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

We are 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. Preferred Care 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.

Using This Manual
The 2016 Provider Manual (this “Manual”) applies to covered services you provide to members under a Preferred Care benefit plan insured by UnitedHealthcare. This Manual is an extension of your provider agreement. Except when indicated, this Manual is effective on September 1, 2016 for physicians, health care professionals, facilities and ancillary providers currently participating in our network and effective immediately for physicians, healthcare professionals, facilities and ancillary providers who join our network on or after June 1, 2016.

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 health care 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.
- “Our,” “us,” “we,” or “Preferred Care” refers to Preferred Care Partners.

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 mypreferredprovider.com. Alternatively, you may request a copy of this Manual from Network Management Services (NMS) via toll-free fax, at 888-659-0619.

WellMed Medical Management, Inc. (WellMed)
Administrative, claims and utilization management services have been delegated to WellMed, a medical management organization. WellMed provides specific Utilization Management and Claims services for Medicare Advantage members in the Preferred Secure Options, (HMO) H1045 PBP #023 members residing in the following Central Florida counties: Hernando, Hillsborough, Manatee, Orange, Osceola, Pasco, Pinellas, Polk, Seminole and Volusia and for any members enrolled or assigned to a Primary Care Physician belonging to the Preferred Care Partners Medical Group (PCPMG).

Please refer to the members ID card, bottom right corner on the front of the ID card, for verification. Please refer to Chapter 3: Utilization Management and Chapter 10: Claim Processes for required administrative protocols and important contact information for WellMed.
Chapter 1: Introduction

How to Contact Us

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

Contact Us Table – Numbers, addresses, and websites.

