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¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).  
² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
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Welcome

We would like to thank you for choosing to participate in Preferred Care Partners’ network. Preferred Care Partners is committed to improving the health of our members through a managed care environment that provides access to quality healthcare services, resulting in better outcomes and general health status.

This manual should serve as a key resource for you and your staff in understanding our plans, our policies and procedures, and the responsibilities of our network of healthcare professionals. It is recommended that you and your staff read this manual and refer to it as necessary.

Our Network Management Services representatives are available to assist you and your staff in understanding the policies, procedures and information contained in this manual. We can be reached toll-free at: (877) 670-8432. We value your feedback and want to hear from you.

We look forward to a long and productive relationship with you and your staff. Thank you again for choosing Preferred Care Partners.

Sincerely,

Orlando Lopez-Fernandez, Jr., M.D
Introduction

About Preferred Care Partners
Preferred Care Partners, Inc (PCP), a wholly owned subsidiary of UnitedHealthcare (UHC), is a Medicare Advantage health plan. PCP offers Medicare Advantage plans in 12 counties: Broward, Hernando, Hillsborough, Manatee, Miami-Dade, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, and Volusia.

PCP is committed to delivering quality health care services to its members and quality customer service to its providers. Our mission is to provide members with affordable health care choices to meet their health care needs. A key element of choice is helping customers obtain the information they need to make informed choices and to understand the health and financial impact of those decisions. PCP currently offers a full range of Medicare Advantage health care coverage choices to our members.

Mission Statement
Our primary mission is to improve the health of our members by providing ready access to health care services, choices regarding their health care needs, and simplification of the health care delivery system. To provide the best experience and eliminate unnecessary barriers for our members and providers, we strive to streamline authorization and referral processes and to build our provider networks around the diverse needs of our members. We are committed to providing members with direct, immediate access to knowledgeable customer service representatives who understand their needs and can help them make informed choices.

Non-Discrimination
You must not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a member of PCP, or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any members in need of the services you provide.

Using This Manual
The 2015 Provider Manual (this “Manual”) applies to covered services you provide to members under a PCP benefit plan insured by UnitedHealthcare. This manual is an extension of your provider agreement. Except when indicated, this Manual is effective on January 1, 2015 for physicians, health care professionals, facilities and ancillary providers currently participating in the PCP network and effective immediately for physicians, healthcare professionals, facilities and ancillary providers who join the PCP network on or after January 1, 2015.

Terms used in this Manual include the following:

- “Member” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement with us.
- “You”, “your”, or “provider” refers to any provider subject to this Manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated all items are applicable to all types of providers subject to this Manual.
Introduction

- “The Plan,” “our,” “us,” or “we,” refers to PCP.

In the event of a conflict or inconsistency between your agreement with us and this Manual, the provisions of your agreement with us will control. This entire Manual is subject to change. The most recent version of the Manual is available on our provider website, at www.mypreferredprovider.com. Alternatively, you may request a copy of this Manual from Network Management Services (NMS) via toll-free fax, at (888) 659-0619.

Questions or Comments

Questions or comments about this Manual should be emailed to NMS at NMS@UHCsouthflorida.com, or submitted by mail to:

Preferred Care Partners
Network Management Services
9100 South Dadeland Blvd.
Suite 1250
Miami, FL 33156-6420
Section 1: Contact & Administrative Information

Important Contact Information

Notifications/Authorizations  (800) 995-0480
For notifications, prior authorizations, referrals, admissions, and discharge planning, call our Utilization Management department at the toll-free number listed above, Monday through Friday, 9:00 a.m. to 5:00 p.m. or fax us toll-free at (866) 567-0144. For after-hour or weekend emergencies, notifications or hospital admissions, please call the Plan’s after-hours telephonic answering service, 1-800-WEANSWER at (800) 995-0480 for assistance.

Claims  (866) 725-9334
For claims, encounters, inquiries, status, or review requests, please call our Claims department at the toll-free number listed above, Monday through Friday, 8:00 a.m. to 5:00 p.m., or fax us toll-free at (866) 725-9337.

For questions related to the use of Emdeon’s claim submission network, such as password or technical support issues, call Emdeon toll-free at (800) 845-6592.

Pharmacy  (800) 591-6144
To verify pharmacy benefits and eligibility, adjudications, or authorizations, contact our Pharmacy department at the toll-free number listed above, Monday through Friday, 9:00 a.m. to 5:00 p.m., or fax us toll-free at (800) 203-1664. For more information see Pharmacy Benefits: Section 9.

Benefits and Eligibility Verification  (800) 587-5114
To verify eligibility and benefits, please call our Member Services department at the toll-free number listed above.

WellMed Medical Management, Inc.
WellMed Medical Management, Inc. (WellMed) is the medical management organization to whom the Plan has delegated the provision of specific Utilization Management and Claims services for Medicare Advantage members in the Preferred Secure Options, (HMO) H1045 PBP #023, in the following Central Florida counties: Hernando, Hillsborough, Manatee, Orange, Osceola, Pasco, Pinellas, Polk, Seminole and Volusia. Please refer to the members ID card, bottom right corner on the front of the ID card, for verification.

WellMed has assumed the administrative procedures for the Preferred Secure Options HMO members as outlined in the following sections: please refer to Section 5: Utilization Management and Section 12: Filing a Claim for required administrative protocols and important contact numbers for WellMed.
Additional Contact Information

Credentialing
(800) 963-6495
Call our Credentialing department toll-free Monday through Friday, 9:00 a.m. to 5:00 p.m., at the toll-free number listed above for issues regarding credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility.

If you prefer, you can fax us toll-free at (866) 567-0144.

Fraud, Waste and Abuse (FWA) Hotline
(866) 678-8822
Call our FWA Hotline toll-free Monday through Friday, 9:00 a.m. to 5:00 p.m., at the number listed above, to report any suspected fraudulent or abusive activity. If you prefer, you can e-mail us at ReportFraud@UHCsouthflorida.com, or write to:

Preferred Care Partners
Special Investigations Unit
P.O. Box 56-5748
Miami, FL 33256-5748

You can also contact us via the Fraud Hotline link on our provider website, www.mypreferredprovider.com.

Grievances & Appeals
(888) 291-5721
Contact our Grievance and Appeals department toll-free Monday through Friday, 9:00 a.m. to 5:00 p.m., at the number listed above for questions about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms. If you prefer, you may send a fax toll-free to (866) 261-1474, or mail documentation to:

Preferred Care Partners, Inc. Health Plan
Grievance & Appeals Department
P. O. Box 56-6420
Miami, FL 33256-6420

Healthcare Risk Management
(877) 778-4099
(954) 378-0478
Fax: (954) 378-0771

Member Incident Reporting
Report incidents involving members to the Plan’s Risk Manager by faxing the appropriate report form to the number listed above. For more information, refer to Healthcare Risk Management: Section 7.

Privacy Incident Reporting
Report incidents involving all privacy issues (potential breaches of PHI and/or PII) immediately to the Plan’s Risk Manager at the number listed above.
Member Services  (866) 231-7201
Member Line  TTY:  711
Member Services can assist our members with any questions, help locate specialists, and perform other related functions. This toll-free phone number is also printed on the member’s Plan ID card. Hours are Monday through Friday, 9:00 a.m. to 5:00 p.m. If you prefer you may sent a fax toll-free to (866) 567-0144.

Network Management Services  (877) 670-8432
Contact Network Management Services toll-free Monday through Friday, 9:00 a.m. to 5:00 p.m., at the number listed above for questions regarding provider agreements, in-servicing and follow-up/outreaches, demographic changes, informal complaints, and requests for forms or other materials. You may also send an e-mail to NMS@UHCSouthflorida.com, or fax us at (786) 888-1291.

Utilization Management  (800) 995-0480
We recommend that you initiate requests for notifications and authorizations electronically. (See Provider Services Online, below) If additional medical information is needed, or the request cannot be completed electronically, call Utilization Management (UM) Monday through Friday, 9:00 a.m. to 5:00 p.m., at the number listed above. You may also fax us toll-free at (866) 567-0144. UM staff is available to answer any of your questions or discuss any UM issue you may have and to assist with information regarding referrals, prior authorizations, case management, concurrent review, and admission certification / notification. For more information on Utilization Management, see Utilization Management: Section 5.

Ancillary and Enhanced-Benefit Providers
Certain health care services and other benefits are offered exclusively through specific networks and providers. Members must obtain these services and/or products from the providers listed on the following pages in order for the services or products to be covered.

Note that not all benefits are offered in all plans. If you are unsure, you can check benefits on our provider website, or call Member Services at (800) 587-5114 to verify benefits.

24-Hour Nurse Hotline  (866) 523-4728
Carenet
The toll-free 24-Hour Nurse Hotline is provided through Carenet. Working from the Carenet script, nurses are available to triage callers to emergency or urgent care, or to refer them to their primary care physician. NOTE: This benefit is only available under certain plans; contact Member Services to verify availability.

Acupuncture  (877) 670-8432
American Specialty Health
A list of American Specialty Health acupuncture providers is included in the Provider Directory. Note that this benefit is only available under some plans. To determine if acupuncture is covered for a particular member, contact Member Services. For other assistance with this program, contact
Network Management Services Monday through Friday, 9:00 a.m. to 5:00 p.m. at the toll-free number listed above.

**Behavioral Health Services**  
**Psychcare**  
Psychcare, Inc. (Psychcare) is the Managed Behavioral Health Organization (MBHO) to whom the Plan has delegated the provision of behavioral health and substance abuse services for all members.

Psychcare has licensed clinicians on call 24 hours a day, 7 days a week for triage and referral of emergent or urgently needed care. For routine outpatient services, Psychcare’s Member Services department is available 8:00 a.m. to 8:00 p.m. Monday through Friday. Call the toll free number listed above for Behavioral Health services.

A list of behavioral health practitioners and providers are included in the Provider Directory.

**Dental**  
**Solstice**  
A list of Solstice dental providers is included in the Provider Directory and on our website. For assistance with this program, contact Network Management Services toll-free Monday through Friday, 9:00 a.m. to 5:00 p.m. at the number listed above.

**DME, Home Health, Home Infusion**  
**All-Med Services of Florida**  
DME, home health, home infusion and similar medical supply items are provided by All-Med Services of Florida. Contact All-Med at the number listed above to arrange for these services. Hours of operation are Monday through Friday from 8:30 a.m. to 7:00 p.m. and Saturday from 8:30 a.m. to 5:30 p.m.

On Sundays staff members are on call and will respond within 15 minutes of notification.

For assistance with this service, contact Utilization Management Monday through Friday, 9:00 a.m. to 5:00 p.m., at (800) 995-0480, or fax us at (866) 567-0144.

If you should have additional questions, you may contact Network Management Services at (877) 670-8432 Monday through Friday, 9:00 a.m. to 5:00 p.m.

**Fitness**  
**Silver & Fit®**  
For information on this program, members can log onto the Silver & Fit website at [www.silverandfit.com](http://www.silverandfit.com) or they can call the toll-free number listed above, Monday through Friday, 8:00 a.m. to 9:00 p.m.
Hearing
Hear-X/HearUSA
For information on this program, contact Network Management Services Monday through Friday, 9:00 a.m. to 5:00 p.m., at the toll-free number shown above.

Laboratory
Quest Diagnostics
Contact Quest Diagnostics at the toll-free number listed above for information on locations, to make an appointment, and to order lab tests and view results. Or you may obtain this information by logging onto www.questdiagnostics.com. Quest Diagnostics will set up an account with your office and make arrangements to pick up specimens when necessary.

Pharmacy Mail Order
OptumRx
Members can obtain mail-order medications by contacting OptumRx at the toll-free number above, or by logging onto www.optumrx.com

Podiatry
Foot and Ankle Network
A list of podiatrists is included in the Provider Directory. For assistance with this program, contact Network Management Services Monday through Friday, 9:00 a.m. to 5:00 p.m. at the number listed above.

Transportation
For assistance with transportation, contact Member Services Monday through Friday, 9:00 a.m. to 5:00 p.m., at the number listed above.

Vision
UHC Vision a/k/a Spectera Eyecare Networks
A list of vision providers is included in the Provider Directory. For assistance with this service, contact Network Management Services Monday through Friday, 9:00 a.m. to 5:00 p.m.

Provider Services Online

Provider Website
Our provider website, www.mypreferredprovider.com, is an information resource to help you meet the healthcare needs of our members efficiently and effectively. The website has services that are available to the public and members and secure services accessible by participating providers. Public services include, but are not limited to the following:

Find a Drug
Search the most current version of our Formulary by drug category, tier, or name. A printable, PDF version of the entire Formulary may also be downloaded and printed.
Find a Pharmacy
Search the most current list of our in-network pharmacies by pharmacy name, location or zip code. You may also view, download, and print the entire list.

Find a Provider
Search for a provider by name, specialty, language, or location. You may also view, download and print the complete Provider Directory.

Provider Online Services
The secure services available to registered providers include but are not limited to the following:

- Verify a member’s eligibility, including plan benefits, deductibles, and information on the member’s primary care provider, as applicable.
- Submit, search for, and print authorizations for outpatient services or inpatient stays.
- Search for, view, and check the status of claims.
- Provider Resources, such as Fraud, Waste and Abuse Training materials, forms, ICD-9-CM codes and clinical and preventive guidelines.

Providers must register with us prior to using these services. Should you need help with registration, contact our Network Management Services Department by email at NMS@UHCsouthflorida.com . If you are already registered and wish to add a user or need help with an issue, contact Network Management Services at (877) 670-8432 Monday through Friday, 9:00 a.m. to 5:00 p.m. For complete information on registration and use of these services, refer to the Provider Registration User Guide.

Office Location:

Miami Office
9100 Dadeland Blvd.
Suite 1250
Miami, FL 33156
Section 2: Provider Information & Administrative Responsibilities

General Administrative Requirements

Introduction

The following requirements are basic guidelines to which you have agreed to follow in your Provider Agreement. You will be updated as necessary regarding regulatory changes that require revisions to these responsibilities.

Cooperate with Quality Improvement Activities

All participating physicians, healthcare professionals and facilities must cooperate with all of our quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and annual Health Care Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies or access to such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax;
- Use of performance data.

Provider Network Bulletins

Throughout the year, PCP publishes the “Provider Network Bulletin,” a user-friendly newsletter resource, which includes notice to our network physicians and facilities of any protocol, policy, or program updates and changes, as well as an array of other useful and interesting items. It includes information relevant to our Medicare Advantage products.

The Provider Network Bulletins are available on our website at www.mypREFERREDprovider.com, or you may call (877) 670-8432 to receive a copy.

Please read the Network Bulletins to view important information on protocol and policy changes, administrative information and clinical resources.

Physician Specific Standards

Demographic Changes

We are committed to providing our members with the most accurate and up-to-date information about our network. Report changes to your practice information thirty (30) days prior to the date of the change. Unless otherwise stated below, these demographic changes can be submitted by facsimile to (786) 888-1291. Demographic changes include changes to any of the following: Taxpayer Identification Number, address, service locations, and additions and deletions to practice professional staff.
You may submit demographic changes by faxing a completed Provider Demographic Update Form (found at www.mypreferredprovider.com) or by faxing a written, detailed description of the change and its effective date. Any notice of a change to a Taxpayer Identification Number and any addition of a physician or other healthcare professional must include a completed W-9 form (which can be found at www.IRS.gov).

