2024

AMERICAN HEALTH PLANS

Participating Provider Manual

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INTRODUCTION TO AMERICAN HEALTH PLANS

Welcome to American Health Plans Institutional Special Needs Plans (ISNP). We are pleased to have you as a Participating Provider within our network. This manual is a general overview of our plans and offers important information related to your participation in our network. In addition to this Provider Manual, additional information and procedurals guides and forms may be found on the individual plan website listed on the following pages.

In 2024, American Health Plans is currently operational in twelve states: Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Texas, and Utah.

- Georgia Health Advantage
- American Health Advantage of Idaho
- American Health Advantage of Indiana
- Iowa Health Advantage
- Kansas Health Advantage
- American Health Advantage of Louisiana
- American Health Advantage of Mississippi
- American Health Advantage of Missouri
- American Health Advantage of Oklahoma
- American Health Advantage of Tennessee
- American Health Advantage of Texas
- American Health Advantage of Utah

Our plans are offered in approved counties in each state, and all Members must reside within those specific counties. Please see specific market contact information on the following pages.

Each state plan is a Health Maintenance Organization (HMO) contracted with Medicare and offers Institutional Special Needs Plans specifically designed for eligible Medicare beneficiaries living in one of our participating long-term care nursing homes or assisted living facilities or individuals living in the community that require an institutional level of care. In addition to providing all standard benefits offered by traditional Medicare, we include Part D pharmacy benefits, supplemental benefits not covered by traditional Medicare, and extensive clinical care management to ensure every member receives the services necessary to achieve their short- and long-term care goals, addressing each member's full range of medical, functional, and behavioral health care needs in a coordinated and member-centric manner.

Georgia Health Advantage – GeorgiaHealthAdvantage.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**844-917-0645 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**844-917-0645 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**844-917-0645 (option 4)**
Website	**GeorgiaHealthAdvantage.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**844-917-0645 (option 1) Fax: 877-319-4345**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-665-5420**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31140
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Idaho – ID.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**855-521-0627 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**855-521-0627 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**855-521-0627 (option 4**
Website	**ID.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**855-521-0627 (option 1) Fax: 833-434-0552**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-674-6196**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31145
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Indiana – IN.AmHealthPlans.com

201 Jordan Road Suite 200

Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**844-657-0447 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**844-657-0447 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**844-657-0447(option 4)**
Website	**IN.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**844-657-0447 (option 1)** **Fax:866-381-1494**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**855-434-8397**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31130
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

Iowa Health Advantage – IowaHealthAdvantage.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**866-327-0523 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**866-327-0523 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**866-327-0523 (option 4)**
Website	**IowaHealthAdvantage.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**866-327-0523 (option 1) Fax: 866-439-0076**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**855-476-7801**

Claims processing

Electronic claims (preferred)	Clearinghouse: Change Healthcare Clearinghouse EDI billing number: RP075
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

Kansas Health Advantage – KansasHealthAdvantage.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**800-399-7524 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**800-399-7524 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**800-399-7524 (option 4)**
Website	**KansasHealthAdvantage.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**800-399-7524 (option 1) Fax: 866-381-0843**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-502-6757**

Claims processing

Electronic claims (preferred)	Clearinghouse: Change Healthcare Clearinghouse EDI billing number: 71066
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Louisiana – LA.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**866-266-6010 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**866-266-6010 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**866-266-6010 (option 4)**
Website	**LA.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**866-266-6010 (option 1)** **Fax: 866-730-1560**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-661-1989**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31130
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Mississippi – MS.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**844-917-0642 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**844-917-0642 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**844-917-0642 (option 4)** **Fax: 844-917-0641**
Website	**MS.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**844-917-0642 (option 1)** **Fax: 877-319-5573**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-661-1993**

Claims processing

Electronic Claims (preferred)	Clearinghouse**:** Change Health Care Clearinghouse EDI billing number: 31135
Mailing Address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Missouri – MO.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**844-228-7934 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**844-228-7934 (option 3)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**844-228-7934 (option 3)**
Website	**MO.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**844-228-7934 (option 1) Fax: 866-381-0792**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-661-1990**

Claims processing

Electronic claims (preferred)	Clearinghouse: Change Health Care Clearinghouse EDI billing number: MMS01
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Oklahoma – OK.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**866-583-4649 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**866-583-4649 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**866-583-4649 (option 4)**
Website	**OK.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**866-583-4649 (option 1) Fax: 866-372-1517**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**844-633-1063**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31125
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Tennessee – TN.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**844-321-1763 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**844-321-1763 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**844-321-1763 (option 4)** **Fax: 844-869-0884**
Website	**TN.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**844-321-1763 (option 1)** **Fax: 866-381-0293**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-478-6370**

Claims processing

Electronic Claims (preferred)	Clearinghouse**:** Change Health Care Clearinghouse EDI billing number: 31130
Mailing Address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Texas – TX.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**855-521-0628 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**855-521-0628 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**855-521-0628 (option 4)**
Website	**TX.AmHealthPlans.co**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**855-521-0628 (option 1) Fax: 866-439-0073**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-674-6201**

Claims processing

Electronic claims (preferred)	Clearinghouse: Change Health Care Clearinghouse EDI billing number: 31155
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Card

American Health Advantage of Utah – UT.AmHealthPlans.com

201 Jordan Road Suite 200
Franklin, TN 37067

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**855-521-0627 (option 4)**
Customer service: Verify member's benefits / coverage, general benefits questions	**855-521-0627 (option 4)**
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**855-521-0627 (option 4)**
Website	**UT.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**855-521-0627 (option 1) Fax: 866-439-0076**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-674-6196**

Claims processing

Electronic claims (preferred)	Clearinghouse**:** Change Healthcare Clearinghouse EDI billing number: 31145
Mailing address (paper claims)	PO Box 981604 El Paso, TX 79998-1604

Sample Member ID Cards

I. Model of Care

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees. MOCs are plan-developed narratives that must be submitted to and approved by CMS. SNPs must also implement and will be audited against the processes and commitments described in their MOCs on file with CMS.

The following four elements are to be addressed in the Plan's Model of Care narrative: (1) the Special Needs Plan Population; (2) Care Coordination; (3) Provider Network and (4) Quality Measurement and Performance Improvement.

Population and Care Coordination: The American Health Plans Model of Care focuses on providing a unique level of customized clinical care and services for residents living in contracted nursing facilities or individuals living in the community or a contracted assisted living facility (ALF) but requiring an institutional level of care. Our care model concentrates on addressing each Member's full range of medical, functional, and behavioral healthcare needs in a coordinated and Member-centric manner. American Health Plans' Model of Care organizes best practices and industry innovations including:

- American Health Plans Advanced Practice Provider (APP) and the Member's Primary Care Physician (PCP) team to provide onsite, facility-based primary care.
- A risk-assessment tool designed for a senior nursing facility patient population.
- A comprehensive history and physician assessment that generates an Individualized Care Plan (ICP)
- A care management platform that helps identify needed preventive health/HEDIS services, ensures the use of evidence-based clinical guidelines, and facilitates care team communication.
- Frequent face-to-face Member and caregiver/family interaction to identify Member care preferences and allow time for important care discussions, counseling, and decisions.

American Health Plans care teams place a strong focus on preventive care, working with nursing home staff and clinicians to help ensure regular assessments and early detection of Member needs and problems. They also advocate for Members and assist with maximizing the benefits available to them.

Per CMS MOC requirements, all American Health Plans Members are required to have an initial comprehensive Health Risk Assessment (HRA) within 90 days of enrollment in the plan, and then at least annually thereafter as well as a care plan developed and implemented based on the Member's needs identified in the HRA.

The APP uses the findings from the assessment to develop an individualized care plan (ICP) which is tailored to the needs and preferences of the Member. The HRA is also used to identify a risk level for the Member – high or low risk – which corresponds with the Member's visit schedule by APP. All Low-risk Members are seen at least monthly and High-risk members are seen bi-monthly for comprehensive assessments and care plan reviews.

The APP coordinates the Member's care plan with the care team, which will include at a minimum the APP, the Member's PCP, an American Health Plans RN Case Manager, the facility staff and the Member or their family/responsible party.

American Health Plans supports Members through care transitions (e.g. hospitalizations, transitions from facility to facility, etc.) including providing this single point of contact – the APP. The APP and care team also coordinate to share the Member's care plan between settings in order to maintain continuity of care. The APP or facility staff also inform the PCP and the Member's family/responsible party in the event of a Member's transition. When the Member returns to the facility after a hospitalization, the APP will conduct a post-discharge assessment and medication reconciliation and update the care plan and communicate any updates to the plan as needed.

The MOC-required HRA, care plan development and care team communication processes described above are repeated on at least an annual basis and also with each significant change in condition or care transition.

Provider Network: American Health Plans is required to offer MOC training to network Providers upon initial contracting and at least annually thereafter. American Health Plans must also offer training to non-contracted providers who see American Health Plans members routinely. Initial MOC training for newly credentialed network Providers is included in their Welcome Packet for New providers. Training is also available on the Providers and Partners page of the specific plan website noted on the Key Contacts Page in this Provider Manual. This annual training may be done electronically via the website or through an in-person training conducted by American Health Plans Provider Relations staff.

Quality Measurement and Performance Improvement: American Health Plans' Model of Care is evaluated on an ongoing basis as part of American Health Plans' overall Quality Improvement (QI) Program. Multiple metrics are collected and analyzed to determine how the MOC is performing, which include but are not limited to: care coordination and compliance-related process measures (e.g. annual HRA completion, timely post-hospitalization APP visits, etc.), HEDIS® measures and utilization measures such as admissions and readmissions. Results are reported to the Quality Improvement Committee (QIC) to which the Board of Directors delegates oversight of the QI Program and the MOC. The MOC is formally evaluated on at least an annual basis.

The Role of the Primary Care Physician

The following specialties are considered PCPs:

- Family practice
- General practice
- Geriatrics
- Internal medicine

All American Health Plans Members must select a PCP. If the Member does not select a PCP, one will be assigned based on the Member's nursing facility of residence and/or the geographic area. The scope of services to be provided by the PCP may include, but is not limited to, the following:

- Office or nursing facility visits for illness, injury and prevention
- Diagnostic testing and treatment
- Injections and injectable substances

The PCP has the primary responsibility for coordinating the Member's overall healthcare among the Member's various healthcare providers. The PCP works closely with the American Health Plans Advanced Care Practitioner, who is a Nurse Practitioner or Physician Assistant, to reduce fragmented,

redundant or unnecessary services and provide the most cost-effective care. American Health Plans monitors referrals to promote the use of network providers, analyzes referral patterns and assesses medical necessity.

