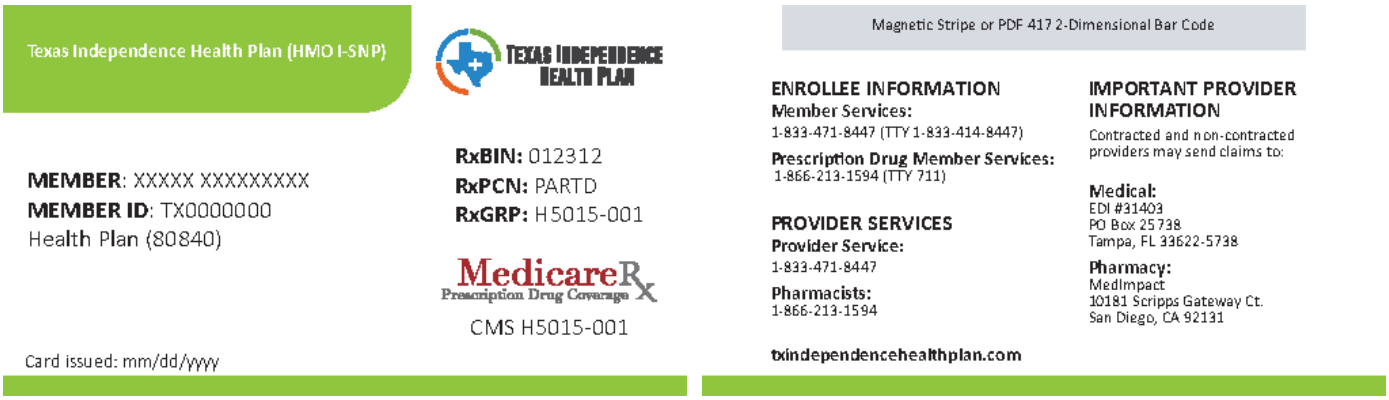
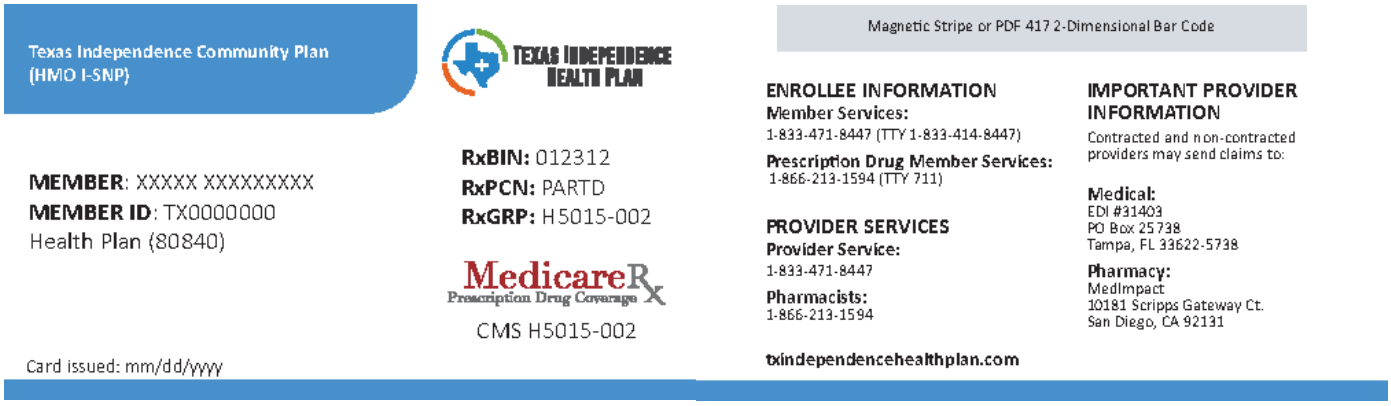
Network Participating Provider Manual

Sample TIHP Member ID Card
Texas Independence Health Plan



Sample TIHP Member ID Card
Texas Independence Community Plan



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II. Introducing Texas Independence Health Plan (HMO)

Welcome to the Texas Independence Health Plan (TIHP) Special Needs Plan (SNP). We are pleased to have you as a participating provider. TIHP is a Health Maintenance Organization (HMO) dedicated to Medicare Advantage (MA) product offerings. TIHP serves individuals with Medicare living in a long-term care residential healthcare facility.