**Access Standards**

Physician accessibility and availability monitoring is conducted on an ongoing basis to measure performance against established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after-hours service. Monitoring activities may include practitioner surveys, on-site visits, evaluation of member experience, and evaluation of complaints, and geo-access surveys.

The following table includes the established standards for appointment access and after-hours care to make sure members have prompt and timely access to medical care and services. Performance against these established standards is measured at least annually.

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<th>Type of Service</th>
<th>Appointment Standard</th>
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<tr>
<td>Preventive Care</td>
<td>Within 4 weeks</td>
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<tr>
<td>Regular/Routine Care</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Same Day</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediately</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>24 hours/7 days a week for primary care physicians</td>
</tr>
</tbody>
</table>

The guidelines listed above are general UHC guidelines; state or federal regulations may require more stringent standards.

**After-Hours Care**

You must have a mechanism in place for members calling your office after-hours to have access to care outside your regular office hours.

Callers with an emergency must be directed to:
- Hang up and dial 911; or
- Go to the nearest emergency room.

Callers with non-emergent circumstances should be directed to:
- Go to an in-network urgent care center, if unable to wait until the next business day to be seen;
- Stay on the line to be connected to the physician on call; or
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames.
Substitute Coverage

If you are unable to provide care and are arranging for a substitute, you must arrange substitute care with a physician in network with PCP. We encourage you to go to our website at [www.mypreferredprovider.com](http://www.mypreferredprovider.com) to find the most current directory of our network physicians and health care professionals. If the covering physician is not recognized by the Plan, their claims will be denied.

Providing Official Notice

You must send notice to us at the address noted in your agreement with us and delivered via the method required, within ten (10) calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of, liability insurance;
- Bankruptcy or insolvency;
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice; For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility;
- Relocation or closing of your practice, and, if applicable, transfer of member records to another physician/facility.

Confidentiality of Protected Health Information (PHI)

Our UM Program is designed to comply with the policies of UnitedHealth Group (UHG) related to Ethics and Integrity. Through application of the policies related to Privacy, the Program seeks to retain the trust and respect of our members and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

All employees, contracting providers, and delegates of PCP are required to maintain the confidentiality of protected health information (PHI), including member records. All information used for UM activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA Privacy and Security requirements. Reasonable efforts are made to limit PHI access to the minimum necessary required to accomplish the intended purpose, in order to conduct health plan operations.

All PCP contracted providers must report all privacy issues immediately to Risk Management at (877) 778-4099, or locally at (954) 378-0478.

Examples of privacy incidents that must be reported include but are not limited to:

- Reports and correspondence containing PHI or Personally Identifiable Information (PII) sent to the wrong recipient;
- Member or provider correspondence that includes an incorrect member’s information;
- Complaint received indicating that PHI or PII may have been misused;
• Concern about compliance with a privacy or security policy;
• PHI or PII sent unencrypted outside of your office;
• Lost or theft of laptops, PDAs, CDs, DVDs, flash/USB drives and other electronic devices;
• Caller mentions he/she is a regulator (i.e. person is calling from the Office for Civil Rights, Office of E-Health Standards & Services, State Insurance Departments, Attorney General’s Office, Department of Justice), or threatens legal action or contacting the media in relation to a privacy issue;
• Caller is advising your office of a privacy risk.

For more information on Confidentiality, refer to Medical Records: Section 6.

**Member Participation in Treatment Options**

Members have the right to freely communicate with their physician and participate in the decision making process regarding their health care, regardless of their benefit coverage. Physicians should encourage and provide active member communication and participation in their treatment planning and course of care. This includes the member’s right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with federal and state laws.

Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable. Physicians must communicate information, regarding the risks, benefits, and consequences of treatment or non-treatment, at a level the member can understand to decide among the treatment options.

Competent members have the right to refuse recommended treatment, counsel or procedure. The physician may regard such refusal as incompatible with the continuance of the physician/patient relationship and the provision of proper medical care. If this occurs, and the physician believes that no professionally acceptable alternatives exist, the physician must so inform the member in writing, via certified mail. The physician must give the member 30 calendar days to find another provider. During this time, the physician is responsible for providing continuity of care to the member. For more information, refer to Quality Improvement: Section 4.

**Physician Extender Responsibilities**

Physician extenders are state licensed healthcare professionals who may be employed or contracted by physicians to examine and treat Medicare members. Physician extenders are Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA). When care is provided by a physician extender, the following requirements must be met:

• Physician extenders must be under direct supervision of a physician when providing care. This means that a physician must be present on the premises at all times when the physician extender is seeing patients.

• The member must be notified of the physician extender’s credentials and the possibility of not being seen by a medical doctor.

• All progress notes made by the physician extender must be signed by the sponsoring physicians.
• Physician extenders will provide services as defined by protocol developed and signed (approved) by the sponsoring physician.

Common Provider Standards

Inform Members of Advance Directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients’ rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform members of state laws on advance directives through our members’ benefit material. We encourage these discussions with our members. For more information on Advance Directive refer to Medical Records: Section 6.

Access to Medical Records

We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you shall provide copies of those records free of charge unless your participation agreement provides otherwise.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our members within fourteen (14) calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise.

Medical records must be maintained and protected for confidentiality for a minimum of ten (10) years to comply with state and federal regulations or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

Provider Forms

The latest versions of all forms referenced in the Manual are available on our website at www.mypreferredprovider.com, or contact Network Management Services at (877) 670-8432. We recommend that you check our website to ensure that you are using the latest version of any form.
Fraud, Waste and Abuse

Prevention

Detecting and preventing fraud, waste and abuse is the responsibility of everyone, including employees, Plan members, physicians, vendors, subcontractors, hospitals, and other persons who may be subject to federal or state laws relating to fraud waste and abuse. By the terms of your contract with the Plan, you must have and maintain an effective compliance program that provides: a) measures to detect, correct, and prevent fraud, waste and abuse, b) training and education for everyone within your organization, including managers and directors, and c) effective lines of communication with the organization’s compliance officer.

Education and Training

CMS requires that all employees who work or contract with Part C Medicare Advantage Programs and/or Part D Medicare Prescription Drug Programs meet annual compliance and education training requirements with respect to fraud, waste and abuse.

The Plan has training materials available on our website at: www.mypreferredprovider.com. You are responsible for ensuring compliance with CMS training requirements. Please note that, upon request, you must be able to submit records of training logs documenting employee participation in the training.

Reporting Fraud, Waste and Abuse

Preferred Care Partners has established a Fraud, Waste and Abuse Prevention Plan to objectively and systematically monitor, investigate and report possible insurance fraud for further investigation and prosecution. The Plan has the duty to investigate and report suspected fraudulent activity to the appropriate federal and/or state agency.

If you have information regarding fraud, waste and abuse misconduct or potential misconduct, report the information or complaint to the Plan Special Investigation Unit (SIU). All reports are treated confidentially, and you may remain anonymous.

You may report fraud, waste or abuse to the Plan via:

FWA Hotline: (866) 678-8822
Email: ReporFraud@UHCsouthflorida.com
Mail: Preferred Care Partners
Special Investigations Unit
P.O. Box 56-5748
Miami, FL 33256
Online: www.mypreferredprovider.com

You may report suspected cases of Medicare fraud directly to CMS at:

(800) MEDICARE

You may also report fraud to the Health and Human Services Office of the Inspector General. The address and phone numbers are:
Additional Medicare Advantage Requirements

If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements for services you provide to our Medicare Advantage members.

- You may not discriminate against members in any way based on health status.
- You must allow members to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.
- You must provide female members with direct access to a women’s health specialist for routine and preventive health care services.
- You must make sure that members have adequate access to covered health services.
- You must make sure that your hours of operation are convenient to members and do not discriminate against members and that medically necessary services are available to members 24 hours a day, 7 days a week. Primary Care Physicians must have backup for absences.
- You may only make available or distribute plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member’s medical record whether the Customer has executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
You must cooperate with our processes for notifying members of network participation agreement terminations.
You must comply with our Medicare Advantage medical policies, quality improvement programs and medical management procedures.
You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS.
You must cooperate with our procedures for handling grievances, appeals and expedited appeals.

Credentialing and Recredentialing

We are dedicated to providing our members with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our provider directory, and then recredential them at least every thirty-six (36) months thereafter, in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS) and State of Florida requirements.

You must notify Network Management Services at (877) 670-8432 if you add a new physician, physician assistant, or advanced nurse practitioner to your staff. Note that these practitioners may not see our members until a credentialing approval letter has been received.

We accept the Council for Affordable Quality Healthcare (CAQH) credentialing application. The Health Plan is able to use the CAQH Universal Provider Data Source to obtain credentialing and recredentialing documentation for providers that participate with CAQH. If the provider is not a CAQH participant, or if the CAQH file is not updated, the Plan will fax the provider’s office a request for current documentation. Providers must maintain an active, Florida Medical License, DEA license and current malpractice insurance. Current documentation must be maintained in the CAQH system or sent directly to the Health Plan.

A site audit and medical record review is conducted at the time of recredentialing. Physicians are expected to cooperate and facilitate scheduling of these activities. Results will be made available to the physician, including any Corrective Action Plan, if needed.

Rights Related to the Credentialing Process

Physicians and other health care providers applying for network participation have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request.

Termination of Contract Agreements
The Agreement may also be terminated immediately for cause with written notice to the physician by us. If your participation agreement terminates for any reason, you may be required to assist in the transition of our members’ care to another physician or health care professional who participates in the PCP network. This may include providing services for a reasonable time at our contracted rate during the continuation period, per your participation agreement and any applicable laws. Our UM staff is available to help you and our members with the transition. We will notify affected members at least thirty (30) calendar days prior to the effective date of termination of your agreement, or as required under applicable laws.

As a participating physician, the records of the members that were under your care must be made available to the next physician at no cost to that physician or the member, and must be available to the Plan upon request.

In the event that a member chooses to change to another healthcare provider in or out of Network, the current provider must supply all the necessary information and documentation to allow for a timely and smooth transition at no cost to the member, recipient physician or the Plan.

**Resolving Disputes – Agreement Concern or Complaint**

If you have a concern or a complaint about your relationship with us, send a letter containing the details to the address listed in your Agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion. If our internal process does not resolve the dispute, please refer to your agreement’s dispute resolution section, if applicable, for more information.
Section 3: Member Rights & Responsibilities

Introduction

We inform our members that they have specific rights and responsibilities as outlined in the member materials for Medicare Advantage benefit plans, all of which are intended to help uphold the quality of care and services that they receive from you.

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC) available on the PCP website at www.mypreferredcare.com. A copy of the Member Rights and Responsibilities Statement can also be obtained by contacting the Network Management Department at (877) 670-8432. If your patient has questions about his or her rights as a Medicare Advantage member, please refer them to the Member Services phone number on the back of their ID Card.

Federal Patient Self-Determination Act of 1990

According to the Federal Patient Self-Determination Act of 1990, every member over the age of 18 enrolled in a health plan has the right to make decisions concerning his or her medical treatment. This law states that members’ rights and personal wishes must be respected even when the member is too sick to make decisions on his/her own. You may find the Patient Self-Determination Act on the PCP website at www.mypreferredcare.com.

Member Financial Responsibility

Members are responsible for the copayments, deductibles and coinsurance associated with their benefit plan. You should collect copayments at the time of service; however, to determine the exact member responsibility related to benefit plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) when billing members for their financial responsibility.

If you prefer to collect payment at the time of service, you must make a good faith effort to estimate the member’s responsibility using the tool we make available and collect no more than that amount at the time of services. A tool, Claims & Payments, is available on our website at www.mypreferredprovider.com to help you determine member and health plan responsibility.
Section 4: Quality Improvement

Overview

PCP is a health care delivery organization that provides comprehensive medical/clinical care and services for Medicare Advantage members through a network of physicians, facilities and other health care professionals. PCP operates under the UnitedHealthcare, Medicare Advantage Quality Improvement (QI) Program (hereafter referred to as the Program) which is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and services provided to all Medicare Advantage members and to provide oversight and guidance for all Medicare Advantage plans. The Program is universal and is implemented by all of the UnitedHealthcare Medicare Advantage plans, both national and regional. At the individual Plan Benefit Package (PBP) level these activities may have unique metrics and systematic improvements that are designed to fit the population of each PBP.

Health promotion, health management, and patient safety activities are an integral part of the Program and are specialized according to regulatory requirement, population needs, and available delivery models.

The Program identifies planned activities related to program priorities that address the quality and safety of clinical care and services, including special attention to high volume and high risk areas of care and service. These QI activities include but are not limited to:

- Credentialing / Recredentialing;
- Peer Review;
- Practitioner Access and Availability Monitoring;
- Preventive and Clinical Practice Guidelines;
- Disease Management;
- Utilization Management / Utilization Review;
- Behavioral Health;
- Patient Safety;
- Continuity and Coordination of Care;
- Ambulatory Medical Record Review;
- Monitoring Complaints, Appeals and Grievances;
- Member Experience;
- Physician Satisfaction;
- Delegation Oversight; and
- CMS Programs and Projects:
Provider contracts include the obligation to participate in the Program. Upon request, PCP makes the information within the program available to members and providers.

**Quality Improvement Committee (QIC)**

UnitedHealthcare’s National and Regional Quality Committees, the National Quality Oversight Committee (NQOC) and the Regional Quality Oversight Committee (RQOC) are responsible for assuring quality, safe, and comprehensive health care services are provided to Medicare Advantage members through an ongoing, systematic evaluation and monitoring process that facilitates continuous process improvement. These committees have distinct goals and objectives to accomplish their primary functions of oversight of the clinical and operational systems as they affect care and services provided to Medicare Advantage members.

Specific performance activity outcomes/results are shared with our providers through this Manual and/or Provider Newsletters.

**Program Activities**

**Physician Access and Availability**

The Plan requires physicians to meet the access and availability standards described in detail in *Provider Information & Administrative Responsibilities*: Section 2. Access and availability to health care services is a key component of health care quality that ensures each member is heard and has his or her medical needs met in a reasonable and timely manner.

**Behavioral Healthcare Programs**

Psychcare is the Managed Behavioral Healthcare Organization (MBHO) to whom the Plan has delegated the provision of behavioral healthcare services for all members. Psychcare is accredited by the National Committee for Quality Assurance (NCQA) and submits regular reports to the Plan for oversight and monitoring. A Senior Behavioral Healthcare Practitioner is actively involved in the key activities of the behavioral healthcare aspects of the UM program. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal health outcomes. For more information on how to access the Behavioral Healthcare programs, you may reference Section 2, *Contact & Administrative Information* or you or your patients may contact a Psychcare representative through the phone number listed on the back of their health care ID card.

To promote coordination of care and collaboration between medical and behavioral health care, a Psychcare Medical Director and the VP of Utilization Management are voting members of the Plan’s Utilization Management Committee.
Clinical and Preventive Health Guidelines

The Plan uses evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. We hope you consider this information and use it when it is appropriate for your eligible patients. A list of the current guidelines is available through our website at, www.mypreferredprovider.com.

Continuity and Coordination of Care

An annual analysis is conducted to review the continuity and coordination of medical care provided to our members across settings and/or during transitions of care. The scope of activities includes transitions in care (including changes in management of care among practitioners), changes in settings (including inpatient and ambulatory location), or other changes in which practitioners partner to provide ongoing care for a member. The primary activities may include but are not limited to:

- Prescription of controlled substances.
- Member satisfaction with continuity and coordination of medical care.
- Provider satisfaction with coordination of medical care.
- Steerage to transplant centers of excellence.
- Continuity of care between dialysis centers and nephrologists.
- Continuity of medical and behavioral healthcare.

