious jeopardy.

SIGNATURE:

Name of Person Completing this Form:

Date Completed:

Contact #:

Authorization Notification Fax:

To check on the status of an authorization or for other questions, please call Provider Services:

For ISNP: 855-969-5861

For CSNP: 855-969-5869

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

This facsimile message is privileged and confidential. It is transmitted for the exclusive use of the addressee. This communication may not be copied or disseminated except as directed by the addressee. If you have received this communication in error, please notify us immediately.

PCP Dismissal Form

Form is downloadable from www.communicare-advantage.com under Resources



PCP DISMISSAL FORM

Member Name	Member's CCA ID Number	Member's DOB

Reason for Dismissal:

- ☐ Member is abusive to provider or staff
- ☐ Member fails to follow medical advice
- ☐ Member fraud
- ☐ Member fails to keep appointments (List dates) _____
- ☐ Other (Please describe) _____

Explanation: _____

Full list of current medications:

Provider Signature _____ Date _____

FAX COMPLETED FORM TO 1-513-530-1378

This form is intended solely for PCP requesting "Termination of a Member" (refer to CCA Provider Manual). Complete this request in its entirety. Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the member until such time that written notification is received from CommuniCare stating, "The member has been transferred from the provider's practice." Providers are not allowed to communicate directly with plan members regarding intent to transfer a member from their panel. After receiving adequate documentation and making an administrative ruling, the plan will contact members regarding any changes in PCP assignments.

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APPENDIX B – QUALITY LINKS

CMS STARS Links

- [CMS 2022 CAI Measure Selection](#)
- [CMS 2022 Display Measures](#)
- [2022 CMS Cut-Point Trends](#)

HEDIS

- [NCQA Technical Notes - HEDIS MY 2022](#)
- [Required Measures](#) for HEDIS® Reporting Year 2023 and CAHPS® Reporting Year 2022

Part D Information

- [CMS COVID-19 2022 Part D Information](#)
- [CMS Prescription Drug Coverage 2022 STAR Ratings Fact Sheet](#)

CAHPS Survey

- [CMS CAHPS Survey Information \(site updated 12/01/2021\)](#)
- [NCQA 2022 CAHPS Guidance](#)

HOS Survey

- [CMS HOS Survey Information \(site updated 12/01/2021\)](#)

APPENDIX C – SERVICES REQUIRING PRIOR AUTHORIZATION

- | | |
|---|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Medical Nutrition Education |
| <input type="checkbox"/> Acute Rehabilitation Facility | <input type="checkbox"/> Medical supplies >\$500 (except diabetic supplies) |
| <input type="checkbox"/> Air Ambulance | <input type="checkbox"/> MOHS Procedure (Dermatology) |
| <input type="checkbox"/> Ambulance (for non-emergency transport) | <input type="checkbox"/> Non-Participating Provider |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Obstetrical Care |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Opioid Treatment |
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Orthotics >\$250 |
| <input type="checkbox"/> Outpatient and Partial Hospital | <input type="checkbox"/> Outpatient Hospital (excludes labs, ultrasounds, x-rays) |
| <input type="checkbox"/> Neurological Testing | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation Therapy/Radiation Oncology |
| <input type="checkbox"/> Clinical Trials (not approved by Medicare) | <input type="checkbox"/> Radiology/Diagnostic Test: Barium Enema, Cardiac, CT, CTA, Echo, MRA, MRI, Nuclear Med, PET, Pill, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasounds |
| <input type="checkbox"/> Dental Services | <input type="checkbox"/> Rehab Therapy: PT, OT, ST, Outpatient and Office |
| <input type="checkbox"/> Diabetic Shoes | <input type="checkbox"/> Rehab: Cardiac/Pulmonary/Respiratory |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> DME (ISNP – all; CSNP >\$250) | <input type="checkbox"/> Sleep Study |
| <input type="checkbox"/> Enteral Feeding | <input type="checkbox"/> Sterilization |
| <input type="checkbox"/> Experimental/Investigational Procedures | <input type="checkbox"/> TMJ Treatment |
| <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Home Health Services | <input type="checkbox"/> Wound Care (outpatient hospital only) |
| <input type="checkbox"/> Hospice (Notification Only) | |
| <input type="checkbox"/> Hospital – Inpatient | |
| <input type="checkbox"/> Hospital – Long-Term Acute Care | |
| <input type="checkbox"/> Hyperbaric Oxygen Therapy | |
| <input type="checkbox"/> Implantable Pump, Device, Stimulator | |
| <input type="checkbox"/> Infusion Therapy | |