PCPs, as well as all other providers, are expected to:

- Maintain high quality
- Provide the appropriate level of care
- Use healthcare resources efficiently
- Be active participants in Members' care team along with the American Health Plans clinical team and participating facility staff.

The Role of the Specialist

Members may see in-network Specialists without a referral from the PCP or American Health Plans APP for office visits and certain other services. Female Members may see in-network gynecologists or their PCP for a well-woman examination without any prior authorization or referral.

American Health Plans does require authorization for certain services and procedures; please reference the list of services on the Plan's website. Providers should use the authorization request form provided on the website and fax the request directly to the Utilization Management (UM) team. Providers are encouraged to speak with the Member's PCP or American Health Plans APP to ensure an appropriate care plan.

To maximize their benefits and reduce any out-of-pocket costs, Members are encouraged to see in-network Specialists. If Members see an out-of-network provider without authorization, the service may not be covered. With questions about network provider participation, please contact the Provider Help Desk identified in the key contacts section of this Manual or visit the Plan website.

Preventive Screenings and Disease Management

The American Health Plans APP visits each facility Member at least monthly. In addition, a PCP visit is recommended at least annually to perform a complete medical evaluation, addressing the Member's specific needs and conducting appropriate preventive screenings. Preventive guidelines to be addressed include, but are not limited to:

- Screening for colorectal cancer
- Mammography
- Influenza vaccine administration
- Pneumonia vaccine administration

Gaps in Member compliance require appropriate intervention to improve and meet recommended goals. Either the American Health Plans APP or the Member's PCP may provide this intervention.

The following charts list suggested guidelines for Providers to follow when ordering preventive tests and treatments for Members with chronic conditions.

Prevention Measurements Table

GENERAL PREVENTIVE CARE	
Pneumonia Vaccine	Once per lifetime = >65 years
Influenza Vaccine	Once every 12 months
Breast Cancer Screening	Once every 12 months
Body Mass Index (BMI)	Once every 12 months
Prostate Cancer Screening	Once every 12 months
Colorectal Cancer Screening: Fecal Occult	Once every 12 months
Colonoscopy	Every 10 years and as medically appropriate

Chronic Conditions Measurements Table

DIABETES/OBESITY	
Eye Exam	Once every 12 months
Hgb A1C	Once every 6 months
URAC (Urine albumin creatinine)	Once every 12 months
GFR	Once every 12 months
CHF	
Ejection Fraction measurement	Once per lifetime
CAD	
LDL Levels	Once every 12 months

II. Provider Standards and Procedures

Provider Credentialing

Credentialing of Providers may be conducted internally by American Health Plans or delegated to an external entity. If delegated, American Health Plans will conduct both pre- delegation and annual delegation audits to ensure credentialing standards are maintained throughout the network. The standards below outline the overall approach to credentialing by American Health Plans. The delegated entity's standards shall be conducted consistent with those of American Health Plans. If there are any questions, please contact the Plan at the appropriate phone number for your market.

The Provider credentialing process involves several steps: application, primary source verification, notification and Credentialing Committee review.

Providers who would like to participate in the American Health Plans network should request a Participation Agreement by visiting the appropriate market website or contacting the Plan at the phone number for your market.

To initiate the credentialing process, the Provider may either submit the CAQH (Council for Affordable Quality Healthcare) Provider identification number or complete the applicable state-mandated credentialing application form along with all required supporting documents. For Facility credentialing, the Facility must submit the following: the completed application, Facility Medicare number, and copies of the Accreditation, Certificate of Insurance, and if applicable the business/state license. All documents must be submitted by mail or faxed to the Provider Credentialing Department at the address listed below:

American Health Plans
201 Jordan Road, Suite 200
Franklin, TN 37067
Fax: 615.800.8862
Attn: Credentialing

American Health Plans follows NCQA standards involving credentialing and re- credentialing of Providers. Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information to the primary source data. If American Health Plans notes any discrepancies, the Provider is notified in writing and given two weeks to forward the correct information.

In addition, a Provider has the right to review the information submitted in support of the application. If the Provider discovers erroneous information on the application, he or she has an opportunity to correct this information before the Plan Credentialing Committee reviews. The Provider must initial and date the corrected information.

Credentialing Committee Review

Completed credentialing files are presented to the American Health Plans Credentialing Committee for review and final decision.

Once the Provider is approved for participation by the Committee, American Health Plans will send a welcome letter to the Provider which will state the Provider's effective date with the Plan.

Providers are notified in writing if they are tabled and/or denied credentialing status. If a Provider wishes to appeal a denial decision, the Provider must submit a request in writing to the chair of the American Health Plans Credentialing Committee. (Please see Credentialing Denials and Appeals section of this manual.)

Re-credentialing Process

All Providers must be re-credentialed within three years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except Providers are also evaluated on their professional performance, judgement, clinical competence and compliance with American Health Plans Quality Program, Utilization Management Program and policies and procedures. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with American Health Plans policies and procedures
- American Health Advantage of Texas sanctioning related to utilization management, administrative issues or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

American Health Plans or its designee will send an application for re-credentialing to Providers three (3) months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to return the completed re-credentialing application and supporting documentation by the deadline may result in suspension and/or termination from the network. If the recredentialing application is submitted after the deadline, the application will be processed as initial credentialing.

Malpractice Insurance

American Health Plans requires Providers to carry minimal professional liability insurance. Please refer to the Provider's Participation Agreement to verify those amounts.

Credentialing Denials and Appeals

American Health Plans will send to a Provider whose credentialing application has been denied a letter that includes the following:

- The specific reason for the denial
- The Provider's right to request a hearing
- A summary of the Provider's right in the hearing
- The deadline for requesting a hearing
- A request for consent to disclose the specifics of the Provider's application and all credentialing documentation to be discussed
- Appropriate requirements specific to the state in which the practice is located.

The Provider has thirty (30) days following receipt of the notice in which to submit a request for a hearing; failure to request a hearing within thirty (30) days shall constitute a waiver of the rights to a hearing.

Upon receipt of the Provider's request for a hearing, American Health Plans will notify the Provider of the date, time and place of the hearing.

The Provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause for denial. The Provider may be represented by legal counsel or another person of the Provider's choosing, as long as, American Health Plans is informed of such representation at least seven (7) days before the hearing.

There is no appeal process if a Provider is denied credentialing based on administrative reasons, such as:

- Network need
- Failure to cooperate with the credentialing or re-credentialing process
- Failure to meet the terms of minimum requirements (e.g., licensure).

Provider Termination

The relationship between a Provider and American Health Plans may be severed for several reasons, which may include any of the following:

- Provider is non-compliant with Malpractice and/or Liability insurance coverage requirements.
- Provider's license, certification or registration to provide services in the Provider's state is suspended or revoked.
- Provider makes a misrepresentation with respect to the warranties set forth in the Provider Participation Agreement.
- Provider is sanctioned by the Office of Inspector General (OIG), Medicare, Medicaid or any Federal Health Care Program.

American Health Plans may initiate the termination process, or the Provider may initiate the termination. In all cases, if a Provider began treating a Member before the termination, the Provider should continue the treatment until the Member can, without medically injurious consequences, be transferred to the care of another participating Provider. The terminating Provider will be compensated for this treatment according to the rates agreed to in the Provider's Participation Agreement.

Should the terminating Provider note special circumstances involving a Member – such as treatment for an acute condition, life-threatening illness, or disability – the Provider should ask American Health Plans for permission to continue treating that Member. In such cases, American Health Plans will reimburse the Provider at the compensation rates specified in the Provider's Participation Agreement.

The Provider may not seek payment from the Member of any amount for which the Member would not be responsible if the Provider were still in the American Health Plans network. The Provider shall abide by the determination of the applicable grievance and appeals procedures and other relevant terms of the Provider's Participating Agreement.

When the American Health Plans Credentialing Committee makes a determination to terminate a Provider's participation that will result in a report to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and/or applicable state licensing agency, American Health Plans shall promptly notify the affected Provider by certified mail, return receipt requested.

Such notice shall:

- State the specific reason for the termination
- Inform the Provider that he/she has the right to request a hearing
- Contain a summary of the Provider's right in the hearing under this policy
- Inform the Provider that he/she has thirty (30) days following receipt of the notice within which to submit a request for a hearing
- State that failure to request a hearing within the specified time period shall constitute a waiver of the right to a hearing
- State that upon receipt of the hearing request, the Provider will be notified of the date, time and place of the hearing
- Allow the Provider to be represented by an attorney or another person of his/her choice and in such case shall notify American Health Plans seven (7) days in advance of the scheduled hearing date.

A Provider shall have thirty (30) days following receipt of notice to file a written request for a hearing. Requests shall be sent by certified mail, return receipt requested, to the Credentialing Dept at American Health Plans at the address noted at the beginning of this section. If such a hearing is requested, the American Health Plans Credentialing Committee shall follow the steps as defined by the American Health Plans Credentialing and Fair-Hearing policies and procedures. (Copies of such policies and procedures are available upon request.)

A Provider who fails to request a hearing within the time and in the manner specified in this policy waives any right to a hearing. Such a waiver shall constitute acceptance of the action, which then becomes the final decision of the American Health Plans Credentialing Committee and is not subject to appeal.

In accordance with 42 CFR §422.202(d)(4) and as specified in the Provider Participation Agreement, the Provider must provide at least ninety (90) days advance written notice to American Health Plans before terminating the Provider Participation Agreement without cause and leaving the American Health Plans network. Provider must supply copies of medical records and facilitate a Member's transfer of care to a network participating Provider upon request by American Health Plans, the Member or the Member's authorized representative.

For terminations initiated by PCPs, American Health Plans shall notify affected Members in writing providing the effective date of PCP termination and the name of the new assigned PCP, office phone number and address. In addition, the notice shall provide instructions on how to select a new PCP. As specified in the Provider Participation Agreement, PCPs must continue to provide care for up to ninety (90) days following the termination date.