The Plan and Psychcare offer a medical integration program that is available to all members. This program is called Encompass. The focus of Encompass is to treat all aspects for the members who require coordination of care between the medical and behavioral specialists. Referrals to the program may be made by the member, the provider or by the member’s care-giver.

Encompass offers care coordination, intensive case management, and several primary and secondary preventive behavioral healthcare programs. These programs include:

- Alzheimer’s Disease Preventive Health Program
- Domestic Violence Prevention Program
- Eating Disorders Prevention Program
- Stress Management Prevention Program
- Tobacco Cessation Program

These educational, website articles may be printed to assist and educate the member and/or provider in recognizing the illness, managing the symptoms of the disorder, how to prevent relapse, and various treatment options and community resources. You may also call Psychcare at (800) 221-5487 for more information.

Member Experience

Member experience is assessed through the CMS CAHPS® member survey, complaints, and appeals data. This data is measured annually and is used to:

- Measure member experience with health plan performance;
• Establish benchmarks against national CAHPS® performance data;
• Assess service performance compared to competitors; and
• Identify opportunities for improvement.

Physician Experience
A survey is conducted annually by Network Management Services in order to obtain physicians’ experience with our services. When opportunities for improvement are identified through analysis of the data, appropriate action(s) are implemented to improve our services and our physicians’ experience.

Patient Safety
We are committed to patient safety which is demonstrated through the programs available to support our members. Patient safety programs and activities are a collaboration of initiatives across many areas that include, but are not limited to: Pharmacy, Case Management (CM), Disease Management (DM), Utilization Management (UM), medical record reviews, best practice, and evidence based practice guidelines and clinical decision-making criteria.

The objectives of the Patient Safety Programs are to:

• Improve the effectiveness of communication and continuity of care among caregivers;
• Educate members on the importance of patient safety in the continuity and coordination of care;
• Provide members and providers with updated and accurate patient safety information;
• Reduce preventable medical errors; and
• Monitor and evaluate member complaints and appeals for potential quality of care concerns.

Ambulatory Medical Record Review
The Plan performs ambulatory medical record review as part of the Medicare Advantage QI Program. Medical record documentation should facilitate communication, coordination, and continuity of care, and promote efficiency and effectiveness of treatment. Through medical record review, the Plan is able to evaluate the quality, timeliness, and appropriateness of the services rendered. Refer to Medical Records, Section 6 for more information on this topic.

Delegation Oversight
Some functions/activities that the Plan would normally perform, under regulatory and accreditation standards and requirements, may be delegated to another organization/entity. These delegated functions/activities are described in a written, mutually agreed upon contract. The agreement outlines the delegated activities, reporting responsibilities, and remedies for inadequate performance, including revocation of the delegation agreement. Oversight of these delegated functions/activities is required by CMS and the NCQA. PCP conducts ongoing oversight and opportunities for improvement are identified and addressed, as applicable.
Chronic Care Improvement Program
As required by CMS, the Plan must implement a Chronic Care Improvement Program (CCIP) and establish criteria for participation in the program. The CCIP is a clinically focused project made up of 6 disease management elements: Population Identification, Evidenced-Based Guidelines, Collaborative Care, Patient Self-Management, Process and Outcomes Measures, and Routine Reporting. The CCIP must include a methodology for identifying the members with multiple or sufficiently severe chronic conditions who would benefit from participation in the program.

Quality Improvement Projects
As required by CMS, the Plan must implement Quality Improvement Projects (QIPs) that are designed to address clinical or non-clinical areas of healthcare that promote improvement in the health outcomes of its members. QIPs, whether clinical or non-clinical, must measure and improve performance. For each project, quality indicators are used to assess performance. The quality indicators must be clearly defined and based on current clinical knowledge or health services research and capable of measuring outcomes.

For a complete copy of the QI Program Description outlining the structure and process, please call Customer Service at 866-231-7201. Customer Service hours are Monday through Friday, 9:00 a.m. to 5:00 p.m.

Preferred Care Partner’s Medicare Advantage Quality Improvement Program Milestones for 2014:
The Medicare Advantage QI Program uses a variety of activities to continually measure, evaluate and improve the services provided to our members. Below are summaries of some of these activities and the outcomes/results.

HEDIS
HEDIS® (Healthcare Effectiveness Data Information Sets) is one of the performance measurement indicators PCP uses to measure, and drive, health outcomes. Some of the data is obtained administratively (through claims information, etc.) and some is obtained through in office chart reviews performed by a certified vendor. During the measurement year 2013, PCP improved on nine (9) indicators and declined in five (5) indicators.

Our top 3 performing indicators included:
- Adult BMI Assessment
- Breast Cancer Screening
- Comprehensive Diabetes Care-Medical Attention Diabetic Nephropathy

Our bottom 3 performing indicators included:
- Comprehensive Diabetes Care – LDL-C Level Screening
- Plan All-Cause Readmission
- Osteoporosis Testing in Older Women
Overall, PCP was able to maintain a favorable HEDIS® rating compared to our Florida competitors. We will continue to focus our initiatives on the HEDIS® STARS measures (as defined by CMS) and improving those rates.

**Member Experience (CAHPS® and STAR Ratings)**

The CAHPS® (Consumer Assessment HealthCare Providers and Systems) Survey “is a public-private initiative to develop standardized surveys of patients’ experience with ambulatory and facility-level care” (AHRQ.gov). The annual survey measures members’ experiences with their health plan over a six month period. Certain CAHPS® (and HEDIS®) scores are given a 1 to 5 star rating by CMS. These ratings are used to provide information to members to help them choose their plans, effect Medicare payments, and help PCP focus on quality improvement initiatives. Ratings are as follows:

- 5 is considered excellent
- 4 is above average
- 3 is average
- 2 is below average
- 1 is poor

Several of the PCP scores for CAHPS® Composite questions are listed below for 2012-2014. The specific questions making up the composite scores are bulleted below each score.

To summarize:

- The composite for Getting Needed Care has remained at a 4 star rating over the past three year measurement period.

### Getting Needed Care

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<td>Star</td>
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- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

- The composite for Getting Appointments and Care Quickly has declined from a 4 star rating in 2012 to a rating of only 2 for 2014.

### Getting Appts/ Care Quickly

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In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?

In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Physician Experience

The Physician Experience Survey is conducted annually by PCP’s Network Management Staff. Responses to questions relevant to obtaining authorization, referral of services, and Case Management and Disease Management Programs are utilized to measure practitioners’ (Primary Care and Specialist) experience with these processes during the previous calendar year. The results for these specific questions are analyzed by PCP and opportunities for improvement are implemented to enhance the process for our physicians and to meet our members’ needs. Results for calendar year 2013 indicates that PCP can improve on referral turn-around times and the Online Physician WebPortal services.

Special Needs Plans

Special Needs Plans (SNP) Model of Care (MOC)

The MOC is a framework for providing healthcare and healthcare plans designed by theory, evidence-based protocols and accepted standards. The MOC contains specific elements that delineate implementation, analysis and improvement of care.

These elements include description of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

SNP MOC Structure and Process

The structure and processes of the SNP MOC program is based upon six structure and process measures to evaluate the structure, processes, and performance of SNPs. Through these measures, SNPs must demonstrate that they are providing quality health care for the Plan’s members. These measures are:

- Complex case management;
- Improving member satisfaction;
- Clinical quality improvements;
- Care transitions;
- I-SNP relationships with facility; and
- Coordination of Medicare and Medicaid coverage.

Quality Performance Measures

The Medicare Advantage QI Program includes activities designed to continually monitor, analyze and evaluate the care and services provided to members by network practitioners/providers. In order to accomplish this, quality tools and measures are used such as: the CMS STAR Rating System, Health Outcome Survey (HOS) Program, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Program, and the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures.

STAR Rating System
The CMS STAR Rating System rates Medicare Advantage health plans and drug plans on how well they perform on more than 50 items, which are grouped into five (5) and four (4) different categories, respectively.

Health plans are rated on:

- Staying healthy: screening, tests, and vaccines;
- Managing chronic (long-term) conditions;
- Member experience with the health plan;
- Member complaints, problems getting services, and improvement in the health plan’s performance; and
- Health plan customer service.

Drug plans are rated on:

- Drug plan customer service;
- Member complaints, problems getting services, and improvement in the drug plan’s performance;
- Member experience with the drug plan; and
- Patient safety and accuracy of drug pricing.

What the “STAR” ratings mean:

Medicare Advantage health and prescription drug plans get overall and/or summary ratings that summarize all categories and measures into a single “star” rating. The star rating of the plan’s performance makes it easy for you to compare plans. If you’re interested in more detail, you can look at the health or drug plan summary scores, or you can “drill down” to the star ratings category details (like member experience with drug plan) or to individual measures within the categories (like members’ ability to get prescriptions filled easily when using the plan). A plan’s star rating is calculated each year and results are available each fall.

- Five Stars = “Excellent”
- Four Stars = “Above Average”
- Three Stars = “Average”
- Two Stars = “Below Average”
- One Star = “Poor”

If you are interested in obtaining more information you may visit [www.Medicare.gov/find-a-plan](http://www.Medicare.gov/find-a-plan). Enter the appropriate information for a general search and once you see the list of plans, you may view the star ratings by selecting the plan name.

**HOS Program**

NCQA administers the HEDIS® Medicare Advantage HOS in partnership with the CMS. HOS is the first patient-based health outcomes measure for the Medicare Advantage care population. The goal of the HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as for targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and
advancing the science of functional health outcomes measurement. Managed care plans with Medicare Advantage (MA) contracts must participate.

**CAHPS® Program**

The CAHPS® program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. The goals of the CAHPS® program are twofold:

- Develop standardized patient questionnaires that can be used to compare results across sponsors and over time.
- Generate tools and resources that sponsors can use to produce understandable and usable comparative information for both consumers and health care providers.

While CAHPS® surveys are similar to patient satisfaction surveys, they are not the same. As with satisfaction surveys, CAHPS® surveys can include ratings of health plans or providers (such as doctors, hospitals, and nursing homes), but go beyond ratings by asking patients to report on their experiences with health care services. Reports about care are regarded as more specific, actionable, understandable, and objective than general ratings alone.

**HEDIS® Measures**

HEDIS® is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS® is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans.

HEDIS® is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS® consists of 80 measures across 5 domains of care. Because so many plans collect HEDIS® data, and because the measures are so specifically defined, HEDIS® makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS® results themselves to see where they need to focus their improvement efforts.

HEDIS® measures address a broad range of important health issues. Among them are the following:

- Asthma Medication Use
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management
- Childhood and Adolescent Immunization Status
- Childhood and Adult Weight/BMI Assessment
We have a Stars Improvement Department that has a direct focus on Quality Performance Measures, and we work closely with UHC to continually improve the Plan’s performance. Many of these performance measures involve you, the provider, and can be positively impacted by the relationship between the Plan and its network providers. Preferred Care Partners, therefore, continually strives for improved lines of communication and exchange of helpful tools and looks forward to receiving provider feedback in order to continually improve the quality of care and services provided to our members.
Section 5: Utilization Management

Introduction

The Plan’s Utilization Management (UM) Program outlines the program structure and accountability, scope, processes and information utilized for clinical decision making. The UM Program is designed to interface with and support the Medicare Advantage Quality Improvement (QI) Program.

The scope of the UM Program covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which include behavioral health/substance abuse, and case and disease management.

UM clinical review is performed by health care professionals utilizing pre-established clinical decision making criteria to assist in decisions regarding requests for health care services that require authorization.

Services NOT Requiring Prior Authorization

The Plan does not require Prior Authorization for certain services. A listing of these services is provided during new provider orientation and throughout the year, via Fax Blast, when there are revisions in these requirements.

The Plan also publishes a CPT listing of healthcare services, the Participating Provider No Authorization Reference Guide (NARG), to assist South Florida (Miami-Dade and Broward Counties) providers in determining if a Prior Authorization is required prior to services being rendered. A listing of these services is provided during new provider orientation and throughout the year, via Fax Blast, when there are revisions in these requirements.

Please Note: For Preferred Secure Options HMO members (H1045 PBP #023), providers must reference the WellMed Florida Prior Authorization List. This list can be found in the WellMed secure provider portal at https://eprg.wellmed.net, in the provider resource tab.

Some of the services that do not require Prior Authorization before services are rendered are listed below:

Emergency Services

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

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

- Serious jeopardy to the health of the individual;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
Members have been instructed to access care in an emergency through the 911 system or by going to the nearest emergency room. Should you encounter a patient in an emergent health situation, refer them to the nearest emergency room.

**Urgent Care Services**

Urgently-needed services are covered services that:

- Are not emergency services as defined in this section but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition such as but are not limited to: high fever, animal bites, fractures, complications from respiratory infections or flu;
- Are provided when the member is temporarily absent from the Plan’s service area, or under unusual and extraordinary circumstances, when the member is in the service area, and the network is temporarily unavailable or inaccessible; and it was not reasonable given the circumstances to wait to obtain the services through the Plan network.

**Out-of-Area Renal Dialysis**

Prior Authorization for out-of-area renal dialysis services are not required prior to the service being rendered when provided during extenuating, urgent or emergent circumstances.

**Open Access Providers**

Open access providers do not require referrals from primary care physicians. They do however need to abide by Medicare Guidelines (i.e., they may only bill for Medicare-covered services.) The following specialties are considered open access providers:

- Podiatrists
- Dermatologists
- The Well-Woman visit to an OB/GYN does not require a referral when done once annually.

**Prior Authorization/Notification Requirements for Physicians, Healthcare Professionals and Ancillary Providers**

**Authorization Requirements**

- Physicians, health care professionals and ancillary providers are responsible for obtaining prior authorization for all services requiring authorization before these services are scheduled and/or rendered, such as, but not limited to: outpatient services or planned hospital admissions.
- Prior authorization for outpatient services or planned hospital admissions should be submitted as far in advance of the planned service as possible to allow for coverage review. Prior authorizations are required to be submitted at least seven (7) calendar days prior to the planned date of service.
- Prior authorizations for home health and home infusion services, durable medical equipment, and medical supply items should be submitted to All-Med Services of Florida at (800) 369-1416. When requesting that a prior authorization be expedited by placing STAT/urgent on the Prior Authorization Form, please note that you should not request an expedited (72 hours) review...
unless it is determined that waiting for a standard (14 calendar days) review determination could place the member’s life, health, or ability to regain maximum function in serious jeopardy.

- Prior authorizations are required for referrals to out-of-network specialty or ancillary providers when the member requires a necessary service that cannot be provided within the available PCP network. The referring physician must submit a completed Prior Authorization Form for approval. The Prior Authorization Form is available at our website at [www.mypreferredprovider.com](http://www.mypreferredprovider.com).
- It is important that you and the member are fully aware of coverage decisions before services are rendered.
- If you provide the service before a coverage decision is rendered, and we determine that the service was not a covered benefit, we may deny the claim and you must not bill the member; by not waiting for the coverage determination decision you made it impossible for the member to decide, with knowledge of the non-coverage determination, whether to receive and pay for the services.
- For Preferred Secure Option HMO members (H1045 PBP #023) you may submit Prior Authorization Requests on the WellMed provider portal at: [https://eprg.wellmed.net](https://eprg.wellmed.net). Or you may fax a request to 866-322-7276, or you may call WellMed Utilization Management Department at 877-299-7213 from 8 a.m. to 5 p.m. (EST) Monday through Friday.

