LIBERTY MEDICARE ADVANTAGE
Planning your advantage

Provider Manual

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WELCOME TO LIBERTY MEDICARE ADVANTAGE

We are excited you have chosen to be a participating provider with Liberty Medicare Advantage. We view you as an integral partner in providing the highest quality of health to our unique Special Needs population.

ABOUT LIBERTY MEDICARE ADVANTAGE

Liberty Medicare Advantage (LMA) is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. Our mission is to improve the health and well-being of our members within our community by offering a complete and cost-effective senior care continuum, close to home and family. We believe by combining our Customized Care team and community resources we enhance the health and well-being of our members and enforce the core values of our company's founders of quality, honesty, and integrity that guide us to this day.

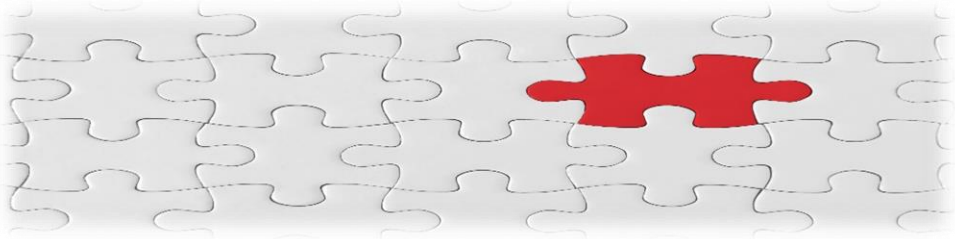
Liberty Healthcare Management, LMA's parent company, is an experienced family-owned company that has been helping people manage their healthcare and residential needs for more than 145 years. The company founders, who opened their first pharmacy in 1875, established Liberty's core values of quality, honesty, and integrity that guide us to this day.

Liberty Healthcare Insurance oversees the development, operation of independent living, assisted living, memory-care communities, and continuing care retirement communities ("CCRCs"). Through our affiliated companies, we also offer a range of home health, hospice, in-patient short-term rehabilitation, long-term care, and outpatient services to residents of many of our communities and to seniors living outside of our communities. The continuum extends beyond the walls of our communities and to the affiliated company's home health, pharmacy and medical equipment branches to meet the needs of patients following discharge.

For the most vulnerable population, it is particularly essential the Plan delivers services in a manner that will be consistent with the members' capacity and abilities. For example, if a member is visually impaired, any instructions will need to be in Braille, large print or recorded based on members' preference. In addition, it may be important

for the Plan to provide services in the member's facility/home, maximizing member access to covered benefits and minimizing the disruptions associated with seeking services outside the home environment.

Our relationship with providers like you helps us to achieve these goals and much more!



Products Offered

Product and Name	Description	Designed For
C-SNP – Liberty Medicare Advantage Plan	Chronic Condition Special Needs Plan	Qualify for one of the following Chronic Conditions: • Diabetes • Congestive Heart Failure • Cardiovascular Disorders Our goal is to keep our members healthy and independent.
D-SNP – Liberty Medicare Dual Plan	Dual Eligible Special Needs Plan	Members with both Medicare and Medicaid
I-SNP – Liberty Medicare Advantage Nursing Home Plan	Institutional Special Needs Plan	Members who are expected to be in a Nursing Facility for 90 days or longer must have Medicare Parts A and B.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Key Contacts at LMA

The following table includes several important telephone and fax numbers available to Providers and their office staff.

Topic	Link/Address	Phone Number
Member Services	LibertyMemberIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Provider Services	LibertyProviderIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Prescribers Part D - Navitus	www.navitus.com	1-866-270-3877 (TYY 711)
Pharmacies Part D - Navitus	www.navitus.com	1-866-270-3877 (TYY 711)
Home Office	2334 41st Street Wilmington, NC 28403	1-910-815-3122
Claims Processing	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 LibertyProviderIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Concurrent Review/Clinical Information	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 UM@LibertyMedicare Advantage.com	1-844-854-6884 Fax: 1-877-760-3560
Appeals and Grievances	Liberty Medicare Advantage – Appeals and Grievances PO Box 3325 Spring Hill, FL 34611 Email: LibertyMemberIVR@mirrahealthcare.com	Fax: 1-877-760-3620
Care Management	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 UM@LibertyMedicareAdvantage.com	1-844-854-6884
Prior Authorization	UM@LibertyMedicareAdvantage.com	1-844-854-6884
Contracting	Contracting@LibertyMedicareAdvantage.com	
Credentialing	Credentialing@LibertyMedicareAdvantage.com	1-844-854-6884

CHAPTER TWO: PROVIDER MANUAL

Medicare Regulatory Requirements

As a Medicare contracted Provider, you are required to follow all Medicare regulations and CMS requirements. Some of these requirements are found in your Provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare Members in any way based on the health status of the Member.
- Providers may not discriminate against Medicare Members in any way based on race, color, national origin, sex, age, or disability in accordance with subsection 92.8 of Section 1557 of the Patient Protection and Affordable Care Act.
- Providers must ensure that Members have adequate access to covered health services.
- Providers may not impose cost sharing on Members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow Members to directly access screening mammography and influenza vaccinations.
- Providers must provide Members with direct access to health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- LMA will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 days. Providers agree to notify LMA according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operation are convenient to the Member and do not discriminate against the Member for any reason. Providers will ensure necessary services are available to Members 24 hours a day, 7 days a week.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to LMA Members without CMS and/or LMA approvals of the materials and forms.
- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, Members who are deaf or hard of hearing or are blind or have low vision and diverse cultural and ethnic backgrounds.

- Providers will work with LMA procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the Member's medical record whether the Member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care. Providers must cooperate with LMA to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit Members to make an informed choice about their Medicare Advantage coverage.
- Providers must cooperate with LMA in notifying Members of Provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any LMA medical policies, QI programs, Utilization Management policies and medical management procedures.
- Providers must cooperate with LMA procedures for handling grievances, appeals, and expedited appeals.
- Providers must request prior authorization from the Plan if the Provider believes an item or service may not be covered for a member or could only be covered under specific conditions. If the Provider does not request prior authorization, the claim may be denied, and the Provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the Member's Evidence of Coverage, no prior notice of denial is required, and the Member may be held responsible for the full cost of the item or service.
- Providers must allow CMS or its designee access to records related to LMA services for a period of at least ten (10) years following the final date of service or termination of this agreement unless a longer period is required by applicable state or federal law.
- Providers must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- The provider shall provide services in accordance with LMA policy for all Members, for the duration of the LMA contract period with CMS.
- The provider shall disclose to LMA all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS

THE PROVIDER MANUAL

This manual applies to any health care provider, including physicians, health care professionals, hospitals, facilities and ancillary providers, except when indicated otherwise. It includes LMA policies and procedures. LMA may add, delete or change policies and procedures, including those described in this manual, at any time. Please read this manual carefully. Your agreement requires you to comply with LMA policies and procedures including those contained in this manual.

Please visit www.libertymedicareadvantage.com to find programs we offer that could benefit your LMA patients. You will also find contact information, so you can reach us whenever you need to.

You will find information on how to get your claims paid faster, your pre-authorization requests processed promptly, and your administrative burdens lessened. We want you to find what you need quickly and efficiently.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for LMA. LMA also has a portal where you can look up Eligibility and Claims status 24 hours a day 7 days a week. Access to this website can be found under member responsibility verifying eligibility.

Changes and Updates

When things change, we will let you know. You are required to provide us with your email or practice address so we can contact you with important information, such as updates about our members and group health plans. Likewise, we update this manual periodically and certain changes can affect you, such as clinical policies, procedures, plan names or ID cards.

CHAPTER THREE: MEMBERS RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

The Right to Be Treated with Dignity and Respect

Members have the right to be treated with dignity, respect and fairness always. LMA and contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say LMA, and contracted providers cannot discriminate against members for any of the following reasons:

- Race
- Disability
- Religion
- Gender
- Sexual orientation
- Health
- Ethnicity
- Creed
- Age
- National origin

Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. If a member needs help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access facilities (such as wheelchair access).

Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The Right to see Participating providers, get covered services and get prescriptions filled promptly

Members will get most or all their healthcare from participating providers – the doctors and other health providers who are part of LMA.

- Members have the right to choose a participating provider. LMA will work with members to ensure they find physicians who are accepting new patients.

- Members have the right to go to a woman's health specialist (such as a gynecologist) without a referral.
- Members have the right to timely access to their providers and to see specialists when care from a specialist is needed.
- Members also have the right to access their prescription benefit promptly.
- Timely access means members can get appointments and services within a reasonable amount of time.

The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

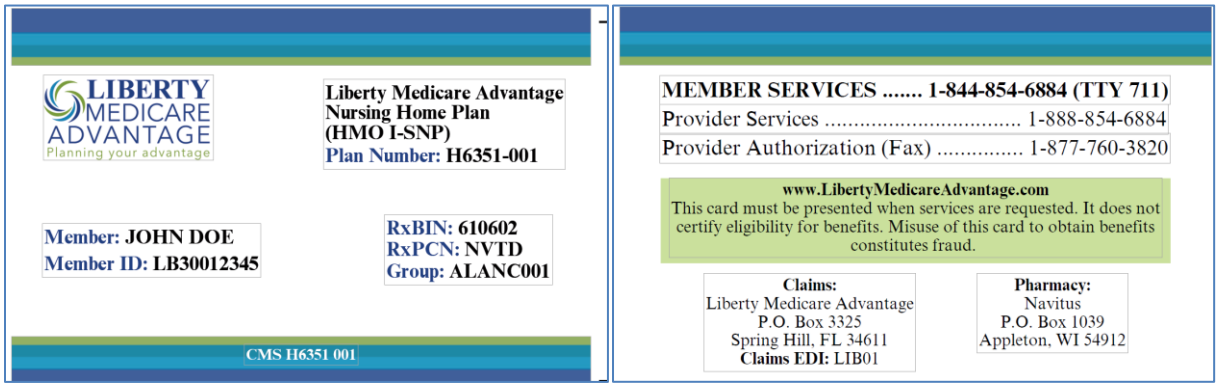
The right to know about treatment choices and to participate in decisions about their healthcare

- Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their healthcare.
- LMA providers must explain things in a way that members can understand.
- Members have the right to know all their treatment choices that have been recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether LMA covers them.
- This includes the right to know about the different Medication Management Treatment Programs LMA offers and those in which members may participate.
- Members have the right to be told about any risks involved in their care.
- Members have the right to receive a detailed explanation from LMA if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.
- Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave.
- Members have the right to stop taking their medication.
- If members refuse treatment, they accept responsibility for what happens because of refusing treatment.

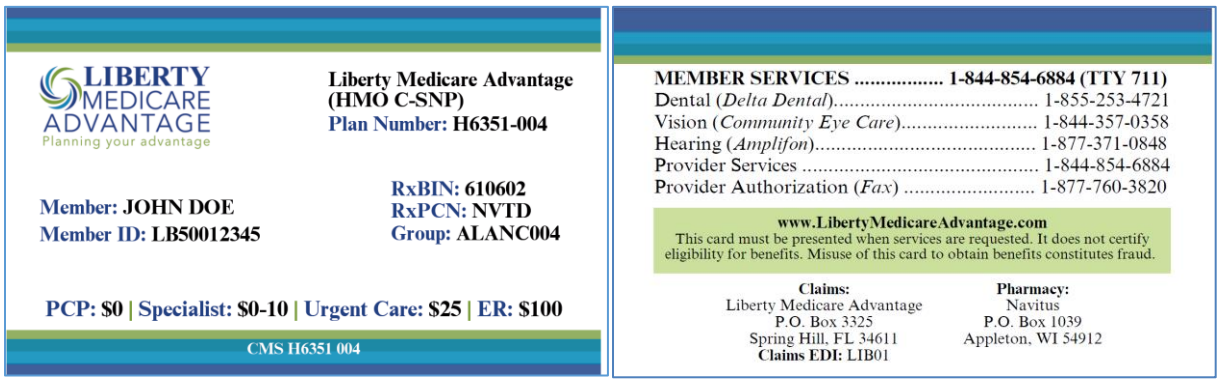
Members have the right to make complaints

- Members have the right to file a complaint if they have concerns or problems related to their care or coverage.
- Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations.
- If members make a complaint or file an appeal determination, LMA must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination.