Members must reside in the approved service area in order to enroll in the plan in 2026. The Texas service area includes the following counties: Aransas, Atascosa, Austin, Bandera, Bastrop, Bee, Bexar, Blanco, Brooks, Burleson, Burnett, Caldwell, Calhoun, Cameron, Cass, Chambers, Colorado, Comal, Cooke, Denton, DeWitt, Dimmit, Duval, Fayette, Fort Bend, Franklin, Frio, Galveston, Gillespie, Goliad, Gonzales, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Harrison, Hays, Hidalgo, Jack, Jackson, Jefferson, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kleberg, La Salle, Lampasas, Lavaca, Lee, Liberty, Live Oak, Llano, Marion, Mason, Matagorda, McMullen, Medina, Mills, Montgomery, Morris, Nueces, Palo Pinto, Panola, Real, Refugio, Rusk, San Jacinto, San Saba, Smith, Somervell, Starr, Tarrant, Travis, Upshur, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Wise, Wood, Zapata and Zavala.

Model of Care

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

Our MOC ensures early diagnosis and intervention by the Nurse Practitioner (NP) and/or Primary Care Physician (PCP) and encourages improved communication between providers and Members (and family, if desired) and the delivery of the appropriate services. Care coordination is central to our MOC. This approach is centered in the belief that an individualized, closely monitored and highly coordinated level of care can reduce fragmentation and enhance well-being.

As a result, TIHP's MOC is grounded in the following core principles:

- NPs orchestrate and provide care for those members residing in a network residential care facility, with an emphasis on a Member's psychosocial well-being and maintaining an optimal level of function.
- Clinicians monitor the complete picture of a Member's physical, social and psychological needs.
- Plan providers have experience or additional education in geriatric medicine, with a specific interest in caring for the frail elderly and disabled.
- The MOC minimizes Member transfers of care and provides a greater amount of care within the nursing home or other least restrictive setting by bringing providers to the Member, when possible.

- Clinicians place a strong focus on preventive care, working with nursing home staff and clinicians to help ensure regular assessments and early detection of member needs and problems.

- Care teams advocate for patients and assist with maximizing the benefits available to them.

- Families/responsible parties are encouraged to be involved in Members' care. Through coordination of the ICT, TIHP facilitates stronger and more consistent communication among the family/responsible party, their care team, and nursing home staff.

Each Member has a PCP and is also assigned a dedicated NP who works with the PCPs, nursing facility staff, and the responsible party/family to provide intensive primary and preventive services.

Per CMS MOC requirements, all SNP members are required to have an initial comprehensive Health Risk Assessment (HRA) within 90 days of enrollment in the plan and then at least annually thereafter as well as a care plan developed and implemented based on the member's needs identified in the HRA. TIHP's HRA form is called the Comprehensive Health Record (CHR).

Within 30 days of enrollment in the Plan, the NP visits the member in the nursing facility to conduct the initial HRA. The NP uses the findings from the assessment to develop an individualized care plan (ICP) which is tailored to the needs and preferences of the member. The HRA is also used to identify a risk level for the member – high, moderate or low risk. These risk levels correspond with the member's visit schedule by TIHP clinical staff (e.g. the NP or the Registered Nurse Care Coordinator (RNCC)). High Risk members are visited at least once every 10 days; whereas, moderate risk members are seen at least bi-weekly. All members are seen at least monthly for comprehensive monthly assessments and care plan reviews.

The NP coordinates the member's care plan with the member's ICT. Every member has an ICT to oversee their care plan and coordinate care. Composition of the ICT is based on member needs but at a minimum, each member's ICT includes the NP, RNCC, member or responsible party, facility staff and the PCP.

The NP coordinates communications among ICT members and may identify and communicate with additional participants to support the member's care plan.

TIHP supports members through care transitions (e.g. hospitalizations, transitions from facility to facility, etc.) including providing a single point of contact (the NP) to coordinate transitions. The NP, RNCC and facility staff also coordinate to share the member's care plan between settings into order to maintain continuity of care. TIHP or facility staff also inform the PCP and the member's family/responsible party in the event of a member's transition. When the member returns to the facility after a hospitalization, the NP will conduct a post-discharge assessment and medication reconciliation within two business days and update the care plan. The NP will also communicate the updated care plan to the ICT as needed.

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

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

The MOC's care coordination and quality improvement processes are supported by TIHP's operations, administrative, IT, analytics, compliance, customer service and provider network infrastructure. TIHP is required to offer MOC training to network providers upon initial contracting and at least annually thereafter. TIHP must also offer training to non-contracted providers who see TIHP members routinely. Provider MOC training can be found at the following links:

Texas Providers: https://www.txindependencehealthplan.com/model-of-care-provider-training/

The Role of the Primary Care Physician

The following specialties are considered PCPs:

- Family practice
- General practice
- Geriatrics
- Internal medicine

All TIHP Members must select a PCP. If the Member does not select a PCP, one will be assigned based on the Member's geographic area and/or nursing facility of residence.