**General Notification Requirements**

- For any inpatient or ambulatory outpatient service requiring Prior Authorization, the facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation; in cases where it is determined that the service will not be covered; the member can then decide whether to receive and pay for the service
- Facilities are responsible for admission notification for inpatient services even if the coverage approval is on file.
- If a member is admitted through the emergency room, notification is required no later than 48 hours from the time the patient is admitted for purposes of concurrent review and follow-up care.
- If a member receives urgent care services, the provider must notify the Plan within 48 hours of the services being rendered.
- For after-hour and weekend notifications please call the Plan’s after-hours telephonic answering service, 1-800-WEANSWER at (800) 995-0480 for assistance.

**Please Note: For Preferred Secure Options HMO members (H1045 PBP #023):**

- To submit an inpatient hospital admission notification, fax notifications to 877-757-8885. Notifications must be received by WellMed no later than the first business day following the admission.
- **Referral for Specialty Care:** WellMed requires a referral from the assigned primary care physician prior to rendering services for selected specialty providers.
o Except for emergencies, before a specialist treats a Preferred Secure Option HMO member they are required to obtain a referral from the member’s assigned Primary Care Physician.

o The referral must be entered by the Primary Care Physician in the WellMed provider portal at https://eprg.wellmed.net. (This link is located on the back of the member’s ID card.


**Admission Notification Requirements**

- Facilities are responsible for Admission Notification for the following types of inpatient admissions:
  
  o Planned/elective admissions for acute care
  o Unplanned admissions for acute care
  o Skilled Nursing Facility (SNF) admissions
  o Admissions following outpatient surgery
  o Admissions following observation

- Unless otherwise indicated, Admission Notification must be received within twenty-four (24) hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For after-hour, weekend and federal holiday admissions, please call the Plan’s after-hours telephonic answering service, 1-800- WEANSWER at (800) 995-0480 for assistance.

- Admission Notification by the facility is required even if notification was supplied by the physician and a coverage approval is on file.

- Receipt of an Admission Notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual member’s benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility’s participation agreement with us.

- Admission Notifications must contain the following details regarding the admission:
  
  o Member name and member health care ID number
  o Facility name
  o Admitting/attending physician name
  o Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code
  o Actual admission date

- For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify PCP as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

Failure to comply with the requirements described in this Section may result in claims being denied in whole or in part and, as required under your agreement with us, the member being held harmless.
Subject to state regulation and Medicare Advantage policies, receipt of a Notification or a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual member’s benefit plan, the provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with PCP.

**Why is Authorization/Notification Required?**

Information gathered about planned member care/services supports the pre-service clinical coverage review process, where applicable, and the care coordination process, which allows us to support our members throughout their course of treatment, including pre-service planning and coordination of home care and other discharge plans.

**How to Request Prior Authorization**

- It is recommended that you initiate prior authorization requests electronically via the provider web portal at [www.mypreferredprovider.com](http://www.mypreferredprovider.com). Providers must register with us prior to using this service.
- If you do not have electronic access, you may call us at the number on the back of the members’ health care ID card. For manual prior authorizations, the requesting provider must fill out the Prior Authorization Form, sign it, and fax it to the Utilization Management Department at (866) 567-0144. This form can be used by both primary care physicians and specialists. The Prior Authorization Forms are available on the provider web portal at, [www.mypreferredprovider.com](http://www.mypreferredprovider.com), or you may contact UM at (800) 995-0480 to request a copy.

**Information That Must be Included in the Request for Prior Authorization**

Prior Authorizations must contain the following information about the planned service:

- **Member Information**: Name, DOB, and Membership ID number.
- **Requesting Provider Information**: Name, Specialty, Designate Par or Non-Par, Address and Phone and Fax Numbers
- **Primary Care Physician Information**, if different from the Requesting Provider: Name, Phone and Fax Numbers.
- **Referral Information**: Name of Referral Provider, Designate Par or Non-Par, Address, Phone and Fax Numbers.
- **Diagnosis/Symptoms**: Include the Diagnosis Description and the corresponding ICD-9 Code for each diagnosis to the highest specificity.
- **Service(s) Requested**:
  - If the referral is for one or more specific procedures, identify each procedure, and its corresponding CPT code.
  - In the Additional Comments field, document any pertinent clinical summary information which would be helpful to that specialist or for the UM determination.
  - Enter the date of service and number of visits requested, and sign where indicated.
Where a clinical coverage review is required in the member’s benefit plan, we may request additional information in order to make the necessary determination, as described in more detail in the Clinical Coverage Review: Clinical Information section below.

- **Note:** Certain services may not be covered within an individual member’s benefit plan, regardless of whether Prior Authorization is required.
- In the event of a conflict or inconsistency between applicable regulations and the Advance Notification Requirements in this Manual, the notification process will be administered in accordance with applicable regulations.

**Clinical Coverage Review: Clinical Information**

You must cooperate with all PCP requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, providing pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment.

As a network provider, you must return/respond to calls from our UM staff and/or medical director. You must provide complete clinical information as required within 24 hours of the request for additional information.

In addition:

- We may also use tools developed by third parties, such as the MCG™ guidelines®, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For Medicare Advantage members, we use CMS coverage determinations, the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine benefit coverage for Medicare members. If other clinical criteria, such as the MCG™ guidelines or any other coverage determination guidelines contradict CMS guidance, then we follow the CMS guidance.

You may request a copy of the clinical criteria from your Case Reviewer by calling (800) 995-0480.

**Coverage Determination Decisions**

Coverage determinations for health care services are based upon the member’s benefit documents and applicable federal requirements. Our UM Staff, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing adverse non-coverage determinations. PCP and its delegates do not offer incentives to physicians to encourage underutilization of services or to encourage barriers to receiving the care and services needed.

Coverage decisions are made based on the definition of “reasonable and necessary within Medicare Advantage coverage regulations and guidelines”. Hiring, promoting or terminating physicians or other
individuals are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Clinical Coverage Review Criteria

PCP utilizes established, nationally recognized criteria to determine medical necessity and appropriateness for requested care and services. Medical necessity and appropriateness coverage determinations for inpatient and outpatient care and services are made using clearly written, published criteria which are based on sound medical evidence. These criteria include, but are not limited to:

- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- InterQual® Intensity/Severity/Discharge Screening & Indications for Surgery and Procedures.
- MCG™ guidelines (formerly known as Milliman Care Guidelines®)

You must cooperate with all Plan requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, providing pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment.

Timeframes for Processing Prior Authorization Requests

The Plan makes a determination of your request within fourteen (14) calendar days of receipt of request, or within seventy-two (72) hours for an expedited review request. It is important that you provide all necessary supporting documents and information at the time of the request to help facilitate the decision.

Prior Authorization Denials

The Plan may deny a prior authorization request for several reasons:

- Member is not eligible with the plan;
- Service requested is excluded, not a covered benefit;
- Member’s benefit has been exhausted; or
- Service requested is determined not to be medically necessary (based upon clinical criteria guidelines).

The Plan must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. The notice must state the specific reasons for the decision, and reference to the benefit provision and clinical review criteria used in the decision making process. The Plan provides the clinical criteria used in the review process for making a coverage determination along with the notification of denial. However, if you have additional questions regarding the criteria, you may call UM at (800) 995-0480.

Please Note: For members in the Preferred Secure Options HMO plan (H1045 PBP #023)

Denials for prior authorization requests are made by WellMed, including the notifications to you and the member of these decisions and references to the benefit provisions and clinical review criteria used in the
decision making process. For any questions regarding the decision and/or the criteria used you may call WellMed Utilization Management Department at 877-299-7213.

Peer-to-Peer Clinical Review

PCP physicians conducting clinical review determinations are available, by telephone or in person, to discuss medical necessity review determinations with the member’s physician requesting the service. If a peer-to-peer conversation does not occur prior to an adverse determination/non-certification notification, the requesting physician has the opportunity to discuss the adverse determination/non-certification decision with the Plan physician reviewer making the initial determination. If the initial physician reviewer is not available within one business day of the notification a peer-to-peer may occur with another appropriate physician reviewer.

If you would like to discuss the case with one of the Plans physician reviewers, please contact UM at (800) 995-0480.

Additional UM Information

Members Requiring External Agency Services

Some members may require medical, psychological or social services outside the scope of their plan benefits from external agencies (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, you should either contact your NMS representative, or have the member contact our Member Services Department at (866) 231-7201 for assistance with, and referral to, appropriate external agencies.

Hospitalist Program for Inpatient Hospital Admissions

The Hospitalist Program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and skilled nursing facilities). A hospitalist oversees the member’s inpatient admission and coordinates all inpatient care. The hospitalist is required to communicate with the member’s selected physician by providing records and information such as the discharge summary, upon the member’s discharge from the hospital or facility.

Discharge Planning

Discharge planning is a collaborative effort between the concurrent reviewer, the hospital/facility case manager, the member, and the admitting physician to ensure coordination and quality of medical services through the post-discharge phase of care.

The Plan may, but is not required to, assist in identifying health care resources, which may be available in the member’s community following an inpatient stay.

Nurse Case Managers conduct onsite and/or telephone reviews to support discharge planning, with a focus on coordinating health care services prior to the discharge.

The facility or physician is required to contact the Plan and provide clinical information to support discharge decisions under the following circumstances:
• An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
• The member’s discharge plan indicates that transfer to an alternative level of care is appropriate.
• The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

Please Note: Discharge planning for members in the Preferred Secure Options plan (H1045 PBP #023)
Discharge planning for these members is conducted by WellMed. For any questions regarding discharge planning for these members, please contact WellMed Utilization Management Department at 877-299-7213.

Complex Case Management and Disease Management Program Information

PCP offers case and disease management programs to support physicians’ treatment plans and assist members in managing their conditions. We use medical, pharmacy and hospital discharge data to identify members who are at high risk and may benefit from our programs. Eligible members may also be identified via a Health Risk Assessment, discharge planners, or referrals from health care practitioners, caregivers or by self-referral. If you have patients who are PCP members and would benefit from case or disease management, you can refer them by the following means:

• PCP Telephone: 1-800-995-0480
• PCP Fax: 305-671-4072
• PCP Email: PCP-CCM_DL@uhc.com

Please Note: Case Management and Disease Management Programs for members in the Preferred Secure Options plan (H1045 PBP #023)

These services are provided by WellMed. For Case Management and/or Disease Management services or questions, please contact WellMed at:
• Phone: 1-800-494-6192 or
• Fax: 1-877-757-4449

Case Management

The core of case management is identifying high-cost, complex, at-risk members who can benefit from these services. We partner with members and their physicians or other health care professionals to facilitate health care access and decisions that can have a dramatic impact on the quality and affordability of their health care. Specifically, our programs are designed to assist in ensuring individuals:

• Receive evidence-based care
• Have necessary self-care skills and/or caregiver resources
• Have the right equipment and supplies to perform self-care
• Have requisite access to the health care delivery system
• Are compliant with medications
• Understand and follow the physician’s treatment plan to manage their conditions
• Receive educational materials to support self-management

A comprehensive assessment by our Nurse Case Managers is performed to help determine the appropriate level and frequency of interventions. The highest risk individuals will receive outbound telephone calls on a regular basis to address particular gaps in care. You will be notified when patients are identified for the high-risk program. Nurse Case Managers engage the appropriate internal, external or community-based resources needed to address members’ health care needs. When appropriate, we provide referrals to other internal programs such as disease management, social workers and behavioral health. Case management services are voluntary and members can opt out at any time.

**Disease Management**

We offer disease management programs designed to provide our members with specific conditions assistance in managing their health. Participation in disease management programs is voluntary and members can opt out at any time. The following programs are offered:

- Heart Failure
- Diabetes

Our programs include:

- A comprehensive assessment by Nurse Case Managers to help determine the appropriate level and frequency of interventions.
- Screening for depression and helping members access the appropriate resources.
- Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes education and stress management, as appropriate.
- Helping members understand and manage their condition and its implications.
- Education for reducing risk factors, maintaining a healthy lifestyle, and adhering to treatment plans and medication regimens.

Members may receive:

- Educational mailings, newsletters and tools to assist them in tracking their laboratory results, health status and recommended targets or other screenings.
- Information on gaps in care and encouragement to discuss treatment plans, goals and results with their physician.
- Outbound calls for the highest risk individuals to address particular gaps in care. You will be notified when patients are identified for a high-risk disease management program.
Medicare Advantage Hospital Discharge Appeal Rights Protocol

Medicare Advantage members have the statutory right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Florida is KEPRO.

The BFCC-QIO notifies the facility and PCP of an appeal and:

- PCP facility onsite Concurrent Review Staff completes the Detailed Notice of Discharge (DNOD), and delivers it to the Medicare Advantage member, or his or her representative as soon as possible but no later than 12:00 p.m. local time of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO; or
- When there are not any PCP facility onsite staff, the facility completes the DNOD, and delivers the DNOD to the Medicare Advantage member or his or her representative as soon as possible but no later than 12:00 p.m. local time of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and PCP.

Protocol for Facility (SNF, HHA, CORF) Notice of Medicare Non-Coverage (NOMNC)

CMS requires SNFs, HHAs and CORFs to deliver the NOMNC required notice to members at least two (2) calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the Customer's services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of Customer or Customer's authorized representative, if the Customer is incompetent. You must use the standard CMS approved notice entitled, "Notice of Medicare Non-coverage" (NOMNC). The standardized form and instructions regarding the NOMNC may be found on the CMS website at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html) or you may contact KEPRO the BFCC-QIO for Florida at this link: [www.keproqio.com](http://www.keproqio.com) for information. There can be no modification of the NOMNC notification text.

New Technology

The technology assessment process is utilized to evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals, or devices. This information allows the Plan to make decisions about treatments which best improve member’s health outcomes, efficiently manage utilization of healthcare resources, and make changes in benefit coverage to keep pace with technology changes and to ensure that members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for your patient, please contact Utilization
Appeal & Reconsideration Processes

Clinical Appeals: Standard and Expedited

To appeal an adverse decision (a decision by the Plan not to prior authorize a service or procedure because the service is determined not to be medically necessary or appropriate), on behalf of a member, you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter you received provides you with the filing deadlines and the address to use to submit the appeal. In the event a member designates a healthcare professional to appeal the decision on the members’ behalf, a copy of the member’s written consent is required and must be submitted with the appeal.

When the final decision is made, you will be notified via mail. If the decision is to overturn the original determination, the service will be authorized. If the decision is to uphold the original denial determination, there will be no further action for you to undertake.

How to File an Appeal

Upon receiving an adverse organization determination, you may appeal the determination on the member’s behalf following the instructions detailed in the denial notification you received from us. To initiate an appeal:

1. Complete the Appeal/Reconsideration Request form, which can be downloaded from our website at www.mypreferredprovider.com. Alternatively, you can provide a letter stating the reason why you want the reconsideration.
2. Ensure that the letter or form is signed by the person requesting the appeal.
3. Assemble all supporting documents for us to review in reconsidering the decision.
4. Send the form or letter and supporting documents to:

   Preferred Care Partners  
   Grievance & Appeals  
   P. O. Box 56-6420  
   Miami, FL  33256-6420

Upon receipt of the appeal, the appeals coordinator may call you if it is necessary to clarify your request and supporting documents.
Section 6: Medical Records

Overview

Medical record documentation should facilitate communication, coordination, and continuity of care, as well as promote efficiency and effectiveness of treatment. The Plan’s providers are required to keep accurate and complete medical records of Plan members for at least ten (10) years. Through medical record review, the Plan is able to evaluate the quality, timeliness, and appropriateness of the services rendered.