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<th>What you can do there</th>
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<tr>
<td><strong>Authorizations and Notifications</strong></td>
<td>Phone: 800-995-0480 M-F, 9 a.m. to 5 p.m. (EST)</td>
<td>• For notifications, prior authorizations, referrals, admissions, and discharge planning</td>
</tr>
<tr>
<td></td>
<td>Fax: 866-567-0144</td>
<td>• For after-hour or weekend emergencies, notifications or hospital admissions, please call our after-hours telephonic answering service</td>
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<td></td>
<td>Online: mypreferredcare.com (Registered providers) After hours: 800-995-0480</td>
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<tr>
<td><strong>Eligibility and Benefits Verification</strong></td>
<td>Phone: 800-587-5114</td>
<td>• Verify eligibility and benefits of enrolled members</td>
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<tr>
<td></td>
<td>Fax: 305-670-2308</td>
<td>• A summary of benefits for each plan is available online.</td>
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<tr>
<td></td>
<td>Online: mypreferredcare.com (Registered providers)</td>
<td></td>
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<tr>
<td><strong>Claims - Preferred Secure Option HMO (H1045PBP #023) (WellMed)</strong></td>
<td>Phone: 800-550-7691</td>
<td>• Review your clearinghouse’s payer listing to confirm that WELM2 is listed as payer ID#.</td>
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<tr>
<td></td>
<td>Online: empg.wellmed.net</td>
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<tr>
<td></td>
<td>Address: WellMed Claims P.O. Box 400066 San Antonio, TX 78229</td>
<td></td>
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<tr>
<td><strong>Claims (all other Preferred Care plans) (Emdeon)</strong></td>
<td>Phone: 866-725-9334 M-F, 8 a.m. to 5 p.m. (EST)</td>
<td>• For claims, encounters, inquiries, status, or review requests</td>
</tr>
<tr>
<td></td>
<td>Fax: 866-725-9337</td>
<td>• Payer ID #65088</td>
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<td></td>
<td>Online: mypreferredcare.com</td>
<td>• Password or technical support issues</td>
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<td></td>
<td>Phone: 800-845-6592</td>
<td>• Information on electronic claims submission</td>
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<tr>
<td><strong>Covered Services per Plan</strong></td>
<td>Online: mypreferredprovider.com &gt; Provider Resources &gt;Summary of Benefits</td>
<td>• 2016 Summary of Benefits for each Preferred Care Partners plan.</td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td>Phone: 800-963-6495 M-F, 9 a.m. to 5 p.m. (EST)</td>
<td>• For issues regarding credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility.</td>
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<tr>
<td></td>
<td>Fax: 866-567-0144</td>
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<tr>
<td><strong>Electronic Remittance (Facilitated by Emdeon Business Services, Inc.)</strong></td>
<td>Facilitated by Emdeon Business Services, Inc.</td>
<td>• Information and registration for electronic payment services</td>
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<td></td>
<td>Phone: 800-845-6592</td>
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<td></td>
<td>Online: emdeonpayment.com</td>
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<td><strong>Fraud, Waste, and Abuse (FWA) Hotline</strong></td>
<td>Phone: 866-787-8822 M-F, 9 a.m. to 5 p.m. (EST)</td>
<td>• Report concerns related to fraud, waste, or abuse.</td>
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<td></td>
<td>Fax: 305-671-4085</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:ReportFraud@UHCsouthflorida.com">ReportFraud@UHCsouthflorida.com</a></td>
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<td></td>
<td>Mail: Preferred Care Partners Special Investigations Unit P.O. Box 56-5748 Miami FL 33256-5748</td>
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<tr>
<td>Resources</td>
<td>Where to Go</td>
<td>What you can do there</td>
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<td><strong>Grievances &amp; Appeals</strong></td>
<td>Phone: 888-291-5721</td>
<td>• For questions about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms.</td>
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<td></td>
<td>MF, 9 a.m. to 5 p.m. (EST)</td>
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<td></td>
<td>Fax: 866-261-1474</td>
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<td></td>
<td>Online: mypreferredcare.com (print form)</td>
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<td></td>
<td>Mail: Preferred Care Partners, Inc.</td>
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<tr>
<td></td>
<td>Grievances &amp; Appeals Department</td>
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<tr>
<td></td>
<td>P.O. Box 56-6420</td>
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<td></td>
<td>Miami, FL 32356-6420</td>
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<tr>
<td><strong>Member Services</strong></td>
<td>Phone: 866-231-7201</td>
<td>• To assist our members with any questions, help locate specialists, and perform other related functions.</td>
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<tr>
<td></td>
<td>MF, 800 a.m. to 5 p.m. (EST)</td>
<td>• This toll-free phone number is also printed on the member's Plan ID card</td>
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<td>TTY: 711</td>
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<td></td>
<td>Fax: 866-567-0144</td>
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<td></td>
<td>Online: mypreferredcare.com &gt; Members</td>
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<td><strong>Network Management Services</strong></td>
<td>Phone: 877-670-8432</td>
<td>• For questions regarding provider agreements, inservicing and follow-up or outreachs,</td>
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<tr>
<td></td>
<td>MF, 9 a.m. to 5 p.m. (EST)</td>
<td>• Report demographic changes,</td>
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<td></td>
<td>Fax: 786-888-1291</td>
<td>• Informal complaints,</td>
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<td></td>
<td>Email: <a href="mailto:NMS@UHCsouthflorida.com">NMS@UHCsouthflorida.com</a></td>
<td>• Requests for forms or other materials.</td>
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<tr>
<td><strong>Pharmacy</strong></td>
<td>Phone: 800-591-6144</td>
<td>• Verify pharmacy benefits and eligibility, adjudications, or authorizations</td>
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<td>MF, 9 a.m. to 5 p.m. (EST)</td>
<td>• See Pharmacy Benefit Updates</td>
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<td>Fax: 800-203-1664</td>
<td>• Get printable versions of the formulary for each plan</td>
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<td>Online: mypreferredprovider.com &gt; 2015 Formulary</td>
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<td><strong>Risk Management (Healthcare)</strong></td>
<td>Phone: 800-310-7622</td>
<td>Member Incident Reporting or Privacy Incident Reporting</td>
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<td>954-378-0478</td>
<td>• Report incidents involving members to our Risk Manager by faxing the appropriate report form</td>
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<td>Fax: 954-378-0771</td>
<td>• Report incidents involving all privacy issues (potential breeches of PHI or PII) immediately to our Risk Manager</td>
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<td><strong>Utilization Management</strong></td>
<td>We recommend that you initiate requests for</td>
<td>If additional medical information is needed, or the request cannot be completed</td>
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<td>notifications and authorizations electronically.</td>
<td>electronically:</td>
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<td></td>
<td>Online: mypreferredprovider.com</td>
<td>• 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 or notification</td>
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<td></td>
<td>Phone: 800-995-0480</td>
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<td></td>
<td>954-378-0478</td>
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<tr>
<td></td>
<td>Fax: 866-567-0144</td>
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<tr>
<td><strong>WellMed Medical Management, Inc.</strong></td>
<td>Please refer to number on the bottom right corner of the member's ID card.</td>
<td>• In the following Central Florida counties: Hernando, Hillsborough, Manatee, Orange, Osceola, Pasco, Pinellas, Polk, Seminole and Volusia</td>
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<tr>
<td><strong>Ancillary and Enhanced Benefit Providers</strong></td>
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<td><strong>Behavior Health Svc Psychcare, Inc.</strong></td>
<td>Phone: 855-371-2285</td>
<td>• Behavioral health and substance abuse services for all members.</td>
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<td></td>
<td>MF, 9 a.m. to 5 p.m. (EST)</td>
<td>• A list of behavioral health care providers is included in the Provider Directory.</td>
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<td></td>
<td>Licensed clinicians are on-call 24 hours a day,</td>
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<td></td>
<td>7 days a week.</td>
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<td><strong>Dental (Solstice)</strong></td>
<td>Phone: 877-670-8432</td>
<td>• A list of Solstice dental providers is available in the Provider Directory.</td>
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<td>MF, 9 a.m. to 6 p.m. (EST)</td>
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<td><strong>DME/Infusion (MedCare)</strong></td>
<td>Phone: 800-819-0751</td>
<td>• Contact MedCare to arrange for these services.</td>
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<td></td>
<td>MF, 9 a.m. to 5 p.m. (EST)</td>
<td>• Call UM or Network Management (listed above) for additional assistance.</td>
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<td>On call: 24 hours</td>
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<tr>
<td><strong>Fitness</strong>&lt;br&gt;(Silver Sneakers®)</td>
<td>Phone: 888-423-4632&lt;br&gt;Online: silversneakers.com</td>
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<td><strong>Hearing</strong>&lt;br&gt;(Hear-X/HearUSA)</td>
<td>Phone: 877-670-8432&lt;br&gt;M-F, 9 a.m. to 5 p.m. (EST)</td>
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<tr>
<td><strong>Home Health</strong>&lt;br&gt;(MedCare)</td>
<td>Phone: 305-883-2940</td>
<td>• Contact MedCare to arrange for these services. • Call UM or Network Management for additional assistance.</td>
</tr>
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<td><strong>Laboratory</strong>&lt;br&gt;Quest Diagnostics</td>
<td>Phone: 866-697-8378&lt;br&gt;Online: questdiagnostics.com</td>
<td>• Information on locations, to make an appointment, and to order lab tests and view results. • Quest Diagnostics will set up an account with your office and make arrangements to pick up specimens when necessary.</td>
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<tr>
<td><strong>Mail Order Pharmacy</strong>&lt;br&gt;(OptumRx)</td>
<td>Phone: 877-889-6358&lt;br&gt;Online: optumrx.com</td>
<td>• Obtain mail-order medications</td>
</tr>
<tr>
<td><strong>Nurse Hotline</strong>&lt;br&gt;(Carnet)</td>
<td>Phone: 866-523-4728&lt;br&gt;Available 24 hours a day, 7 days a week.</td>
<td>• Only available under certain plans. • Nurses are available to triage callers to emergency or urgent care, or to refer them to their primary care physician.</td>
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<tr>
<td><strong>Podiatry</strong>&lt;br&gt;(Foot and Ankle Network)</td>
<td>Phone (Network Mgmt Services): 877-670-8432, M-F, 9 a.m. to 5 p.m. (EST)</td>
<td>• A list of podiatrists is included in our Provider Directory.</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>Phone (Member Services): 888-774-7772&lt;br&gt;M-F, 9 a.m. to 5 p.m. (EST)</td>
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<tr>
<td><strong>Vision</strong>&lt;br&gt;(iCare)</td>
<td>Phone (Network Mgmt Services): 877-670-8432, M-F, 9 a.m. to 5 p.m. (EST)</td>
<td>• A list of vision providers is included in our provider directory.</td>
</tr>
</tbody>
</table>
**General Administrative Requirements**

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.

**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 Preferred Care, 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.

**Cooperate with Quality Management Activities**

All participating physicians, healthcare professionals, and facilities must cooperate with all of our quality management and patient safety activities including the following:

- Timely provision of medical records upon requests including contracted business associates requests if the provision of copies or access to such records will be free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax;
- Cooperation with quality of care investigations including timely response to queries 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;
- Allowing the use of provider performance data.

**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 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 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 IRS.gov).

**Official Notice Requirements**

You must send notice to us at the address noted in your agreement with us and delivered via the method required, within ten 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 or facility.

**Access Standards**

We monitor physician accessibility and availability on an ongoing basis to measure performance against established standards for reasonable location of health care providers, number of care providers, appointment availability, provision for emergency care, and after-hours service. Monitoring activities may include surveys (including geo-access surveys), on-site visits, evaluation of member experience, and evaluation of complaints.

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.
The guidelines listed above are general Preferred Care 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 Preferred Care. We encourage you to go to our website at mypreferredprovider.com to find the most current directory of our network physicians and health care professionals. If the covering physician is not recognized by us, their claims will be denied.