Member Enrollment ID Care ISNP



Member Enrollment ID Card for CSNP



Privacy Regulations – Health Insurance Portability and Accountability Act (HIPAA)

HIPAA privacy regulations offer full federal protection for member's health care information. These regulations control the internal and external uses and disclosures of member data. They also create member rights.

- Access to protected health information
  - Members may access their medical records or billing information either through you or LMA. If their information is electronic, they may ask that you or LMA send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.
  - Amendment of PHI – our members have the right to ask that you or LMA change information they believe to be inaccurate or incomplete. The member request may be in writing and explain why they want the change. You or LMA must act on the request within 60 days, or may extend another 30 days with written notice. If you deny the request, provide certain information to the member explaining the denial reason and actions the member must take.
- Accounting of Disclosures
  - Our members have the right to request an accounting of certain disclosures of their PHI, made by you or LMA, six years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:
    - For treatment, payment and health care operations purposes
    - To members or pursuant to member's authorization
    - To correctional institutions or law enforcement officials
    - For which federal law does not require us to give an accounting
- Right to request restriction
  - Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Through guidelines established by the CMS, HEDIS requirements, and the Plan's policy and procedures, LMA requires all participating providers to have a process in place under the intent of the Patient Self-Determination Act.

There are three types of Advance Directive:

- A Durable Power of Attorney for healthcare (POA) allows the member to name a patient advocate to act on their behalf.
- A Living Will allows the member to state his or her wishes in writing, but does not name a patient advocate.
- A Declaration for Mental Health Treatment gives instructions regarding a member's future mental health treatment if the member becomes unable to make personal decisions. The instructions state whether the member agrees or refuses to have the treatment described in the declaration, with or without conditions and limitations.

All providers contracted directly or indirectly with LMA may be informed by the member that the members have executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and LMA.

LMA and PCP/NFist and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives. LMA conducts periodic patient medical record reviews to confirm the required documentation exists.

Member Eligibility

For an individual to enroll with LMA plans, the individual must be entitled to Medicare Parts A and B in addition to living within the service area the plan is offered. Refer to the LMA website for a list of areas we do business in. Medicare Advantage eligible beneficiaries who request enrollment with LMA will be effective the first day of the following completed enrollment application and it is accepted by CMS.

For our DSNP an eligible member must have both Medicare and Medicaid.

See products offered for additional eligibility requirements based on the plan LMA offers.

Verifying Eligibility

The most efficient way to verify eligibility is to request portal access. This will allow you to check Member Eligibility as well as claims. To access the portal go to our website and click on Provider – go to bottom of page and download request to access our portal. See below for details.

RE: Provider Portal Access

Dear Participating Provider,

Liberty Medicare Advantage appreciates your participation in our network and the valuable care you provide to our members.

A provider portal is now available for you to access and obtain fast resolution of routine needs such as:

- Member Eligibility Check
- Member Search
- Member Details
- Claims Search & Listing

To request access to the provider portal please go to LibertyMedicareAdvantage.com, hit provider tab, click on Provider Portal Link to register.

- Provider/Facility Address
- NPI (group or individual)
- Tax ID (group or individual)
- User First, Middle and Last Name
- Gender
- DOB
- Contact Number
- Fax Number
- Email Address

Once the request has been made, the requester will be set up and instructions will be sent to the requester regarding how to access the portal. Please reach out to our customer service number at 844-854-6884 with questions or registration requests.

We remain committed to providing you with the best tools possible to support your administrative needs.

Liberty Medicare Advantage

CHAPTER FOUR: COVERED SERVICES

COVERED SERVICES

All LMA members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers should go to ***www.libertymedicareadvantage.com*** then choose the members' plan for breakdown of coverage.

Benefits and Services

All participating providers are obligated to bill and collect applicable member copayments and/or cost sharing as permitted under the LMA or by law. Participating providers of LMA are however, prohibited from balance-billing members copayments and /or cost sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, go to CMS.gov.

Emergent and Urgent Services

LMA 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 Department (ED) Utilization: The PCP collaborates with the Care Manager for enrollment in Care Management and Disease Management Programs where opportunities are identified.

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

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

Emergency services: a provider qualified to furnish emergency services and needed to evaluate or treat an emergency medical condition performs covered inpatient and outpatient services.

Urgently needed services: Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required because of an unforeseen illness, injury, or condition.
- Are provided when the member is temporarily absent from the plan'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 the plan network.

The LMA network includes multiple hospitals, emergency rooms, and providers able to treat the emergent conditions of LMA members 24 hours a day 7 days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals.

Benefits Over and Above Original Medicare

Benefit	***I-SNP***	***C-SNP***	***D-SNP***
Customized Care Team	X	X	X
Hearing	Routine exam, hearing aid fittings, and $3,450.00 for hearing aids for two years.	Liberty Medicare Advantage Freedom Flex card allows you to choose where to spend your annual $2,000 benefit for either Vision, Dental or Hearing in any combination. This benefit does not rollover year to year. This benefit does not apply to	Routine annual exam and up to $2,500 for both ears combined every two years.

		co-pays or deductibles.	
Vision	Routine eye exam and up to $450.00 every year for eyewear.	Liberty Medicare Advantage Freedom Flex card allows you to choose where to spend your annual $2,000 benefit for either Vision, Dental or Hearing in any combination. This benefit does not rollover year to year. This benefit does not apply to co-pays or deductibles.	Routine eye exam and up to $300 every year. Limit to one frame and set of lenses or contacts.
Podiatry	12 routine foot care visits every year.	4 routine foot care visits every year.	4 routine foot care visits every year.
Non-Emergency Transportation	55 one-way rips annually, not to exceed 25 miles per trip.	Freedom Flex Card allows for $40.00 per month for either transportation or fitness and rollover does apply.	20 one-way trips for non-emergency medical service not to exceed 25 miles per trip.
Prescription Drugs	Prescription Drug coverage, plus pharmacy coordination and monitoring	Prescription Drug coverage, plus pharmacy coordination and monitoring	Prescription Drug coverage, plus pharmacy coordination and monitoring
Fitness Benefit	N/A	Freedom Flex Card allows for $20.00	N/A

		per month for either transportation or fitness and rollover does apply.	
Skilled Nursing	No prior hospital stay required.	No prior hospital stay required.	No prior hospital stay required.
Primary Care Physician	$0 copay for Primary Care Physician visits.	$0 copay for Primary Care Physician visits. Also includes no copay for endocrinologist and cardiologist	$0 copay for Primary Care Physician visits.
Meal Preparation	N/A	Eligible to receive 2 meals per day for up to 14 days following an acute inpatient stay.	Eligible to receive 2 meals per day for up to 7 days following an acute inpatient stay.
At Home Monitoring	N/A	Remote monitoring of vital signs with referral from RN case manager.	Remote monitoring of vital signs with referral from RN case manager.
Insulin Coverage	Maximum cost sharing $35.00.	$0 co-pay for insulins covered on our formulary.	Maximum cost sharing $35.00.
Dental	N/A	Liberty Medicare Advantage	Preventative and Comprehensive

		Freedom Flex card allows you to choose where to spend your annual $2,000 benefit for either Vision, Dental or Hearing in any combination. This benefit does not rollover year to year. This benefit does not apply to co-pays or deductibles.	treatments included with plan, maximum amount $2,500 annually.
Over The Counter	$250.00 every three months. No rollover.	$75 per month with no rollover.	???

Excluded Services

In addition to any exclusions or limitations described in the members EOC, the following items and services are not covered under the Original Medicare Plan or by LMA:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: or orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypergamy unless otherwise included in the members Part D benefit. Please see the formulary for details.
- Radial keratotomy, LASIK surgery, vision therapy, and plastic surgery.
- Reversal of sterilization measures and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost-sharing amount.

Continuity of Care

Continuity of Care is essential to maintain member stability. As a part of the care transition process, the Nurse Practitioner (or Care Manager) will be the primary advocate in ensuring the member's well- being across multiple care settings and across the health spectrum.

The Nurse Practitioner or Care Manager will work with the PCP to ensure that the highest quality of health care will be delivered to the member in each of the health care settings. LMA nurses understand how coordinated health care improves the care of this vulnerable membership, and will work to ensure coordinated care by:

- Providing members and caregivers/families one accountable point of contact – the assigned Nurse Practitioner or Care Manager.
- Following members across care settings during transitions (i.e., admission to a hospital)
- Educating members and caregivers/families on member diagnoses
- Setting goals that promote coordinated care
- Making and keeping specific tasks/appointments, follow up items with members
- Coordinating care within and across treatment settings between external and internal stakeholders
- Creating a process through which health care providers can communicate with one another about the member's care
- Making member preferences known and accessible to all health care providers

LMA's policy is to provide continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a medical practitioner leaves LMA network and a member is in an active course of treatment, LMA will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. If the Plan terminates a participating provider, LMA will work to transition a member into care with a Participating Physician or other provider within LMA network.

LMA is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances. LMA also recognizes that

new members join the health plan and may have already begun treatment with a provider who is not in our network. Under these circumstances, we will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

LMA will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the PCP evaluates the member and establishes medical necessity.

CHAPTER FIVE: CLAIMS

CLAIMS

Claim Submission

While LMA prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact LMA Provider Services Department at 1-844-854-6884 (TTY 711).

As an LMA provider, you have agreed to submit all claims within the timeframes outlined in your provider agreement. Forward all completed paper claim forms to the address below:

Liberty Medicare Advantage, PO Box 3325, Spring Hill, FL 34611

Timely Filing

As a LMA participating provider, you have agreed to submit all claims within the timeframe outlined in your provider agreement with LMA.

If your agreement does not specify a filing guideline, please use the following:

- Submit claim within 180 calendar days after the date of service.
- Initial bills submitted after 365 days will be denied as untimely.

Corrected claims or requests for review are considered if information is received within 180-days from the date on the remittance advice.

Providers must bill within 180 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when LMA is secondary. An original bill along with a copy of the EOB is required to process the claim. Requests for reviews/corrections of processed claims must be submitted within 180 calendar days from the date of the corresponding remittance advice. All claims submitted after the 180-day period following receipt of the EOB or after the 180-day follow-up period from the date on the remittance will be denied.

Any claim that has been submitted to LMA but does not appear on the remittance advice within 60 days the following submission should be researched by calling LMA

Provider Services Department to inquire whether the claim was received and/or processed.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim. Standards are in the CMS Claims Processing Manual. The link to the CMS Claims Processing manual is cms.gov Claim Manual Chapter 3.

LMA can only pay claims which are correctly submitted. The provider is always responsible for accurate claims submission. LMA will make its best efforts to inform the provider of claim errors, ultimately claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and receive payment as though they are a single physician. If the same physician or more than one physician in the same specialty group provides more than one service on the same day to the same patient, they must bill and receive payment as though they were a single physician.

- Example: Only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and receive payment without regard to their membership in the same group.

Claim Payment

LMA pays clean claims according to contractual requirements. A clean claim is a claim for a covered service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by LMA, or a particular circumstance requiring special handling or treatment, which prevents timely claim payment.

The standard CMS required forms and data elements are in the CMS claims processing manual located at cms.gov, claim manual Chapter 3. Appropriate forms and data elements must be present for a claim to be a clean claim.

Offsetting Claims

Contracted providers are informed of any overpayments or other payments you may owe LMA. You will have 30 days from receipt of our repayment demand to refund such amounts to LMA. If you have not refunded the amount within a 30-day recovery period, LMA will offset the recovery amounts identified in the initial repayment demand, or in accordance with the terms of your agreement.

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

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

Non-Payment/Claim Denial

- Any denials of coverage or non-payment for services by LMA are addressed on the EOP or RA. An adjustment/denial code will be listed for each billed line if applicable.
- An explanation of all applicable adjustment codes per claim is listed below the claim on the EOP/RA.
- Per your contract, the member may not be billed for services denied by LMA unless the member received the denial before the service was provided and the member indicated they wanted to receive the services regardless of coverage.
- The member may not be billed for a covered service when the provider has not followed LMA procedures.
- In some instances, providing the needed information may reverse the denial.
- When no benefits are available for the members or the services are not covered, the EOP/RA will alert you to this.
- Obtaining pre-services review will reduce denials.

Provider Claim Payment Disputes

If your claim was paid and you dispute the payment amount, please follow the process below.

- Payment dispute procedures are separate and distinct from the appeal process.