For terminations initiated by specialists, non-PCP Providers and/or facilities, American Health Plans will send a written notification to all Members who are currently receiving care from them or have received care within the past three (3) months. This notification will alert the Member of the Provider's forthcoming termination date and allow for the transition of care to another contracted Provider (or Facility).

Practice Information

At the time of credentialing and re-credentialing, American Health Plans will verify important demographic details about a Provider's practice to help ensure the accuracy of information, such as, claims payments and Provider directory information. Providers should notify American Health Plans of any changes in practice information at least sixty (60) days before the effective date of the change to avoid improper claims payment and incorrect directory information. All network Providers must have the hours of operation clearly posted in their office.

Office Requirements

Providers are to bill American Health Plans for all services performed in their offices or at the Nursing Facilities for assigned Members. The services should be within the standard practices of the Provider's license, education and board certification. However, reimbursement for such services will vary by Provider. Providers should refer to their participation agreement for reimbursement rates and terms.

American Health Plans wants to make sure that all Members—including those with limited English proficiency, diverse cultural backgrounds, the homeless and individuals with physical and mental disabilities—receive healthcare services and assistance with their health plan in a culturally competent manner. Each Member is entitled to receive healthcare needs in a manner that is respectful and consistent with the Member's cultural perspective. The goal of this policy is to enhance patient care compliance. Once cultural expectations and health service needs are determined, Providers may be required to supply interpreters to overcome barriers of language and/or understanding. To further promote understanding and support, Providers also may be required to supply the Member with appropriate educational materials and information about community

resources. For assistance with Members requiring culturally competent services, Providers may call the Provider Help Desk listed in the key contacts section of this Manual.

While on vacation or a leave of less than 30 days, a Network Provider must arrange for coverage by another American Health Plans provider. If a Provider goes on a leave of 30 days or longer, the Provider must notify the Provider Help Desk at the number listed in the key contacts section of this Manual. If a Network Provider arranges with either a participating or non-participating physician to cover for his/her patients during an absence, the Network Provider is responsible for making sure the covering physician will:

- Accept compensation from American Health Plans as full payment for covered services
- Not bill the Member, except for applicable copayments, coinsurance and deductibles
- Obtain prior authorization from the Utilization Management Department, as set forth in this Manual
- Comply with the rules, protocols, policies, procedures and programs set forth in this Manual

All in-network Providers are required to provide 24-hour on-call coverage. If a Provider delegates this responsibility, the covering Provider must participate in American Health Plans' network and be available 24 hours a day, seven days a week.

Accessibility Standards for Office-based Appointments

American Health Plans follow accessibility requirements set forth by applicable regulatory and accrediting agencies. The purpose of these standards is to make sure services are available and accessible to Members in a timely fashion. American Health Plans monitors compliance with these standards annually. The table below describes sample types of services and the respective standards to be followed.

PRIMARY CARE PHYSICIAN	
Routine Physical Examination	Within 30 days
Mild Respiratory Symptoms > 3 days	Next day
Chest Pain	Same day
OBSTETRICS/GYNECOLOGY	
Routine Referral	Within 2 weeks
Urgent Referral	Next day
Well-woman Exam	Within 10 weeks
SPECIALTY CARE PHYSICIANS	
Routine Referral	Within 30 days
Urgent Referral	Next day
Emergency	Same day

Physicians Rights and Responsibilities

American Health Plans is committed to offering its Members access to physicians and healthcare services and facilities that provide quality care in a manner that preserves a Member's dignity, privacy and autonomy.

As such, American Health Plans employees and contracted Providers shall:

- Treat all Members with respect and courtesy.
- Not discriminate against Members in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, and source of payment or other protected class.
- Respond promptly to Members' questions and document communications with Members as appropriate.
- Protect Members' rights by publicizing such rights to Members, employees and network Providers.
- Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to health maintenance organizations, their employees and their network Providers.
- Provide Members with information concerning the benefits available to them so they may avail themselves of such benefits as appropriate.
- Make sure Members have reasonable access to the services to which they are entitled under their plans.
- Give Members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Healthcare Providers shall obtain informed consent as required by law.
- Inform Members of their rights to an appeal if a Provider chooses not to supply a service or treatment requested by the Member.
- Preserve the integrity and independence of clinical decision-making by network Providers. In making such decisions concerning a Member's medical care, network Providers shall not allow themselves to be influenced by financial compensation to the provider or provider network that results from such decisions or by coverage of a particular treatment or course of care by the Member's plan.
- Follow the guidance of provider marketing training as required by the Medicare Improvements for Patients and Providers Act (MIPPA).

Provider Role in HIPAA Privacy Regulations

American Health Plans policies and procedures include regulatory information to make sure American Health Plans complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach- Bliley Act.

Hospitals and Providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations – as is the staff at American Health Plans.

Throughout its business areas, American Health Plans has incorporated measures to make sure potential,
current and former Members' Protected Health Information (PHI), individually identifiable health information and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. American Health Plans employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment and healthcare operations), by the Member's written request, or if required to be disclosed by law, regulation or court order.

American Health Plans developed its Authorization Request Form in accordance with the core elements and required statements contained in the HIPAA privacy rules. To determine pre- service medical necessity, Providers should complete, sign and return the Authorization Form to American Health Plans.

All Members receive the American Health Plans Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Members also receive a copy of the privacy information with their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). These documents clearly explain the Members' rights concerning the privacy of their individual information, including the processes established to provide them with access to their PHI and procedures to request to amend, restrict use and have accounting of disclosures. The documents further inform Members of American Health Plans precautions to conceal individual health information from employers.

American Health Plans Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices Providers are required to give to their patients under HIPAA. To view the Privacy Statement and Notice of Privacy Practices, contact American Health Plans Provider Help Desk at number listed in the key contacts section of this manual or view the Notice of Privacy Practices on the specific American Health Plans plan website.

Complying with the Americans with Disabilities Act

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines and any of its amendments, Section 504 of the Rehabilitation Act of 1973 (Section 504), and other applicable state or federal laws.

American Health Plans requires that network Provider offices or facilities comply with these

aforementioned statutes/laws.

The ADA and Section 504 require that Provider offices have the following modifications:
(i) the office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs; (ii) patient rest rooms should be equipped with grab bars; and (ii) handicapped parking must be available near the provider's office and be clearly marked.

These aforementioned requirements are not an exhaustive list of the standards or access requirements mandated by the ADA, Section 504, or any other applicable state or federal law.

Anti-Kickback Statute

American Health Plans is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, American Health Plans must ensure that all Providers adhere to the Federal Anti- Kickback Statute and state equivalents (the "Anti-Kickback Policy"), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties, such as being barred from participation in federal programs.

Discounts, rebates or other reductions in price may violate the anti-kickback statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

In order to be permissible, an activity that implicates the anti-kickback statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

III. Member Administration

Member ID Cards

All American Health Plans members are provided a Member ID Card to present at the time of medical services; for those members residing in our network skilled nursing facilities, they may present with their Face Sheet from their nursing facility medical record which will also indicate their coverage. Refer to the specific American Health Plans market website for examples and more information about specific benefits, Evidence of Coverage, Member cost-sharing and other coverage information.

Selecting a Primary Care Physician

All American Health Plans Members must select a PCP from the list of participating primary care physicians in the American Health Plans network. If a Member does not select a PCP, American Health Plans will assign a PCP based on the skilled nursing facility and/or geographic area. A Network PCP is not permitted to refuse services to an eligible Member.

Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month.

Verifying Member Eligibility

Possession of an ID card is not a guarantee of eligibility. Providers should photocopy the card and check it for any change of information, such as address and eligibility date. Providers should verify Member eligibility before each visit using the telephone number listed on the back of the Member's ID card and in the key contacts section of this Manual.

Member Benefits, Copayments and Coinsurance

American Health Plans covers the same benefits as Original Medicare as well as some supplemental benefits not covered by Medicare. For a list of benefits and their respective cost-sharing amounts, please visit the plan specific website for the most recent Summary of Benefits and Evidence of Coverage. A list of benefit exclusions is contained within the Member's Evidence of Coverage which may also be accessed on the plan specific website.

Members may also be eligible for the cost sharing benefits provided by State Medicaid. Generally, this will provide the Member with no cost sharing for covered services provided by in-network Providers.

Providers are not allowed to charge co-payments, co-insurance, or deductible charges that are the responsibility of State Medicaid programs.

Advance Directives

All American Health Plans Providers must offer Member written information about their right to make their own healthcare decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

An Advance Directive generally is a written statement that an individual has established – in advance of serious illness – regarding a medical decision. The Advance Directive must be in accordance with the Member's state regulatory guidelines in order for it to be considered valid. All adults have the right to create and initiate an Advance Directive.

The two most common forms of advance directives are a living will and a healthcare durable power of

attorney.

A Member who decides to execute a living will or a healthcare durable power of attorney is encouraged to notify their PCP, or treating provider, of its existence, provide a copy of the document to be included in personal medical records and discuss this decision with the PCP or treating provider. If a Member is under the care of a Provider who is unable to honor the Member's Advance Directive, the Member may transfer to the care of a Provider willing to do so.

Member Appeals

The Evidence of Coverage is distributed to each Member and provides instruction on a member's rights to file an appeal. The Evidence of Coverage is available on the market specific website listed in the key contacts section of this manual.

A Member or their authorized representative must file an appeal within 60 calendar days of receiving notification of an American Health Plans denial decision (adverse organization determination) or provide "good cause" for the delay in filing. Examples of good-cause reasons include the following:

- The Member did not personally receive the adverse organization determination notice or received it late.
- The Member was seriously ill, which prevented a timely appeal.
- There was a death or serious illness in the Member's immediate family.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The Member had incorrect or incomplete information concerning the appeal (reconsideration) process.
- The Member lacked the capacity to understand the time frame for filing a request for reconsideration.

A Member may appoint an authorized representative or request that a physician represent him/her in the appeal process. To be appointed, both the Member and the proposed representative (including attorneys) must sign, date, and complete the Appointment of Representative (AOR) form (CMS 1696 form) or an equivalent written notice. A Member's legal power of attorney (POA) does not need to submit the AOR form, rather the POA would provide a copy of that document. The AOR form is available on the American Health Plans market specific website listed on the contacts page of this Manual, or on the CMS website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf.
A Member's treating physician may file an appeal on the Member's behalf without completing an AOR form. However, the provider must notify the Member that the appeal is being filed on their behalf.