**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 Preferred Care 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 Preferred Care 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:
- 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 or USB drives and other electronic devices;
- Caller mentions they 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 Chapter 6: Medical Records.

**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.

Inform Members of Rights and Advance Directives

Providers 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. Health care professionals must 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.

According to the Federal Patient Self-Determination Act of 1990, 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. For more information on member rights and responsibilities, refer to Chapter 5: Member Rights & Responsibilities.

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 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 or investigation. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place. For more information on medical records requirements, refer to Chapter 6: Medical Records.

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 based on health status.
• You must allow member direct access to 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 help ensure that members have adequate access to covered health services.
• You must ensure that your hours of operation are convenient to 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.
Chapter 2: Provider Administrative Responsibilities

- 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 management 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.

Termination of Contract Agreements

The Agreement may 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 Preferred Care 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 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 us 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 Preferred Care Partners.

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.
Chapter 3: Utilization Management

This chapter outlines our Utilization Management (UM) 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 Management (QM) 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.

WellMed and Utilization Management

As of January 1, 2016 all Utilization Management (Authorizations) & Claims payment services have been delegated to our vendor, WellMed, for all members who are assigned to a Primary Care Physician belonging to Preferred Care Partners Medical Group (PCPMG). Previously, WellMed was our UM vendor only in specific counties.

For Preferred Secure Options HMO members (H1045 PBP #023), and members assigned to a PCPMG primary care physician, providers must reference the WellMed Florida Prior Authorization List. This list can be found in the WellMed secure provider portal at eprg.wellmed.net, in the provider resource tab.

Services Not Requiring Prior Authorization

We do 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.

We also publish a CPT listing of healthcare services, the Participating Provider No Authorization Reference Guide (NARG), to assist you 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.

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.

Should you encounter a member 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 high fever, animal bites, fractures, complications from respiratory infections or flu;

• Are provided when the member is temporarily absent from our service area, or under unusual and extraordinary circumstances, when the member is in the service area, and,

• If, given the circumstances, the network is temporarily unavailable or inaccessible; and it was not reasonable to wait to obtain the services from a network healthcare professional.

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.
Simple Referral Process

Preferred Choice Palm Beach HMO (H1045 PBP #37) and Preferred Medicare Assist Palm Beach HMO (H1045 PBP #38) Members: The Simple Referral Process is a tool to help Primary Care Physicians better coordinate member care. Referrals are necessary for most participating specialists*. Requests for non-participating providers will need additional authorization.

- Register to get online access at mypreferredprovider.com
- Submit requests through our online provider portal at mypreferredprovider.com
- Upon submitting a referral request, the system automatically generates the referral number to be printed.
- Request a referral for one or multiple visits.
- The referral is valid for 6 months.
- No supporting documentation is needed for referrals to specialists.
- The provider portal will automatically fax a copy of the referral to the specialist office.
- You can print a copy for your records and provide members with a copy of the referral confirmation.

*The following specialists and services will not require a referral:
- Preventive Services – as defined in the Summary of Benefit,
- Mental Health Services,
- Podiatrist Services,
- Chiropractic Services,
- Comprehensive Dental,
- Routine Eye Exams and Ophthalmology Services,
- Nutritionist Services,
- Hearing and Physical Exams,
- Speech and Occupational Services

For additional information call us at 877-670-8432 or email us at NMS@UHCsouthflorida.com

Fax inpatient hospital admission notification 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.

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.

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

The WellMed Florida Specialty Protocol List gives more information about which specialties/services may be exempt from the referral process. Providers may view the WellMed Specialty Protocol List in the WellMed Provider portal at eprg.wellmed.net in the Provider Resource Tab.

Why is Authorization or Notification Required?

Information gathered about planned member 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.

Authorization Requirements

- For Preferred Secure Option HMO members (H1045 PBP #023) and members assigned to a Preferred Care primary care physician. You may submit Prior Authorization Requests on the WellMed provider portal at eprg.wellmed.net. 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.

- Physicians, health care professionals, and ancillary providers are responsible for obtaining prior authorization for all services requiring authorization before these services are scheduled or rendered, such as 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 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 must be submitted for a participating provider.

Note: You should not request an expedited (72 hours) review unless it is determined that waiting for a standard (14 calendar days) review could place the member’s life, health, or ability to regain maximum function in serious jeopardy. Once you determine the situation meets this definition, request that a prior
authorization be expedited by placing “STAT/urgent” on the Prior Authorization Form.

• 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 Preferred Care network. The referring physician must submit a completed Prior Authorization Form for approval and is available on our website at 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 the 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. Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

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 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.

• If a member receives urgent care services, the provider must notify us within 48 hours of the services being rendered.

• For after-hour and weekend notifications please call our after-hours telephonic answering service, Stericyle at 800-995-0480 for assistance.

Admission Notification Requirements

• Facilities are responsible for Admission Notification for the following types of inpatient admissions:
  ◦ Planned or elective admissions for acute care
  ◦ Unplanned admissions for acute care
  ◦ Skilled Nursing Facility (SNF) admissions
  ◦ Admissions following outpatient surgery
  ◦ Admissions following observation
  ◦ All observations
  ◦ Acute inpatient rehabilitation admission
  ◦ LTACH admissions

• Unless otherwise indicated, Admission Notification must be received within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday).

• For after-hours, weekend and federal holiday admissions, please call our answering service, Stericyle 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:
  ◦ Member name and member health care ID number
  ◦ Facility name
  ◦ Admitting or attending physician name
  ◦ Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
  ◦ Actual admission date
  ◦ Admission orders written by a physician

• For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us 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 us.
Chapter 3: Utilization Management

How to Request Prior Authorization

It is recommended that you initiate prior authorization requests electronically via the provider web portal at mypreferredcare.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 complete and sign Prior Authorization Form, and fax it to the UM 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, mypreferredcare.com or you may contact UM at 800-995-0480 to request a copy.

Required Information 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, phone and fax numbers,
- Primary care physician information, (if different from the requesting provider): name, phone and fax numbers,
- Referral information: name of referring provider, designate par or non-par, address, phone, and fax numbers,
- Diagnosis or Symptoms: Include the diagnosis description and the corresponding ICD-10 Code for each diagnosis to the highest specificity, and
- Service(s) Requested:
  - Identify each procedure, and its corresponding CPT code.
  - Document any pertinent clinical summary information which would be helpful to that specialist or for the UM determination in the Additional Comments field.
  - 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 section of this chapter.

- 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.

Timeframes for Processing Prior Authorization Requests

Provided the information we receive is complete, we will make a determination of your request within 14 calendar days of receipt, or within 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.

Clinical Coverage Review

Certain services require prior authorization which will result in:

1. A request for clinical information,
2. A clinical coverage review based on medical necessity, and
3. A coverage determination.