- A formal payment dispute request is required from the provider to contest a paid amount on a claim, which does not include a medical necessity or administrative denial. All payment disputes must be:
    - Submitted in writing within 60 days of the original payment
    - Include a cover letter with:
        - Claim identifiable information
        - The specific rationale as to why the payment made is not appropriate or needs adjustment
    - Include necessary attachments:
        - Copy of the original RA
        - All applicable medical records or other attachments supporting additional payment.

Providing the above information enables the Payment Dispute Unit to properly and promptly review the request. Request that does not follow all the above may delay resolution. LMA will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment.

- **Mail providers claim payment disputes to:**
    - Liberty Medicare Advantage, PO Box 3325, Spring Hill, FL 34611

Seeking Payment from Members

The Medicare plan members cannot be billed for covered services. The Health Plan members may receive services from providers that are not covered by Medicare. Providers must have the member sign a release form stating that he/she understands the service is not a covered benefit and he/she is responsible for payment of the charges.

Coordination of Benefits (COB) and Third-Party Recoveries

Some LMA members have other insurance coverage. LMA follows Medicare coordination of benefits rules.

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

Under coordination of benefit rules, if another payer is the primary payer for Covered Services, the Provider must:

- First bill the primary payer; All LMA guidelines must be met to reimburse the provider (i.e., pre-certification, referral forms, etc.).
- Share with LMA the information regarding the primary payer; and
- Reports to LMA all third-party recoveries received by Provider because of providing Covered Services to the Member.

At LMA's request, Provider agrees to complete all necessary forms and consents to permit billing and processing forms from other payers, if necessary, where the Plan is determined to be secondary. The provider further agrees that Plan will be billed on a secondary basis for Covered Services on the balance due, only after Provider has received reimbursement from the primary payer. However, in no event will payment be made if the Provider receives combined payments in excess of the amount Provider would have received for services rendered to a member solely under the applicable Plan coverage.

The provider further agrees to cooperate in Plan's subrogation, workers' compensation, and other third-party recovery programs to the extent permitted by applicable law. Be sure to have the member sign the "assignment of benefits" sections of the claim form. Once payment and/or EOB are received for the other carriers, submit another copy of the claim with the EOB of LMA for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When LMA is primary insurance carrier:

- The provider collects the copayment required under the LMA plan.
- Submit the claim to LMA first.
- Be sure to have the member sign the "assignment of benefits" sections of the claim form.
- Once payment and/or RA has been received from LMA, submit a copy of the claim with the RA to the secondary carrier for adjudication.

Subrogation

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

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by LMA Claim Department.

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 LMA with any information regarding third-party carrier. All claims are processed per the usual claim procedures.

Processing Hospice Claims

When a Medicare Advantage (MA) member has been certified hospice, the financial responsibility for that member shifts from LMA to Original Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services LMA is financially responsible for during this time include any supplemental benefits LMA offers in addition to Original Medicare benefits.

Members can revoke hospice elections at any time. If so revoked and once notified by CMS, LMA will resume coverage for the members the first of the following month. These rules apply for both professional and facility charges.

Claim Correction

You may need to update information on a claim you have already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to Use:

- Submit a corrected claim to fix or void one that has already been processed.
- When submitting late charges on 837 institutional claims, use bill type xx7: Replacement: of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

- If a paper claim, it will need to be clearly marked as a corrected claim. For EDI, box 22 is where you indicate this is a corrected claim. Use code 6 for a corrected claim or a 7 which is a replacement of prior claim.

Resubmitting a Claim

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal of the claim it needs to be corrected through resubmission.

Prompt Pay

LMA will pay Participating Providers in accordance with applicable provisions of their agreement with LMA.

Request for Additional Information

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

- The claim is pended and on the next business day, a notification letter requesting additional information is mailed to the provider.
- For all professional claims, if the requested information is not received within 45 days from the date the claim has been sent a second request will be made.
- If the requested information is not received within 60 days from the claim-receipt date of the claim, the claim will be denied.
- For all inpatient and ancillary claims, if the requested information is not received within 60 days from the claim receipt date, the claim will be denied.

If LMA obtains the requested additional information within 60 days from the receipt of the claim and the information support payment or a favorable reconsideration, the claim will be denied. Providers can access the appropriate dispute process.

Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once LMA receives the additional information requested, the original claim is processed.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CHAPTER SIX: APPEALS AND GRIEVANCES

Appeals and Grievances

Definitions

LMA classifies **appeals** that meet one of the criteria identified below:

- Full or partial denied claim
- Full or partially denied authorization request
- Denied reimbursement request
- Dispute of a copay amount or the calculation of the copay amount

A **grievance** is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested. Examples of grievances can include:

- A change in premiums or cost sharing arrangements from one contract year to the next.
- Lack of quality of the care received.
- Plan benefit design
- Difficulty contacting the plan via phone.
- General dissatisfaction about a co-payment amount, but not a dispute about the amount the enrollee paid or has been billed.

Grievances will be classified by type to facilitate prompt and effective responses.

PROVIDER APPEALS

As defined by CMS Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance, CMS states that Contracted Providers do not have appeal rights. Contracted Providers are not permitted to file appeals on claims. Those must be handled through the Provider Dispute process. See the Claims section of this manual for information on our dispute process.

Contracted providers are only permitted to file appeals on behalf of a member (member must be aware) for pre-service denials and certain types of discontinuation service denials (SNF, HH, or CORF)

- Standard appeal – A standard pre-service appeal request is processed by LMA within a 30-calendar daytime frame, from the date the Plan receives the request.
- Expedited appeal – An e within a 72-hour time frame, from the date and time the Plan receives the request. An expedited appeal request is a time sensitive service appeal request that is processed by LMA

How to request an appeal:

- All appeals must be requested within 60 calendar days of the denial.
- Standard and Expedited appeal request can be requested in writing via fax or postal mail.

Send requests to:

Liberty Medicare Advantage – Appeals & Grievances

PO Box 3325, Spring Hills, FL 34611

Member Appeals

Members of LMA have the right to appeal any decision about LMA failure to provide or pay for what they believe are covered services.

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide,
- A denied claim for any other health service furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by LMA,
- A reduction in or termination of service a member feels is medically necessary

In addition, a member may appeal any decision to discharge from the hospital. In this case, a notice will be given to the member with information on how to appeal. The member will remain in the hospital while the member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to LMA Evidence of Coverage for additional information.

An appeal is a reconsideration of a previous decision not to approve or pay for a service. Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved or the claim paid.

A request for a standard appeal must be submitted to the address/fax listed below within 60 calendar days from the original decision. Appeal requests should include a copy of the denial, and any medical records supporting why the service is needed.

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an appeal orally, please call 1-844-854-6884. A member or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the member or member's ability to regain maximum function.

Providers contracted with LMA may not use the member appeal process to file an appeal for post-service payment disputes.

Member Grievances

Members of LMA have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns,
- Involuntary disenrollment situations, and/or
- Complaints concerning the quality of services a member receives.

All complaints are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

CHAPTER SEVEN: MEDICAL POLICIES

Medical Policies

Model of Care

The Plan's Model of Care (MOC) provides members with a customer care team dedicated to their complete health. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the MOC is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits offer additional services and support for the member's individual needs.

Goals of LMA MOC:

- Improve access to medical, mental health, and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Improve access to preventative health services.
- Assure appropriate utilization of services; and
- Improve overall health outcome and experience.

The participating provider should know:

- All members are required to choose or designate a Primary Care Physician (PCP) at enrollment
- All members are assigned a Nurse Practitioner, Case Manager or an Advanced Practitioner (PA).
- On our **I-SNP** program, CMS has granted LMA permission to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from members PCP, to treat members in the nursing home when appropriate and reserves acute hospital stays for members requiring services that are more intensive.
- Our **C-SNP** Program focuses on three chronic conditions: Diabetes, Chronic Heart Failure and Cardiovascular Disorder.
- The plan is provider friendly and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, and preauthorization and referral process outlined in this manual.

Most importantly, the MOC focuses on the individual member who receives a comprehensive health risk assessment when becoming a member and annually thereafter. Based on the assessment, an individualized care plan is developed, based on evidenced-based clinical protocols. An Interdisciplinary Care Team (ICT), which includes a case manager, PCP and other key partners depending on our members' needs. This customized team is involved in all aspects of our members' wellbeing and care.

Medical Director Responsibilities

Referrals

LMA uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Plan Advanced Practitioner (PAP) to help in care coordination.

A member's PCP or PAP may make referrals for in-network specialists. Whenever possible, specialists are encouraged to provide members with visits to the member's nursing facility for safety and comfort. All specialist physician services must be approved by the members PCP, PAP or Nurse Practitioner.

Referrals should be made to LMA at 1-844-6884.

Referrals to Out of Network physicians or facilities require prior authorization from the Plans Utilization Management Team. Out of network referrals may be allowed in certain circumstances where in-network providers or services are not reasonably available to the member, or there is a continuity of care concern.

CHAPTER EIGHT: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT

Utilization Management (UM) Program

The UM Program is a component of the Medical Management Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care. The UM program facilitates optimal settings for delivery of care and educates physicians and facilities on the advantages of managing care in a medically appropriate and cost-effective manner. The UM structure is routinely evaluated such that appropriate utilization is continuously monitored and corresponding interventions initiated to improve health outcomes. The UM program maintains regulatory compliance and is annually reviewed by LMA Quality and Medical Management Committee.

The UM Program and Quality and Medical Management Committee work together to evaluate the care and service provided to members, identify opportunities for improvement, prioritize the improvement opportunities and interventions, and assist in the re-measurement process to determine the effectiveness of the interventions provided.

Goals of UM Program

The UM program is designed to accomplish the following objectives:

- Ensure all medically necessary services are available to our members,
- Partner with and provide necessary oversight to delegated entities to ensure high quality of care for our members,
- Assuring proper utilization of health care resources within the members benefit plan,
- Educate clinical and support staff on the purpose and philosophy of the UM program,
- Members receive the highest quality care delivered in the most appropriate setting,
- Provide individualized and integrated care to each member,
- Maintain the dignity, rights and responsibilities of our members during all aspects of review,
- Review and analyze UM data and statistics to identify trends and opportunities for improvement,

- Comply with professional standards, guidelines and criteria set by governmental and other regulatory agencies,
- Work closely with our customized care team to improve health outcomes for our members,
- Maintain and monitor the provider network to provide adequate access to covered services to meet the needs of the member population LMA serves,
- Monitor over/under utilization and inappropriate use of services through regular care plan and service utilization reviews.

UM Functions

- Prior Authorization
- Concurrent Review
- Discharge Planning along with Case Manager
- Continuity of Care

Prior Authorization

Prior Authorization is a process whereby approval must be obtained from LMA before certain services will be covered in accordance with the member's EOC.

Requests for prior authorizations of services should be made before or at the time of scheduling the service. Plan PCPs, Practitioners and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures and outpatient services ordered by the PCP or Advanced Practitioner.

When possible prior authorizations should be requested at least 3 business days prior to the date of service/admission to allow LMA time to determine eligibility, level of benefits and medical necessity. Requests for prior authorization will be prioritized according to the level of medical necessity. For prior authorizations, providers should call 1-844-854-6884, Fax 1-877-760-3560 or email UM@LibertyMedicareAdvantage.com.

LMA does not allow providers to submit post service (retrospective) authorizations. If authorization is not received for a service that does require authorization the claim will deny, and you will need to appeal.

Members cannot be held liable for claims denied because a contracted provider did not obtain prior authorization.

Referring/ordering providers are responsible for obtaining prior authorization from LMA for all non-emergent referrals.

Services Requiring Prior Auth:

Please refer to our website: libertymedicareadvantage.com

- Click on the provider page and at the bottom click on Authorization Chart for the services requiring authorization.

Notification

The provider (usually the hospital/facility) is responsible for notifying LMA within 24 hours:

- When a member is admitted to the hospital on an emergency basis, including observation and inpatient admission from the emergency room.
- When a member in observation status changes to inpatient admission.
- When a facility receives a post-emergency room transfer.
- When surgical day care results in an observation stay or inpatient admission.
- When any change (e.g., diagnosis, procedure, date of service, etc.) related to a previous notification is made.

Notification does not guarantee payment by LMA. Only claims for services that are covered under eligible members' benefit plans are reimbursed.

The Utilization Management Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes and authorization determination, and notifies the provider and member of the determination. Below is an example of LMA authorization form and the information required for us to make a decision.