A standard appeal must be submitted in writing, whereas an expedited appeal may be submitted either orally or in writing.

A standard appeal must be resolved within 30 days, which may be extended by up to 14 days, if in the best interest of the member.

American Health Plans provides an expedited determination if a Member or their physician indicates that applying the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. American Health Plans has up to 72 hours to make a

decision, which may be extended by up to 14 days, if in the best interest of the Member.

Appeals may require that American Health Plans obtain additional medical records from the treating provider to adequately perform a complete review. American Health Plans Medical Director may request a peer-to-peer conversation to assure understanding of the Member's unique care needs and the Provider's rationale for the service.

If American Health Plans upholds its original decision (denial), the Member has additional appeal rights as outlined in their Evidence of Coverage.

Appeals regarding payment (service is already provided) cannot be expedited and American Health Plans has up to 60 days to make a decision.

Note: Contracted Providers should refer to the "Provider Disputes" section for their reconsideration rights and process.

Appeals may be faxed to (844) 280-5360 or mailed to:

American Health Plans
201 Jordan Road Suite 200
Franklin, TN 37067 Attn: Member Appeals

Timelines for Provider Submission of Additional Information

In order for American Health Plans to meet CMS timeliness standards, Providers must respond to requests for additional information within five (5) calendar days for a standard appeal and within twenty-four (24) hours for an expedited appeal.

Member Grievances

A grievance is a type of complaint, or expression of dissatisfaction, including those that concern quality of care. A grievance does not involve coverage or payment disputes. The Evidence of Coverage, Chapter 9 provides details on grievances and how Members can file. Members may file a written or oral grievance at any time.

For more information about the appeals and grievances policies and procedures, please contact the Provider Help Desk at the number listed on the key contacts page of this Manual.

IV. Utilization Management (UM)

American Health Plans Utilization Management (UM) team collaborates with our clinical team of APPs and RN Case Managers, and network PCPs, specialists, nursing homes, and other facilities and ancillary providers of care around the appropriate and efficient use of healthcare resources.

Services Requiring Prior Authorization

All American Health Plans contracted Providers are required to obtain authorization from the UM Department for services as outlined on the “Services that Require Prior Authorization List”, located on each market-specific website as listed in the key contacts section of this Manual. Authorization requirements may change annually. Authorization is also known as an Organizational Determination. Failure to submit an authorization request, or failure to submit an authorization in a timely manner, may result in a provider administrative denial of services. An authorization is not a guarantee of benefits or payment. Member eligibility should be verified prior to requesting or providing services.

Requests for authorization of services should be faxed to the market specific fax number for UM listed in the key contacts section of this Manual by completing the Request for Prior Authorization form found on the market specific website. The UM team reviews all requests against clinical criteria and internal policies. Authorization will be provided for those requests which are found to be medically necessary.

Requests not meeting established medical necessity criteria will be referred to the American Health Plans Medical Director for further review and evaluation.

American Health Plans operates a toll-free call center (see the key contacts section of this Manual) to respond to physicians and other providers related to authorization requests. The UM department is available Monday through Friday, except holidays during normal business hours. Providers may also leave messages via voice mail, so that information may be submitted for action 24 hours a day, 7 days a week. After business hours or on holidays, a Provider can leave a message and a representative will return the call the next business day.

Documentation for Prior Authorization Requests

When requesting an authorization documentation must include, at a minimum:

- Member name and American Health Plans Member Identification number
- Location of service (e.g., hospital, outpatient surgery, physician office)
- Servicing/attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description with procedure code or HCPCS code
- Clinical information supporting the need for the service
- Provider contact information

Requests must be received prior to the service unless the Member's condition prevents. Requests that provide the above information, including the necessary clinical documentation, can be addressed quickly. Otherwise, a call will be placed to the Provider office requesting additional information.

For services that do not meet criteria once clinical information is received, the UM Department will offer a peer-to-peer call with the Provider and the American Health Plans Medical Director.

Utilization Management Decision Making and Timeframes

UM decision making is the result of:

- Applying InterQual Criteria
- Application of Medicare National and Local Coverage Determinations
- American Health Plans Policy
- A Member's individual medical condition and social considerations
- Overall needs of the Member's condition

Routine Requests: If all required information is submitted at the time of the request, the determination will be made within 14 calendar days.

Expedited Requests: When Providers believe 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, the Provider may request an expedited determination. Expedited requests will be determined within 72 hours or as quickly as the Member's health requires.

At the request of a Member or a Provider, the UM Department will provide a copy of the InterQual or other guidelines. A Member or a Provider has the option to request the guideline read over the telephone or review the guideline in person at:

American Health Plans
201 Jordan Road Suite 200
Franklin, TN 37067

Authorization Decisions and Time Frames

Service Request	Plan Timeline for Notification
Standard/Non-urgent Pre-service Request: medical services	Within 14 calendar days of request
Standard/Non-urgent Pre-service Request: Part B drugs	Within 72 hours of request
Expedited/Urgent Pre-service Request: medical services	Within 72 hours of request
Expedited/Urgent Pre-service Request: Part B drugs	Within 24 hours of the request

Inpatient Admissions

All inpatient admissions require authorization. Elective admissions must be authorized prior to the date of the requested service. The facility should notify American Health Plans within one business day for an emergent admission. For weekend admissions or for services delivered after normal business hours, authorization must be obtained within one (1) business day of the admission or service being provided.

A request for inpatient authorization will be sent to the American Health Plans Medical Director for review if

- the request does not appear to meet clinical guidelines and/or
- the Member's condition does not meet criteria for an extended length of stay/level of care.

If the request results in a potential denial, or adverse determination, the admitting Provider will have the opportunity to discuss the treatment plan and/or medical guidelines with the American Health Plans Medical Director through a Peer-to-Peer conversation facilitated by the Plan.

American Health Plans communicates any decision, including any member and provider appeal rights, for initial admission non-approval via fax and mail. The hospital is required to comply with all CMS requirements related to provision of the "Important Message from Medicare."

Observation Status

Observation status applies to Members for whom inpatient hospital admission is being considered but is not certain. Observation care is a well-defined set of specific clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether the Member will require further inpatient treatment or if he/she is able to be discharged from the hospital.

Observation services are commonly ordered for Members who present to the emergency department and who then require a significant period of treatment or monitoring to make a decision concerning his/her admission or discharge.

Observation status should be used when:

- the Member's condition is expected to be evaluated and/or treated within 24 hours, with follow-up care provided on an outpatient basis, such as in their respective nursing facility.
- the Member's condition or diagnosis is not sufficiently clear to allow the Member to leave the hospital.

If a physician decides to admit a Member who is in observation status, the facility should notify the UM department within one business day of the admission decision.

If a Member's condition meets inpatient criteria after the observation period, the stay will be converted to inpatient beginning with the observation stay admission date. All claims for this type of stay should be submitted with the entire length of stay as an inpatient.

If a Member is discharged from an inpatient level of care and subsequently readmitted to the same hospital within 24 hours, the UM Department continues the Member's inpatient care under the same authorization number.

The hospital is required to comply with all CMS requirements related to the provision of the "Medicare Outpatient Observation Notice" (MOON).

Emergency Admissions

American Health Plans will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Upon admitting a Member from the emergency department, the hospital should collect the following information:

- Member name and American Health Plans ID number
- The name of the Member's referring Provider (PCP, ISNP APP or the nursing facility), if applicable
- The name of the admitting Provider if different from the referring Provider or PCP
- Clinical documentation that supports the emergent admission and treatment plan

The hospital must notify the American Health Plans UM Intake department via fax within one business day of the emergency admission.

Skilled Nursing Facility (SNF) Care

American Health Plans covers up to 100 medically necessary days per benefit period consistent with Original Medicare. A benefit period begins the day a Member goes into a hospital or SNF. The benefit period ends when the Member has not received any inpatient hospital, LTAC or skilled care in a SNF for 60 consecutive days. The benefit period resets after 60 consecutive days without care in an acute inpatient, LTAC or SNF.

Services must be reasonable and medically necessary for the individual Member. A denial notice will be provided to Members that exceed the 100-day benefit limit.

Concurrent Review

Concurrent review is performed to assess the appropriateness of continued inpatient care in a hospital (medical or psychiatric), rehabilitation center, LTAC, or skilled nursing facility.

Concurrent review includes:

- Review of medical necessity and whether care could be provided in a lower level of care, such as a skilled nursing facility or home health
- Determination of the next review date
- Discharge planning needs

The facility must provide relevant clinical records and the plan of care to the UM Department, as requested to avoid any unnecessary delays in discharge to the appropriate level of care.

Following the initial authorization decision, the UM staff enters a follow-up date in the UM system based on the medical necessity guideline recommendation. Upon review of the request for continued stay/treatment, UM applies medical necessity criteria and establishes a new length of stay/service, or the potential discharge date. If the request does not meet medical necessity criteria, the case is referred to the American Health Plans Medical Director for review and decision. The American Health Plans Medical director or designee makes all medical necessity denial decisions.

Discharge Planning

The American Health Plans UM staff, APP, and Case Manager work with the hospital staff and the long-term care facility where the member may reside to coordinate discharge planning. Contact the UM department for members that may benefit from discharge planning services, as well as to confirm the member's actual discharge date.

Durable Medical Equipment (DME)

CMS defines DME as certain reusable medical equipment that is ordered by a physician or practitioner for use in the home. The term DME is defined as equipment which:

- Can withstand repeated use (i.e. could normally be rented and used by successive patients;
- Is primarily and customarily used to serve a medical purpose (not for convenience);
- Generally, is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a member's home.

A hospital and/or skilled nursing facility that is providing Medicare-covered care does not qualify as the Member's home. The facility is responsible to provide equipment in these circumstances. A long-term care facility may qualify as the Member's home.

American Health Plans covers all medically necessary DME covered by Original Medicare. American Health Plans complies with all Medicare National and Local Coverage Determinations and covers the same items and services as Original Medicare, including relevant limitations and quantity limits. Services, supplies and equipment must be reasonable and medically necessary for the individual Member.