The scope of services to be provided by the PCP may include, but is not limited to, the following:

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

The PCP has the primary responsibility for coordinating the Member's overall healthcare among the Member's various healthcare providers. The PCP works closely with the TIHP NP, who is a nurse practitioner, to reduce fragmented, redundant or unnecessary services and provide the most cost-effective care. TIHP monitors referrals to promote the use of network providers, analyze referral patterns and assess medical necessity.

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

- Maintain high quality
- Provide the appropriate level of care

- Use healthcare resources efficiently
- Be active participants in members' ICTs as requested by the NP or RNCC

The Role of the Nurse Practitioner

Our MOC introduces the concept of the NP as a trusted provider and care coordinator and the "hub" of the ICT. Together with physicians, nursing facility administrators and staff, Members and families/responsible parties, the NPs attempt to treat the "whole person," rather than addressing the member's disease or illness only.

As described above, the NP visits the nursing home setting on a regular basis, working with the nursing home staff, the ICT, and physicians to implement the member's care plan, monitor changes in the member's health status, focus on early diagnosis and intervention, and coordinate communication between all relevant practitioners and family members.

The NPs assess and help develop and manage personalized care plans for TIHP Members. The NPs work closely with the nursing facility staff and PCPs, the Member and the family/responsible party to ensure a responsive plan of care for the Member based on an initial HRA. This HRA is done upon enrollment and at least annually unless triggered by a change in health status or condition, or admission to the hospital. Using the HRA, the NP develops a plan of care and ensures that the care plan is implemented, and the Member's needs are addressed.

The NPs perform the HRA and oversee diagnostic services and treatments to ensure medical and mental health parity, ensure access to comprehensive benefits as needed, and provide education on the health risks and care to the Member and their family/responsible party. They coordinate multiple services, help facilitate better communication between the ICT and help ensure effective integration of treatments.

The NPs are typically available for providers and Members, Monday - Friday from 8:00 a.m. until 5:00 p.m.

The Role of the RN Care Coordinator

Each Member is assigned to an RNCC as a key member of their ICT managing the medical, cognitive, psychosocial, and functional needs of members and communicating to coordinate the care plan with the NP, facility staff, PCP, Member and/or family/responsible party as needed.

A TIHP RNCC is assigned to act as the "air traffic controller" in each nursing facility and an extension of the NP in supporting and coordinating the member's care.

The RNCC ensures timely and appropriate delivery of services, facilitates seamless transitions, and coordinates timely follow-up to avoid lapses in services or care when there is transition across settings or providers, and conducts chart and/or pharmacy reviews.

The Role of the Specialist

Members may see in-network specialists with a referral, from the PCP or NP. Female Members may see in-network gynecologists or their PCP for a well-woman examination

without any prior authorization or referral.

To maximize their benefits and reduce out-of-pocket costs, Members are encouraged to see in-network specialists. If Members see an out-of-network provider, the service may not be covered. Please call the number on the back of your Member ID card with questions about network participating providers or visit www.txindependencehealthplan.com/.

Authorizations

TIHP requires authorization for certain services and procedures. Providers should use the authorization request form provided on the Plan's website and contact the Utilization Management (UM) team directly by fax at 1-877-235-1650. Providers are encouraged to speak with the Member's PCP or NP to ensure an appropriate care plan.

CMS Processing Timeframes (Part C):

Type	Processing Timeframe	With Extension
Pre-Service	14 calendar days	28 days
Part B Drug	72 hours	N/A
Payment	30 days	N/A
Expedited: Pre-Service	72 hours	17 days
Expedited: Part B Drug	24 hours	N/A

For pre-service authorization requests, TIHP must provide an expedited determination if a Member or Member's physician indicates (the physician does not have to use the exact words) that applying the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

Medicare Coverage Determination Guidelines, as well as nationally recognized healthcare guidelines (InterQual) and relevant Plan policy, are used when reviewing authorization requests. The Plan's Medical Director makes all clinical and out-of-network denial decisions. and is available for consultation with both in and out-of-network practitioners. The Medical Director also may contact network specialists to assist with the medical necessity determination process.

Authorization requests, including the authorization form and clinical information that supports the request, must be faxed to 1-877-235-1650. TIHP will review all requests and if additional information is needed, staff will contact the requesting provider to obtain such documentation.

An approved authorization is valid for 90 days. The requesting provider should use the TIHP authorization number, indicated on the approval letter, in the appropriate field of the CMS-1500 claim form.

If TIHP cannot approve the authorization request based on existing documentation provided by the provider, the Provider has the right to request a "Peer-to-Peer" conversation with the Plan's

Medical Director. The intent of the conversation is to provide any additional information or context that may allow the Medical Director to approve the authorization request. The Plan initiates the "Peer-to-Peer" process or the provider may contact the UM team at 866-597-8417 to speak with the Medical Director. The Plan communicates its authorization decision by phone, as well as in writing via fax or mail. Any adverse decision will also contain relevant appeal rights for the member and/or provider.