Decision and Time Frames

Type of Authorization	When to Use	Time Frame

Expedited	If a provider believes 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, you may request the authorization to be expedited	72 Hours
Routine Authorization	If not an urgent matter	14 Calendar Days
Concurrent Review	Medical necessity for continued inpatient stay	24 hours or the next business day following
Retrospective Review	Occurs after services have been rendered	Within 7 calendar days of receiving all pertinent clinical information

Once the Utilization Management Department receives the request for authorization, LMA will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, LMA will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. **Claims for services requiring prior authorization must be submitted with the assigned authorization numbers**. The authorization number can be used to reference the admission, service or procedure.

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, rehabilitation, SNF or other inpatient admission to ensure:

- Covered services are provided at the appropriate level of care, and
- Services are administered according to the member's policy.

LMA utilizes CMS guidelines and InterQual to review criteria, LMA Utilization Management department and the Plan's Medical Directors will conduct a medical necessity review. LMA is responsible for final authorization.

LMA preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility Utilization Management staff within 1 business day of notification or on the last covered day. If clinical information is not received within 24 hours of admission or on the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria.

Specific to our I-SNP – Review is not required for readmission to the referring nursing facility (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be Faxed to 1-877-760-3560.

A LMA Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the LMA Medical Director deems the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The UM nurse or designee will notify the provider(s), e.g., facility, attending/ordering provider verbally and in writing and will notify the member as required by law. 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 1-844-854-6884 (TTY 711).

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Liberty Advantage will approve the request or issue a denial if the request is not medically necessary. LMA 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 representative's right to file an expedited appeal, as well as instructions on how to do so if the member of member's physician does not believe the denial is appropriate.

LMA also issues written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in

the Adverse Determination section of the Provider Manual. The facility is expected to fax a copy of the signed NOMNC back to the UM Department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal. **Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. The Plan will not generate those NOMNs.**

Rendering of Adverse Determinations (Denials)

In some instances, the UM staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility. Late authorization, or not providing clinical information as requested, will result in an administrate adverse determination, and does not allow the provider to appeal.

Only a LMA Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director decides to deny or limit an admission, procedure, service or extension of stay, LMA notifies the facility or provider's office of the denial of service. Notices are issued to the provider, the member, or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal.

The PCP or Attending Physician may contact the Medical Director by phone to discuss decisions only before an adverse determination is rendered.

After the adverse determination is rendered, the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

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

Type	Number of Days
Non-Urgent pre-service decisions	14 Calendar Days of the request
Urgent pre-service decisions	Within 72 hours of the request*
Urgent concurrent decisions	Within 24 hours of the request*

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

Request for Medical Records and Review

The purpose of medical record reviews is to determine compliance with LMA standards for documentation, coordination of care and outcome of services; to evaluate the quality and appropriateness of treatment and to promote continuous improvement. These reviews are performed to evaluate compliance with requirements and do not define standards of care or replace a practitioner's judgement.

On an ad hoc basis, we conduct a review of our members' medical records. The request may be to assist in rendering a decision or periodic audit of member records. The medical records you maintain should include the following:

Problem list with:

- Biographical data with family history
- Past and present medical and surgical intervention
- Significant medical conditions with date of onset and resolution
- Documentation of education/counseling pre and posttests, including results
- Entries dated and signed
- Legible entries
- Medication for allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times).
- Medication record, including names of medication, dosage, amount dispenses and dispensing instructions
- Immunization record

- Tobacco habits, alcohol use and substance abuse
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consist with findings
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or another follow-up
- Consultations, labs, imaging and other special studies initiated by primary care provider to indicate review
- Consultation and abnormal studies including follow-up plans
- Hospitalization Record Requirements:
- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventative screening and services
- Documentation of behavioral health assessment

Hospital Observation

LMA requires notification for a Hospital Observation by furnishing the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though LMA waives the 3 days stay requirement for our I-SNP program.

- The MOON is a form that must be delivered before the member receives 24-hour observation as an outpatient.
- If the member is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of Medicare observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- The MOON notice is required to be delivered to a psychiatric hospital.

Further information can be found at the CMS site: cr9935-moon-instructions.pdf.

Emergency Admissions

Per CMS guidelines: An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention in:

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

Members are instructed to call 911 and/or go to the nearest emergency room for treatment if they believe that they are having a medical emergency. Medical emergencies include but are not limited to: severe chest pain, shortness of breath, uncontrolled bleeding, broken bones, sprains, burns, poisoning, convulsions and extended fever.

All LMA members or responsible parties are informed that they should contact their PCP prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, LMA realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition. In these cases, the member may contact the specialist for instructions. LMA requests that the member and their PCP connect within 24 hours of the ER to schedule and track follow-up care.

Physicians, specialists and covering physicians must provide advice, consultation, and access to care appropriate for each member's medical condition.

- All Life-threatening conditions must be referred to the nearest emergency room.
- All providers must notify LMA of known emergency room visits and emergency room admissions within 1 business day.
- Providers directing members to an emergency room for treatment are required to notify the emergency room of the pending member's arrival.
- Specialty care providers referring members to the ER are required to notify the primary care provider of member's emergency service visit. If the ER visit occurs during a weekend, the specialist must provide notification within 1 business day of referral.

ER services do not require prior authorization but notification of a inpatient admission needs to go to UM at LMA.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. UM will review emergency admissions within one business day of notification. The hospital shall not be entitled to compensation from LMA for provider services rendered if the hospital fails to notify LMA of admission within the agreed upon time period.

LMA makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. LMA.

If a member meets an acute inpatient level of stay, admission starts at the time you write your order.

Inpatient Admissions

All non-emergency hospital admissions require pre-certification by contacting LMA UM department at UM@LibertyMedicareAdvantage.com or fax 1-877-760-3560.

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CHAPTER NINE: CARE MANAGEMENT

CARE MANAGEMENT

Case Management Overview

The Care Manager is the primary point of contact who facilitates communication between the PCP, the member and/or member's family, nursing facility and any required specialty care or other social or other services. The Care Manager engages other core ICT participants including the PCP and the member/caregiver in order to develop trust, strengthen communication, and coordinate individual member's ICPs. This relationship enhances understanding and coordination of services, improving members' care.

Our care model utilizes Care Management Team with the Care Manager as the hub of the members Interdisciplinary Care Team (ICT). ICT is assembled by the Care Manager and is intended to address the entire spectrum of care for the member based on HRAT results and ICP content such as prevalence of certain chronic diseases or conditions, cognitive and social needs. The ICT is primarily responsible for informing, maintaining and coordinating the member's care plan. The ICT includes and collaborates with the member's providers, specifically the member's PCP and appropriate chronic condition specialists, as determined by the Care Manager.

LMA has implemented the MOC in the nursing home, ALF and community settings where the appropriate person/role will provide care management, clinical care, and education to the member, as well as education to the staff or PCP. The Care Management Team facilitates early identification, intervention, communication, and coordination of the appropriate services in a quality cost effective manner.

LMA conducts an initial and annual health risk assessment for each member using the Health Risk Assessment Tool (HRAT) to determine individual health care needs. The HRAT is used for all members. The assessment covers multiple important domains to manage individuals with chronic conditions including medical history, functional status, psychosocial and cognitive status, and mental health history and well-being.

Some members' care may be coordinated by two or more Care Managers who share responsibility for care management, clinical documentation and ICT communications. Care Plans modified by LPNs must be reviewed and approved by an RN or APP.

Coordination of Care Includes:

- Facilitate the completion of the initial and annual HRAT's and review the HRAT schedule to ensure that all annual HRAT's are completed on a timely basis. The HRAT is completed upon enrollment into the plan, and annually before the anniversary of the member's last completed HRAT.
- Reviews and modifies the care plan
- Tracks care plan implementation
- Facilitate the care plan's communication to the ICT for discussion and customization to the member's specific care needs.
- Coordinates Behavioral Health consults based on member needs
- Ensures that Transitions of Care are properly coordinated with all members of the care team.
- Contact members telephonically or in-person and track progress against their care plans
- Promote member empowerment by facilitating resources and benefits to develop skills to remain safely in the most independent health care / residency location available.
- Maintain strong working knowledge of the healthcare community to advise for appropriate care setting in regard to network participation and other factors.
- Maintain strong working knowledge of community-based resources to aid members in their needs for non-healthcare related services such as custodial care, meals, or other traditional Medicaid benefits
- Arrange or coordinate pre- and post-acute care needs upon notification of a transition.

Provides education:

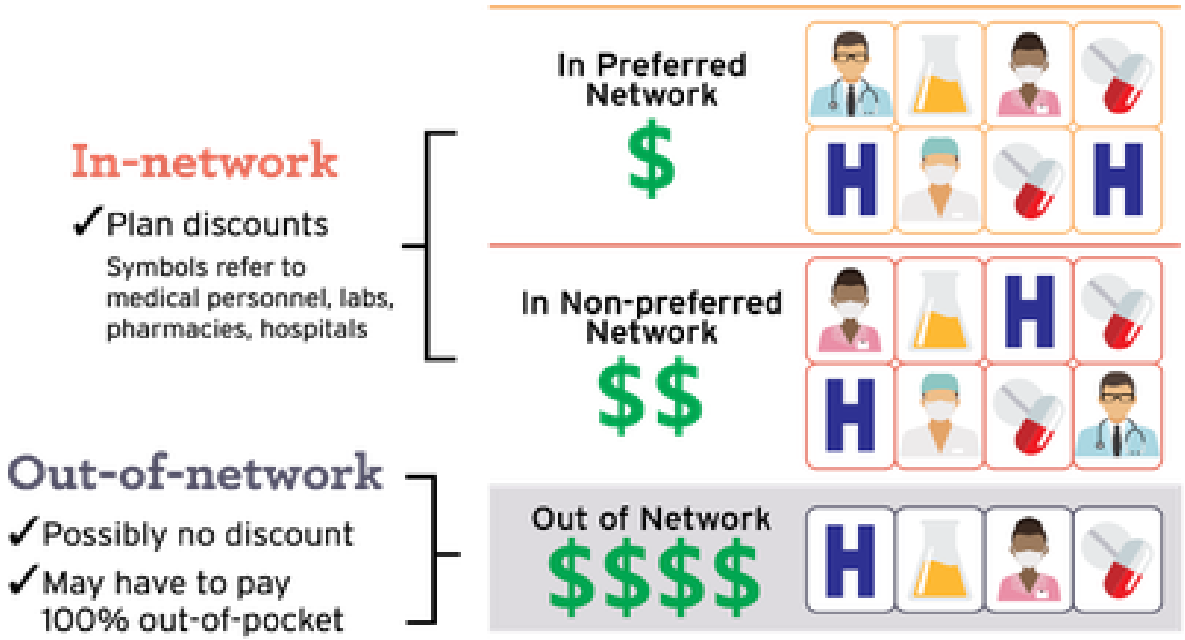
- Advocates, informs and educates members and family members through regular meetings and informal discussions as part of the care team. Provides self-management education to the members.
- Educates NF staff, with assistance from the facility account managers, through ICT meetings and regular communications when on site.

Update of the Individualized Care Plan (ICP)

At a minimum, an ICP update is driven by an annual HRAT reassessment or a re-assessment due to a transition of care or change in health status. The goals and modified ICP are shared verbally with the member or caregiver to promote

understanding of an agreement with what has been captured and the intended course of care management and coordination. The Plan also either mails, faxes, posts to the care management system/portal or makes the updated ICP available upon request to the Interdisciplinary Care Team (including the PCP and other specialists, as needed) and contacts them for telephonic review as appropriate.

CHAPTER TEN: PROVIDER NETWORK NFORMATION



PROVIDER INFORMATION

Joining Our Network

To become part of our Network it starts with an application! First e-mail us at Contracting@LibertyMedicareAdvantage.com. You will be sent an application requesting the information below.

Dear Provider:

Thank you for considering becoming a participating provider with Liberty Advantage! Please complete the information below and a contracting representative will be in touch with you shortly.

Provider NPI	
Provider Last Name, First Name	
PCP Y/N	
Specialty	
Practice/Clinic Name	
Practice Address 1	
Practice Address 2	
Practice City, State, Zip	
Practice County	
Practice Phone	

Contact Name	
Provider e-mail address	

Please email to:

LibertyProviderIVR@mirrahealthcare.com

Thank you so much and we look forward to working with you.

Provider Credentialing Process

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to 60 days for completion from the date a complete application is received by LMA. LMA facilitates all credentialing activities (for non-delegated providers) requiring all sections of the uniform application to be completed accurately, along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform Application to participate as a health care practitioner
- Drug Enforcement Administration (DEA)
- Sufficient comprehensive general liability and professional insurance coverage
- Medicare/Medicaid sanctions
- National Practitioner Databank (NPDB)
- Hospital Privileges or letter stating how patients are admitted
- Board certification*
- Other pertinent documentation
- In some instances, a letter of recommendation from the chief of staff or department chair may be required.