All DME requires the Member's doctor or treating Provider to prescribe the equipment. The Provider must prescribe the type of equipment needed by completing a detailed written order, with medical necessity documented within the Member's medical record.

The prescribing Provider must have evaluated or treated the Member for a condition that supports the DME order within 6 months prior to the written order.

Pre- service authorization is required prior to the Member receiving the DME item, unless the item is less than the dollar limits set by American Health Plans, which may change annually. DME authorization limits are delineated on American Health Plans market specific websites, as well as within the Evidence of Coverage (EOC). The dollar limits are for monthly billed charges in the case of rented DME or per DME item. The Plan limit is set monthly or per item and not cumulative for the life of the item. All services must meet Medicare Coverage Determinations and are subject to retrospective audit.

American Health Plans complies with Original Medicare claims payment rules and guidelines. DME items, such as oxygen may be authorized through the current benefit year. New authorizations, including updated medical necessity, must be submitted for DME services that will continue after an authorization expiration date.

Durable Medical Equipment (DME) authorization requests require diagnosis code(s), HCPCS code(s) and quantity and date(s) of service.

Retrospective Authorization

Retrospective authorization may be requested when the service is performed without prior authorization in extenuating circumstances, which includes:

- Services and situations which may be urgent or emergent, and the Member has already received services
- The ability of the Member to communicate their insurance information either verbally or by providing their member identification card

Providers should initiate a request for authorization via American Health Plans dispute resolution process within 60 days of the denied claim. Please refer to the applicable section of this manual for additional information.

Medical Necessity Denials

An authorization request may be denied for failure to meet guidelines, protocols, medical policies, or to follow administrative procedures as outlined in this provider manual.

Members may not be billed by contracted Providers, except as allowed by CMS. If prior authorization requirements are not met resulting in a denied claim, Members must be held harmless for denied services.

The American Health Plans Medical Director or designee renders all medical necessity denial decisions. Whenever a denial is pending, the UM Department provides the name, telephone number, title and office hours of the American Health Plans Medical Director, for an opportunity of a peer-to-peer

conversation. A peer-to-peer conversation allows the requesting Provider to discuss the nuances of the request with American Health Plans Medical Director.

Administrative Denials

An administrative denial is issued for those services for which the contracted Provider has not followed requirements set forth in the Provider Participation Agreement or this Provider Manual. An administrative denial may be issued for failure to follow prior authorization of an elective service, procedure or admission. It may also be issued for failure to notify the UM Department within one business day of an emergency service, procedure or admission.

Situations that may result in an administrative denial include:

- Failure to obtain authorization pre-service for an elective service
- Failure to request authorization within one business day of determining the Member has coverage, and extenuating circumstances do not exist
- Failure to follow American Health Plans requests for clinical updates related to continuing care (e.g. acute hospitalization, Part A skilled nursing facility services, Part B physical therapy, etc).

American Health Plans offers contracted Providers an administrative dispute process as specified in the Provider Participation Agreement.

Members may not be billed by contracted Providers, except as specified in the Provider Participation Agreement as allowed by CMS. If prior authorization requirements are not met resulting in a denied claim, Members must be held harmless for contractually denied services.

Notice of Medicare Non-Coverage (NOMNC)

Skilled Nursing Providers, Home Health Agencies or Comprehensive Outpatient Rehabilitation Facility Providers must deliver an advance, completed Notice of Medicare Non-Coverage (NOMNC) to members receiving skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services no later than two days before the termination of services. The NOMNC is an OMB-approved standardized notice designed to inform Medicare enrollees, in writing, that the enrollee's Medicare health plan and/or provider have decided to terminate their covered SNF, HHA, or CORF care. The NOMNC language provides instructions on how to request a fast-track appeal, when the Member and/or their representative disagrees covered services should end.

The Provider must deliver the NOMNC face-to-face, except in rare circumstances. In circumstances that prevent physical delivery of the NOMNC to a member or their representative, an alternate delivery method may be used. In these cases, the Provider must document the reason for employing the alternative delivery method.

If the Member's services are expected to be fewer than two days in duration, the Provider must provide the NOMNC to the Member at the time of admission. If a Member is in a non- residential setting, and the span of time between services exceeds two days, the Provider may deliver the notice at the next to last time that services are furnished.

All Home Health Agencies (HHA), Skilled Nursing Facilities (SNF) and Comprehensive Outpatient

Rehabilitation Facilities (CORF) Providers must deliver the Notice of Medicare Non-Coverage (NOMNC) to American Health Plans Members (or their authorized representative) when

the Member's Medicare covered service(s) are ending in compliance with CMS requirements. Providers should place the NOMNC in the Member's medical file and fax a copy of the signed NOMNC to American Health Plans within one business day.

Continuity of Care

American Health Plans promotes continuity of care for Members that are newly enrolled, or Provider's contract is discontinued (other than for cause), while the Member is in an active course of treatment. Continuation of treatment may be authorized through the current period of active treatment, or for up to 90 calendar days, whichever is less, for Members undergoing active treatment for a chronic or acute medical condition.

Non-Contracted Providers

All out-of-network provider requests require prior authorization from American Health Plans except in emergent situations, urgently needed care when access to an American Health Plans network Provider is not available and/or out-of-area dialysis services at a Medicare-certified dialysis facility. American Health Plans should be notified within one business day following an emergent or urgent service.

New Technology Requests

American Health Plans follows Original Medicare coverage policies. American Health Plans utilizes the following process for requests for new technology, or a new use for existing technology:

- Review of information from appropriate government regulatory bodies, such as CMS coverage guidance, FDA, etc.
- Review of information from published scientific evidence, such as peer-reviewed articles, recommendations from professional societies or summaries from organizations that rely on the judgment of experts when determining the effectiveness of new technology.
- Review and input from relevant specialists who have expertise in the technology. Behavioral health professionals are included in the review of any BH service.

Following medical director review, the information is considered by the QI Committee for final recommendation on whether to include the new technology as a covered Plan benefit.

American Health Plans Pharmacy Benefits Manager (PBM), Elixir, is delegated to conduct all pharmaceutical reviews on behalf of American Health Plans. American Health Plans oversees and monitors that the PBM is conducting the reviews in accordance with American Health Plans contractual requirements.

V. Claims: Billing, Reimbursement

Providers should bill American Health Plans rather than Medicare of a Medicare Supplement carrier. Providers should bill all Medicare-covered services in accordance with Medicare and CMS rules, standards, and guidelines applicable to Parts A and B. In addition, providers should use applicable CMS billing forms (i.e., UB- 04/CMS1450, CMS1500, or such successor forms) and follow the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers.

Diagnosis codes should be billed to the highest level of specificity. The following information should be included on claims:

- National Provider Identifier
- The Member's identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.) Providers who are paid based on interim rates should include along with the claim a copy of the current interim rate letter.

Billing questions and/or problems should be directed to the Provider Help Desk at the number listed in the key contacts section of this Manual.

Filing a Claim for Payment

Electronic Submissions

Filing claims electronically reduces administrative costs, speeds claims payment, and improves payment accuracy. Please see all claims submission information, including the EDI Payor ID and Clearinghouse Help Desk phone number in the market specific Key Contacts section of this Manual.

Paper Submissions

Providers who prefer to submit claims by mail should send them to the address included in the claims submission information in the Key Contacts section of this Manual.

Filing Timelines

Requirements for the timely filing of claims for payment are included in your Provider Participation Agreement and are determined by the date of service. Please refer to your Agreement. For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, not the date treatment begins or the patient is admitted for care.

Key Points to Consider When Filing Claims

- Do not bill the Medicare carrier or fiscal intermediary. Doing so will delay payment and Medicare will not process the claim.
- Providers must include their NPI number on all claims.
- Durable Medical Equipment suppliers must use a 10-digit DME Medicare supplier number.
- Laboratories must use their 10-digit CLIA number.
- Providers should submit claims to American Health Plans as soon as possible after the service is rendered.
- Submit claims using the same coding rules as original Medicare and use only Medicare-approved CPT codes and defined modifiers.
- Bill diagnosis codes to the highest specificity.

Claims Payment

American Health Plans complies with Medicare's prompt payment of claims requirements for all Clean Claims. Claims must be submitted within the time frame specified in the Provider Participation Agreement

Clean vs. Unclean Claims

American Health Plans processes and pays all error-free claims, known as "clean claims", for covered services provided to a Member within 30 calendar days of receipt by the plan, or as required by applicable federal law. If a clean claim is not paid within the 30-day time frame, American Health Plans will pay interest on the claim according to Medicare guidelines.

Under CMS guidelines, a "clean" claim ("Clean Claim") is a claim with no defects or improprieties.

An "unclean" claim may include:

- Lack of required substantiating documentation.
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
- Any required fields where information is missing or incomplete.
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)
- A missing Explanation of Benefits (EOB) for a Member with other coverage

American Health Plans will process all non-clean claims and notify Providers of the determination within 60 days of receiving such claims.

National Provider Identifier

All healthcare Providers should have a National Provider Identifier (NPI). The NPI replaces legacy identifiers such as the Unique Physician Identification Number or UPIN.

The purpose of the NPI is to uniquely identify a healthcare Provider in standard transactions, such as healthcare claims. The NPI may also be used to identify healthcare Providers on prescriptions, in internal files to link proprietary Provider identification numbers, in coordination of benefits between health plans, inpatient medical record systems and in program integrity files. The NPI is the only healthcare Provider identifier that can be used for identification purposes in such transactions.

Reimbursement – Hospitals

For certain Medicare-approved providers, American Health Plans pays as follows:

- Eligible hospitals are reimbursed according to CMS IPPS DRG reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under original Medicare based on rates published on the CMS website (CMS.gov). The payment is added to the Inpatient Prospective Payment System (IPPS). However, because Fiscal Intermediaries are responsible for operating IME and DGME, American Health Plans does not reimburse those components of the DRG.
- American Health Plans reimburses qualifying Disproportionate Share Hospitals the same capital exception payments and add-on payments for operating DSH that they would have received under original Medicare. The payment is added to the Prospective Payment System (PPS) rate. American Health Plans reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.
- American Health Plans does not reimburse facilities for bad debt incurred as a result of Members not paying their cost-sharing amounts (if any), unless specified in a Provider's contract.
- American Health Plans does not enter into the annual cost settlement process with Providers, contracted or non-contracted. Providers who have treated American Health Plans Members should contact Medicare or their Fiscal Intermediary regarding their cost settlements.