The provider may request a copy of the clinical criteria utilized that results in a denial by contacting the UM department.

Authorization requirements may change annually and are posted to the Plan's website and notated in the member's Evidence of Coverage. Failure to comply with the Plan's prior authorization requirements may result in an administrative denial.

Preventive Screenings and Disease Management

The NP visits each facility Member at least monthly. In addition, TIHP requests that each member visits their PCP at least annually and perform a complete medical evaluation, addressing the Member's specific needs and conducting appropriate preventive screenings.

Preventive guidelines to be addressed include, but are not limited to:

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

Gaps in Member compliance require appropriate intervention to improve and meet recommended goals. Either TIHP staff or the Member's PCP may provide this intervention.

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

Prevention Measurements Table

GENERAL PREVENTIVE CARE:		
	Pneumonia Vaccine	Once per lifetime = >65 years
	Influenza Vaccine	Once every 12 months
	Breast Cancer Screening	Once every 24 months
	Body Mass Index (BMI)	Once every 12 months
	Prostate Cancer Screening	Once every 12 months
	Colorectal Cancer Screening: Fecal Occult	Once every 12 months

Chronic Conditions Measurements Table

DIABETES/OBESITY:		
	Eye Exam	Once every 12 months
	HgbA1C	Once every 6 months
	Microalbumin	Once every 12 months
CHF:		
	Ejection Fraction measurement	Once per lifetime
CAD:		
	LDL levels	Once every 12 months

III. Provider Standards and Procedures

Provider Credentialing

Credentialing of providers may be conducted internally by TIHP staff or delegated to an external entity. If delegated, TIHP will conduct both pre-delegation and annual audits to ensure credentialing standards are maintained throughout the network. The standards below outline the overall approach to credentialing by TIHP. The delegated entity's standards may differ slightly. If there are any questions, please contact Network Operations at 833-471-8447.

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

Providers who would like to participate in the TIHP network should request a Participation Agreement from Network Operations at 833-471-8447.

Once contracted, the provider may submit the CAQH (Council for Affordable Quality Healthcare) provider identification number and submit via email to: TIHPprovidernetwork@txindependencehealthplan.

TIHP follows NCQA (National Committee for Quality Assurance) standards involving credentialing and re-credentialing of Providers. Once all information is complete, including primary source verification and office site review (if applicable); the Credentialing Department reviews and compares all information to the primary source data. If TIHP notes any discrepancies, it notifies the provider in writing and gives the provider two weeks to forward the correct information to Network Operations.

In addition, a physician has the right to review the information submitted in support of the application. If the physician discovers erroneous information on the application, he or she has an opportunity to correct this information before the TIHP Credentialing Committee or the external vendor reviews it. The physician must update their CAQH profile to reflect the correct information

Credentialing Committee Review

Completed credentialing files are presented to the TIHP Credentialing Committee for review and final decision. Files that do not require committee discussion may also be approved by the Chair of the Credentialing Committee.

TIHP credentialing staff will send notification letters to providers within 30 days of the credentialing decision.

If a provider is denied credentialing and wishes to appeal the decision, the provider must submit a request in writing to the Manager of Credentialing.

Re-credentialing Process

All physicians must be re-credentialed within three years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except that physicians are also evaluated on their professional performance, judgment and clinical competence. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with TIHP's policies and procedures
- TIHP sanctioning related to UM, administrative issues or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

TIHP or its designee will query CAQH for a current application for the purposes of re-credentialing six months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to obtain a current CAQH application by the deadline may result in termination from the network.

Malpractice Insurance

TIHP requires Providers to carry minimum professional liability insurance. Please refer to your Provider's Participation Agreement to verify those amounts.

CMS Preclusion List

The CMS Preclusion List identifies providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished to Medicare Beneficiaries. The Preclusion List was created to ensure patient protections and safety and to protect Medicare Trust Funds from prescribers and providers identified as bad actors.

Claims with a date of service on or after April 1, 2019 that are submitted by providers and prescribers that are on the CMS Preclusion List will be denied. Precluded providers and prescribers must hold TIHP members harmless from financial liability for services provided on or after the claim denial date. Providers are required to work directly with CMS for any errors or updates to the Preclusion List. There is no opportunity for providers to appeal their precluded status with TIHP.