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Please send your completed documents to: Contracting@LibertyMedicareAdvantage.com.

Office Site Evaluations

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary because of a patient complaint, quality of care issue and/or otherwise mandated by all applicable laws and regulations. Practitioner offices are evaluated in the following categories:

- Physical Appearance and Accessibility
- Patient Safety and Risk Management
- Medical Record Management and Security of Information
- Appointment Availability

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

Facility/Organizational Provider Selection Criteria

When assessing organizational providers, LMA utilizes the criteria below:

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body
- If not accredited, it can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meeting other Plan criteria
- Maintains current professional and general liability insurance as applicable
- Has not been excluded, suspended and/or disqualified from participating in Medicare, Medicaid, or any other government health-related program
- Need for coverage related to the organization's location and services
- For "providers of services" under section 1861(u) of the Social Security Act, must have a provider agreement with CMS permitting them to provide services under the original Medicare; is not the precluded provider list

Facility/Organizational Provider Application Requirements

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.

- If responded “Yes” to any disclosure question in the application, an appropriate explanation with sufficient details/information is required
- Copies of all applicable state and federal licenses (i.e., facility license, DEA, Pharmacy License, etc.)
- Proof of current professional and general liability insurance as applicable.
- Proof of Medicare participation
- Copy of DEA Registration
- If accredited, proof of current accreditation
    - Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high-tech radiology providers who perform MRIs, CTs and /or Nuclear/PET studies.
- If accredited, a copy of any state or CMS site survey that has occurred within the last 3 years including evidence the organization successfully remediated any deficiencies identified during the survey.

Pending Credentialing

The LMA credentialing department must deem a practitioner's credentialing complete and effective on or before providing services to a LMA member to receive the practitioner's contracted reimbursement for members covered services.

Claims for covered services provided to members by a non-participating practitioner in a participating provider group will be denied unless pre-approved. LMA members will be held harmless, including copayments, coinsurance and/or deductibles.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least 30 days in advance. The Plan will establish a time for providers to view the information at the LMA office.

Providers have the right to correct erroneous information when information obtained during the credentialing process varies substantially from what was submitted by the practitioner. In instances where there is a substantial discrepancy in information, Credentialing will notify the provider in writing of the discrepancy within 30 days of

receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within 30 days of notification.

Providers have the right to be informed of the status of their application and may request the status of the application either telephonically or in writing. LMA will respond within 2 business days and may provide information on any of the following: application receipt date, any anticipated committee review date, and approval status.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process before approval or re-approval as a participating provider. LMA Medical Director may approve providers who meet all the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration.

The Credentialing Committee is comprised of 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 re-credentialing process must be obtained and verified within 180 days before presentation to the Medical Director of the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discrimination in the Decision-Making Process

LMA Credentialing Program is compliant with all CMS and State Regulations as applicable. Through the universal application of specific assessment criteria, LMA ensures fair and impartial decision-making in the credentialing process. No provider's participation is based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their plan effective date. Providers are advised not to see LMA members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within 60 days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process and Notification of Authorities

In the event a provider's participation is limited, suspended or terminated, the provider is notified in writing within 60 days of the decision. Notification will include:

- The reason(s) for the action,
- Outlines the appeals, process or options available to the provider, and
- Provides the time limits for submitting an appeal.

A panel of peers review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the NPDB are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential, handled and stored confidentially and securely as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information are not disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

LMA conducts routine, ongoing monitoring of the preclusion list, license sanctions, Medicare/Medicaid sanctions, and the CMS Opt-Out list between credentialing cycles. Participating providers who are identified as having been sanctioned are subject to review by the Plan Medical Director or Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider whose license has been revoked or has been precluded, excluded, suspended and disqualified from participating in any Medicare, Medicaid or any other governmental health-related program or who has opted out of Medicare will be automatically terminated from the plan.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the 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- re-credentialing Process for LMA.

Never Event Policy

The CMS Program established in August 2007 initiatives to track “serious preventable events” and “hospital acquired conditions” that occur in a hospital setting.

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events are identified by several internal and external mechanisms such as, but not limited to, claims payment, retrospective reviews, utilization management case review, complaint and grievance review, fraud and abuse investigations, through notification by practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the Quality Improvement Department. The process includes a medical record review and possible telephonic or mail communication with the practitioner/provider. Upon final determination of an actual event occurring, LMA will notify the practitioner/provider by mail that payment denial or retraction will occur.

Quarterly Attestation or Provider Changes

On a quarterly basis, we will require you to attest that all information in our provider directory is accurate and no changes are needed. If changes are made prior to quarterly attestation, please notify LMA. Below is a list of categories we would need to be notified of if a change occurred:

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

By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory.

Closing Patient Panel

When participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against LMA members by closing their patient panels for LMA members only. Providers who decide they will no longer accept any new patients must notify LMA Network Operations Department, in writing, at least 60 days before the date on which the patient panel will be closed.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ADVANTAGE
Planning your advantage

CHAPTER ELEVEN: PROVIDER RESPONSIBILITIES

PROVIDER RESPONSIBILITIES

LMA contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide the best care for our members. Practitioners and other healthcare providers are valued partners in providing continuity and quality of care for our membership.

Role of Primary Care Physician (PCP)

PCPs will provide regular patient care services and work directly with the LMA Nurse Practitioners (or Case manager) to provide and oversee all aspects of member care including evaluating, recommending, or providing treatments to optimize members' health status.

PCPs will be key participants in the member's interdisciplinary care team, directly supervise Plan midlevel care, and be accountable for all care decisions for members assigned to them.

The PCP is responsible for managing all the health care needs of a LMA member as follows:

- Manage the health care needs of LMA members who have chosen the physician as their PCP
- Ensure that members receive treatment as frequently as is necessary based on the member's condition
- Develop an individual treatment plan for each member along with LMA care team
- Submit accurate and timely claims and encounter information for clinical care coordination
- Comply with LMA prior authorization and referral procedures
- Refer members to appropriate LMA participating providers
- Comply with LMA Quality Management and Utilization Management programs
- Use appropriate designated ancillary services
- Comply with emergency care procedures
- Comply with LMA access and availability standards as outlined in this manual, including after-hours care
- Submit claims to LMA in accordance with our billing policies
- Ensure that, when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure

that the codes submitted are supported by proper documentation in the medical record
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to LMA medical record standards as outlined in this manual

Access and Availability Standards

LMA has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance standards, and to take corrective action as needed. LMA also requires all providers to offer standard hours of operation, that:

- Do not discriminate against Medicare enrollees, and
- Are convenient for LMA members, the facilities where members reside, and facility staff who aid in our members' care.

Appointment Standards

LMA members should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate time frame, LMA will facilitate an appointment with another participating provider.

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately seen or instructed to call 911 or go directly to the nearest emergency room
Wait time for Urgent Care Appointments	Within 24 hours
Wait time for Non-Urgent Sick Visit	Within 1 week
Wait time for Routine Wellness Appointment	Within 30 days

After-Hours Care Accessibility	Access to a practitioner 24 hours a day/7 days per week (telephone is acceptable)
Waiting time in the Waiting Room	No more than 30 minutes or up to 1 hour when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult need.
Specialist Visit	21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding member.
Telephone Access includes members and LMA staff	• Emergency calls, both weekdays and after-hours calls, will be dealt with immediately. Returned within 30 minutes. • Routine care calls, both weekdays and after-hours calls will be returned promptly.

A provider may not balance bill a member for providing services that are covered by LMA. This excludes the collection of standard co-pays. 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.

Coverage Arrangements

All participating providers must ensure 24 hour 7 days a week coverage for members. All encounters must be billed under the name of the rendering practitioner, not the member's assigned PCP. Reimbursement will be paid directly to the participating covering practitioner. Covering practitioners, whether participating or not, must adhere to all LMA administrative requirements. Additionally, covering practitioners must agree not to balance bill the member for any covered services. The covering practitioner should report all calls and services provided to the members PCP. Participating practitioners will be held responsible for the actions of the non-participating coverage practitioner. Participating practitioners will not sue any practitioner who is excluded

from the Medicare program for coverage in their absence. PCP agree that, in their absence, timely scheduling of appointments for members should be maintained.

Missed Appointments

A member who misses an appointment without notification is considered a “no-show”. Providers should have a process in place to ensure that the “no-show” is documented within the member's medical record. Members with chronic failure to attend appointments should be brought to the attention of LMA Care Manager for follow-up.

Office Hours

Office hours for all physicians should be posted and should be reasonable. Hours of operations must be convenient and not discriminate against LMA members.

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each provider is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. LMA will assist providers in locating resources upon request.

Provider Marketing Guidelines

Below is a general guideline to assist LMA providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to several plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent.

Providers remain a neutral party to the extent they assist beneficiaries with enrollment decisions. ***LMA Providers Can:***

- Mail or provide a letter to patients notifying them of their affiliation with LMA
- Provide objective information to patients on specific plan attributes and formularies, based on a patient’s medications and healthcare needs while treating the patient.

- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPS), LMA marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Provide beneficiaries with communication materials furnished by LMA in a treatment setting.
- Refer patients to the plan marketing materials available in common areas.
- Display and distribute in common areas LMA marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Display promotional items with LMA logo.
- Allow LMA to have a room/space in provider offices completely separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a LMA sales representative.

Providers Cannot:

- Offer anything of monetary value to induce enrollees to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest.
- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are dis-enrolling from the health plan to encourage re-enrollment in a health plan.
- Call patients to invite patients to the sales and marketing activities of a health plan.

- Advertise using LMA name without LMA prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment to New PCP/NFist – I-SNP Program

LMA PCP/NFists have a limited right to request a member be assigned to a new PCP/NFist. 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.
- The member is disruptive, unruly, threatening or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists. If the member's behavior cannot be remedied through reasonable efforts, and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to LMA. LMA will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment.

If so, LMA will document all actions taken by the provider and to cure the situation, including member education and counseling. A LMA PCP/NFist cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

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

Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues identified by the Utilization Management staff and referred to LMA Quality Improvement Department staff.

They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting indicative of potentially inappropriate or incomplete medical care. Complaints about Quality of Care are those concerns reported by members, families, or providers indicating a potential problem in the provision of quality care and services.

The purpose of identifying these issues is for tracking concerns related to the provision of clinical care and service, evaluating member satisfaction, and trending specific provider involvement with potential quality of care issues.

Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-op complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome) Quality complaints are categorized as:
    - Access to care
    - Availability of services
    - Clinical quality concerns
    - Provider/staff concerns All Quality-of-Care issues are reviewed and investigated.

LMA often requests records from providers and facilities as part of the investigation. The Quality Improvement Committee reviews trends related to Quality-of-Care issues. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re-credentialing.

CHAPTER TWELVE: CORPORATE PROGRAMS

Corporate Programs

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at LMA is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so the Plan may fully realize its vision, mission, and commitment to member care.

In the implementation of the QI Program, LMA will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver healthcare services to meet the health needs of its target population.

The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness, and outcome of care/services delivered to Great Plains Medicare Advantage's members. Also, to provide mechanisms for continuous improvement and problem resolution. LMA Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities
- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes.
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
- Collection and reporting of Structure and Process measures
- Participation and analysis of the Health Outcomes Survey (HOS)
- Participation and analysis of the Consumer Assessment of Health Plan (CAHPS) Survey
- Credentialing and re-credentialing
- Provider peer review oversight
- Clinical practice guidelines

- Monitoring and analysis of under and overutilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data (Pharmacy Department)

Corporate Compliance Program Overview

The purpose of LMA Corporate Compliance Program is to articulate our commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern LMA's operations.

Further, LMA Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations. LMA and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines LMA's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, our members.

LMA and its employees are also committed to meeting all contractual obligations outlined in LMA contracts with the CMS. These contracts allow LMA to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries through the Special Needs Programs. The Corporate Compliance Program is designed to prevent violations of federal and state laws governing LMA lines of business, including but not limited to, healthcare fraud, waste 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. LMA has in place policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement.

LMA also has policies ensuring the Plan will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designers. If you have compliance concerns or questions, call LMA Hotline toll-free at 1-866-380-0075.