Billing for Non-Covered Services

Providers may not bill a Member if American Health Plans denies payment because the service was not covered, unless:

- The provider has informed the Member in advance that the services may not be covered by providing an Advance Beneficiary Notice (ABN), and
- The Member has agreed, in writing, to pay for the services.

For those Members who are Dual-Eligibles, Providers should bill Medicaid for relevant Services that may be covered by the Medicaid program. Please also refer to the section Balance Billing Provisions.

Balance Billing Provisions

A Provider may collect only applicable plan cost-sharing amounts from American Health Plans Members and may not otherwise charge or bill Members. Balance billing is prohibited by Providers who furnish plan-covered services to American Health Plans Members.

Per CMS guidance, Billing Prohibition for Qualified Medicare Beneficiaries (QMBs):
All original Medicare and Medicare Advantage Providers and Suppliers – not only those that accept Medicaid – cannot charge QMBs for Medicare cost sharing for Covered Parts A and B Services. (Note: QMBs cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay.)

- Medicare Remittance Advice notices clearly indicate if a beneficiary is a QMB and show the beneficiary's deductible, copayment, and coinsurance cost-sharing is zero.
- If a provider bills a QMB for Medicare cost-sharing, or turns a bill over to collections, the provider must recall it. If the provider collects any cost-sharing money from a QMB the provider must refund it.
- A provider may be subject to sanctions if it bills a QMB for amounts above the total of all Medicare and Medicaid payments (even when Medicaid does not fully pay the Medicare cost-sharing).

Additional Billing Requirements for Dually Eligible Beneficiaries:
Special instructions apply when a provider issues an Advance Beneficiary Notice (ABN) to a dually eligible beneficiary, based on the expectation that the Plan will deny the item or service because it is not medically reasonable and necessary or constitutes custodial care.

- The provider cannot bill the dually eligible beneficiary when the ABN is furnished.
- Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances.
- If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy
- If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any State laws that limit beneficiary liability.

For more information, see the Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program MLN Matters® article on the Medicare website. Also see the ABN Form and Instructions available on the Medicare website.

Provider Explanation of Payment (EOP)

American Health Plans issues Provider Explanation of Payment once it has received and paid a claim.

Questions regarding the EOP may be addressed to American Health Plans at the Provider Help Desk from 8 AM to 5 PM (local time zone), Monday-Friday (except holidays). Please see the Key Contacts Section of this manual for the toll-free phone number for the Provider Help Desk.

When calling, Providers should have the following information available for the representative:

- Provider's National Provider Identifier (NPI)
- Claim number in question
- Member's name, date of birth, and Member's ID number
- Date of service
- Issue requiring review
- Copy of claim (or electronic transmission information)

Coordination of Benefits

If a Member has primary coverage with another plan, Providers should submit a claim for payment to the primary plan first. The amount payable by American Health Plans will be governed by the amount paid by the primary plan and the coordination of benefits policies.

In order to bill the correct payer, the Provider must obtain all the information that determines whether the Member is covered. The Provider must include all this information on the claim form to facilitate the correct adjudication.

For a Provider who accepts Medicaid and who treats an American Health Plans Member who is a Medicaid patient, American Health Plans will pay the Medicare portion of the claim. The Provider must then submit the claim to the appropriate state Medicaid entity for the Medicaid portion of the claim. The following types of situations, not an exhaustive list, will prevent payment by American Health Plans as the primary payer:

- Elderly Workers Employed Group Health Plan (EGHP): These Members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse's age is not material to the determination of primary coverage, only the qualification of the EGHP.
- Disabled Beneficiaries Employer Group Health Plans: These Members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member's employment. LGHP is defined by at least one of the employers having at least 100 employees.
- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either respiratory or pulmonary diseases. American Health Advantage of Texas is the primary payer for all other care and service needs.
- Workers' Compensation: The Workers' Compensation carrier is responsible for all injuries and illnesses that result from employment. American Health Advantage of Texas pays only when the Workers' Compensation benefits are exhausted or the services/care were not covered by the Workers' Compensation carrier but are Medicare benefits.
- Veterans Administration Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. American Health Advantage of Texas may supplement VA payment when the Member files a claim for Part B services that were not fully reimbursable by the VA.

Provider Payment Dispute Resolution Process

If a Provider believes a Clean Claim should have been paid differently, the Provider has the right to dispute the payment. Providers must address official disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments or the amount of the claim) in writing. Providers may direct any questions to the Provider Help Desk at the market specific phone number listed in the Key Contacts section of this Manual.

To file an official payment dispute, the Provider should

- submit a **Provider Dispute Resolution Request form** along with any supporting documentation. The form can be found on the market specific website listed in the Key Contacts section of this Manual on the Provider and Partners page resources section.
- include a cover sheet outlining the reason for the requested review along with the claim and Provider Explanation of Payment (EOP). American Health Plans will respond to all written disputes regarding claims within 30 business days.

If American Health Plans agrees with the reason for the payment dispute, American Health Plans will issue an Explanation of Payment (EOP) and pay any additional amount due, including any interest due.

American Health Plans will inform the Provider in writing if the decision is unfavorable and no additional amount is owed, as well as supply information regarding the provider's appeal rights.

Claims must be disputed within one-hundred twenty (120) days from the initial American Health Plans payment date/denial date.

VI. Quality Improvement (QI)

The American Health Plans approach to quality improvement is built on a model that involves the entire organization and related operational processes. The American Health Plans QI program provides oversight, direction, and support as well as implements structures and processes to measure and improve quality of care and services throughout the organization. The QI program incorporates information from all American Health Plans departments and encourages providers to participate in our QI initiatives.

American Health Plans' Quality Improvement model employs a cycle of continuous improvement and a "Plan-Do- Study-Act" (PDSA) methodology. Opportunities for improvement are identified through qualitative and quantitative reviews of member care and services.

Quality Improvement is a shared responsibility between American Health Plans and its participating providers and other delegated entities. The QI department oversees and assists with many of the activities that support continuous quality improvement, including:

- Reviewing processes to identify quality improvement needs
- Organizing work groups and committees, such as the Clinical Quality Improvement Committee
- Identifying best practices

- Developing and implementing improvement initiatives
- Collecting data to evaluate the results of the activities and initiatives

Member satisfaction and quality of care/quality of service issues are evaluated and reviewed on a regular basis using the PDSA Methodology. The CMS Star program results and the Quality Reporting Metrics serve as ongoing indicators for the Quality Improvement Work Plan. Participation in the collection, review, and submission of CMS Star quality rating system performance data is one means by which American Health Plans evaluates the quality of Member Services, care and satisfaction.

In addition, American Health Plans is a full participant in CMS-required activities, including but not limited to the Chronic Care Improvement Program (CCIP), and also initiatives related to the reducing the incidence of All-Cause Readmissions to an Acute Care Setting within 30 days.

HEDIS and CAHPS are sets of measurements developed and defined by the National Committee for Quality Assurance (NCQA) as a basis for comparing quality, resource utilization and Member satisfaction across health plans. Examples of these metrics include but are not limited to medication adherence measures, preventive screening rates, positive member satisfaction survey responses, vaccination rates, customer service call center average time-to- answer and network adequacy against CMS time and distance standard

VII. Medicare Risk Adjustment

Risk adjustment is the process by which CMS reimburses Medicare Advantage Plans based on the member age, gender and health statuses throughout the plan year. (American Health Plans is contracted with CMS to offer our Medicare Advantage ISNP plan). The risk of the member is determined by the ICD-10 diagnosis codes included on the encounters and claims submitted to American Health Plans and passed on to CMS.

Physician/Provider Roles

The Physician’s role in this process is to submit encounter records and claims and supporting documentation that are clear, concise, consistent, complete and legible. All ICD-10 diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim. To that end, an increased emphasis is being placed by American Health Plans on physician/provider education and recommendations related to HCCs, ICD-10 diagnoses and documentation regulations. The CMS-HCC model relies on ICD-10-CM coding specificity.

- To comply with risk adjustment guidelines, specific ICD-10-CM codes are required.
- Medical records must support all diagnosis/conditions coded on the claims and encounters you submit using clear, complete and specific language.
- Code all conditions that co-exist at the time of the Member visit and require or affect Member care, treatment or management.
- Never use a diagnosis code for a “probable” or “questionable” diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify if conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the Member’s condition and pertinent history at the time of

the visit. *Do not code conditions that no longer exist.*

- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the Member's condition.
- Check the diagnosis code against the Member's gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted for risk adjustment consideration are subject to federal and/or American Health Plans internal audit. Audits may come from CMS, HHS, or American Health Plans may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please submit any requested medical records quickly and provide all available medical documentation for the services rendered to the Member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

How Does Risk Adjustment Impact Physicians and Members?

Increased coding accuracy helps American Health Plans identify patients who may benefit from disease and medical management programs. More accurate health status information can be used to match health care needs with the appropriate level of care. Risk adjustment helps meet the CMS physician responsibilities when reporting ICD-10-CM codes, including:

- Primary diagnoses, to the highest level of specificity
- Secondary diagnoses, to the highest level of specificity
- Maintaining accurate and complete medical records (ICD-10-CM codes must be submitted with proper documentation)
- Reporting claims and encounter data in a timely manner

Why is Medical Record Documentation Important for Risk Adjustment?

- Accurate risk adjusted payment relies on complete medical record documentation and diagnosis coding
- CMS conducts risk adjustment data validation by medical record review
- Specificity of the ICD-10-CM diagnosis coding is substantiated by the medical record

Medical Record Documentation

- Documentation should be clear, concise, consistent, complete and legible.
- Document coexisting conditions at least annually.
- Use standard abbreviations.
- Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-10-CM code on the date of service, and are signed and dated by the physician or physician extender).
- Identify patient and date on each page of the record.
- Authenticate the record with signature and credentials.

Requests for Medical Records

American Health Plans continually conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding. In addition, if CMS conducts an annual Data Validation Audit on the Medicare Advantage Health Plan, you will be required to assist us by providing medical record documentation for members included in the audit.