If a Provider appears on the Preclusion List, TIHP will send the following notifications:

- Letter to the Provider notifying them that claims 60 days from the date of service will not be paid and members are to be held harmless
- Letters to any members seen by the Provider (or assigned to in the event of a PCP) that they have appeared on the list and they need to change doctors and services will no longer be paid for starting on the cease date.
- Providers will also receive notification of the members impacted

Credentialing Denials and Appeals

TIHP will send a letter to providers who have been denied credentialing that includes the following:

- The specific reason for the denial
- The provider's right to request a hearing
- A summary of the provider's right in the hearing
- The deadline for requesting a hearing
- The timeline of 30 days following receipt of the notice in which to submit a request for a hearing
- Failure to request a hearing within 30 days shall constitute a waiver of the rights to a hearing
- A request for consent to disclose the specifics of the provider's application and all credentialing documentation to be discussed
- Appropriate requirements specific to the state in which the practice is located

Upon receipt of the provider's request for a hearing, TIHP will notify the provider of the date, time and place of the hearing.

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

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

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

Provider Termination

The relationship between a provider and TIHP may be severed for several reasons, which may include any of the following:

- Provider is non-compliant with the contractual coverage requirements
- Provider's license or certification or registration to provide services in the provider's home state is suspended or revoked
- Provider makes a misrepresentation with respect to the warranties set forth in the Provider Service Agreement
- Provider is sanctioned by the Office of Inspector General (OIG), Medicare or Medicaid

TIHP may initiate the termination action or the provider may initiate the termination. In all cases, if a provider began treating a Member before the termination, the provider should continue the treatment until the Member can, without impacting the Member's well-being, be transferred to the care of another participating provider.

The terminating provider will be compensated for this treatment according to the rates agreed to in the provider's contract.

Should the terminating provider note special circumstances involving a Member – such as treatment for an acute condition, life-threatening illness, or disability – the provider should ask TIHP for permission to continue treating that Member. In such cases, TIHP will continue to reimburse the provider at the contracted rates.

The provider may not seek payment from the Member of any amount for which the Member would not be responsible if the provider were still in TIHP's network. The provider also is to abide by the determination of the applicable grievance and appeals procedures and other relevant terms of the provider's contractual agreement.

When the Credentialing Committee decides to terminate a provider's agreement or impose a corrective action that will result in a report to the National Practitioner Data Bank, and/or applicable state licensing agency, the Credentialing Department shall promptly notify the affected provider.

Such notice shall:

- State the specific reason for the termination or corrective action
- Inform the provider that he/she has the right to request a hearing
- Contain a summary of the provider's right in the hearing under this policy
- Inform the provider that he/she has 30 days following receipt of the notice within which to submit a request for a hearing
- State that failure to request a hearing within the specified time period shall constitute a waiver of the right to a hearing
- State that upon receipt of the hearing request, the provider will be notified of the date, time and place of the hearing
- Allow the provider to be represented by an attorney or another person of his/her choice

A provider shall have 30 days following receipt of notice to file a written request for a hearing. Requests shall be hand delivered or sent by certified mail, return receipt requested, to the

chairperson of the Credentialing Committee. If such a hearing is requested, the Credentialing Committee shall follow the steps as defined by the Credentialing Department's policies and procedures. (Copies of such policies and procedures are available upon request.)

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

As indicated in their contracts, providers must give written notice to TIHP before voluntarily leaving the network. Providers also must supply copies of medical records and facilitate a Member's transfer of care upon request by TIHP or the Member.

For terminations initiated by PCPs, TIHP will notify affected Members in writing and ask them to select a new PCP. If a Member does not select a PCP, TIHP will assign a PCP before the provider's effective date of termination. PCPs must continue to provide care for 90 days following termination.

For terminations by specialists, TIHP will notify all Members who have visited the specialist in the past 90 days. This notification will alert the Member of the provider's forthcoming termination and allow for transition of care to another in-network provider.

Practice Information

At the time of credentialing and re-credentialing, and directory printing, TIHP will verify important demographic details about a provider's practice to help ensure the accuracy of information such as claims payments and provider directories. TIHP will also verify if providers are accepting new members to comply with all CMS requirements.

Providers should notify TIHP of any changes in practice information 60 days before the effective date of the change to avoid improper claims payment and incorrect directory information.

All in-network providers must have the hours of operation clearly posted in their office.

Office Requirements

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

TIHP wants to make sure that all Members—including those with limited English proficiency, diverse cultural backgrounds, the homeless and individuals with physical and mental disabilities—receive healthcare services and assistance with their health plan in a culturally competent manner. Each Member is entitled to receive healthcare needs in a manner that is respectful and consistent with the Member's cultural perspective. The goal of this policy is to

enhance patient care compliance.

Once cultural expectations and health service needs are determined, providers may be required to supply interpreters to overcome barriers of language and/or understanding. To further promote understanding and support, providers also may be required to supply the Member with appropriate educational materials and information about community resources.