Documentation of Care / Confidentiality of Medical Records

Providers are required to maintain records, correspondence and discussions regarding the member in the strictest of confidence and protection.

Providers shall maintain a medical records system, which is: a) consistent with professional standards, b) permits prompt retrieval of information, and c) provides legible and timely information that is accurately documented and readily available to appropriate or authorized healthcare practitioners. The patient should sign a Medical Record Release Form as a part of their medical record. The form is available on our website at www.mypreferredprovider.com

The following guidelines are applicable:

- Records that contain medical/clinical, social, financial or other data on a patient is treated as confidential and is protected against loss, tampering, alteration, destruction, or inadvertent disclosure;
- Release of information from your office requires that you have the patient sign a Medical Record Release Form that is retained in the medical record;
- Release of records is in accordance with State and Federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Records containing information on mental health services, substance abuse, or potential chronic medical conditions that may affect the member’s plan benefits are subject to additional specific waivers for release and confidentiality.

Exemption from Release Requirements

HIPAA regulation 45 CFR § 164.512 (d) specifically permits disclosure of protected health information to government benefit programs for which health information is relevant to beneficiary eligibility, without patient authorization.

Medical Records Requirements

Providers must ensure that their medical records meet the standards described in this section. The following are expanded descriptions of these requirements, which may be helpful:

**Patient Identifiers**

Should consist of the patient name and a second unique identifier, and should appear on each page of the medical record.
**Advance Directives**

We are committed to ensuring that our members are aware of their right to execute advance directives, and that our providers and staff are in compliance with federal and state laws, as well as with the Plan’s accrediting body. For detailed information on advance directives, refer to Provider Information & Administrative Responsibilities: Section 2.

It is the provider’s responsibility to provide the member with Advance Directive information, and to encourage the member to place a copy in their office record. This discussion should be documented at least once in the member’s record.

Every adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. To make sure that a person’s choices about health care will still be respected, even when they are no longer able to make such decisions, the Florida legislature enacted Chapter 765, Florida Statutes. By law providers, hospitals, nursing homes, home health agencies, hospices, and HMOs are required to provide their patients with written information. You may download free forms from the State at [http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx](http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx)

There is also information for your patients from the Robert Wood Foundation, *Five Wishes*, which also meets the legal requirements for an advance directive in Florida. *Five Wishes* is a popular, simple, pamphlet which helps each person let their family and doctors know:

- Who you want to make health care decisions for you when you can't make them.
- The kind of medical treatment you want or don't want.
- How comfortable you want to be.
- How you want people to treat you.
- What you want your loved ones to know.

*Five Wishes* is available at [www.AgingWithDignity.org](http://www.AgingWithDignity.org)

**Biographical Information**

Each record should contain the patient’s name, date of birth, address, home and work phone numbers, marital status, sex, primary language spoken, name and phone number of emergency contact, appropriate consent forms and guardianship information if relevant.

**Signatures**

For paper medical records, all entries should be dated and signed or initialed by the author. Author identification may be a handwritten signature or initials followed by the title (MD, DO, PA, ARNP, RN, LPN, MA or OM). There must be a written policy requiring, and evidence of, physician co-signature for entries made by those other
than a licensed practitioner (MD, DO). Electronic signatures are acceptable for electronic medical records.

**Family History**

As part of the past medical history, family history should be documented no later than the first visit.

**Past Medical History**

Documentation should include a detailed medical, surgical and social history.

**Immunization**

Documentation of immunizations performed by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. At a minimum, vaccination history must be recorded.

**Medication List**

The patient’s current medications should be listed, with start and end dates, if applicable and re-conciliated within 30 days post inpatient admissions.

**Referral Documentation**

If a referral was made to a specialist, the consultation report should be filed in the medical record. There should be documentation that the physician has discussed abnormal results with the patient, along with recommendations.

**Chart Organization**

Practitioners should maintain a uniform medical record system of clinical recording and reporting with respect to services, which includes separate sections for progress notes and the results of diagnostic tests.

**Preventive Screenings**

Participating providers will promote the appropriate use of age/gender specific preventive health services for members in order to achieve a positive impact on the member’s health and better medical outcomes.

**Required Documentation**

Every visit must include the following documentation:

- the date of the visit;
- chief complaint or purpose of the visit;
- objective findings for the visit;
- diagnosis or medical impression of the visit;
- studies ordered (lab, x-ray, etc.);
- therapies administered and/or ordered;
- education provided; disposition, recommendations, instructions to the patient and evidence of whether there was follow-up; and,
- outcome of services.

(Documentation that a written policy regarding follow-up care and written procedures for recording results of studies and therapies and appropriate follow-up has been adopted must be available).
Physicians/providers must maintain a medical records system that is: a) consistent with professional standards, b) permits prompt retrieval of information, c) provides legible and timely information that is accurately documented and readily available to appropriate or authorized healthcare practitioners, and d) protects the confidentiality of the records.

The patient should sign a Medical Record Release Form as a part of his or her medical record. The patient should sign a Refusal Form when declining a preventative screening referral.

We also recommend that medical records include copies of care plans whenever home health or skilled nursing services are being provided.

**Medical Record Reviews**

The Plan performs reviews of providers’ medical records through the Medicare Advantage QI Program as part of the Plan’s recredentialing requirements, and for HEDIS® reporting. Our criteria for these reviews incorporate applicable federal, state and regulatory requirements for medical record documentation.

The purpose of periodic medical record reviews is to determine compliance with the Plan’s standards for documentation, coordination of care and outcome of such services; to evaluate the quality and appropriateness of the provider’s office medical records documentation; and to promote continuous improvements. These reviews evaluate medical records and do not define standards of care or replace a physician’s judgment.

The Plan conducts pre-contractual medical record reviews; thereafter, reviews are done every three years for re-credentialing purposes. All primary care providers and high volume specialists are subject to medical record reviews.

At the conclusion of the review, the reviewer will notify the provider of any deficiencies identified during the review. The provider must achieve a score of at least 80% in order to meet the Plan’s standard. Providers who do not meet the standard have up to thirty (30) days to address the items noted and provide a written response, signed by the provider. If applicable, the Plan will issue a Corrective Action Plan, or provide guidance and other tools to assist providers in improving documentation of care. Any provider not meeting the Corrective Action Plan will be reported to the Credentialing Committee for further action.
Section 7: Healthcare Risk Management

In any industry, risk management addresses liability, both proactively and reactively. Proactive is avoiding/preventing risk. Reactive is minimizing loss or damage after an adverse/bad event. Risk management in health care considers patient safety, quality assurance and patients’ rights. The potential for risk permeates all aspects of health care, including medical mistakes, electronic record keeping, provider organizations and facility management.

Identifying something as an adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Examples of adverse events in health care are, but not limited to, unexpected death, failure to diagnose or treat disease, surgical mistakes or accidents. All of those can interfere with a provider’s delivery of medical care. Some can result in litigation.

Agency for Healthcare Administration (AHCA)

The Florida Agency for Healthcare Administration (AHCA), as directed under F.S. 641 Parts I, II, III and other applicable state laws, provides oversight and monitoring of health plans operating in the State of Florida as an HMO and their compliance to applicable regulations. This includes implementation of a Risk Management Program (RMP) with the purpose of identifying, investigating, analyzing and evaluating actual or potential risk exposures. The RMP also corrects, reduces and eliminates identifiable risks through instruction and training to staff and providers. Reporting Adverse and Serious Events annually to AHCA is a statutory requirement under F.S.641, Part III.

AHCA defined Adverse and Serious Incidents include but are not limited to:

- Death of a patient;
- Brain or spinal damage to a patient;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure; or
- Performance of a wrong surgical procedure.

National Quality Forum (NQF)

The National Quality Forum (NQF) is a nationwide public service organization that reviews, endorses, and recommends use of standardized healthcare performance measures and quality of care. NQF is aligned with the accreditation requirements for the health plan. NQF identified and categorized events that are reportable by health entities. It is required to report these to the plan’s Risk Manager.

National Quality Forum (NQF) defined Adverse Events for any injury caused by medical care, include but not limited to:

- pneumothorax from central venous catheter placement
- anaphylaxis to penicillin
- postoperative wound infection
- hospital-acquired delirium (or "sun-downing") in elderly patients
The National Quality Forum (NQF) in 2011, identified 29 events grouped into six (6) categories: surgical, product or device, patient protection, care management, environmental, radiologic, and criminal.

<table>
<thead>
<tr>
<th>Table. 2011 Never Events</th>
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</thead>
<tbody>
<tr>
<td>The National Quality Forum's Health Care &quot;Never Events&quot;</td>
</tr>
<tr>
<td><strong>Surgical events</strong></td>
</tr>
<tr>
<td>Surgery or other invasive procedure performed on the wrong body part</td>
</tr>
<tr>
<td>Surgery or other invasive procedure performed on the wrong patient</td>
</tr>
<tr>
<td>Wrong surgical or other invasive procedure performed on a patient</td>
</tr>
<tr>
<td>Unintended retention of a foreign object in a patient after surgery or other procedure</td>
</tr>
<tr>
<td>Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class I patient</td>
</tr>
<tr>
<td><strong>Product or device events</strong></td>
</tr>
<tr>
<td>Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting</td>
</tr>
<tr>
<td>Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended</td>
</tr>
<tr>
<td>Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting</td>
</tr>
<tr>
<td><strong>Patient protection events</strong></td>
</tr>
<tr>
<td>Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person</td>
</tr>
<tr>
<td>Patient death or serious disability associated with patient elopement (disappearance)</td>
</tr>
<tr>
<td>Patient suicide, attempted suicide, or self-harm resulting in serious disability, while being cared for in a health care facility</td>
</tr>
</tbody>
</table>
### Care management events

- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious injury associated with unsafe administration of blood products
- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- Artificial insemination with the wrong donor sperm or wrong egg
- Patient death or serious injury associated with a fall while being cared for in a health care setting
- Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a health care facility
- Patient death or serious disability resulting from the irretrievable loss of an irreplaceable biological specimen
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

### Environmental events

- Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a health care setting
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting
- Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a health care setting
Radilologic events

Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area

Criminal events

Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider

Abduction of a patient/resident of any age

Sexual abuse/assault on a patient within or on the grounds of a health care setting

Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

### The Centers for Medicare and Medicaid Services (CMS) 2013 Hospital Acquired Conditions (HACs) and Codes

A hospital-acquired condition (HAC) is an undesirable situation or condition that affects a patient arising during a time spent in a hospital or medical facility. It is a designation used by CMS for determining MS-DRG reimbursement.

<table>
<thead>
<tr>
<th>HACs</th>
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<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
</tr>
<tr>
<td>Air Embolism</td>
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<tr>
<td>Blood Incompatibility</td>
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<tr>
<td>Stage III and IV Pressure Ulcers</td>
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<tr>
<td>Falls and Trauma:</td>
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<tr>
<td>Fracture</td>
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<tr>
<td>Dislocation</td>
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<tr>
<td>Intracranial Injury</td>
</tr>
<tr>
<td>Crushing Injury</td>
</tr>
<tr>
<td>Burn</td>
</tr>
<tr>
<td>Other Injuries</td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control</td>
</tr>
</tbody>
</table>
Catheter-Associated Urinary Tract Infection (UTI)

Vascular Catheter-Associated Infection

Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)

Surgical Site Infection Following Certain Orthopedic Procedures

Surgical Site Infection following Bariatric Surgery for Obesity

Surgical site Infection following Cardiac Implantable Electronic Device (CIED) Procedure

Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures

Iatrogenic Pneumothorax with Venous Catheterization

Provider Reporting Responsibilities

It is the affirmative duty of the Plan’s network providers, as outlined in applicable provider contracts, to report all adverse events as identified by AHCA, the NQF and the Hospital Acquired Conditions, whether actual or potential, to the Plan’s Risk Manager. The Plan provides a Member Incident Report Form for reporting these incidents available on the provider website at: www.mypreferredprovider.com.

The Member Incident Report Form must be filed with the Plan’s Risk Manager within three business days of occurrence of any incident that causes injury to an individual, or property damage.

All serious incidents must be reported immediately to the Plan’s Risk Manager at (305) 670-8440 or (800) 872-9750 to access the risk and address liability. These incidents must be reported to AHCA within 24 hours of occurrence.

Examples of Serious incidents include:

- Death or serious injury;
- Brain or spinal Damage;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure;
- Performance of a wrong surgical procedure;
- Abduction of a patient/resident of any age; or
- Sexual abuse/assault on a patient within or on the grounds of a health care setting.

**Note:** The Member Incident Report is confidential. It is the objective record that is established at the time of awareness of an actual or potential incident and records ONLY the facts available at the time. Personal opinions or subjective information are not to be included in the incident report. The individual involved in the incident, or any witness who observed or discovered the incident, should complete the incident report. The incident report should not be copied. Providers are prohibited from keeping a copy of the
incident report in the member’s medical record and from making a notation in the member’s medical record that an incident report was filed. The Plan’s Risk Manager will review and evaluate each incident report to determine whether it meets the requirements for filing with applicable state agencies.
Section 9: Pharmacy

Drug Formulary

We offer an extensive drug formulary. Generic prescriptions, when appropriate, are the most cost effective alternatives. Our Formulary includes a complete list of the drugs we cover, generic and brand name, and any requirements, limits, and/or restrictions for each drug, if applicable. Download the Formulary from our website at www.mypreferredprovider.com, or call our Pharmacy department at (800) 591-6144.

The Plan’s Formulary offers four drug tiers:

- Tier 1: Includes generic drugs
- Tier 2: Includes some generic drugs and also preferred brand-name drugs.
- Tier 3: Includes some generic drugs and non-preferred brand-name drugs.
- Tier 4: Includes brand-name drugs and some generic drugs.

You can look up a drug in our Formulary to find out which tier it is in. The Formulary is subject to change. The most current copy of our Formulary is on our website at www.mypreferredprovider.com.

If a drug is not on our Formulary, members can possibly be switched to a different drug that we do cover, or you can request a formulary exception. While the exception is being evaluated, we may provide members with a temporary supply. For details, refer to Transition Policy, below.

Coverage Limitations

The following highlights some of our drug coverage limitations:

- A maximum quantity of a 90-day supply per prescription when obtained from a pharmacy or from the OptumRx mail order pharmacy.

- For some drugs we may require authorization before the drug can be prescribed (prior authorization), there may be limits on the quantity that can be prescribed per prescription (quantity limits), or we may require that you prescribe drugs in a sequence (step therapy), trying one drug before another drug. For details, refer to Utilization Management Rule below.

An exception process is provided to allow for cases in which the Formulary may not accommodate the unique medical needs of a patient. To make an exception to these restrictions or limits, you must fill out and submit a Coverage Determination Request (CDR) form. The form can be downloaded from our website at www.mypreferredprovider.com.

Additional information on these requirements is available in our Formulary on our website (www.mypreferredprovider.com), or by calling our Pharmacy department.

Drugs Covered Under Part B

Drugs covered under Part B are typically administered and obtained at the provider’s office. Some examples are certain cancer drugs, administered by a physician in his/her office; insulin when administered via pump and diabetes test strips.
Drugs Covered Under Part B or Part D

Some drugs can fall under either Part B or Part D. The determination of coverage as to whether the drug is Part B or Part D is based on several factors such as diagnosis, route of administration and method of administration. For a list of medications in each category, refer to the CMS website at www.cms.gov; choose Medicare -> Prescription Drug Coverage-General Information -> Downloads, and select the appropriate document. Alternatively, you may contact our Pharmacy department.