You must cooperate with all requests for information, documents or discussions for purposes of a clinical coverage review including providing pertinent medical records, imaging studies or reports and appropriate assessments for determining degree of pain or functional impairment.

As a network provider, you must respond to calls from our UM staff or medical director. You must provide complete clinical information as required within the timeframe specified on the Outreach form.

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.
Chapter 3: Utilization Management

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

Clinical Coverage Review Criteria
We use scientifically based clinical evidence to identify safe and effective health services for enrollees, for inpatient and outpatient services. For Inpatient Care Management (ICM’s) utilize evidence based MCG Care Guidelines. Clinical coverage decisions are based on the eligibility of the enrollee, state and federal mandates, the enrollee’s certificate of coverage, evidence of coverage or summary plan description and United Health medical policy, medical technology assessment information, and for Medicare and Retirement, CMS NCDs and LCDs, and other based clinical literature.

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. Preferred Care 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.

Prior Authorization Denials
We may deny a prior authorization request for several reasons:

- Member is not eligible;
- Service requested is not a covered benefit;
- Member’s benefit has been exhausted; or
- Service requested is identified as not medically necessary (based upon clinical criteria guidelines).

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

Preferred Secure Options HMO plan (H1045 PBP #023) Members and members assigned to a Preferred Care primary care physician:
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 WellMed Utilization Management Department at 877-299-7213.

Peer-to-Peer Clinical Review
Peer-to-Peer reviews cannot be made after a decision has been reached by the Medical Director. For Inpatient reviews, providers have until the next day at 3 p.m. to request a peer-to-peer review. Once a denial is processed in the system, the case will not be reopened.

Preferred Care 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. Preferred Care offers pre-denial peer to peer reviews to the providers. If you would like to discuss the case with one of our physician reviewers, please contact UM at 800-995-0480.

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

Technology Assessment Coverage Determination
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 us to support 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 patients please contact Utilization Management at 800-995-0480.
Chapter 3: Utilization Management

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.

Although not required to do so, we may assist in identifying health care resources, which may be available in the member’s community following an inpatient stay.

Utilization Management Nurses conduct onsite 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 us 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, or multiple or specialized durable medical equipment identified prior to discharge.

Discharge planning for members in the Preferred Secure Options plan (H1045PBP #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.

Appeal & Reconsideration Processes
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 Preferred Care of an appeal and:

- Preferred Care facility onsite Concurrent Review Staff completes the Detailed Notice of Discharge (DNOD), and delivers it to the Medicare Advantage member, or their representative as soon as possible but no later than 12 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 Preferred Care facility onsite staff, the facility completes the DNOD, and delivers the DNOD to the Medicare Advantage member or their representative as soon as possible but no later than 12 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 Preferred Care.

Facility (SNF, HHA, CORF) Notice of Medicare Non-Coverage (NOMNC) Protocol
CMS requires SNFs, HHAs, and CORFs to deliver the NOMNC required notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the members’ services are expected to be fewer than two calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. If the span of time between services exceeds two 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 form entitled, “Notice of Medicare Non-coverage” (NOMNC). The form and instructions are found on the CMS website at cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html or you may contact KEPRO the BFCC-QIO for Florida at this link: keproqio.com/ for more information. There can be no modification of the NOMNC notification text.

Clinical Appeals: Standard and Expedited
To appeal an adverse decision (a decision to deny the authorization of 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 Provider Appeal Request form, which can be downloaded from our website at mypreferredprovider.com. Alternatively, you can provide a letter stating 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. Mail 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.
Chapter 4: 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, or restrictions for each drug, if applicable. Download the Formulary from our website at mypreferredprovider.com, or call our Pharmacy department at 800-591-6144.

Our Formulary offers five drug tiers:
- Tier 1: Preferred generic drugs
- Tier 2: Non-preferred generic drugs
- Tier 3: Preferred brand-name drugs
- Tier 4: Non-preferred brand-name drugs
- Tier 5: Specialty drugs

Use our online Formulary to identify a drug’s tier. The most current copy of our Formulary is on our website at 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 later in this chapter.

An exception process is provided to allow for cases in which the Formulary may not accommodate the unique medical needs of a member. 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 mypreferredprovider.com.

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

Part B Covered Drugs
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 their office; insulin when administered via pump and diabetes test strips.

Diabetes Monitoring Supplies
The Preferred Diabetic Supply program is for members who have diabetes (insulin and non-insulin users). Covered services include: Supplies to monitor blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.

UnitedHealthcare only covers the following brands of blood glucose monitors and test strips:
- OneTouch® Ultra®,
- OneTouch® Verio™,
- OneTouch® Verio Flex™,
- OneTouch® UltraMini™,
- ACCU-CHEK® Aviva Plus, and
- ACCU-CHEK® SmartView.

Other brands are not covered. There is a $0 co-payment for Medicare-covered diabetes monitoring supplies.

The Preferred Diabetic Supply program is a Part B covered benefit. It is also available through OptumRx as well as through some of our DME providers.

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 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 Facility (Includes Mental Health Facilities) Pharmacies
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 member’s benefits, contact the Pharmacy department at 800-591-6144. For a current list of vaccines and how they are covered by us, go to mypreferredprovider.com > 2015 Formulary.

**Injectable Medications**

Injectable medications administered 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 on the member portal at mypreferredcare.com > Member Resources > Forms.

Contact our Pharmacy department at 800-591-6144 for details on the rules governing injectable medications.

**Utilization Management Rules**

For certain prescription drugs, we have 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 mypreferredprovider.com or call the Pharmacy department. Certain drugs may require:

- Prior Authorization
- 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 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 our member 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 mypreferredcare.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 mypreferredprovider.com > 2015 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, 3, and 4. However, Tier 5 drugs may be 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 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 a decision we make about Plan D benefits and coverage or about the amount we will pay for prescribed drugs. 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:

- 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)

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 our formulary list, a lower-tiered drug, or additional utilization restrictions would not be as effective in treating the member’s condition or would cause the member to have adverse medical effects.

New members taking drugs that are not on our Formulary List or for which there are restrictions should talk with you to decide if they should switch to another appropriate drug that we do cover, or if you, should request an exception. In certain cases, we will cover the drug during the member’s first 90 days of membership 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 mypreferredprovider.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.

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 mypreferredprovider.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 when new members have an immediate need for a drug that is not on our Formulary or for drugs that become subject to restrictions or are no longer covered.

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 another 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.