Fraud, Waste, and Abuse

LMA has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and LMA has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by LMA encompasses all aspects of LMA business and its business relationship with third parties, including healthcare providers and members.

All employees, contractors, 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 1-866-380-0075. The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affect LMA 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 compliance1@libertyadvantageplan.com

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 another party that reports compliance concerns in good faith can do so without fear of retaliation. Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, LMA conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers.

The analysis allows LMA to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. LMA will review your coding and may

review medical records of providers who continue to show significant variance from their peers.

LMA endeavors to ensure compliance and enhance the quality of claims data, a benefit to both LMA medical management efforts and our provider community. To meet your FWA obligations, please 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. You may request a copy of the LMA Compliance Program document by contacting compliance1@libertyadvantageplan.com.

CHAPTER THIRTEEN: PHARMACY OPERATIONS

PHARMACY OPERATIONS

Liberty Medicare Advantage provides Medicare Part D prescription drug coverage through our partner Navitus Health Solutions.

Navitus Health Solutions is a full-service pharmacy benefit management company committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence.

For Prescribers:

To Access Formulary and Prior Authorization Forms at www.navitus.com

- Select “Prescribers” and click on “Prior Authorization”
- Enter your NPI number and State to access the prescriber portal
- Navitus Health Solutions Pharmacy Helpdesk

- Phone number 1-866-270-3877
- TTY phone number: 711
- Refer to the Prescription Drug Benefit page for formulary, prior authorization criteria, and step therapy criteria

For Pharmacies:

To Access payer sheets and other information at www.navitus.com

- Select “Pharmacies” and click “Pharmacies Login”
- Enter your NPI number and NCPDP number to access the pharmacy portal
- Navitus Health Solutions Pharmacy Helpdesk
- Phone number 1-866-270-3877
- TTY phone number: 711
- Refer to the Prescription Drug Benefit page for formulary, prior authorization criteria, and step therapy criteria

Navitus Part D Formulary Administration

Purpose:

Navitus Health Solutions (NHS) manages formularies for Liberty Medicare Advantage Part D Plan. This process demonstrates how Navitus implements and maintains Medicare Part D formularies as needed to comply with the Center for Medicare and Medicaid Services (CMS) Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements.

Policy:

Navitus is responsible for making appropriate coverage decisions and ensuring that covered Part D drugs and managed Part D formularies meet the requirements in Chapter 6 – Part D Drugs and Formulary Requirements of the Medicare Prescription Drug Benefit Manual.

Part D drugs are defined in Title XVIII of the Social Security Act (the Act) and in regulations (42 CFR 423.100). Subject to exclusions, a Part D drug means a drug that may only be dispensed with a prescription, is being used for a medically accepted indication as defined by section 1927(k)(6) of the Act, and is one of the following:

• A drug that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act.

• A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act.

• Insulin described in section 1927(k)(2)(C) of the Act;

• Medical supplies associated with the delivery of insulin; or

• A vaccine licensed under section 351 of the Public Health Service Act and its administration.

Part D specifies that a drug prescribed to a Part D eligible individual cannot be considered a covered Part D drug if payment for such drug "...is available (or would be available but for the application of a deductible) under Part A or B for that individual."

If payment could be available under Part A or Part B to the individual for such drug, then it will not be covered under Part D. Consequently, drugs covered under Parts A and B are considered available (and excluded from Part D) if a beneficiary chooses not to pay premiums or if a beneficiary has enrolled in Part B but that coverage has not yet taken effect.

In accordance with section 1860D-2(e)(3) of the Act, Navitus may exclude from qualified prescription drug coverage any Part D drug

- For which payment would not be made if items and services are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (except for Part D vaccines); or
- Which is not prescribed in accordance with the Part D sponsor.

Such exclusions are coverage determinations subject to reconsideration and appeal. Unlike other Part D drugs that may be excluded when not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, Part D vaccines may only be excluded when their administration is not reasonable and necessary for the prevention of illness.

Part D drugs do not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act, except for smoking cessation agents.

Navitus may include coverage of drugs that would meet the definition of a Part D drug as a supplemental benefit under enhanced alternative coverage.

Part D formularies must include drug categories and classes that cover disease states consistent with Part D program requirements. Part D sponsors may use existing classification systems or create their own. CMS will evaluate the sufficiency of a Part D sponsor's formulary categories and classes in conjunction with the formulary drug list to ensure that the formulary provides access to an acceptable range of Part D drug choices.

Each category or class must include at least two drugs (unless only one drug is available for a particular category or class, or only two drugs are available, but one drug is clinically superior to the other for a particular category or class), regardless of the classification system that is utilized. The two-drug minimum requirement must be met through the provision of two chemically distinct drugs. Aside from the inclusion of two drugs in each category or class, multiple strengths and dosage forms should also be available for each covered drug. This should encompass dosage forms used commonly in long term care (LTC) facilities and home infusion.

CMS may require more than two drugs for categories or classes if additional drugs present unique and important therapeutic advantages in terms of safety and efficacy, and their absence from the Plan Sponsor's formulary would substantially discourage enrollment by beneficiaries with certain disease states.

Navitus provides medically necessary prescription drug treatments in accordance with the two drug requirements for enrollees in the general Medicare population, as well as those enrollees who reside in LTC facilities. When determining days supplies for residents in LTC facilities, Navitus follows industry best practices and allows for at least 31 days per fill.

42 CFR 423.578(a)(7) allows Navitus to exempt a formulary tier, in which it places very high cost and unique items, from tiered cost-sharing exceptions. Cost-sharing associated with the specialty tier is limited to 25% after the deductible and before the initial coverage limit (or an actuarially equivalent for sponsors with decreased or no deductible under alternative prescription drug coverage designs).

In response to CMS inquiry regarding Medication-Assisted Treatment (MAT) coverage, Navitus ensures accessibility for MAT options for opioid abuse or overdose.

Navitus formularies must also include all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes.

Formularies must include substantially all drugs in these six categories that are FDA approved by the last CMS-specified Health Plan Management System (HPMS) formulary upload date for the upcoming contract year. Medications in protected classes and with orphan status are added to the formulary with appropriate clinical or utilization edits after NHS review of the initial CMS Formulary Reference File (FRF).

New drugs or newly approved uses for drugs within the six classes that come onto the market after the CMS-specified formulary upload date will be subject to an expedited Pharmacy and Therapeutics (P&T) committee review. The expedited review process requires P&T committees to decide within 90 days, rather than the normal 180-day requirement. At the end of the 90-day period, these drugs must be added to Part D formularies.

Navitus reviews all new molecular entities, new drug formulations and FDA indication updates during monthly Formulary Advisory Committee (FAC) meetings and/or quarterly P&T meetings. Protected class drugs are reviewed by committee(s) within the CMS required 90 days. Navitus coverage decisions following the review of each FRF are informed by committee outcomes. If a protected class drug has not been reviewed by committee prior to its addition to the FRF, Navitus will make a coverage determination that maintains formulary compliance with CMS substantially all rules. Coverage is adjusted as necessary to account for protected class drug deletions from the FRF.

Coverage decisions are provided to Liberty Medicare Advantage (LMA) following the review of each FRF. LMA is required to return sign off on all coverage decisions; LMA is required to specify coverage in the event they reject a Navitus recommendation.

Formulary Operations will enter coverage decisions in the Formulary and Benefit Management System (FBMS) system for the creation of CMS submission files. NHS NaviClaim Rx (NCRx) files are created in FBMS or RXFlex, depending on the client. Submission files are based on RxCUI-related National Drug Codes (NDCs) and submitted to CMS. NCRx files are generic product indicator (GPI)-based and sent to the Benefits Configurations Analysts (BCA) department to be set up in the NCRx adjudication system. These files are compared monthly to ensure the CMS submission file and the NCRx formulary file contain the same information.

All other enhancements or negative changes to any Navitus managed Medicare Part D formularies must come from Liberty Medicare Advantage, be approved by a Navitus clinical committee, or be mandated by CMS. For negative changes, NHS must also inform CMS and plan participants prior to implementing the negative change. Changes are submitted during the next appropriate submission cycle.

Formulary documents, including Formulary Drug Lists, Step Therapy requirements, and Prior Authorization requirements are printed monthly using the formulary files and distributed to clients and/or posted to the appropriate web portals.

Part D sponsors that fail to meet formulary submission and re-submission deadlines during the formulary approval process may face a CMS determination that CMS cannot approve their Part D bids. For most Part D sponsors, a failure to obtain bid approvals will result in the termination of their Part D sponsor or MA organization contracts effective at the end of the existing contract year. In the case of an initial Part D sponsor or MA organization contract applicant, CMS would decline to enter a contract with the organization.

All Part D sponsors that fail to meet CMS established formulary timelines will be precluded from entering a contract with CMS. Such a determination would be made on the basis that the organization had failed to submit a bid which CMS could approve, a determination that would not be subject to a request for appeal under Subpart N of 42 CFR 423 (for Part D sponsors) and 42 CFR 422 (for MA organizations). Clients are responsible for meeting all Navitus deadlines, which are set to provide ample time to review prior to submission.

Prior Authorization Coverage Determinations

The adjudication timeframe, notice, and other requirements applicable to coverage determinations under part 423, subpart M of the Medicare Part D regulations apply to requests that involve a PA or other utilization management (UM) requirement in the same manner they apply to all coverage determinations.

- Upon receipt of a prior authorization coverage determination request, the pre-established criteria is reviewed against the information submitted.
- If the request is for a protected class drug, every effort will be made to understand prior utilization of the requested medication including review of available paid claims history.

- If there is evidence of established therapy (in the previous 180 days), approval will be granted.
- If there is not at least 108 days of claims history/eligibility available, efforts will be made to
- determine whether therapy has been established. If this information is obtained or available, approval will be granted.
- If the request clearly meets the CMS approved criteria, the Specialist will process the request and complete the effectuation.
- If the request does not clearly meet the CMS approved criteria, the request is forwarded for pharmacist review.

- If all information required to approve the request is not provided, the requestor will be notified of the specific information needed.
  - Additional information can be supplied in oral or written form. If PA criteria require supplemental documentation to be provided, oral information will not be accepted.
  - All determinations will be made within the required timeframes regardless of whether additional information is received.
  - For expedited and standard requests, the provider will be notified via fax to request the information needed to approve the request.
  - The outreach attempt is made after the clinical pharmacist's initial review of request.
  - All outreach attempts will be documented as part of the record.

- Determinations will be rendered, and the notifications provided no later than:
  - Expedited: 24 hours from the time of the request
  - Standard: 72 hours from the time of the request

Exceptions

When evaluating a coverage determination, a Navitus pharmacist is responsible for determining whether the request is an exception or not. The following types of requests would be classified as exceptions:

- Request to obtain a drug in a higher cost -sharing tier at a more favorable cost-sharing tier (tiering exception).

- Request for a quantity of medication that exceeds the quantity limit submitted to and approved by CMS (quantity limit exception). Request for a medication that is not on the CMS-approved formulary (non-formulary exception).
- Request to bypass one or more prior authorization requirements submitted to and approved by CMS (prior authorization exception).
- Request to bypass the step therapy requirement(s) submitted to and approved by CMS (step
- therapy exception).
- Request to bypass opioid safety edits

- Specifically, regarding prior authorization and step therapy coverage determinations:
  - Navitus will only classify these requests as exceptions when documentation clearly indicates that the beneficiary, authorized representative, or provider is asking for a waiver of one or more of the CMS-approved utilization management criteria.
  - Additionally, if the submitted diagnosis is outside of the approved utilization management criteria (for example, non-FDA labeled indication), the request will be classified as an exception unless otherwise determined by Navitus clinical staff
  - Finally, if upon outreach and subsequent receipt of additional information and/or a supporting statement the classification of the request changes, the reported request type will remain as previously categorized prior to outreach, if changing the request type would impact the original turnaround time. Request type may be updated if the allowable timeframe is not impacted.
  - For example, if (based on initial documentation) the request is determined to be a prior authorization exception, sent for outreach, and additional information is received indicating that the request would subsequently be classified as a prior authorization (non-exception), the request type would continue to be identified as a prior authorization exception, since changing the request type after tolling would be outside the allowable timeframe.
  - This process is to ensure that a decision is rendered within the allowable timeframes based on the documentation that was available to the reviewer at the time of original classification.

Tiering Exception

Navitus pharmacists review tiering exception requests according to the guidance provided in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

1) Requests will be processed according to timeframes and outreach requirements as previously outlined in Prior Authorization Coverage Determinations (below).