Long Term Care Facilities (Includes Mental Health Facilities)

We provide convenient access to network long-term care (LTC) pharmacies for all members residing in LTC and mental health facilities. For a list of network pharmacies covering long term care facilities, refer to the Provider Directory.

Home Infusion

Our Plan will cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. However, Medicare Part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department.

Vaccines

Most vaccines and the associated administration fees are covered under Part D. Our plan provides coverage of a number of vaccines, some of which are considered to be medical benefits (Part B medications) and others of which are considered to be Part D drugs.

Part D covers most preventative vaccines; Part B covers flu, pneumococcal, hepatitis B, and some other vaccines (e.g., rabies) for intermediate or high-risk individuals when directly related to the treatment of an injury or direct exposure to a disease or condition.

The rules for coverage of vaccinations are complex and dependent on a number of factors. If you are unsure of how a vaccine will be covered by the Plan, contact the Pharmacy department at (800) 591-6144. For a list of vaccines and how they are covered by the Plan, refer to the Plan’s Formulary which is available on our website at www.mypreferredprovider.com.

Injectable Medications

Injectable medications administrated in the provider’s office and self-administered medications can be obtained from specialty pharmacy suppliers and are covered under the Part D benefit. Prior authorization may be required for these drugs. Refer to the section Prior Authorization below for more information.

Injectable medication authorizations should be ordered one to two weeks in advance of the service date to allow for eligibility and coverage review and for shipping. To order injectable medications, complete and submit a Coverage Determination Request (CDR) form to our Pharmacy department. The form is available for download from our website at www.mypreferredprovider.com.

Contact our Pharmacy department at (800) 591-6144 for details on the rules governing injectable medications.
Utilization Management Rules

For certain prescription drugs, the Plan has additional requirements for coverage or limits on coverage. The medications subject to utilization management rules are subject to change. Prior to prescribing medications you should check our Formulary online at www.mypreferredprovider.com or call the Pharmacy department. Certain drugs may require:

- Prior Authorization - We require prior approval for the drug.
- Quantity Limits - We limit the amount of the drug that we will cover per prescription or for a defined period of time.
- Generic Substitution - We recommend and/or provide members with the generic version, unless the provider has told us that the member must take the brand-name drug and we have approved the request.
- Step Therapy - We require you to first try certain drugs before we will cover another drug for that condition.

If a drug is subject to one of the above restrictions or limitations and the restrictions are not followed we will reject the claim.

If a drug is subject to one of these restrictions and your patient is not able to meet the additional restriction for medical necessity reasons, you or the member may request an exception. For more information, refer to Exceptions below.

Prior Authorization

Drugs that require prior authorization are marked PA in our Formulary. You must fill out and submit a Coverage Determination Request (CDR) form available on our website at www.mypreferredprovider.com.

We will send you a reply via fax. For additional information contact our Pharmacy department.

Response Times

For Part D drugs that require prior authorization we will respond within 72 hours for standard requests and 24 hours for expedited requests.

For Part B drugs our response time is 14 days for standard requests and 72 hours for expedited requests.

Quantity Limits

Quantity limits ensure that prescription drug coverage reflects drug manufacturers and FDA dosing guidelines. Medications subject to quantity limits are identified in the Formulary. These limits specify that coverage is allowed for a maximum quantity of prescribed medication, per prescription. You can find out if a drug is subject to these quantity limits by checking our Formulary at www.mypreferredprovider.com/formulary or by calling our Pharmacy department at (800) 591-6144.

Both retail and mail order pharmacy drugs can be prescribed for up to a 90 day supply for Tiers 1, 2, and 3. Tier 4 drugs are always limited to a 30-day supply per prescription.
Generic Substitution

When there is a generic version of a brand-name drug available our network pharmacies may recommend and/or provide members with the generic version unless you, the provider, tells us that the member must take the brand-name drug and we have approved this request.

Step Therapy

Step therapy requires the use of a designated prerequisite drug first, in order for another drug to be covered. Medications subject to the step therapy requirement are identified in our Formulary with an ST.

If you determine that the prerequisite drug is medically unacceptable, you must submit a Prior Authorization using our Coverage Determination Request (CDR) form. For more information, refer to Prior Authorization, above.

Coverage Determinations

A coverage determination is any decision made by the Plan regarding what Part D prescription drugs will or will not be covered by us. The prescribing physician or the member may request a coverage determination. It may be requested orally, in writing, or by fax. Coverage determinations may include, but are not limited to:

- Deciding whether or not a drug is medically necessary
- Determining if a drug falls into the benefit exclusion list
- Determining if a drug meets the established prescribing criteria
- Quantity limitations (i.e., requesting more than are typically allowed)

A coverage determination is a decision we make about benefits and coverage or about the amount we will pay for prescribed drugs.

Exceptions

We offer a formulary exception process to allow for cases where the Formulary or its restrictions may not accommodate the unique medical needs of members. To request an exception, you must fill out and submit a Coverage Determination Request (CDR) form. If you request an exception, you must also submit a supporting statement explaining why the exception is being requested.

Generally, we will only approve your request for an exception if alternative drugs included on the Plan’s formulary, a lower-tiered drug, or additional utilization restrictions would not be as effective in treating the member’s condition and/or would cause the member to have adverse medical effects.

New members taking drugs that are not on our Formulary or for which our Plan has restrictions should talk with you to decide if they should switch to another appropriate drug that we do cover, or if you, the provider, should request an exception. In certain cases, we will cover the drug during the member’s first 90 days of membership in the Plan while you and the member determine the desired course of action.
How to Request an Exception:

1. Fill out our Coverage Determination Request (CDR) form available on our website at www.mypreferedprovider.com;

2. Write a supporting statement indicating why the exception is necessary; provide any pertinent clinical notes to support the need for the medication.

3. Fax the form, clinical notes, and supporting statement to our Pharmacy department at (800) 203-1664. Note that providers have 72 hours from the date of the initial request to provide us with a supporting statement. If the statement is not received within the allowed timeframe, an adverse coverage determination may be made.

4. We will respond within 72 hours of receipt of your request and supporting statement.

Expedited Exception Requests

To submit an expedited exception request follow the same steps as you would for a standard request and write “STAT” on the top of the Coverage Determination Request (CDR) form. We will respond within 24 hours of receipt of the request and supporting statement.

If we grant your request to cover a drug that is not on our Formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the fourth tier.

You may make a verbal request for an exception, but we will request a follow-up in writing. For information please call our Pharmacy department at (800) 591-6144 or go to our website at www.mypreferedprovider.com.

NOTE: The physician or member may appeal an adverse decision. For more information refer to Appeals below.

Transition Policy

Our Transition Policy provides temporary coverage where new members have an immediate need for a drug that is not on the Plan’s Formulary or for drugs that become subject to restrictions or are no longer covered starting with a new Plan year.

If your patient is a new member or a current member taking a drug that we remove from our formulary or to which we add a restriction from one Plan year to the next, you can either switch the member to a different drug or request a formulary exception. While you pursue an exception, we may provide the member with a temporary transition supply provided it is a Part D drug purchased at a network pharmacy.

IMPORTANT:

- Only Formulary changes that take effect at the beginning of the year are subject to the Transition Policy. There is a separate process for changes to the formulary that occur mid-Plan.
- Members subject to formulary changes in the middle of the Plan year receive a 60-day notice
prior to the change. During that time we will cover the prescribed drug while the member coordinates with the provider to either switch to another drug or have the provider request an exception.

The following table summarizes the rules for receiving a transition supply of a drug:

<table>
<thead>
<tr>
<th></th>
<th>Current Member (with the Plan &gt; 90 days)</th>
<th>New Member (with the Plan &lt; 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy</strong></td>
<td>Length of the prescription up to a maximum of 30 days.</td>
<td>Length of the prescription up to a maximum of 30 days.</td>
</tr>
<tr>
<td>(Not in a Long Term Care Facility)</td>
<td>One-time supply only.</td>
<td>One-time supply only.</td>
</tr>
<tr>
<td></td>
<td>During first 90 days of plan calendar year only.</td>
<td>During first 90 days of plan calendar year only.</td>
</tr>
<tr>
<td><strong>Long Term Care Facility Pharmacy</strong></td>
<td>One-time supply only.</td>
<td>Length of the prescription up to a maximum of 34 days.</td>
</tr>
<tr>
<td></td>
<td>Length of the prescription up to a maximum of 34 days.</td>
<td>We will cover refills if necessary.</td>
</tr>
<tr>
<td></td>
<td>During first 90 days of plan calendar year only.</td>
<td>During first 90 days of plan calendar year only.</td>
</tr>
</tbody>
</table>

To request a Formulary exception call our Pharmacy department at (800) 591-6144, or fax us at (800) 203-1664. To protect the health information of members we discourage emailing any personal/health information as emails may not be sent in a secure manner.

**Pharmacy Network**

Members must go to a network pharmacy to receive covered drugs. Refer to the Plan’s Provider/Pharmacy Directory for a list of participating retail, chain, long-term care, home infusion, and mail-order pharmacies, and other relevant information. This information is available on our website at www.mypreferredprovider.com-Mail Order.

Physicians must prescribe a 30- to 90- day supply (a 30-day supply with two refills is not the same). Members may obtain the Mail Order form on our website at www.myPreferredCare.com. To download the form: choose Pharmacy > Forms > Mail Order Form. Follow the instructions on the form to order drugs via mail order. Alternatively, you can call Member Services at (866) 231-7201.

**Drug Utilization Review**

We conduct drug utilization reviews to make sure members are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications.

We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews we look for medication problems such as:

- Possible medication errors;
• Duplicate drugs that are unnecessary because the member is taking another drug to treat the same medical condition;
• Drugs that are inappropriate because of age or gender;
• Possible harmful interactions between drugs;
• Drug allergies; and/or
• Drug dosage errors.

If we identify any problems that warrant a modification, we will share our findings with you and discuss a possible alternate course of action with respect to how drugs are being prescribed. You may receive calls and/or faxes from our Pharmacy department following up on any findings. If you have any questions, please contact the Pharmacy department.

Appeals and Redetermination Processes

Part D Appeals: Standard and Expedited

To appeal an unfavorable decision on behalf of a member, you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter will provide you with the filing deadlines and the address to use to submit the appeal.

In the event a member designates a healthcare professional to appeal the decision on their behalf a copy of the member’s written consent is required and must be submitted with the appeal.

When the final decision is made you will be notified via mail. If the decision is to overturn the original determination, the service will be authorized. If the decision is to uphold the original denial determination, there will be no further action for you to undertake.

Appeals

An appeal is a written request to have the Plan reconsider an unfavorable coverage determination. If you wish to file an appeal on behalf of a member, you must do so within 60 days of an adverse coverage determination. Providers or members may file appeals for Part D drugs. Part D drug appeals are also called “redeterminations.”

Note: It is only after we have made a coverage determination that you may request an appeal. To simply ask that an exception be made to our drug policy, you must submit an exception request. For more information, refer to Exceptions above.

To request an appeal, you or the member must fax or mail a written request. You may use our standard Provider Appeal Request form or have the member submit an appeal using the Member Appeal Request form, available on our website at www.MyPreferredCare.com. Our address is:

Preferred Care Partners
Grievance and Appeals
P.O Box 56-6420
Miami, FL 33256-6420

You may also call us toll-free at (888) 291-5721 (coverage is provided 24 hours a day, 7 days a week), or fax us toll-free at (866) 261-1474.
We must have all necessary supporting documentation before we can begin processing your appeal. We will answer your Part D appeal within seven calendar days of receipt. We will answer your Part B appeal within 30 calendar days of receipt.

If we deny your Part D appeal, the member may re-file an appeal to an independent review entity within 60 days of the initial denial; details on how to do so will be provided in our denial letter. Note that only members (not providers) may re-file appeals, unless the provider re-files the appeal acting as the member’s authorized representative.

If we deny your Part B appeal, there is no second level review.

**MTM (Medication Therapy Management)**

The Medication Therapy Management (MTM) Program is a free service we offer to members. We conduct reviews on members who:

- Have multiple chronic conditions;
- Are taking at least 8 unique Part D Drugs; and
- Incur an annual cost of at least $3,138 for all covered Part D drugs.

We use the MTM program to help make sure our members are using appropriate drugs to treat their medical conditions and to identify possible medication errors. We attempt to educate members as to drugs currently on the market, making recommendations for lower-cost and/or generic drugs where applicable.

We may relay this information to the provider as well with the option for doctors to change drug therapies, as appropriate. You may receive calls and/or faxes from our Pharmacy department following up on any interventions discussed with your patient. If you have any questions, please contact our Pharmacy department.
# 2015 Pharmacy Benefit Summaries by Plan