Note:
- 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-year.
- Members subject to formulary changes in the middle of the enrollment year receive a 60-day notice prior to the change. During that time, we will cover the prescribed drug while the member coordinates with their provider to either switch to another drug, or have their provider request an exception.
Chapter 4: Pharmacy

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

<table>
<thead>
<tr>
<th></th>
<th>Current Member (enrolled &gt; 90 days)</th>
<th>New Member (enrolled &lt; 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy (Not in a Long Term Care Facility)</td>
<td>Length of the prescription up to a maximum of 30 days. One-time supply only. During first 90 days of plan calendar year only.</td>
<td>Length of the prescription up to a maximum of 30 days. One-time supply only. During first 90 days of plan calendar year only.</td>
</tr>
<tr>
<td>Long Term Care Facility Pharmacy</td>
<td>One-time supply only. Length of the prescription up to a maximum of 34 days.</td>
<td>Length of the prescription up to a maximum of 31 days. We will cover refills if necessary. 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 your request to 800-203-1664. To protect the health information of members we discourage emailing any personal health information (PHI) as emails may not be sent in a secure manner.

**Drug Utilization Review**

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

A drug utilization review is conducted 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 is inappropriate because of age or gender;
- Possible harmful interactions between drugs;
- Drug allergies; 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 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 us 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.”
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 section 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 mypreferredcare.com.

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

Phone: 888-291-5721 (24/7)
Fax: 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. 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.

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

- Have multiple chronic conditions;
- Are taking at least eight unique Part D Drugs; and
- Incur an annual cost of at least $3,507 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 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 or faxes from our Pharmacy department following up on any interventions discussed with the member. If you have any questions, please contact our Pharmacy department.
# 2016 Pharmacy Benefit Summaries by Plan

Please note the number of formulary tiers has increased from 4 tiers to 5 tiers. The nomenclature for the tiers has changed as well.

<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>82935 / 82967</td>
<td>82936 / 82961</td>
<td>829371 / 82952</td>
</tr>
<tr>
<td>Deductible</td>
<td>Dade</td>
<td>Broward</td>
<td>Dade &amp; Broward</td>
</tr>
<tr>
<td>Initial Coverage*</td>
<td>$7,000</td>
<td>$3,310</td>
<td>$3,310</td>
</tr>
<tr>
<td>Tier 1, 30-day Retail</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 2, 30-day</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 3, 30-day</td>
<td>0</td>
<td>$20</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 4, 30-day</td>
<td>$35</td>
<td>50</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 5, 30-day</td>
<td>33% Co-insurance</td>
<td>33% Co-insurance</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>3 month supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1, 90-day Retail</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 2, 90-day</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 3, 90-day</td>
<td>0</td>
<td>$60</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 4 90 day</td>
<td>$105</td>
<td>$150</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 5, 90 day</td>
<td>33% Co-insurance</td>
<td>33% Co-insurance</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Mail Order Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1, 90-day Retail</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 2, 90-day</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tier 3, 90-day</td>
<td>0</td>
<td>$50</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 4, 90-day</td>
<td>$95</td>
<td>$140</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Tier 5, 90 day</td>
<td>33% Co-insurance</td>
<td>33% Co-insurance</td>
<td>Refer to 2016 LICS sheet</td>
</tr>
<tr>
<td>Catastrophic Coverage: After yearly member out-of-pocket drug costs reach $4,850, member pays the greater amount</td>
<td>After out-of-pocket drug costs reach $4,850 member pays $2.95 for Generics or $7.40 for all other drugs or 5% Co-Ins, Whichever is greater</td>
<td>After out-of-pocket drug costs reach $4,850 member pays $2.95 for Generics or $7.40 for all other drugs or 5% Co-Ins, Whichever is greater</td>
<td>After out-of-pocket drug costs reach $4,850 member pays $2.95 for Generics or $7.40 for all other drugs or 5% Co-Ins, Whichever is greater</td>
</tr>
<tr>
<td>Coverage Gap Coverage</td>
<td>Tier 1&amp;2 $0 copay</td>
<td>Tier 1&amp;2 $0 copay</td>
<td>Tier 1&amp;2 $0 copay</td>
</tr>
<tr>
<td>Coverage of enhancement drugs** (i.e., Oral ED (Erectile Dysfunction), Folic Acid, and Injectable B-12)</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% for Part B covered drugs</td>
</tr>
<tr>
<td>Part B Chemo drugs (Buy and Bill only** *)</td>
<td>Member pays $0 - 20% of the cost for covered Chemo drugs</td>
<td>Member pays 20% of the cost for covered Chemo drugs</td>
<td>Member pays $0 copay for covered Chemo drugs</td>
</tr>
<tr>
<td>Part B Out of Pocket Limit (MOOP)</td>
<td>$3,400</td>
<td>$6,700</td>
<td>$3,400</td>
</tr>
</tbody>
</table>

* Before the total yearly drug costs (paid by both the member and Preferred Care) reach $***, the member pays the amounts listed for prescription drugs.

** Coverage for Enhancement Drugs no longer includes Benzodiazepines & Barbiturates – These are now covered under Part D under the applicable formulary tiers.
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 our website at 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 their rights as a Medicare Advantage member, please refer them to the Member Services phone number on the back of their ID Card.

**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. 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.

Competent members have the right to refuse recommended treatment, counsel or procedure. The health care professional may regard such refusal as incompatible with the continuance of the provider/patient relationship and the provision of proper medical care. If this occurs, and the health care professional believes that no professionally acceptable alternatives exist, they must so inform the member in writing, via certified mail. The health care professional must give the member 30 calendar days to find another provider. During this time, the health care professional is responsible for providing continuity of care to the member. For more information, refer to Chapter 7: Quality Management (QM) Programs.

**Advance Directives**

The federal Patient Self-Determination Act (PSDA) of 1990 gives individuals age 18 and older the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive.

This law states that members’ rights and personal wishes must be respected even when the member is too sick to make decisions on their own. You may find the Patient Self-Determination Act at gpo.gov.

To help ensure 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. Providers, hospitals, nursing homes, home health agencies, hospices, and HMOs are required to provide their patients with written information regarding treatment options.

This discussion should be documented at least once in the member’s record.

To comply with this requirement, we also inform members of state laws on advance directives through our members’ benefit material. We encourage you to have these discussions with our members.

**Online Resources:** You may find the federal Patient Self-Determination Act at gpo.gov. You may download free forms from the State at floridahealthfinder.gov/reports-guides/advance-directives.aspx.

Information is also available from the Robert Wood Foundation, Five Wishes. The information there meets the legal requirements for an advance directive in Florida and may be helpful to members. Five Wishes is available at AgingWithDignity.org.

**Member Financial Responsibility**

Members are responsible for the copayments, deductibles, and co-insurance 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 co-insurance, we recommend that you submit claims first and refer to the appropriate Summary of Benefits (SOB) 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 mypreferredprovider.com to help you determine member and health plan responsibility.
A well-documented medical record reflects the quality and completeness of care delivered to patients. Participating providers are required to keep accurate and complete medical records of our members for at least ten years. Medical record review is a tool we use to evaluate the quality, timeliness, and appropriateness of the services rendered.

Documentation and Confidentiality of Medical Records

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

You must 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 providers. Our member should sign a Medical Record Release Form as a part of their medical record. Contact Network Management Services, 877-670-8432, to request a copy of this form.