The collection of risk adjustment data and requests for medical records to validate payment made to Medicare Advantage organizations is considered a health care operation and does not violate the privacy provisions of HIPAA (CFR 164.502).

Frequently Asked Questions regarding Medicare Risk Adjustment

Q: *How often does the diagnosis have to appear to be counted for risk adjustment?*
A: The diagnosis has to appear at least once a calendar year.

Q: *Is a "typed" signature on a report acceptable for office consultation notes, a discharge summary and hospital consultations?*
A: No. The provider who dictated the report must sign it, regardless of the record type, and add his/her credentials. Electronic signatures are acceptable but must be accompanied by such words as "electronically signed by," "authenticated by" or "signed by."

Q: *Are medical records containing dictated progress notes that are dated but not signed acceptable for medical review?*
A: No. Medical record documentation should be signed and dated by the physician.

Q: *If providers submit an unsigned medical record, will American Health Plans return the record to the provider for a signature?*
A: Yes, as long as it is within 30 days. Otherwise, providers must submit a new medical record with the provider's signature to substantiate the HCC.

Q: *Can a pathology report alone substantiate a risk adjustment assignment?*
A: No. Pathology and other laboratory reports simply present the actual results and generally do not have a documented diagnosis and the physician's signature. However, if such a report is signed by an M.D., has a final diagnosis and can be tied back to the actual visit, then it can be used as a coding source.

Q: *Can a radiology report alone substantiate a risk adjustment assignment?*
A: Radiology is not an acceptable source to report diagnoses for risk adjustment because it generally does not have a documented diagnosis but instead provides an impression of the findings.

Q: *Many providers use (ICD-10-CM code 125.2) if the only documentation of an old myocardial infarction (MI) is an EKG report?*
A: No. The EKG report cannot be used as a source until the procedure has been interpreted and documented in the medical record.

Q: *How often should providers document chronic conditions, such as an old myocardial infarction (MI)?*
A: Yearly, or as often as the diagnosis factors into the medical decision making.

Helpful CMS Webpages for Coding

- Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
- Medicare Billing: 837P and Form CMS-1500: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS- 1500.pdf
- Medicare Billing: 837I and Form CMS-1450: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pd

VIII.Pharmacy – Part D Services

The American Health Plans Pharmacy Department manages the administration of pharmacy benefits. The American Health Plans clinical pharmacist and team members are available to answer any formulary and/or medication-related questions. You can contact the American Health Plans pharmacy team via email at: pharmacysupport@AmHealthPlans.com.

American Health Plans partners with Elixir, a Prescription Benefits Manager (PBM) to administer the prescription programs for American Health Plans Members.

The American Health Plans formulary as well as coverage determination and prior authorization forms may be found by going online to the market specific website listed in the Key Contacts section of this Manual or to elixirsolutions.promptpa.com.

Pharmacy Policies

Generics
All formularies include the concept of generic medications as the preferred use medication.

Formulary
Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for American Health Plans. Some covered drugs may have additional requirements or limits on coverage. These requirements and limits include prior authorizations, quantity limits, and/or step therapy.

- To request coverage for a drug that has additional requirements call the Pharmacy Technical Help Desk at the phone number listed in the Key Contacts Section of the beginning of this manual.

Excluded Medications

Medicare has excluded certain medication classes from coverage by Part D Medicare programs.

- Medications used for erectile dysfunction
- Medications used for anorexia, weight loss or weight gain
- Medications used for cosmetic purposes or hair growth
- Medications used to promote fertility
- Medications used for the symptomatic relief of cough or colds
- Nonprescription medications – Medications that, by federal law, do not require a prescription
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Alert—No Appeal for Excluded Medications

Medications falling into the categories listed above cannot be covered even for medical necessity. The decision of non-coverage cannot be appealed, nor can exceptions be made to allow for coverage.

Discontinuing, Changing or Reducing Coverage

Generally, if an American Health Plans Member is taking a formulary drug that was covered at the beginning of the year, American Health Plans will continue coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or when adverse information about the safety or effectiveness of a drug is released.

Other types of formulary changes, such as removing a drug from the formulary, will not affect Members currently taking the drug and will remain available at the same cost sharing for the remainder of the coverage year.

Notification of Formulary Changes

If American Health Plans removes drugs from the formulary; adds coverage determinations, such as prior authorizations, quantity limits, and/or step therapy restrictions on a drug; or moves a drug to a higher cost-sharing tier, American Health Plans must notify affected Members and Providers of the change at least sixty (60) days before it becomes effective.

If the Food and Drug Administration deems a formulary drug to be unsafe or if the drug's manufacturer removes it from the market, American Health Plans will immediately remove the drug from the formulary and notify Members who take the drug.

Transition Policy

American Health Plans may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. American Health Plans may grant a temporary 30-day supply within the Member's first 90 days of coverage by American Health Plans, during which time the Provider should initiate the same coverage determination process outline previously.

Transition coverage also is available for residents of long- term care facilities or Members whose medications are affected by a level-of-care change (e.g., discharge from an acute setting or admission to/discharge from a long-term care facility).

Pharmacy Network

Participating pharmacies include retail pharmacies, pharmacies that serve long-term care facilities, specialty pharmacies (home infusion pharmacies) and pharmacies owned by Indian tribal councils.

Members must fill all medications at network pharmacies for coverage at the lowest out-of- pocket cost. Members who use non-participating pharmacies may pay higher out-of-pocket costs and must submit receipts for reimbursement.

Mail-order Services

American Health Plans does not offer mail-order services to our Members.

IX. Medicare Advantage and Part D Fraud, Waste and Abuse

Fraud, Waste and Abuse

Healthcare fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any healthcare benefit program.

Healthcare waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Healthcare abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Medical Identity Theft

Medical identity thieves may use a person’s name and personal health information, such as their health insurance number, to make doctor’s appointments, obtain prescription drugs, and file claims with Medicare Advantage Plans. This may affect the person’s health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

To limit the number of alleged incidents of medical identity theft involving Members, Provider claim personnel should verify Member account numbers when filing medical claims for processing.

Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse (FWA) may be reported anonymously 24 hours a day / 7 days a week to the American Health Plans Compliance Department at

Compliance Hotline (866) 205-2866

You may also report suspected fraud, waste and abuse by regular mail or email by writing to:

American Health Plans
ATTN: Compliance/FWA Report
201 Jordan Road, Suite 200
Franklin, TN 37067
Compliance@AmHealthPlans.com

Additional information is available and phone numbers are available below.
U.S. Office of Inspector General
Hotline: 1-800-447-8477
TTY: 1-800-377-4950
Website: oig.hhs.gov/report-fraud/index.asp

Medicare Customer Service Center
Hotline: 1-800-633-4227
TTY: 1-877-486-2048
Website: medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud

X. Medicare Improvements for Patients and Providers Act (MIPPA)

Rules Related to Marketing Medicare Advantage Plans

Effective January 1, 2009, the Medicare Improvements for Patients and Providers Act (MIPPA) imposed prohibitions on certain sales and marketing activities under Medicare Advantage (MA) and Medicare Advantage-Prescription Drug (MA-PD) plans. Such activities include door-to-door sales, cold calling, free meals and cross-selling of non- health-related products. These prohibited activities also include specific marketing activities in a healthcare setting by a plan sponsor or by providers with which the plan sponsor has a relationship, contracted or otherwise.

In general:

- Doctors and office staff may not encourage patients to enroll in the plan in any way; doing so is considered “steering.”
- CMS draws no distinction between exclusive and non-exclusive groups when it comes to regulations on steering.
- Providers may make available to their patients information for all plans with which they are affiliated, including common area availability for health plan events and CMS-approved marketing materials.

Providers may:

- Provide the names of plan sponsors with which they contract and/or participate (See Medicare Communications and Marketing Guidelines for additional information on provider affiliation).
- Provide information and assistance in applying for the Low-Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials.
- Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their State Medicaid Office, local Social Security Office, and CMS' website at http://www.medicare.gov or **1-800-MEDICARE**.
- Share information with patients from CMS' website, including the "Medicare & You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov) or other documents written by or previously approved by CMS.
- Providers must remain neutral when assisting with enrollment decisions and may not:
    1) Offer scope of appointment forms.
    2) Accept Medicare enrollment applications.
    3) Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
    4) Mail marketing materials on behalf of plan sponsors.
    5) Offer anything of value to induce plan Members to select them as their provider.
    6) Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
    7) Conduct health screening as a marketing activity.
    8) Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
    9) Distribute materials/applications within an exam room setting.

Plan Affiliations

Providers may:

- Release the names of plans with which they are affiliated.
- Announce plan affiliations through general advertising, including but not limited to direct mail, email, telephone, or advertisement.
- Display affiliation banners, brochures and/or posters for all plans that have provided such materials and with which the provider is affiliated.

Providers should not:

- Make phone calls, direct, urge, offer inducements or attempt to persuade any prospective Medicare member to enroll in a plan.
- Suggest that a plan is approved, endorsed or authorized by Medicare.

Plan Benefits

Providers should not compare plan benefits against other health plans, unless the materials were written or approved by CMS (for example, information generated through Medicare Plan Finder via a computer terminal for access by beneficiaries).

Contact Information

When requested, Providers may provide American Health Plans' contact information to a prospective enrollee so that the enrollee may contact American Health Plans directly regarding an expressed interest in enrolling in a plan in which the Provider participates.

However, for marketing purposes, Providers shall not release a prospective enrollee's contact information to American Health Plans or an agent unless the beneficiary approves and/or requests that American Health Plans contact him or her.

Sales Presentations

Providers may allow health plans or plan agents to conduct sales presentations and to distribute and accept enrollment applications in their offices as long as the activity takes place in the "common areas" and patients are not misled or pressured into participating in such activities. ("Common areas" where marketing activities are allowed would include areas such as a hospital, nursing home or other health provider cafeteria, community or recreational rooms and conference rooms.)

Providers must not allow health plans to conduct sales presentations and distribute and/or accept enrollment applications in areas where patients primarily receive healthcare services. (These areas generally include but are not limited to: waiting rooms, exam rooms, hospital patient rooms and pharmacy counter areas.)

Marketing Materials

Providers may make available marketing materials about American Health Plans and inform beneficiaries where they can obtain information on all available options within the service area (e.g., **1-800- MEDICARE** or www.medicare.gov). If Providers choose to allow information for one plan, they must allow other plans affiliated with that Provider to do the same.