<table>
<thead>
<tr>
<th>GROUP NUMBER</th>
<th>Preferred Choice Dade (HMO-POS)</th>
<th>Preferred Choice Broward (HMO)</th>
<th>Preferred Medicare Assist (HMO-POS SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Area</td>
<td>Dade</td>
<td>Broward</td>
<td>Dade &amp; Broward</td>
</tr>
<tr>
<td>Deductible</td>
<td>No Deduct.</td>
<td>No Deduct.</td>
<td>No Deduct.</td>
</tr>
<tr>
<td>Initial Coverage: Before the total yearly drug costs (paid by both the member and PCP) reach $***, the member pays the following for prescription drugs</td>
<td>$7,000</td>
<td>$3,250</td>
<td>$2,960</td>
</tr>
<tr>
<td>30 Day Retail (Tier 1)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>30 Day Retail (Tier 2)</td>
<td>$0</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>30 Day Retail (Tier 3)</td>
<td>$25</td>
<td>$40</td>
<td>Depends on LICS level - refer to 2015 LICS cheat sheet</td>
</tr>
<tr>
<td>30 Day Retail Specialty Drugs (Tier 4)</td>
<td>33% Co-Ins</td>
<td>33% Co-Ins</td>
<td>Depends on LICS level - refer to 2015 LICS cheat sheet</td>
</tr>
<tr>
<td>90 Day Retail (Tier 1)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>90 Day Retail (Tier 2)</td>
<td>$0</td>
<td>$60</td>
<td>$0</td>
</tr>
<tr>
<td>90 Day Retail (Tier 3)</td>
<td>$75</td>
<td>$120</td>
<td>Depends on LICS level - refer to 2015 LICS cheat sheet</td>
</tr>
<tr>
<td>90 Day (Tier 1) Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>90 Day (Tier 2) Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$50</td>
<td>$0</td>
</tr>
<tr>
<td>90 Day (Tier 3) Preferred Mail Order Pharmacy</td>
<td>$65</td>
<td>$110</td>
<td>Depends on LICS level - refer to 2015 LICS cheat sheet</td>
</tr>
<tr>
<td>90 Day (Tier 1) Non-Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>Non-preferred mail order not covered</td>
</tr>
<tr>
<td>90 Day (Tier 2) Non-Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$60</td>
<td>Non-preferred mail order not covered</td>
</tr>
<tr>
<td>90 Day (Tier 3) Non-Preferred Mail Order Pharmacy</td>
<td>$75</td>
<td>$120</td>
<td>Non-preferred mail order not covered</td>
</tr>
<tr>
<td>Coverage Gap Coverage</td>
<td>Formulary Tier 1 Only - $0 copay</td>
<td>Formulary Tier 1 Only - $0 copay</td>
<td>Formulary Tier 1 Only - $0 copay</td>
</tr>
<tr>
<td>Catastrophe Coverage: After yearly member out of pocket drug costs reaches $4,700 member pays:</td>
<td>$2.65 for Generics or 5% Co-Ins, whichever is greater; $6.60 for all other drugs or 5% Co-Ins, whichever is greater</td>
<td>$2.65 for Generics or 5% Co-Ins, whichever is greater; $6.60 for all other drugs or 5% Co-Ins, whichever is greater</td>
<td>After out-of-pocket drug costs reach $4,700 member pays a $0 Co-pay.</td>
</tr>
<tr>
<td>Coverage of Benzodiazepines, Barbiturates, &amp; ED Drugs (Enhanced Drugs)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Part B Drugs (Non-Chemo)*</td>
<td>Member pays 20% of the cost for Part B-covered drugs</td>
<td>Member pays 20% of the cost for Part B-covered drugs</td>
<td>Member pays 0% of the cost for Part B-covered drugs.</td>
</tr>
<tr>
<td>Part B Chemo Drugs (Buy &amp; Bill Only)**</td>
<td>Member pays $0 to 20% of the cost for Chemo covered drugs</td>
<td>Member pays 20% of the cost for Chemo covered drugs</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Part B Out of Pocket Limit (MOOP)</td>
<td>$3,400</td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>Service Area</td>
<td>Preferred Complete Care (HMO)</td>
<td>Preferred Special Care (HMO-SNP)</td>
<td>Preferred Secure Option (HMO)</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>GROUP NUMBER</td>
<td>PSO016</td>
<td>PSO018</td>
<td>PSO023</td>
</tr>
<tr>
<td>Service Area</td>
<td>Dade</td>
<td>Dade</td>
<td>Orlando/Tampa</td>
</tr>
<tr>
<td>Deductible</td>
<td>No Deduct.</td>
<td>No Deduct.</td>
<td>No Deduct.</td>
</tr>
<tr>
<td>Initial Coverage: Before the total yearly drug costs (paid by both the member and PCP) reach $***, the member pays the following for prescription drugs</td>
<td>$6,000</td>
<td>$5,000</td>
<td>$2,960</td>
</tr>
<tr>
<td>30 Day Retail (Tier 1)</td>
<td>$0</td>
<td>$0</td>
<td>$6</td>
</tr>
<tr>
<td>30 Day Retail (Tier 2)</td>
<td>$0</td>
<td>$0</td>
<td>$45</td>
</tr>
<tr>
<td>30 Day Retail (Tier 3)</td>
<td>$25</td>
<td>$25</td>
<td>$95</td>
</tr>
<tr>
<td>30 Day Retail Specialty Drugs (Tier 4)</td>
<td>33% Co-Ins</td>
<td>33% Co-Ins</td>
<td>33% Co-Ins</td>
</tr>
<tr>
<td>90 Day Retail (Tier 1)</td>
<td>$0</td>
<td>$0</td>
<td>$18</td>
</tr>
<tr>
<td>90 Day Retail (Tier 2)</td>
<td>$0</td>
<td>$0</td>
<td>$135</td>
</tr>
<tr>
<td>90 Day Retail (Tier 3)</td>
<td>$75</td>
<td>$75</td>
<td>$285</td>
</tr>
<tr>
<td>90 Day, (Tier 1) Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$12</td>
</tr>
<tr>
<td>90 Day, (Tier 2) Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$125</td>
</tr>
<tr>
<td>90 Day, (Tier 3) Preferred Mail Order Pharmacy</td>
<td>$65</td>
<td>$65</td>
<td>$275</td>
</tr>
<tr>
<td>90 Day, (Tier 1) Non-Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$18</td>
</tr>
<tr>
<td>90 Day, (Tier 2) Non-Preferred Mail Order Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$135</td>
</tr>
<tr>
<td>90 Day, (Tier 3) Non-Preferred Mail Order Pharmacy</td>
<td>$75</td>
<td>$75</td>
<td>$285</td>
</tr>
<tr>
<td>Coverage Gap Coverage</td>
<td>Formulary Tier 1 &amp; Tier 2 Only - $0 copay</td>
<td>Formulary Tier 1 &amp; Tier 2 Only - $0 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Catastrophe Coverage: After yearly member out of pocket drug costs reaches $4,700 member pays:</td>
<td>$2.65 for Generics or 5% Co-Ins, whichever is greater; $6.60 for all other drugs or 5% Co-Ins, whichever is greater</td>
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<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Part B Drugs (Non-Chemo)*</td>
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<td>Member pays 0% of the cost for Part B-covered drugs.</td>
<td>Member pays 20% of the cost for Part B-covered drugs.</td>
</tr>
<tr>
<td>Part B Chemo Drugs (Buy &amp; Bill Only)**</td>
<td>$0 copay</td>
<td>Member pays 0 to 20% of the cost for Chemo covered drugs</td>
<td>Member pays 20% of the cost for Chemo covered drugs</td>
</tr>
<tr>
<td>Part B Out of Pocket Limit (MOOP)</td>
<td>$3,400</td>
<td>$3,400</td>
<td>$6,700</td>
</tr>
</tbody>
</table>
Section 10: Documentation & Coding

Guidelines for Success in the Medical Risk Adjustment Model

We are committed to providing the resources necessary to assist plan providers in meeting the guidelines for the Centers for Medicare and Medicaid (CMS)-compliant documentation and coding. Our team of certified coders can meet with providers, by request, to ensure success in the CMS Medical Risk Adjustment (MRA) model.

What is the Purpose of Risk Adjustment?

Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage organizations based on the health status of their enrolled beneficiaries. Accurate payments to Medicare Advantage organizations help ensure that providers are paid appropriately for the services they provide to Medicare beneficiaries. Finally, risk adjustment provides Medicare Advantage organizations with incentives to enroll and treat less healthy individuals.

Why is Risk Adjustment Important to Physicians and Providers?

The risk adjustment model relies on the ICD-9-CM diagnosis codes to prospectively reimburse Medicare Advantage organizations based on the health status of their enrolled beneficiaries. Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-9-CM coding guidelines.

ICD-10 Delay

The U.S. Department of Health and Human Services (HHS) issued a final rule on August 4, 2014 changing the compliance date for the ICD-10-CM from October 1, 2014 to October 1, 2015 as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10. This final rule establishes the required use of ICD-9-CM through September 30, 2015. Learn more about ICD-10 at UntiedHealthcareOnline.com by selecting the “ICD-10 and Regulatory Outreach” Quick Link provided in the top right section of the screen.

What are the Responsibilities of Physicians and Providers?

Physicians must report the ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately. This requires accurate and complete medical record documentation. They are required to alert the Medicare Advantage organization of any erroneous data submitted and to follow the Medicare Advantage organization’s procedures for correcting erroneous data. Finally, they must report claims and encounter information in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient facilities).

Links to resources for the latest ICD guidelines and MRA resources are available online at www.mypreferredprovider.com.
CPT and HCPCS Codes

The American Medical Association (AMA) and the CMS update procedure codes quarterly, with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted, or revised to reflect changes in healthcare and medical practices.

If a claim is submitted with an invalid or deleted procedure code, it will be denied or returned; a valid procedure code is required for claims processing.

Because of the importance of proper coding, the Plan encourages you to purchase current copies of CPT and HCPCS reference guides. You can access CPT, HCPCS and ICD-9 coding resources and materials at the American Medical Association’s website (www.ama-assn.org), or from another vendor.
Section 11: Overpayment Recovery & Audit

Overview
Whenever possible, we work with providers to eliminate incorrect or duplicate claims. As a Plan provider, you are contractually obligated to return any overpayments.

The following are examples of overpayments:

- payment based on a charge that exceeds the Fee Schedule
- duplicate processing of the same charges/claims (for example, duplicate billing)
- payment made to incorrect payee
- payment for non-covered services or medically unnecessary services
- payment for items/services provided during a period of member non-entitlement
- claims processed incorrectly by the Plan as the primary payer
- payment for unauthorized services

If You Discover an Overpayment
If you discover an overpayment, duplicate payment, or other payment in excess of the member's benefits payable according to the member's benefit plan, remit payment promptly to us. The standard overpayment recovery look-back period is 30 months from the time the provider received the payment.

Send us a letter including the following information:

- claim number or reference number
- member name
- your patient account number
- date of service, if available

Send the letter to:

Preferred Care Partners
Audit and Recovery
P.O. Box 56-6118

If We Discover an Overpayment
If we discover an overpayment, we will send the provider a letter asking for a refund of the overpaid amount. The standard overpayment recovery look-back period is always thirty (30) months from the time the provider received the payment.

For questions related to overpayments, call our Audit and Recovery Department at (305) 671-4044.
Section 12: Filing a Claim

Claim Forms

Please note that all claim and other forms are available on our website at: www.mypreferredprovider.com.

Compensation

Additional Fees for Covered Services

You may not charge our members fees for covered services beyond copayments, coinsurance or deductibles as described in their benefit plans. You may not charge our members retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or otherwise comply with our protocols as required by your Agreement with us, or based on our reimbursement policies and methodologies. Please note, CMS does not allow the provider to charge for “missed appointments” unless the provider has previously disclosed that policy to the member.

Hospice – Medicare Advantage

Hospice Services

When a member elects hospice, CMS pays Medicare Certified Hospice providers for all covered services related to the member’s terminal illness. Claims for hospice services should be billed directly to CMS. For services covered under Medicare Part A and Medicare Part B that are not related to the member’s terminal issue, claims must be billed to the applicable Medicare Administrative Contractor. PCP is not financially responsible for these claims; however, we may be financially responsible for any additional or optional supplemental benefits under the member’s benefit plan such as eyeglasses and hearing aids. Additional and optional supplemental benefits are not covered by Medicare and are not related to the member’s terminal condition, e.g. eyeglasses, hearing aids.

Emdeon Business Services

About Emdeon

Physicians/providers are encouraged to submit claims electronically through our clearinghouse, Emdeon Business Services, a leading provider of revenue and payment services for healthcare professionals. For more information on electronic submissions, call Emdeon at (800) 845-6592, or visit their website at www.emdeon.com.
Electronic Remittance Options (ePayment)

If you would like to receive claims and capitation payments electronically, you can sign up for this service through Emdeon. Multiple enrollments for all health care payers are not necessary. Visit www.emdeonepayment.com to learn more about Emdeon ePayment services or to request additional information. For assistance by phone, including service inquiries and enrollment support, call Emdeon toll-free at (866) 506-2830.

Claims Submission

For Preferred Secure Option HMO members (H1045 PBP #023) in central Florida, please submit claims directly to WellMed.

<table>
<thead>
<tr>
<th>Paper Claims</th>
<th>Electronic Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail to: WellMed Claims</td>
<td>Payer ID: WELM2</td>
</tr>
<tr>
<td>P.O. Box 400066</td>
<td></td>
</tr>
<tr>
<td>San Antonio, TX 78229</td>
<td></td>
</tr>
</tbody>
</table>

Please Note: To ensure accurate electronic claim submission please review your clearinghouse’s payer listing to confirm that WELM2 is listed as payer ID# for WellMed. If not, utilize the payer ID# that your specific clearinghouse has designated for WellMed. If nothing is listed notify your clearinghouse that you would like to submit claims to WellMed using payer ID# WELM2.

Claims Status Inquires:

- WellMed Provider Portal ePRG: https://eprg.wellmed.net
- Phone: (800) 550-7691

Basic Requirements

Claims are processed in accordance with CMS, AHCA, the Office of Insurance Regulation, and other applicable standards and requirements. The Plan recommends that claims be submitted electronically. For details, refer to Electronic Claims Submission Section below. However, when a claim requires an attachment, or has an issue that precludes electronic submission; it may be submitted via mail using a paper CMS-1500 or UB-04 form.

Claims eligible for payment must meet the following requirements:

- The member is a current member on the date of service
- The service provided is a covered benefit under the member’s plan on the date of service
- Referral and prior authorization processes were followed
- The patient name and number on the claim form matches the name and number shown on the patient’s member ID card. A Preferred Care Partners member ID number always begins with the letter P followed by 10 digits and it is listed on the front of the card. For a sample of the member ID card refer to the section Our Plans.
The Plan has accurate billing information on file for the following:

- Provider’s name (as noted on his/her current W-9 form)
- Provider’s nine-digit Medicare Number
- Provider’s National Provider Identifier (NPI)
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- Tax Identification Number

Before we can process a claim, it must be a “clean” or complete claim submission. Failure to submit a clean claim will result in the delay or rejection of the claim. Following are definitions of “clean” and “non-clean” claims:

**Clean Claim**

A clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim has no defect or impropriety, including lack of required substantiating documentation.

**Non-Clean Claim**

A non-clean claim requires further investigation or additional information due to errors or omissions in the submitted claim. We may ask the provider or other external sources to resolve or correct data omitted from the bill, review additional medical records, or request other information to resolve discrepancies. Non-clean claims may also involve issues of medical necessity.

We will issue a determination to the provider within sixty (60) calendar days of receipt of the non-clean claim. We will not delay the determination past sixty (60) days, even to wait for medical records or additional information.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the guidelines outlined in this manual.

Please note that we may provide available information concerning an individual's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits.

**National Provider Identifier (NPI)**

All claims must be submitted with a provider’s National Provider Identifier (NPI). We require this on all electronic and paper claim submissions. Providers must send a copy of the confirmation letter from the Enumerator to the Preferred Care Partners Credentialing department to ensure that the NPI is loaded correctly into our claims payment database.

- Providers may register for an NPI at: [nppes.cms.hhs.gov/NPPES/](http://nppes.cms.hhs.gov/NPPES/)
Encounter Data

Encounter data is used to evaluate quality and utilization management. PCP requires capitated providers to submit an encounter (also called a “proxy claim”) or a claim for each service that you render to a Plan member. The information for each member visit must be submitted on a standard CMS-1500 or UB-04 form and completed with a dollar value. This is a requirement of AHCA and the State of Florida. We will monitor provider compliance for submission of encounter data.

Diagnosis Codes

A valid ICD-9 diagnosis code is required on all claims submissions. The diagnosis must be coded to the highest level of specificity (4th and 5th digits). Claims submitted without the correct diagnosis code will not be processed and the provider will be responsible for the resubmission of the claim. For additional information, refer to Documentation and Coding Guideline: Section 10.

Time Limit for Filing

Providers must submit all claims and encounters, electronic and paper, within 180 calendar days of the date of service.

Where Preferred Care Partners is the secondary payer, we must receive the claim within 90 days of the date of final determination of the primary payer.

ICD-10 Delay

The U.S. Department of Health and Human Services (HHS) issued a final rule on August 4, 2014 changing the compliance date for the ICD-10-CM from October 1, 2014 to October 1, 2015 as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10. This final rule establishes the required use of ICD-9-CM through September 30, 2015. Learn more about ICD-10 at UntiedHealthcareOnline.com by selecting the “ICD-10 and Regulatory Outreach” Quick Link provided in the top right section of the screen.

Electronic Claims Submission

PCP accepts electronic submission of claims in the HIPAA-compliant formats listed below. Providers are encouraged to submit claims through their electronic claims provider to our clearinghouse, Emdeon Business Services (Emdeon Payer ID #65088). For more information, call (800) 845-6592.