Please follow these confidentiality guidelines:

- 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: For detailed information on advance directives, refer to Chapter 5: Member Rights & Responsibilities. It is your responsibility to provide the member with Advance Directive information, and to encourage the member to retain a copy for their personal records. This discussion should be documented at least once in the member’s medical record.

Biographical Information: The member’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 physician (MD, DO). Electronic signatures are acceptable for electronic medical records.

Family History: Family medical history should be documented no later than the first visit.

Past Medical History: Documentation should include a detailed medical, surgical, and social history.

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

Chart Organization: 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 or gender specific preventive health services for members in order to achieve a positive impact on the member’s health and better medical outcomes.
**Chapter 6: Medical Records**

**Required Encounter Documentation:** Every visit must include the following documentation:

- **The date;**
- **Chief complaint or purpose;**
- **Objective findings;**
- **Diagnosis or medical impression;**
- **Studies ordered (lab, x-ray, etc.);**
- **Therapies administered or ordered;**
- **Education provided; disposition, recommendations, instructions to the member 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.

Health care 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 providers, and d) protects the confidentiality of the records.

The member should sign a **Medical Record Release Form** as a part of their medical record, as well as 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**

As part of our recredentialing requirements and for HEDIS reporting, we perform reviews of providers’ medical records through the Medicare Advantage QM Program. Our review criteria incorporate applicable federal, state, and regulatory requirements for medical record documentation.

The purpose of periodic medical record reviews is to determine compliance with 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.

We conduct 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 our quality standard. Providers who do not meet the standard have up to 30 days to address the items noted and provide a written response, signed by the provider. If applicable, we 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.
Chapter 7: Quality Management (QM) Programs

Preferred Care is a health care delivery organization that provides comprehensive medical or clinical care and services for Medicare Advantage members through a network of physicians, facilities and other health care professionals. Preferred Care operates under the UnitedHealthcare, Medicare Advantage Quality Management (QM) 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 QM 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 QM Program and are specialized according to regulatory requirement, population needs, and available delivery models.

The QM 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. Examples of QM activities include:

- Identification of the scope of care and services rendered by the provider
- Development of clinical guidelines and service standards by which clinical performance is measured
- Objective evaluation and systematic monitoring of the quality and appropriateness of services and medical care received from our network of providers
- Assessment of the medical qualifications of participating physicians and other health care professionals
- Continued improvement of member health care and services
- Efforts to ensure patient safety and confidentiality of member medical information
- Resolution of identified quality issues.

The ultimate authority and oversight responsibility for our QM Program lies with our board of directors. Day-to-day QM operations are delegated to the Regional Quality Director and Senior Medical Director.

Provider contracts include the obligation to participate in the Program. Upon request, we will make the information within the program available to members and providers. For a complete copy of the QM Program Description outlining the structure and process, please call Customer Service at 866-231-7201. Customer Service hours are Monday through Friday, 9 a.m. to 5 p.m.

Quality Management Committee

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.

UnitedHealthcare’s Medical Advisory Committee (MAC) also oversees QM activities and addresses specific issues that arise. These issues include review and recommendations regarding clinical practice guidelines, medical policies, service standards, over-utilization, and under-utilization of services by physicians and other health care professionals. The MAC also makes recommendations regarding the selection of QM studies (based on identified high-volume, high-risk and problem-prone areas in their regions) and develops and implements regional components of the QM Work Plan.

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

Quality Management Program Activities

Scope of QM Program Activities

- Identifying high-volume, high risk, and problem-prone areas of care and service affecting our population.
- Developing clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage, based on the availability of accepted national guidelines, the ability to monitor compliance and aspects of care.
- Undertaking quality improvement studies in clinical areas identified through careful claims data analyses; including frequency and cost breakdowns by member ages, sex and line of business, episode treatment groups, major medical procedure categories, diagnosis, and diagnosis-related groups (DRGs).
- Utilizing population-based preventive health care audits to assess the level of preventive care rendered across our membership; separate studies are completed for special risk groups.
• Conducting regular surveys to assess member satisfaction, physician satisfaction, and reasons for voluntary physician disenrollment.
• Tabulating adherence to physician service standards in areas such as wait times for appointments, in-office care and practice size and availability; some measurement methods we use are complaint data, Consumer Assessment of Healthcare Providers and Systems survey information and GeoAccess analysis.
• Monitoring performance of AM-related functions for compliance with contract, including activities such as oversight of medical policies and procedures reporting activities, encounter reporting, and regulatory compliance.
• Conducting routine medical record audits to assess physician compliance with the medical record review standards and preventive care guidelines, as well as monitoring coordination and continuity of care between primary care physicians and Specialists. **Note:** This is not the only reason we conduct such audits. Such audits may have different procedures and processes depending on their purpose and design.
• Reviewing and resolving member complaints regarding the provision of medical care and services; investigation may include verbal and written contact with the member and the physician or other health care professional, as well as a review of relevant medical records and responses to potential concerns identified.

**Medicare Advantage and Prescription Drug Plans**

Several industry quality programs, including the programs for CMS Star Ratings, provide external validation of our Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1 to 5-star scale, with 1 star representing the lowest quality and 5 starts representing the highest quality. Star Ratings scores are derived from 4 sources:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or patient satisfaction data;
2. HEDIS or medical record and claims data;
3. Health Outcomes Survey (HOS) or patient health outcomes data; and
4. CMS administrative data on plan quality and Customer satisfaction.

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D plans, go to the CMS consumer website at [cms.gov](http://cms.gov).

**Clinical and Preventive Health Guidelines**

We use 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 our members who are your patients. A list of the current guidelines is available through our website at, [mypreferredprovider.com](http://mypreferredprovider.com).

**Ambulatory Medical Record Review**

We perform ambulatory medical record review as part of the Medicare Advantage QM Program. Good Medical record documentation facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. Regular review of medical records can provide data that helps physicians and other healthcare professionals improve preventive, acute, and chronic care provided to members. Accreditation and regulatory organizations, such as your state Department of Health and CMS, include review of medical records as part of their oversight activities. We require medical records to be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review. Refer to Chapter 6: Medical Records for more information on this topic.

**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 re-credential them at least every 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. New health care professionals may not see our members until a credentialing approval letter has been received.

We accept the Council for Affordable Quality Healthcare (CAQH) credentialing application. We 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, we will fax a request for current documentation to your office. Providers must maintain an active, Florida Medical
Chapter 7: Quality Management Programs

License, DEA license and current malpractice insurance. Current documentation must be maintained in the CAQH system or sent directly to us.

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.

Delegation Oversight
Some functions or activities that we would normally perform, under regulatory and accreditation standards and requirements, may be delegated to another organization. These delegated 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 is required by CMS and the NCQA. We conduct ongoing oversight. Opportunities for improvement are identified and addressed, as applicable.