- If the supporting statement is not received, Navitus will toll the request for 14 calendar days from receipt of the request. The notification will be sent on or immediately following the 14th day, not to exceed 72 hours (standard) or 24 hours (urgent) passed the decision date.
- Additional information and supporting statements can be supplied in oral or written form.
- An approval will be granted when submitted information supports medical necessity criteria
- indicated above.
- A denial will be rendered when supporting information is not supplied upon request and/or if all information supplied within the required timeframe fails to indicate medical necessity criteria indicated above.
- Navitus decisions regarding a tiering exception requests will not be based solely on the label of the tier containing alternative drugs, rather what types of drugs (brand or generics/authorized generics) are included in the individual tiers.
- For the purposes of Tiering Exceptions, authorized generics are treated as generics.
- Navitus will limit the availability of tiering exceptions for:
    - A brand name drug or biological product at the cost sharing level of alternative drugs, where the alternatives include only generic or authorized generic drugs. Specialty drugs at a specialty tier will not be eligible for tiering exception
    - A non-formulary drug which was approved under the formulary exception process
    - A brand drug when requested at a generic cost sharing tier if the plan sponsor maintains a formulary with separate and distinct tiers for brands and generics.
    - A drug that is already at the lowest cost sharing tier or if the plan sponsor maintains a formulary with only one tier/cost sharing is the same for all formulary tiers.

- Navitus will grant a tiering exception when:
  - A supporting statement (as outlined in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance) is received that establishes medical necessity and does not meet one of the scenarios listed above.
  - Approvals will apply cost-sharing to the lowest applicable cost-sharing tier that contains alternatives for the requested drug.

Formulary Exceptions – Appeals, Grievances and Organizational/Coverage Determinations

Liberty Medicare Advantage uses Navitus as our Part D vendor. At Navitus, their goal is to make each member's pharmacy benefit experience seamless and accurate. However, there are rare occasions where that experience may fall short. When this happens, they do their best to make it right.

What do I do if I believe there has been a pharmacy benefit processing error?
Start with the Customer Care number listed on the card you use for your pharmacy benefits. Customer Care can investigate your pharmacy benefits and review the issue. Most issues can be explained or resolved on the first call.

What does Navitus do if there is a benefit error?
They make it right. If there is an error on a drug list or formulary, you will be given a grace period to switch drugs. If you have been overcharged for a medication, we will issue a refund. Typically, Navitus sends checks with only your name to protect your personal health information (PHI).

What are my Rights and Responsibilities as a Navitus member?
Your rights and responsibilities can be found at navitus.com/members/member-rights.

What if I have further concerns?
If you have a concern about a benefit, claim or other service, please call Customer Care

at the number listed on the card you use for your pharmacy benefits. If you wish to file a formal complaint, you can also mail or fax:

Address: Navitus Health Solutions
Attn: Grievance and Appeals Department
PO Box 999
Appleton, WI 54912-0999

Toll-Free Fax: 855-673-6507
Attn: Grievance and Appeals Department

Upon receipt of a formulary exception request, a Navitus pharmacist will determine if a supporting statement has been received and meets the standards defined in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

- Requests will be processed according to timeframes and outreach requirements as previously outlined in Prior Authorization Coverage Determinations (above).
  - If the supporting statement is not received, Navitus will toll the request for 14 calendar days from receipt of the request. The notification will be sent on or immediately following the 14th day, not to exceed 72 hours (standard) or 24 hours (urgent) passed the decision date.
  - Additional information and supporting statements can be supplied in oral or written form.
  - If the supporting statement is received, but further information is necessary, Navitus will perform one outreach attempt via fax to the provider's office to obtain that information. If the additional information is not received prior to TAT (24 hours for expedited, 72 hours for standard) the case will be closed based off the supporting statement information.
  - An approval will be granted when submitted information supports medical necessity criteria as outlined in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
  - A Quantity Limit will not be applied to formulary exception approvals, unless there is a maximum daily dose limit that is clearly established by the FDA for patient safety reasons.

- A denial will be rendered when supporting information is not supplied upon request and/or if all information supplied within the required timeframe fails to meet medical necessity criteria outlined in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

General Coverage Determination Processes

- If Navitus receives a coverage determination marked as expedited or any verbiage implying the same, the request will automatically be processed according to the expedited Timeframe. The expedited Timeframe does not begin until the Medicare UM Department at Navitus receives the request.
- If a coverage determination request is received without indication that the requesting party is requesting expedited processing, Navitus processes the request under the standard Timeframe without first applying established accepted standards of medical practice in assessing an individual's medical condition to determine the urgency of the coverage request and subsequently prioritize the request according to these standards.
- If a member, provider, or appointed representative indicates orally or in writing that they no longer want to proceed with an active coverage determination they requested it will be considered withdrawn. The withdrawn notification will be issued as outlined in the Written Notifications section of this policy (below).
- If Navitus receives a coverage determination request from an entity other than the enrollee or prescriber, Navitus must first attempt to obtain the CMS 1696 form or an equivalent written notice as defined by CMS (20.2 – Appointment of Representative (AOR) Form or Equivalent Written Notice), or other legal or court issued papers to verify the requestor is the enrollee's appointed representative.
  - To avoid delays in reviewing a case in instances where Navitus does not have the CMS1696 form or an equivalent written notice as defined by CMS (20.2 – Appointment of Representative (AOR) Form or Equivalent Written Notice), or other legal or court issued papers to verify enrollee appointed representative, Navitus will reach out to the prescriber to see if they are willing to initiate the request.
  - If the prescriber is willing to initiate the request, Navitus will use the prescriber initiation date/time as the received date/time.
  - To avoid member confusion, Navitus will not issue a dismissal in these instances and will continue with the original Coverage Determination.

- Navitus will keep all the notes from the initial request, outreach to prescriber and subsequent decisions/notifications in one case file.
- If the prescriber is not willing to initiate the request or If Navitus cannot obtain the CMS 1696 form, or an equivalent written notice as defined by CMS (20.2 – Appointment of Representative (AOR) Form or Equivalent Written Notice), other legal or court issued papers and establish they are an appointed representative for the enrollee within 5 business days, the request will be dismissed and the enrollee and submitter will receive written notification of the dismissal.
- Subsequent coverage determination requests submitted within 60 days of the denial of the initial coverage determination will be processed as a redetermination.

Notification of Determinations

- **Written Notifications:**
  - Written notice of all decisions will be sent to the enrollee within the established TAT. The written notification will be placed in a courier drop box within the CMS defined TAT to ensure timeliness of written notification as defined by 10.5.3 of the CMS Prescription Drug Benefit Manual - Parts C & D
  - Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
  - If an enrollee has identified a representative with the request, the written notice will be mailed to the enrollee's representative instead of the enrollee.
  - Each letter is inserted into an envelope and run through a postage machine. The postage machine dates stamps the letter.
  - The front of the envelope is scanned, and a copy of the PDF image is saved to a folder on a network drive. Each envelope results in its own unique document. At the time of scanning, each letter is logged by last name, first initial that can be used for audit purposes. The scanned envelope images are stored by the date the case was resolved (date the letter was generated).
  - All coverage determinations closed prior to 3:00PM CST Monday through Friday will be picked up by the mail courier at 4:00PM CST. All coverage determinations closed after 3:00PM Monday through Friday or over the weekend and/or on a Holiday, will be picked up by the courier on the following business day at 4:00PM CST.

- Any requests were TAT falls outside of the 4:00PM CST pick-up time will be placed in a courier drop box before TAT expires to ensure timeliness of notification.
- Daily, a report is generated to ensure that a letter was printed/mailed for each case that was resolved the day before. The report identifies the requests that were closed and compares against the log created at the time of scanning. In the event of a d discrepancy, the supervisor is notified immediately, and a letter is generated and mailed immediately.

Denial Notifications:

- The CMS model denial notice will be used, and written denial notifications will provide:
  - OMB-approved specific language for Part B vs. Part D denials found in standardized denial notice
  - Criteria used for denial, including any formulary criteria used (including formulation and strength as appropriate), compendia or FDA recommendations used in decision, and Medicare or CMS-approved plan coverage criteria used.
  - For exceptions, if a supporting statement is not obtained from the prescriber, the denial notice to the enrollee must clearly explain that the request was denied due to a lack of medical necessity and that the prescriber did not produce the necessary supporting statement.
- All denial language will be using predefined templates based on the guidelines outlined
- above and customized by the clinical reviewer.
- Denial reasons will be included within the denial notifications include the following: not medically necessary, ineligible Benefit requested, Medicare D excluded drug, Medicare
- Part B Benefit, and plan exclusion.
- Contact information for the provider to discuss denial decisions.
- Information regarding the right to appoint a representative to file an appeal on the enrollee's behalf.
  - A description of appeal rights including the right to submit information relevant to the appeal in a culturally and linguistically appropriate manner.

  - A description of both the standard and expedited redetermination (expedited not applicable for payment denials) processes and time frames, including conditions for obtaining an expedited reconsideration, and the rest of the appeals process.
- **Approval Notifications:**
  - Approvals must indicate the date the coverage approval will expire.
- **Withdrawal Notifications:**
  - Notifications are issued to both the member and prescriber indicating the case has been dismissed and no further review will occur at that time.
- **Dismissal Notifications:**
  - Notifications are issued to both the requestor and the member when an unauthorized representative submits a coverage determination and Navitus is unable to obtain the necessary documents to review the request.
  - Notifications are issued to both the member and prescriber when an Exception to Coverage request has been approved and Tier Lowering is requested.
- **Prescriber Notifications:**
  - Prescribers will be notified via fax of all coverage determinations within 1 business day of the decision.

Implementing Favorable Decisions:

- **Duration:**
  - Standard prior authorizations will be approved for one year unless clinically inappropriate or unless a different duration has been established via the CMS approved criteria.
  - Standard step therapy and step therapy exception requests will be approved for lifetime.
  - Prior Authorization, Non-formulary, Quantity Limit and Tier Lowering Exception requests will be approved for one year.
    - Based on clinical review, certain drug approval situations may require a shorter approval duration of contract year
    - A next day oversight report is used to monitor for any exception requests that have been approved for less than 1 year.
- Protected class drugs are approved for one year.
  - If a member is adherent to therapy (no gap in utilization greater than 180 days), the drug will continue to auto-adjudicate beyond the one-year approval.

- Safety Edit requests will be approved throughout the plan year. Based on clinical review, certain drug approval situations may require a shorter approval duration.
- For requests where a Coverage Determination is not required and the case is covered per the formulary without UM restrictions, Navitus will treat these as approvals and notify the member as required. For reporting purposes, the effectuation date will be equal to the received date, as the member could have filled the medication being requested as of that date without an override.
- B vs D requests will be approved for one year.
    - For plan sponsors who are not the Part B payer (PDP, EGWP, etc.) a Part B approval would not be issued.
- The Part D utilization management criteria and formulary status are not applied to Part B eligible drugs.
- Hospice requests, when determined to be unrelated to the terminal illness and/or related conditions, will be approved for one year or according to the UM criteria, if applicable.
- If the duration of approval is extended past that was originally communicated, the enrollee must receive written notice at least 60 days prior to the new termination date. The notice must:
    - ▪ Explain the exception will not be extended more than 60 days past the notification,
    - Provide the date that coverage will end (e.g., on December 31, 2015),
    - Explain the right to request a new exception once the current expires and provide instructions for making a new request.
- An approval of a prescription drug claim based on medical necessity, appropriateness, level of care or effectiveness will not be reversed by Navitus unless:
    - A client instructs Navitus to do so OR
    - ▪ Evidence of fraud is discovered in the documentation supporting the original certification.
    - ▪ If a previous approval is reversed, the member and prescriber will receive a standard denial
    - notification indicating the clinical rationale for the denial using the information available at the time of the reversal.
- **Overrides:**

- When an approval decision is granted for a coverage determination, an override will be entered into the claim processing system to allow the claim to pay at the point of sale. The override is effectuated as of the date of the decision.
- A test claim will be run to ensure overrides are entered appropriately and claims will process at the point of sale.
- The pharmacy is notified of an approved coverage determination when there is a rejected claim for the approved medication within 30 days.
- If the pharmacy requests the approval to be backdated (so they could reimburse the member if they paid out of pocket), the override will be backdated as appropriate.