Providers that bill electronically are responsible for:

- filing claims in one of the following HIPAA-compliant formats: 837P, 837I, 837D or X12
- Filing claims within the same filing deadlines as providers who file paper claims.
- Monitoring their error reports and Explanation of Payment statements to ensure all submitted claims and encounters appear on the reports.
- Correcting any errors and resubmitting the affiliated claims and encounters.
NOTE: A claim that requires an attachment (e.g., operative reports, medical or office notes, etc.) may not be filed electronically.

### Claims Requiring Attachments

<table>
<thead>
<tr>
<th>Situation</th>
<th>Required Claim Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management services that involve high-complexity components, such as a level-5 office visit (ex., code 99215) an unlisted procedure (ex., code 19499), or an unlisted HCPCS code.</td>
<td>Appropriate, detailed documentation explaining the services. Name of drugs, corresponding National Drug Code (NDC) numbers, and the dosage administered to the member. If this is not submitted with the claim, it will be rejected.</td>
</tr>
<tr>
<td>Preferred Care Partners is not the primary payer (for example, in the case of an auto accident).</td>
<td>A copy of the primary carrier EOP (Explanation of Payment).</td>
</tr>
<tr>
<td>A Tax Identification Number (TIN), group name, or provider’s name has changed. (Note: Contact Network Management Services for these changes.)</td>
<td>A copy of the W-9.</td>
</tr>
</tbody>
</table>

### Paper Claims

Follow the guidelines below when submitting paper claims to ensure prompt and accurate processing:

- Use commercially-available “red form” versions of the CMS-1500 or UB-04 (not black and white copies). The Plan will return all paper claims submitted on black and white forms with a request to submit on red form or in electronic format.
- Print claim forms on a printer with sharp, legible type, such as a laser printer.
- Use black ink only.
- Use a plain, readable font such as Arial 10 point or larger.
- Each claim form is a complete billing document. Do not carry over totals from one claim form to another.
- For paper claims, remember that all entries will be electronically scanned in order to get the data into our claims processing system. Be sure that forms are clear and readable so that the information scans correctly. If the form is not legible and entirely.
- Be sure to verify that patient met eligibility requirements as of the date of service for the claim being submitted.

**AVOID:**

- faint or broken characters
- the use of all capital letters
- decorative, hard-to-read fonts like italics or cursive styles
- red or blue ink, or any color other than black
• small, unreadable font sizes
• dot-matrix impact printers (these have generally been replaced by ink-jet printers)

DO NOT SUBMIT a claim form with:
• changes made in liquid correction fluid
• data touching the edges of boxes, or overlapping borders of boxes
• More than 6 service lines (CMS-1500). Use a new claim form for the additional services.
• Narrative descriptions of procedure, modifier, or diagnosis; use only the appropriate CPT, ICD-9, HCPCS, and/or Revenue codes. (Exception: If the code is unlisted or “not otherwise classified,” include a narrative description. See the following pages for specific instructions.)
• stickers or rubber stamps, especially for provider’s name and address
• handwriting
• punctuation or ditto marks
• Attachments smaller than 8.5” X 11” (NOTE: Make copies of prescriptions on letter-sized paper.)

Date Formatting

For date fields, you must enter the date in:
• 8-digit format: MMDDYYYY or in
• 6-digit format: MMDDYY

The line by line instructions on the following pages indicate which date format to use.

Claim Filing Address
All paper claims and encounters should be submitted to:

Preferred Care Partners
Claims Department
P. O. Box 56-5790
Miami, FL 33256-5790

Completing the CMS-1500 Claim Form

Providers must bill with their NPI number in box 24J. We will return claims when billing information does not match the information that is currently in our files.

The CMS-1500 Claim Form (version 02/12) and instructions for filling out the form can be found on our website at www.mypreferredprovider.com. Claims missing the requirements in bold on the form will be returned and a notice will be sent to the provider creating payment delays. Such claims are not considered “clean” and therefore, cannot be entered into the system. Each field on the form is described and all required fields are marked. Required fields must be completed legibly and accurately in order to submit a clean claim.

Completing the UB-04 Claim Form

Claims submitted on the UB-04 form must adhere to the requirements described by the National Uniform Billing Committee (NUBC) in the UB-04 Data Specifications Manual.
The UB-04 Claim Form (version 08/10) and instructions for filling out the form can be found on our website at www.mypreferredprovider.com. Each field on the form is described and all required fields are marked. All required fields must be completed legibly and accurately, otherwise the claim will be returned, and a notice will be sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be entered into the system.

**Helpful Hints**

- Providers must bill with their NPI number in box 56. We will return claims when billing information does not match the information that is currently in our files.
- For inpatient hospital services you must bill all procedures provided on the same date of service on a single claim. For all other services, if there is not enough space on the UB-04 to bill all procedures provided on the same date of service, complete a separate billing form for the rest of the procedures.
- To avoid processing delays, make sure information is left-aligned in the following fields:
  - 4 = Type of Bill
  - 6 = Statement from and through dates
  - 8b = Patient name
- Use only one prior authorization number in field 63.
- In field 57, always enter the provider number to which payment should be sent. An invalid or missing provider number could delay your payment, make payment to a wrong provider, or cause denial of your payment.

**Claims Processing**

**Time Limits**

The time limit for the Plan to process a claim is thirty (30) calendar days from date of receipt for clean claims, or sixty (60) calendar days from date of receipt for non-clean claims. The time limit is the same whether the claim is electronic or paper.

**Claim Status Inquiries**

You can check the status of your claim by visiting our website at www.mypreferredprovider.com. Select “Medicare”, and then click on the Provider Portal link at the top of the page. You may also call Claims at (866) 725-9334.

If our Enrollment department notifies us of retroactive eligibility, we reprocess all claims on file for that member.

**Coordination of Benefits**

Coordination of Benefits refers to two or more insurance plans covering one individual, coordinating their respective benefits to share the cost of health care. COB rules identify one plan as the primary payer (this plan pays regular contract benefits first) and the other plan as secondary (this plan pays the balance of charges up to the limits of its contact, but never more than what it would have paid if primary).
As a participating provider, you must make reasonable efforts to determine the legal liability of third parties to pay for services furnished to the Plan’s members. If you are unsuccessful in obtaining necessary cooperation from a member in identifying potential third party resources, please inform our Claims department that such efforts have been unsuccessful. We will make every effort to work with you to determine liability coverage.

The terms of our participation contracts apply whether the member’s policy is their primary or secondary form of coverage. Coinsurance amounts are the lower of the PCP health plan allowance or the provider’s charge. Our payment, when added to other payments, shall not exceed 100% of the amount agreed to be paid for the services under the applicable PCP provider agreement.

Follow the steps below to determine what payments are due when a member has two insurance carriers. Note that COB claims should always be filed as paper claims:

1. Verify the primary insurance.
   i. File the claim to the primary insurance carrier.
   ii. Include all other insurance carrier information in the appropriate COB fields in blocks
   iii. 9a-d of the CMS-1500, or 50A-C of the UB-04.
2. File the claim to the secondary insurance carrier.
3. If Preferred Care Partners is the secondary carrier, participating providers should file the claim to Preferred Care Partners once the primary insurance has completed processing.
4. Include all other insurance carrier information in the appropriate COB fields of the electronic form or in blocks 9a-d of the CMS-1500, or field 50A-C of the UB-04 claim form.
5. Attach a copy of the other carrier’s remittance advice.
   i. Note: If you submit the HIPAA compliant 837 claim format, you can electronically submit COB data on a secondary claim by entering the primary payment information in the COB segment. If you cannot submit the 837 claim format, when billing the secondary plan, always attach a copy of the explanation of benefits form from the primary plan. COB rules may vary by contract and the rules below do not cover every situation.
6. Collect the Preferred Care Partners coinsurance, copayment, and/or non-covered services amount.
7. The terms of Preferred Care Partners’ participation contracts apply whether the member’s policy is their primary or secondary form of coverage.
8. Coinsurance amounts should be based on the lower of the Preferred Care Partners allowance or the provider’s charge. Preferred Care Partners’ payment when added to other payments shall not exceed 100% of the amount agreed to be paid for the services under the applicable Preferred Care Partners provider agreement.
9. Do not balance bill the member.
10. It is recommended that you wait to collect the coinsurance amount from the member until payments from both insurance companies have been received, which will alleviate the need to issue refunds.
COB and Medicare

Special rules apply to Coordination of Benefits with Medicare. In many cases, group health plans or other insurance will pay before Medicare. Following are some, but not all, instances in which group health plans or other insurance would be the primary payer:

Working Aged
If the employee has Medicare coverage due to age (65 and older) and is actively employed through an employer with 20 or more employees, or is self-employed and covered by an association group health plan with 100 or more members, the group health insurance through active employment must pay first.

Disability
Employees who are entitled to Medicare due to a disability other than ESRD, who are actively employed or who are covered as a dependent through an employer that employs 100 or more employees must have their group coverage as the primary payer and Medicare as the secondary payer.

End-Stage Renal Disease
For employees entitled to Medicare due to ESRD who also have group coverage through current or former employment - active, retiree, or COBRA, the employer group health plan coverage is the primary payer and Medicare is the secondary payer for the first thirty months of entitlement to Medicare. Thereafter, Medicare is the primary payer and group coverage is secondary.

No-Fault Auto Insurance
In general, no fault auto insurance provides coverage for losses sustained as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle. Payments for such claims are made by the carrier that provides coverage for the owner or driver of the vehicle in which the injured party was a passenger. Auto insurance provides medical, disability, and death benefits. The auto carrier assumes the responsibility of the primary payer up to policy limits; Preferred Care Partners will pay as secondary to the auto carrier.

If the auto carrier denies payment due to exclusion under its contract, the notice of the rejected claim must be submitted with the claim to Preferred Care Partners. A participating physician may not elect to withhold claims for members with Preferred Care Partners insurance coverage in favor of collecting from settlement proceeds for an injury that has third-party liability. To do so, constitutes balance billing, which is a breach of contract for participating providers.

Workers’ Compensation
In order to avoid delays in claims, providers must determine if the illness or injury being billed for is the result of an accident or a Workers Compensation incident. If it is, Preferred Care Partners can only be billed after the third-party carrier has considered the charges.

Workers Compensation is designed to provide cash and medical care benefits for workers who sustain injuries or illness arising out of, or in the course of, employment. Work-related injuries must be billed to the Workers’ Compensation carrier. According to Florida law, payment from a Workers’ Compensation carrier is considered as payment-in-full. Therefore, benefits would not be coordinated with preferred Care Partners for work-related illnesses or injuries.
If Preferred Care Partners makes payment in error, we are entitled to seek full restitution. If the Workers Compensation carrier has denied payment, a copy of both the denial and the claim should be submitted for consideration to Preferred Care Partners.

**Subrogation**

Subrogation typically occurs when one party is injured as a result of the actions or negligence of another. Examples include slip and fall accidents; assault; and frequently, auto accidents where subrogation applies. Preferred Care Partners has the right to “stand in the shoes” of the insured against a “wrongdoer.”

In the event that Preferred Care Partners makes any payment to or on behalf of a member for any claim in connection with or arising from a condition resulting directly or indirectly from an intentional act or from the negligence or fault of any third party or entity, Preferred Care Partners may exercise its subrogation rights to recover the cost of the medical expenses. Subrogation recoveries may not be claimed by a participating physician or other health care provider in lieu of, or in addition to, making a claim for payment pursuant to the terms of and provisions of the provider agreement.

**Claim Review Requests**

A provider can make a Claim Review Request if he or she is dissatisfied with a claim determination. Note that a Claim Review Request is different from a claim status inquiry or a claim appeal. For information on how to check claim status, refer to the section **Claim Status Inquiries** above. To file a claim appeal, follow the instructions in the section **Claim Appeals**, below.

If you wish for a claim to be reviewed, the provider or an office staff member must submit a Claim Review Request Form, or call our Claims department toll-free at (866) 725-9334. A copy of the Claim Review Request Form is located on our website at [www.mypreferredprovider.com](http://www.mypreferredprovider.com).

Claim inquiries must be submitted within 120 days (4 months) of EOP receipt. The Plan will respond to the claim inquiry within 30 days from date of receipt.

The Plan will respond to the provider in writing on all Claim Review Requests that do not result in the re-adjudication of a claim. Review of the Claim Review Request does not guarantee payment. Send written Claim Review Requests to:

**Preferred Care Partners**  
Claims Inquiry  
P.O. Box 56-5790  
Miami, FL 33256-5790

**IMPORTANT:** Submitting a Claim Review Request is not the same as filing a Claim Appeal. You have 120 days from the date of the EOP to file a Claim Appeal. If you file only a Claim Review Request, the 120 days will continue to elapse until you either file a Claim Appeal, or the 120-day timeframe expires.

**Please Note:** All disputes of claims related to Preferred Secure Option members (H1045 PBP #023) should be submitted to WellMed. The Claim Reconsideration Request Form is recommended for each claim dispute submitted. The Claim Reconsideration Request Form can be found on WellMed

Mail To:

WellMed Claims
Attn: Claims Payment Disputes
P.O. Box 400066
San Antonio, TX 78229

Claim appeals for reconsideration of a claim payment reduction or denial are processed by PCP as outlined in the Claim Appeals section below.

Claim Appeals

A claim appeal is a written request for reconsideration of a claim payment reduction or denial. The EOP will provide an explanation as to why the claim was reduced or denied. The provider has the right to appeal a payment decision. A non-contracted physician or other provider who has furnished a service may also file an appeal of a denied claim if he or she completes a Waiver of Liability (WOL) statement, which says he or she will not bill the member regardless of the outcome of the appeal.

A claim appeal does not refer to pre-certification, concurrent review, claim status requests, claim review requests, telephone inquiries, or any other type of provider communication. The Plan generally will not overturn claim denials based on the provider’s failure to comply with required procedures and time limits.

Commonly appealed claims decisions include payment for services for which preauthorization was not obtained, such as urgently needed services, or payment for health services furnished by a non-contracted provider or facility that you believe should have been reimbursed by Preferred Care Partners.

Requirements

Provider claim appeals must:

- Be submitted in writing
- Be submitted using the Provider Appeal Request form, or clearly marked “Provider Claim Appeal”
- Have a copy of the EOP attached
- Include any necessary supporting documentation as attachments, as indicated by the reason for the denial or reduction
- Be filed within 120 days of the date of the EOP

Send all claim appeals to:

Preferred Care Partners
Claims Appeals
P.O. Box 56-6420
Miami, FL 33256-6420
**Appeals Process**

Upon receipt of your appeal, the Appeals Coordinator will document and log your request for processing, and may also call you to clarify information, if necessary.

If the appeal is approved, the claim will be forwarded for adjustment and payment. If the appeal is denied, a letter will be sent advising you of the denial. Appeal decisions are final and may not be re-appealed.

Providers may not balance bill members for covered services, including disputed amounts.

**Time Limits**

We will determine the appeal status within sixty (60) calendar days of the date of your appeal. You will be notified of the final decision via mail.

**Overpayments**

If you discover an overpayment, duplicate payment, or other payment in excess of the member's benefits payable according to the member's benefit plan, payment should promptly be remitted to us.

**Retroactive Reductions**

PCP can issue a retroactive reduction on either a previously paid claim, or as a retroactive demand for refund of an overpayment. These will be reconciled to the specific claim, unless the parties agree to other reconciliation methods and terms. For more information on policies and procedures regarding overpayments, refer to *Overpayment Recovery & Audit: Section 11.*