For assistance with Members requiring culturally competent services, providers may call Provider Services at 833-471-8447.

While on vacation or a leave of less than 30 days, a network provider must arrange for coverage by another TIHP provider. If a provider goes on a leave of 30 days or longer, the provider must notify Provider Services at 833-471-8447.

If a network provider arranges with either a participating or non-participating physician to cover for his/her patients during an absence, the network provider is responsible for making sure the covering physician will:

- Accept compensation from TIHP as full payment for covered services
- Not bill the Member, except for applicable copayments
- Obtain approval from the Health Services Department, as set forth in this manual, before all non-emergency hospitalizations and non-emergency referrals
- Comply with the rules, protocols, policies, procedures and programs set forth in this manual

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

Accessibility Standards

TIHP follows accessibility requirements set forth by applicable regulatory and accrediting agencies. The purpose of these standards is to make sure services are available and accessible to Members in a timely fashion. TIHP monitors compliance with these standards annually.

TIHP sets standards to be met for services within providers' offices. The next table describes sample types of services and the respective standards to be followed:

REASON FOR APPOINTMENT	COMPLIANCE STANDARD
PRIMARY CARE PHYSICIAN	
Chest pain	Same day
Mild respiratory symptoms >3 days	Next day
Routine physical examination	Within 30 days
Obstetricians-Gynecologists	

Urgent referral	Next day
Non-urgent referral	Within 2 weeks
Well-woman examination	Within 10 weeks
SPECIALISTS	
Emergency	Same day
Urgent referral	Next day
Routine referral	Within 30 days

Provider, Member and Member's Family Satisfaction Surveys

Satisfaction surveys provide TIHP with feedback on performance relating to:

- Access to care and/or services
- Overall satisfaction with TIHP
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Member Administration

Contacting TIHP

Website: https://www.txindependencehealthplan.com/

Provider Services:

Phone:	833-471-8447 833-414-8447 TTY for hearing impaired (8:00 a.m. to 8:00 p.m. Eastern Time)
E-mail:	info@txindependencehealthplan.com
Mailing Address:	**1908 N. Laurent Street** **Suite 250** **Victoria, TX 77901** **Attn: Provider Services**
Authorization Department:	866-597-8417
Authorization Fax Number:	1-877-235-1650
Prior Authorization Department Phone:	866-597-8417

Medical Claims submissions:

Mailing Address:	Texas Independence Health Plan PO Box 25738 Tampa, FL 33622

Credentialing:

To request a hearing:	Texas Independence Health Plan Attn: Provider Relations 1908 N. Laurent Street Suite 250

Pharmacy: Victoria, TX 77901

Pharmacy Management Department:

Email:	pharmacysupport@txindependencehealthplan.com MedImpact Coverage Determination and Appeals:
Phone:	1-866-213-1594
Fax:	1-877-503-7231
Web:	www.txindependencehealthplan.com/

Fraud Waste & Abuse Hotline:

Medicare Fraud Hotline:	1-800-447-8477
Report online:	https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx

Member ID Cards

All TIHP members are provided with a Member ID Card and that card should be presented at the time of medical services. Refer to the TIHP website at www.txindependencehealthplan.com for information about specific benefits, Member cost-sharing and product logo. A copy of the Member ID card is located on the inside on page 2 of this manual.

Selecting a Primary Care Physician

All TIHP Members must select a PCP from the list of participating primary care physicians in the TIHP Provider directory. If a Member does not select a PCP, TIHP will assign a PCP based on geographic access. A PCP is not permitted to refuse services to an eligible Member. Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month.

Verifying Member Eligibility

Possession of an ID card is not a guarantee of eligibility. Providers should photocopy the card and check it for any change of information, such as address and eligibility date. Providers should verify Member eligibility before each office visit using the telephone number

listed on the back of the Member's health plan ID card. This number is 833-471-8447.

Member Copayments and Coinsurance

TIHP covers the same benefits as Original Medicare as well as some enhanced services.

For a list of benefits and their respective cost-sharing amounts, go to www.txindependencehealthplan.com for the most recent Summary of Benefits and Evidence of Coverage (EOC).

As an Institutional SNP, some members may be eligible for the cost sharing benefits provided by Texas Medicaid. Generally, this will provide the member with no cost sharing for covered services provided by in-network providers. Other members of the plan will have the same cost sharing expenses as with Original Medicare Part A and Part B with applicable deductibles, copayments, and co-insurance costs.

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

Benefit Exclusions

The following list indicates some, but not all, of the services not covered by Medicare or TIHP. Some of these services may be covered by the State Medicaid program. TIHP staff will help coordinate benefits and services.