- **Reopens:**
  - If a coverage determination needs to be reopened and a new review or decision must be made on a case that has not already been reviewed at the redetermination level, Navitus will reopen the request, and the applicable TAT starts over.
  - If additional information or a supporting statement is received at Navitus prior to the original TAT of the request expiring, a case will be reopened to review the information.
  - If during an internal audit or oversight, Navitus finds information was not reviewed or included with the original review, the case will be reopened.
  - If a decision is made on a B versus D determination where the decision defaults to D, due to lack of information, additional outreach will be performed to determine correct billing. If alternative information is received, the case will be reopened.
  - If a case is incorrectly closed as a Duplicate, Dismissal, or Received in Error, the case will be reopened for proper review.
  - Once the new review has occurred, new notification letters are issued to the enrollee and prescriber.

Missed Turnaround-Time Requirements:

- Navitus will notify C2C Innovation Solutions, Inc via fax or C2C online portal. The request must be submitted to IRE within 24 hours following the expiration of the adjudication Timeframe.
  - C2C Innovative Solutions, Inc.
  - Fax: (904) 539-4099

- Portal: https://www.c2cinc.com//Appellant -Signup

- If Navitus makes a completely favorable decision within 24 hours af ter the adjudication Timeframe expires:
  - This is used sparingly and only when approval can be clearly granted based on the information available for the case.
  - The case file will not be forwarded to the IRE.
  - The enrollee will be notified of the approval decision.
  - The standard approval notice will be sent.
  - Email notification containing case details is provided to Government Programs who completes the issue notification.
- If Navitus cannot make an approval decision within 24 hours or it has been greater than 24 hours after the adjudication Timeframe expires, the case is to be forwarded to IRE. Navitus will not decide or send a determination letter to the enrollee.
- Navitus must inform the enrollee within 24 hours following the expiration of the adjudication Timeframe that the case has been forwarded to IRE using the Case Status Model Notice. The notice must advise the enrollee of his/her right to submit additional evidence that may be pertinent to the enrollee's case, if the enrollee chooses; and direct the enrollee to submit such evidence to the IRE; and include information on how to contact the IRE.
- If the IRE approves the request, Navitus will implement the approval by entering an override and updating the Prior Authorization Record within 24 hours of receipt of the notice from the IRE or Plan Sponsor.
- Navitus will inform the notifying party when the override has been entered.

Definitions:

Adverse Determination	Any unfavorable decision regarding coverage or payment, in whole or in part, for prescription drug Benefits an enrollee believes they are entitled to.
Parts C & D Enrollee Grievances,	A coverage determination is any determination (i.e., an approval or denial) made by the Part D plan sponsor, or its delegated entity, with respect to the following:

Organization/Coverage Determinations, and Appeals Guidance	1. A decision about whether to provide or pay for a Part D drug (Including a decision not to pay because the drug is not on the plan's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out -of network pharmacy, or because the Part D plan sponsor determines that the drug is otherwise excluded under section 1862(a) of the Act if applied to Medicare Part D) that the enrollee believes may be covered by the plan. 2. Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the enrollee. 3. A decision concerning a tiering exceptions request under 42 CFR 423.578(a). 4. A decision concerning a formulary exceptions request under 42 CFR 423.578(b). 5. A decision on the amount of cost sharing for a drug; or 6. A decision whether an enrollee has, or has not, satisfied a prior authorization or other utilization management requirement. See §30.1.

CMS (Centers for Medicare & Medicaid Services	The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). The programs CMS administer include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
Expedited Coverage Determination	Any decision made by or on behalf of a Part D plan sponsor regarding payment or Benefits in response to urgent/expedited coverage request (oral or written) by the prescribing physician or enrollee. An expedited determination can be requested when the enrollee or prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life , health, or ability to regain maximum function in serious Jeopardy. Any indication on the request as urgent will be processed as expedited.
Exception	Tiering exception: If a plan utilizes a tiered cost-sharing structure to manage its Part D drug Benefits, it must establish and maintain reasonable and complete exceptions procedures that permit enrollees to obtain a nonpreferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier Formulary exception: If a plan utilizes a formulary to manage its Part D drug Benefits, it must have procedures in place that ensure enrollees have access to

	Part D drugs that are not included on its formulary, have dose restrictions or apply to transition f ills.
IRE (Independent Review Entity)	An independent entity contracted by CMS to review Part D plan sponsor denials of coverage determinations.
PBM (Pharmacy Benefit Manager)	A pharmacy Benefit manager (PBM) is a third-party administrator (TPA) of prescription drug programs for commercial health plans, self -insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.
POS (Point of Sale)	The point of sale is the time and place where a retail transaction is completed.
P & T	Pharmacy and Therapeutics
Redetermination	The first level of appeal which involves a Part D plan sponsor re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
Standard Coverage Determination	Any decision made by or on behalf of a Part D plan sponsor regarding payment or Benefits in response to a routine coverage determination request when the request is not designated by the enrollee or his/her prescribing physician as expedited or urgent.
TAT (Turnaround-Time)	The amount of time allowed by CMS for a plan sponsor to complete a coverage determination request after it received.

Formulary Transition Policy

Policy:

Navitus will execute a transition process for new members transitioning to a Navitus plan formulary whose current drug therapies may not be included on the member's formulary. This process will also be executed when current member's formularies are experiencing a negative formulary change. Any changes or modification to this policy and procedure will be reviewed and approved by the Formulary Advisory Committee (FAC) and captured in the FAC meeting minutes. All formulary transition policies, communications and notification timelines are subject to approval from the client.

Formulary (Clinical) Transition for New Members:

- As part of Navitus' new client implementation process when historical claims data are available from the previous plan, Navitus Clinical Account Executive staff will review utilization and determine which medications currently utilized are not part of the new formulary.

- In situations where members are stabilized on drugs that are not on the plan's new formulary and which are known to have risks associated with any changes in the prescribed regimen, the Navitus P&T Committee (or the client's P&T Committee, if applicable) will be involved to ensure that the transition decisions appropriately address the situation. Members taking medications in certain therapeutic categories as determined by the Navitus P&T Committee (or the client's P&T Committee, if applicable) may not be required to transition to a formulary medication. This exception does not include medications for which an A-rated generic exists.
    - Example drug classes may include:
    - Antidepressants
    - Anticonvulsants
    - Anti-psychotics
    - HIV / AIDS

- The Client/Plan Sponsor in collaboration with Navitus' Implementation Coordinator and
    - the designated Clinical Account Executive determine which medications will be part of
    - clinical transition and process details including, but not limited to,:
    - Timeline for transition (generally 3-6 months after plan implementation)
    - Notification Process (Recipients, methods of contact such as letters and web

  - postings, look-back period for claim utilization, goal date for notifications, etc.) Transitional coverage (Tier, applicability to deductibles, max out of pockets, etc.)

- Whenever possible (based on availability of member eligibility, member claim history,
  - and finalization of the client's new formulary) and within Client discretion, Navitus will
  - notify new members in writing at least sixty (60) days prior to the client's effective date
  - with Navitus.

- The Navitus Clinical Account Executive, when data is available, will generate a Transition Report using the Navitus Clinical Mailings 3D object which, will generate a
  - report including the following data if available:
  - Kit Name
  - Carrier ID
  - First and Last Name and complete address of member
  - Date of Birth
  - Family and/or Individual Member ID
  - Language Code
  - Complete provider information
  - GPI or NDC for the transition medication
  - Drug Name
  - Carrier Name
  - Plan Name
  - Formulary Type
  - Combined Family and Carrier ID including
  - Person Code

- Using the Transition Report, written communications to new members related to Clinical
  - Transition will include:

- The medications currently covered under their plan which will be not covered or
  - covered at a higher tier with Navitus,

- The new coverage level under the Navitus plan (non-preferred or not covered)

- A list of common formulary alternatives for each,

- The transitional coverage tier and period when applicable,

- Indication that Navitus P&T (or the client's P&T Committee, if applicable) makes
  - formulary decisions and the basis by which these decisions are made,

- The Navitus web address (or the client's web address, if applicable) for
  - accessing the applicable formulary,

- Contact information for Navitus Customer Care (or other applicable contact if
  - Navitus does not provide customer service for the client).

- Using the same Transition Report, the Clinical Account Executive will facilitate entry of
  - overrides for those members using a medication with a transition period
  - (the drug will continue to be covered at a lower patient pay amount for a specified period
  - of time.) The goal is to prevent unnecessary rejections at the point of sale for members
  - who meet the transition criteria and for whom historical claim data is available.
    - Customer Care (or applicable client contact if Navitus does not provide customer service for the client) receives a copy of the communication prior to mailing along with "Talking Points" from the Clinical Account Executive for assistance when triaging calls related to the Transition.

- In the event a new member attempts to refill an existing medication that was not transitioned for them due to a lack of historical data, Customer Care will access the transition communication for that client and enter the appropriate override for the member. The members will be educated on the transition period details. When possible, the member will be mailed a copy of the communication.

- In the event the new member presents a new prescription during the clinical transition period, the member will be instructed to receive a prescription for a formulary alternative or will incur the applicable cost for filling the original prescription.

- Navitus Customer Care (or applicable client contact if Navitus does not provide customer service for the client) receives a request for a new member to receive a

transitional fill override for a medication not identified as part of the transition process and/or for a new prescription for a medication covered under the transition process for medical reasons, one or more of the following will occur:

- Member is granted a one-time override as determined by the plan design and documented in the transition "Talking Points" and/or Client Component Guide.
- Customer Care (or applicable client contact) reviews the request with a Navitus clinician for approval.
- Customer Care (or applicable client contact) reviews the request with the Clinical Account Executive for approval.

Formulary Transition (Change) for Current Members:

- Negative Formulary Changes include but are not limited to:
  - A drug product or chemical entity being removed from the formulary.
  - A drug being moved to a higher tier.
  - The addition of or more aggressive use of utilization criteria such Prior Authorization, Step Therapy, or Quantity Limits.

  - All Negative Formulary Changes and appropriate alternatives are approved by the Navitus P&T Committee (or the client's P&T Committee, if applicable) prior to implementation with the following exceptions.
    - Branded medications that have A-rated equivalent generics or an equivalent chemical entity available at an equal or lower tier.
    - Products that have been recalled by the FDA Please see Navitus' Member Safety (Drug Recall Communications) P&P for the recall process

  - If it is determined that a member will be affected by a negative formulary change, Navitus notifies the member at least sixty (60) days in advance of the change.

  - Using a claim utilization Transition Report which is generated by the Navitus Clinical Mailings 3D object, written communications to current users will include:
    - The medication(s) affected by the negative change,
    - The reason for the change,
    - A list of common formulary alternatives,
    - The transitional coverage tier and time period when applicable,

- Indication that Navitus P&T (or the client's P&T Committee, if applicable) makes
- formulary decisions and the basis by which these decisions are made,
- The Navitus web address (or client web address, if applicable) for accessing the applicable formulary,
- Instructions to contact their prescriber to discuss available alternatives,
- Contact information for LMA Customer Service.

- When applicable, Navitus will implement claims processing system messaging which informs submitting pharmacies of preferred or covered alternatives for these medications.

- When applicable, Navitus will generate a FAX Blast to affected pharmacies which will identify the change in formulary and the effective date of the change.

- When applicable, the Clinical Account Executive or designee will facilitate entry of clinical transition overrides for those members using a medication with a transition period (the drug will continue to be covered at a lower patient pay amount for a specified period.) The goal is to prevent unnecessary rejections at the point of sale.

- If a 60-day member notice is desired, then the transition period on the override should be 90 days to ensure time to review and generate letters.

Definitions

Clinical Account Executive (CAE)	Navitus pharmacist assigned to manage clinical aspects of a client's pharmacy benefit.
Formulary Transition (Change)	Change in drug coverage for Navitus members.

Formulary Advisory Committee	Routine P&T sub-committee composed of pharmacists and physicians that address day-to-day issues related to drug therapy that require attention more immediately than can be accommodated by the P&T meeting schedule
P & T Committee	Committee composed of clinicians who serve as the clinical oversight body for all clinical criteria employed in Navitus programs to ensure promotion of rational, clinically appropriate, and safe drug therapy.
A-rated generic	A generic determined to be therapeutically equivalent to the brand name drug by the Food and Drug Administration (FDA)
3 D	Navitus's proprietary reporting tool
GPI	Generic Product Indicator
NCD	National Drug Code
NCQA	The National Committee for Quality Assurance is a independent organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

URAC	An independent organization that helps promote health care quality through the accreditation of organizations involved in medical care services.


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