Complex Case Management and Disease Management Program Information
Preferred Care 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 (HRA), discharge planners, or referrals from health care providers, caregivers or by self-referral. If you have patients who are our members and would benefit from case or disease management, you can refer them by the following means:

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

Preferred Secure Options plan (H1045 PBP #023) Case Management and Disease Management Programs for members
These services are provided by WellMed. For Case Management or Disease Management services or questions, please contact WellMed at
• Phone: 800-494-6192 or
• Fax: 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 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; and
• 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 a member is 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. Currently offered are programs for heart failure and 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 a member is identified for a high-risk Disease Management Program.

Behavioral Healthcare Programs

Psychcare, LLC, is the Managed Behavioral Healthcare Organization (MBHO) we have contracted with to behavioral healthcare services for our members. Psychcare is accredited by the National Committee for Quality Assurance (NCQA) and submits regular reports to us for oversight and monitoring. As much as possible, and as permitted by law, behavioral health and general medical management is combined for the best possible health outcomes. For more information on how to access the Behavioral Healthcare programs, see How to Contact Us in Chapter 1, or you or our member may contact a Psychcare representative through the phone number listed on the back of their health care ID card.

Medicare Advantage Quality Management Program Milestones for 2015

The Medicare Advantage QM Program uses a variety of activities each year to continually measure, evaluate and improve the services we provided to our members. We measure these activities based upon:

• Accessibility and availability of care;

• Member and physician satisfaction;

• Effectiveness of clinical care using the HEDIS and other evidence-based measures;

• Continuity and Coordination of care; and

• Initiatives to address racial and ethnic disparities in health care.

HEDIS

HEDIS is one of the performance measurement indicators we use 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. Several HEDIS measures are also Star Measures. For the 2014/2015 measurement year, Preferred Care’s top performing and lowest performing HEDIS/Star indicators are:

Our top 3 performing indicators included:

• Adult BMI Assessment (4 Stars)

• Colorectal Cancer Screening (5 Stars)

• Comprehensive Diabetes Care Nephropathy (4 Stars)

Our bottom 3 performing indicators included:

• Controlling High Blood Pressure (4 Stars)

• Flu Shots for Older Adults (1 Star)

• Osteoporosis Management in Women Who Had a Fracture (3 Stars)

Overall, we were 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)

Preferred Care Medicare CAHPS Composite question ratings for 2015 increased slightly for ‘Getting Care Quickly’, however the rating for ‘Getting Needed Care’ decreased slightly. Member engagement initiatives continue to be deployed to improve HEDIS/CAHPS measures.

NCQA Health Plan Accreditation

Preferred Care obtained the highest NCQA accreditation status of Excellent for service and clinical quality that met or exceeded NCQA’s rigorous requirements on August 27, 2015. This Excellent rating is awarded for a three year period.
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 our 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.

We have a Stars Improvement Department that has a direct focus on Quality Performance Measures, and we work closely with UnitedHealthcare to continually improve our performance. Many of these performance measures involve you, the provider, and can be positively impacted by the relationship between Preferred Care Partners and its network providers. We 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.
Chapter 8: Healthcare Risk Management

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

An adverse event is defined as an event over which healthcare personnel could exercise control rather than as a result of the member’s condition. Identifying something as an adverse event is not meant to imply “error,” “negligence,” or poor quality care. It 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 include unexpected death, failure to diagnose or treat disease, or surgical mistakes or accidents. Adverse events interfere with a provider’s delivery of medical care and may 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 by a state licensed risk manager. The RMP also corrects, reduces, and eliminates identifiable risks through instruction and training to staff and providers.

Examples of Adverse and Serious Incidents as defined by AHCA include:

- Death of a patient;
- Severe 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.

For more information, go to the AHCA website at ahca.myflorida.com.

CMS 2015 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. For more information go to cms.gov > Medicare > Hospital Acquired Conditions.

HACs as of 2016:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma:
  - Fracture
  - Dislocation
  - Intracranial Injury
  - Crushing Injury
  - Burn
- Other Injuries
- Manifestations of Poor Glycemic Control
- 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

Network Providers are contractually required to report to our Risk Manager all adverse events as identified above, whether actual or potential. Call, the risk manager at so they may access the risk and address liability. To report such incidents, please use the Member Incident Report Form available on the provider website at mypreferredprovider.com and call 954-378-0478 or 800-310-7622.
The Member Incident Report Form must be filed with our Risk Manager within three (3) business days of occurrence of any incident that causes injury to an individual, or property damage.

Serious incidents must be reported to AHCA within 24 hours of occurrence. Consequently, all serious incidents must be reported immediately. This allows us to quickly assess the risk and address liability. 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;
- Medically unnecessary surgical procedure
- Surgical repair of damage from a planned surgical procedure; and
- Removal of unplanned foreign object remaining from a surgical procedure.

Provider contracts include the obligation to participate in Quality Management inquiries upon request from the Clinical Quality Analyst. For more information, refer to Chapter 7: Quality Management (QM) Programs.

Confidentiality

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. Health care 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. Our Risk Manager will review and evaluate each incident report to determine whether it meets the requirements for filing with applicable state agencies.
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-10-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-10-CM coding guidelines.

What are the Responsibilities of Physicians and Providers?
Physicians must report the ICD-10-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 30 days of the date of service (or discharge for hospital inpatient facilities).

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, we encourage you to purchase current copies of CPT and HCPCS reference guides. You can access CPT, HCPCS and ICD-10 coding resources and materials at the American Medical Association’s website (ama-assn.org), or from another vendor.

Links to resources for the latest ICD guidelines and MRA resources are available online at mypreferredprovider.com.
Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the guidelines outlined in this manual. We may provide you with available information concerning an individual’s status, eligibility for benefits, or level of benefits. The receipt of such information is not a promise or guarantee of payment. The receipt of such information is not a promise or guarantee of eligibility of any such individual to receive benefits.

**Claim Forms**
Claim and other forms are available on our website at mypreferredprovider.com.

**Billing Members**
You may not charge our members fees for covered services beyond copayments, co-insurance or deductibles as described in their benefit plans. You may not charge our members retainers, membership, or administrative fees, voluntary or otherwise. This includes concierge or 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. 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**
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. We are 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**
Health care 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 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 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**
Preferred Secure Option HMO (H1045 PBP #023) in central Florida, please submit claims directly to WellMed.

**Electronic Claims**
Payer ID: WELM2

**Paper Claims**
Mail to: WellMed Claims
P.O. Box 400066
San Antonio, TX 78229

Please confirm: 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.