SERVICE	NOTE
Abortion	
Acupuncture	Covered with a diagnosis of Chronic Lower Back Pain
Ambulance	Ambulance is covered only if transportation in any other vehicle would endanger the Member's life. Air ambulance is paid only in emergency situations. If land ambulance would not seriously endanger the Member's health, Medicare will reimburse land ambulance rates only.
Chiropractic services	Exception: Manual manipulation of the spine to correct subluxation.
Contraceptives	
Cosmetic surgery	Exception: Reconstructive surgery is a covered benefit, as it is primarily intended to improve bodily function, relieve symptoms or improve appearance altered by disease, trauma or previous Therapeutic processes (e.g., when breast reconstruction is performed following a mastectomy), or exists because of congenital or developmental abnormality.
Custodial care or respite care	

Dental services	TIHP covers preventive and comprehensive Dental services up to $1,500 for 2026
Foot care, routine	TIHP covers up to 6 routine foot care visits
Durable medical equipment (DME) and medical supplies that do not meet Medicare coverage criteria	Examples include shower chairs, safety tubs, stair lifts and blood pressure monitors.
Exercise programs	
Experimental or investigative procedures	
Eye surgery for refractive defects	Exception: Veterans Affairs hospitals and military treatment facilities are considered for payment according to current legislation.
Government treatment	Same as above.
Homemaker services	
Naturopath services	
Obesity treatment	Exception: This exclusion does not apply to surgical obesity treatment if treatment is necessary to treat another life-threatening condition involving obesity or if providers document that non-surgical obesity treatments have failed.
Orthodontia	
Orthopedic shoes, unless part of a leg brace	
Personal comfort items	
Private duty nursing	Exception: If TIHP determines that such services are medically necessary before service is rendered
Sex transformation	
Work-related conditions	

Quality Improvement (QI)

TIHP's QI Program provides oversight, direction and support as well as implements structures and processes to measure and improve quality of care and services throughout the organization.

TIHP's approach to QI is built on a model that involves the entire organization and related operational processes. The QI program incorporates performance results from all clinical and member services related TIHP departments and encourages providers to participate in QI initiatives.

The QI Program promotes improved member health and satisfaction outcomes and cost-effective care by instilling a discipline of rigorous data collection, goal setting, analysis, intervention implementation, reporting and accountability, stakeholder communication and dissemination of best practices related to TIHP's clinical and member services functions.

The QI model employs a cycle of continuous improvement and a “Plan-Do-Study-Act” (PDSA) methodology involving identification of key metrics and benchmarks, data collection and analysis, comparison of results against established goals/benchmarks and implementation of remediation/action plans. Opportunities for improvement are identified through qualitative and quantitative reviews of clinical care and services.

QI is a shared responsibility between TIHP and its contracted networks and other delegated entities. The QI department oversees and assists with many of the activities that support continuous QI, including:

- Reviewing processes to identify QI needs
- Organizing work groups and committees, such as the QIC
- Identifying best practices
- Developing and implementing improvement initiatives
- Collecting data to evaluate the results of the activities and initiatives

HEDIS® results and other department/function-specific metrics as identified in the QI Work Plan serve as ongoing indicators for the QI Program. Examples of these metrics include but are not limited to: medication adherence measures, preventive screening rates, positive member satisfaction survey responses, vaccination rates, customer service call center average time-to-answer and network adequacy against CMS time and distance standards.

Participation in the collection, review, and submission of performance data is one means by which TIHP evaluates the quality of Member Services, care and satisfaction.

In addition, TIHP is a full participant in CMS-required activities, including but not limited to the Chronic Care Improvement Program (CCIP) that targets the improvement of care for Members with COPD and/or Asthma.

The TIHP QI program includes initiatives related to the CMS-mandated Quality Improvement Project (QIP), which is focused on reducing the incidence of All-Cause Readmissions to an Acute Care Setting within 30 days.

Advance Directives

All healthcare providers who participate in the MA program must offer Members written information about their right to make their own healthcare decisions, including the right to accept or refuse medical treatment and the right to execute Advance Directives.

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

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

Living Will – A living will take effect while the individual is still living. It is a written document concerning the kind of medical care a person wants or does not want if he or she is physically or mentally unable to make a decision.

Healthcare Durable Power of Attorney – A healthcare durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is physically or mentally unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Neither document becomes effective unless the individual is unable to make decisions (generally as certified by a treating physician). The individual can change or revoke either document at any time. Otherwise, it should remain effective throughout the person's life.

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

Member Appeals

A Level 1 appeal consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the Plan. The Evidence of Coverage (EOC) is provided to each Member and provides detailed instruction on how to file an appeal with the Plan related to adverse organization determinations service (authorization) or payment (claims).