Providers must not make available sales or MA plan promotional materials that are not CMS- Approved (CMS-approved material has a footer in the lower right corner with a Material ID assigned by the plan), nor should they mail marketing materials (e.g., enrollment kits) on behalf of plans with which they participate.

Distributing Information

Providers may distribute CMS-approved "Plan Finder" information. They may print out and share such information from the Medicare.gov website with their patients.

Providers must not perform health screening when distributing American Health Plans information to patients. This is prohibited under MIPPA. Providers are encouraged to participate in educational events, including health fairs. However, they must not engage in marketing activities at such events.

Providers must not accept enrollment applications from beneficiaries or offer scope of appointment forms to beneficiaries.

Providers must not expect or accept compensation, directly or indirectly, in consideration for the enrollment of a beneficiary or for enrollment or marketing activities.

Questions should be directed to the Provider Help Desk at the market specific number listed in the Key Contacts section of this Manual.

XI. Legal and Compliance

Overview

A sound Medicare Advantage corporate governance program requires adherence with legislation, regulation and general good practice. Compliance itself is the demonstrable evidence of an entity to meet prescribed standards and be able to maintain a history of meeting those standards, which form the requirements of an established compliance structure.

A Compliance Program provides a framework from which the organization can assess its compliance with applicable State and Federal regulations and established organizational policies and procedures.

In this section, Legal and Compliance refers to State and Federal regulations as well as Federal laws governing the Health Information Portability & Accountability Act (HIPAA), the protection and security of a Member's Protected Health Information (PHI) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The Compliance Program

American Health Plans has established a comprehensive Compliance Program and is committed to ensuring that all organizational areas are, and remain, compliant with applicable State and Federal regulatory requirements. The Compliance Program is an organizational value-based system that will identify, detect, prevent, correct and report suspected non-compliance with State and Federal regulatory requirements. American Health Plans works collaboratively with State and Federal regulatory agencies to achieve the mutual goals of providing quality healthcare and the effective elimination of fraud, waste and abuse.

American Health Plans designed the Compliance Program and all efforts surrounding this program to establish a culture that promotes prevention, detection and resolution of conduct that may not conform to State and Federal laws, including Federal healthcare program requirements as well as American Health Plans ethical and legal policies and standards of conduct.

In practice, the Compliance Program and the Code of Conduct and Business Ethics effectively articulate and demonstrate American Health Pans' commitment to legal and ethical conduct.

Responsibilities

The Compliance Program has responsibilities in three functional areas:

- Medicare Advantage Operational Compliance;
- Monitoring & Delegated Entity Oversight (MDO) and
- Compliance – Sales Oversight (CSO)

The following three sections detail of each area of responsibility.

Medicare Advantage Compliance Operational Oversight

This functional area includes:

- Managing regulatory affairs
- Distributing and providing guidance regarding interpretation of CMS Health Plan Management System (HPMS) released policy and other regulatory updates
- Ensuring operational and technical compliance across all operations and clinical areas via internal monitoring and audits and open lines of communications
- Enforcing disciplinary and corrective actions for compliance violations and deficiencies
- Ensuring the development and maintenance of operational and corporate policies and procedures
- Building and maintaining relationships with CMS
- Managing the review and approval of all collateral materials including sales and marketing as well as all Member, Agent and Provider materials.

Compliance Monitoring & Delegation Oversight

This functional area includes:

- Annual and routine monitoring of the activities of delegated entities and the various Business and Operational Areas
- Assignment and oversight of the Corrective Action Plan process
- Validation of the timely implementation of regulatory mandates which may impact current processes and protocols
- Annual Risk Assessment
- Ensuring the appropriate and timely management of activities to prevent, detect and correct fraud, waste and abuse
- Providing oversight for the Health Information Portability and Accountability Act (HIPAA)

Compliance Sales & Marketing Oversight

This functional area includes:

- Investigating allegations of agent misconduct
- Ensuring appropriate Agent training and certification
- Market Event Surveillance activities (i.e. event secret shopping)
- The Compliant registration of agent marketing/sales events upon CMS' request
- Ongoing review and processing of the HPMS Complaints Tracking Module
- Agent Quality, including, but not limited to, Agent verification call monitoring, telephonic scope of appointment monitoring, monitoring applications for timeliness, etc.
- Ongoing auditing and monitoring of all Agent activities within the service area as well as oversight of sales support, which includes sales training, Agent contracting, Agent commissions and sales quality.

XII. Federal and State Regulations

Overview

There are a number of Federal Regulations that affect American Health Plans day-to- day operations. These regulations set the benchmarks by which American Health Plans reviews all internal business and operational processes as well as external business initiatives and relationships.

These regulations include, but are not limited to:

- The Health Information Portability & Accountability Act (HIPAA)
- The Medicare Improvements for Patients and Providers Act (MIPPA)
- The False Claims Act and Fraud Enforcement Recovery Act
- Physician Self-Referral Law (Stark Law)
- Anti-Kickback Statute
- Fraud, Waste and Abuse
- The HITECH Act

Health Information Portability & Accountability Act (HIPAA)

Congress introduced this act in 1996 to protect health insurance coverage for workers and their families when they change or lose their jobs. It also requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and employers; and helps people keep their information private.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well- being.

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the “covered entities”).

Medicare Improvements for Patients and Providers Act (MIPPA)

Congress introduced this act in 2008 to enhance the quality of healthcare, expand access to care and provide coverage for certain preventative services. MIPPA is addressed in more detail in a prior section of this Manual.

False Claims Act and Fraud Enforcement Recovery Act

The federal False Claims Act (31 U.S.C. Sections 3729-33) is aimed at preventing fraud against the government, including fraudulent billing and fraudulent submission of claims or statements to any Federal healthcare program. The False Claims Act (FCA) applies when a false claim for reimbursement is submitted for payment to a government program and the provider knew or should have known that the information or certification of the claims was false. The federal FCA and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are knows as a “qui tam” plaintiff or, “whistleblower”. The federal FCA prohibits retaliation against an employee for investigating, filing or participating in a whistleblower action.

Congress strengthened and broadened the scope of the False Claims Act by passing the Fraud Enforcement and Recovery Act (FERA) of 2009. FERA extends the liability for False Claims Act violations to claims not directly submitted to the government (e.g., the False Claims Act attaches for false claims presented to Medicare Advantage plans). FERA strengthened whistleblower protection, relaxed the standard for False Claims Act violations, and made retention of overpayments made to a provider a violation of the False Claims Act.

Physician Self-Referral Law (Stark Law)

Congressional concern with the implications of self-referral arrangements led to the inclusion in the Omnibus Budget Reconciliation Act of 1989 (“OBRA 1989”) of a provision barring self- referral arrangements for clinical laboratory services under the Medicare program.

The Omnibus Budget Reconciliation Act of 1993 (“OBRA 1993”), known as “Stark II,” extended the ban, effective January 1, 1995, to an additional list of services and applied it to Medicaid at the same time. CMS has issued a series of implementing regulations. CMS issued “Phase III” of the final regulations September 5, 2007.

“Self-referrals” occur when physicians refer patients to for services in which they (directly or indirectly) have a financial interest. This interest can be in the form of ownership or investment interest in the entity; it may also be a compensation arrangement between the physician and the entity.

In September 2010, CMS published the Medicare Self-Referral Disclosure Protocol ("SDRP") which sets forth a process to enable providers to self-disclose actual or potential violations of the Stark Law. For further information on SDRP, please use the email 1877CallCenter@cms.hhs.gov or call **410-786-4568.**

Anti-Kickback Statute

American Health Plans is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, American Health Plans must ensure that all Providers adhere to the Federal Anti-Kickback Statute and state equivalents (the "Anti-Kickback Policy"), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties such as being debarred from participation in federal programs.

Discounts, rebates or other reductions in price may violate the Anti-Kickback Statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

In order to be permissible, an activity that implicates the Anti-Kickback Statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute. (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

Fraud, Waste and Abuse

Congress enacted Fraud, Waste, and Abuse in 2007 as part of the Deficit Reduction Act (DRA) of 2005. This act requires entities to establish written policies providing detailed information about fraud, waste and abuse in Federal healthcare programs and to distribute these policies to employees, agents and contractors.

The HITECH Act

The American Recovery and Reinvestment Act (ARRA) was signed into law on February 17, 2009. Among many other things, the ARRA dedicates substantial resources to health information technology that supports the secure electronic exchange and use of health information.

Title XIII of Division A and Title IV of Division B of the Act are referred to as the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The HITECH Act includes a number of measures designed to broaden the scope and increase the rigor of HIPAA compliance. The HITECH Act expands the reach of HIPAA data privacy and security requirements to include the

Business Associates of those entities (healthcare providers, pharmacies, and the like) that are subject to HIPAA. Business Associates are companies such as accounting firms, billing agencies, law firms or others that provide services to entities covered under HIPAA.

Under the HITECH Act, companies are now directly subject to HIPAA security and privacy requirements as well as to the same civil and criminal penalties that hospitals, pharmacies and other HIPAA-covered entities face for violations. Before HITECH came into force, Business Associates that failed to properly protect patient information were liable to the covered entities via their service contracts, but they did not face governmental penalties.

The HITECH Act specifies that Business Associates will be subject to the same civil and criminal penalties previously imposed only on covered entities. As amended by the HITECH Act, civil penalties range from $100 to $50,000 per violation with caps of $25,000 to $1.5 million for all violations of a single requirement in a calendar year. Criminal penalties include fines up to $50,000 and imprisonment for up to one year. In some instances, fines are mandatory.

State Regulations

Many state regulations also have an impact on American Health Plans day- to-day operations. Many of these regulations relate to Medicaid and/or relationships existing between governmental entities and American Health Plans.

In addition, many states now have enforceable regulations related to HIPAA, the False Claims Act and Patient Anti-Brokering or Anti-Referral Acts, which mirror the Federal regulations and, rather than being pre-emptive, are in addition to the Federal mandates under which American Health Plans operates.

To address these regulations on a state-by-state basis would be too voluminous to include in this provider manual. However, American Health Plans Compliance Department is always available to Providers to discuss any concerns or questions regarding the applicability of state regulations to our relationship with Providers.

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