Claim Status inquiries for Preferred Secure Option HMO members (H1045 PBP #023) in central Florida:

1. Access the WellMed Provider Portal ePRG: eprg.wellmed.net
2. Call WellMed at 800-550-7691

**Basic Requirements**
Claims are processed in accordance with CMS, AHCA, the Office of Insurance Regulation, and other applicable standards and requirements. **We strongly recommend 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; and
• The member name and number on the claim form matches the name and number shown on the member's 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. We have accurate billing information on file for the following:
  • Provider’s name (as noted on their 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); and
  • 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 60 calendar days of receipt of the non-clean claim. We will not delay the determination past 60 days, even to wait for medical records or additional information.

**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. Providers may download forms from cms.hhs.gov.

**Encounter Data**
Encounter data is used to evaluate quality and utilization management. We require capitated providers to submit an encounter (also called a “proxy claim”) or a claim for each service that you render to a Plan member. As required by law, the information for each member visit must be submitted on a standard CMS-1500 or UB-04 form and completed with a dollar value. We will monitor provider compliance for submission of encounter data.

**Diagnosis Codes**
A valid ICD-10 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 Chapter 9: Risk Adjustment & Coding.

**Time Limit for Filing**
Providers must submit all claims and encounters, electronic and paper, within 180 calendar days of the date of service.

If we are the secondary payer, we must receive the claim within 90 days of the date of final determination of the primary payer.

**Electronic Claims Submission**
**NOTE:** A claim that requires an attachment (e.g., operative reports, medical or office notes, etc.) may not be filed electronically.

• We accept 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). However, a claim that requires an attachment (e.g., operative reports, medical or office notes, etc.) may not be filed electronically. For more information, call Emdeon at 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 (EOP) statements to ensure all submitted claims and encounters appear on the reports.
• Correcting any errors and resubmitting the affiliated claims and encounters.
### Claims Requiring Attachments

Reminder: A claim that requires an attachment may not be filed electronically.

<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) or 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. (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). We 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 readable the claim may be denied.
- 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-10, HCPCS, 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” (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 [mypreferredprovider.com](http://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 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
- Box 56: Providers must bill with their NPI number in this box. 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
- Field 63: Use only one prior authorization number.
- 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 us to process a claim is 30 calendar days from date of receipt for clean claims, or 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:
1. Visiting our provider portal at mypreferredprovider.com. Select “Medicare”, and then click on the Provider Portal link at the top of the page.
2. Calling Claims at 866-725-9334 (Not applicable to Preferred Secure Option HMO members (H1045 PBP #023) in central Florida).

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

Coordination of Benefits
Coordination of Benefits (COB) 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 our 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. Co-insurance amounts are the lower of the Preferred Care 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 provider agreement.

Follow the steps below to determine what payments are due when a member has two insurance carriers. 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 we are the secondary carrier, participating providers should file the claim to us 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. **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 co-insurance, co-payment, 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. Co-insurance 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 co-insurance 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 COB 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 30 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. A participating physician may not elect to withhold claims for members with Preferred Care 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 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 for work-related illnesses or injuries.

If we make 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 to us for consideration.
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.

In the event that we make 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, we may exercise our 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.

Overpayment Recovery & Audit
Whenever possible, we work with providers to eliminate incorrect or duplicate claims. As a network 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 (for example, duplicate billing)
- Payment made to incorrect payee
- Payment for non-covered services or medically unnecessary services
- Payment for items or services provided during a period of member non-entitlement
- Claims processed incorrectly by us 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
Miami, FL 33256-6118

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 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.
Claim Review Request

A Claim Review Request is different from a claim status inquiry or a claim appeal. A provider can make a Claim Review Request if they are dissatisfied with a claim determination. 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 Claim Appeals section below.

To request a claim review you must submit a Claim Review Request Form, located on our website at mypreferredprovider.com. Call our Claims department at 866-725-9334 for assistance.

Claim inquiries must be submitted within 120 days (4 months) of EOP receipt. We will respond to the claim inquiry within 30 days from the date we receive your request.

We will respond to you in writing on all Claim Review Requests that do not result in the re-adjudication of a claim. Reviewing a claim does not guarantee or indicate a change in our payment decision.

Send written Claim Review Requests to:
Preferred Care Partners
Claims Inquiry
P.O. Box 56-5790
Miami, FL 33256-5790

Claims Disputes 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 at eprg.wellmed.net > Provider Resources > WellMed Florida.

Mail to: WellMed
Attn: Claims Payments Disputes
P.O. BOX 400066
San Antonio, TX 8229

Review vs. Appeal

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.

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. Generally we 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 us.

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; and
- 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 for Claims Appeals

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

Retroactive Reductions

We 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 the section on Overpayment Recovery & Audit.
Chapter 12: 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 us, 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
The CMS requires that all employees who work or contract with Part C Medicare Advantage Programs or Part D Medicare Prescription Drug Programs meet annual compliance and education training requirements with respect to fraud, waste, and abuse.
We have training materials available on our website at mypreferredprovider.com. You are responsible for ensuring compliance with CMS training requirements. You must be able to submit records of training logs documenting employee participation in the training upon our request.

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. We have the duty to investigate and report suspected fraudulent activity to the appropriate federal or state agency.
If you have information regarding fraud, waste and abuse misconduct or potential misconduct, report the information or complaint to our Special Investigations Unit (SIU). All reports are treated confidentially, and you may remain anonymous.
You may report fraud, waste, or abuse to us:

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

Online:  mypreferredprovider.com
Or, report suspected cases of Medicare fraud directly to CMS at 800-MEDICARE (800-633-4227)
You may also report fraud to the Health and Human Services Office of the Inspector General:

Office of the Inspector General
US Department of Health and Human Services
Attn: HOTLINE P.O. Box 23489
Washington, DC 20026

Online:  oig.hhs.gov/report-fraud
Phone:  800-HHS-TIPS (800-447-8477)
TTY:  800-377-4950
Network Bulletin

UnitedHealthcare publishes the “Network Bulletin” monthly. This publication is 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 Network Bulletins are available on our website at unitedhealthcareonline.com > Tools and Resources > News and Network Bulletin, 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.

Provider Website

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. Some public services include:

Find a Drug: Search the most current version of our Formulary by drug category, tier, or name.

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 Forms: The latest versions of all forms referenced in the Manual are available on our website at mypreferredprovider.com or contact Network Management Services at 877-670-8432. We recommend that you check our website frequently to ensure that you are using the latest version of any form.

Provider Portal

Some online services are available 24 hours a day, 7 days a week, only to registered providers on mypreferredcare.com and include the following:

- **Member information**: Verify a member’s eligibility, including plan benefits, deductibles, and information on the member’s primary care provider, as applicable.
- **Authorizations**: Submit, search for, and print authorizations for outpatient services or inpatient stays.
- **Claims**: Search for, view, and check the status of claims.
- **Provider Resources**: Such as Fraud, Waste, and Abuse Training materials, forms, ICD-10 code FAQs and look-up tool, and clinical and preventive guidelines.

Providers must register with us prior to using secure services. Go to mypreferredcare.com, to register. 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 a.m. to 5 p.m., EST.