When the Plan renders a decision to deny a service or claim, the member and/or provider receive notification and any appeal rights available. Subsequently, if the denial is upheld on appeal, the Member's appeal will be forwarded to the Independent Review Entity (IRE) contracted by CMS to conduct Level II appeals.

As defined by CMS, "the parties to an organization determination (Part C) for purposes of an appeal include:

- The enrollee (including his or her representative*);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formerly agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding."

*A Member may appoint an authorized representative. To be appointed, both the Member and

the proposed representative (including attorneys) must sign, date, and complete the Appointment of Representative (AOR) form (CMS1696 form) or an equivalent written notice. The AOR form is available on the CMS website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf. For pre-service authorization requests, a Member's treating physician or non-physician provider may file an appeal on the Member's behalf without representation documentation. However, Medicare regulations require that the physician notify the member that the appeal is being filed.

A Level 1 appeal must be submitted in writing for a standard request but may be verbally for an expedited request. Member appeal requests must be filed within 60 days from the date of the notice of the initial determination, unless good cause can be established.

Level 1 Appeal Adjudication Timeframes:

Plans must authorize or provide the service or benefit as expeditiously as the Member's health condition requires, but no later than the timeframes listed below (based on when the request was received).

Type	Part C	Part C with Extension	Part D
Standard Pre-Service or benefit	30 days	44 days	7 days
Expedited Pre-Service, Benefit or Part B Drug	72 hours	17 days	72 hours
Part B Drug	7 days	N/A	N/A
Payment	60 days	N/A	14 days

For pre-service authorization appeal requests, TIHP must provide an expedited determination if a Member or Member's physician indicates (the physician does not have to use the exact words) that applying the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

If a member has already received a service, and the authorization process was not followed, a contracted provider must utilize the "Provider Payment Dispute Resolution Process".

Standard appeals requests must be submitted in writing to:

Texas Independence Health Plan
Attn: Member Appeals
1908 N. Laurent St., Ste. 250
Victoria, TX 77901

Expedited appeal requests should be faxed to 1-833-605-4044. The CMS Member appeals (reconsideration) process includes up to five (5) levels of review.

CMS Timeliness Standards Regarding Member Appeals

CMS regulations require that TIHP respond to pre-service standard appeals within 30 calendar days and within 60 calendar days for post-service appeals. Therefore, providers must respond to

requests for information from TIHP within five calendar days so that TIHP is able to obtain all appropriate and complete information to make a timely and fully-informed decision. The deadline for pre-service standard appeals may be extended by 14 calendar days if doing so is in the interest of the Member.

TIHP must make a determination for expedited appeal requests within 72 hours of receipt. Providers must respond to TIHP's requests for information regarding expedited pre-service appeals within 24 hours to ensure timely resolution. The deadline for pre-service expedited appeals may be extended by 14 calendar days if doing so is in the interest of the Member. (Post- service (payment) appeals cannot be processed as expedited.)

Expedited appeals should be faxed to1-833-605-4044.

Member Grievances

CMS defines a grievance as "an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken." The Member's Evidence of Coverage (EOC) provides details on how to file a grievance with the Plan, including those involving a potential quality of care concern expressed by the Member. CMS defines a quality-of-care grievance as "related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings."

Members may file a grievance with the Plan either orally or in writing, typically no later than 60 days after the incident that precipitates the grievance. The Plan will investigate as expeditiously as the case requires, but no later than 30 days, unless an extension is taken, of receipt of the request, or within 24 hours for expedited grievances.

If a Member expresses dissatisfaction to you or your staff, please refer them to their Evidence of Coverage or suggest they call Customer Service at 833-471-8447.

IV. Hospitalization Guidelines

Overview

TIHP strives to deliver a coordinated approach to providing care for our Members. This coordination is led by the Nurse Practitioner (NP) working in conjunction with the PCP and the Member's Interdisciplinary Care Team (ICT). The Member's ICT may include community and facility-based providers, as well as the long-term care facility staff where the member may reside. It is through this coordinated approach that services are delivered in the most effective and efficient manner. TIHP has incorporated certain prior authorization processes as described in the Authorizations section. Network facilities must be utilized, except for extenuating circumstances. The Plan's Model of Care (MOC) emphasizes care at the most clinically appropriate setting to minimize Member disruption and the risk of adverse events, such as infections and falls.

Transition Liaison

The NP is the central resource in coordinating transitions of care and ensuring that Members are appropriately and successfully transferred from one care setting to another. The majority of transitions are from the nursing facility to the hospital, and back again to the nursing facility.

If a Member must be hospitalized and is admitted via the ER, the NP will contact hospital staff to offer an assessment and discuss the Member's typical functioning level within two business days. This communication can assist in avoiding unnecessary therapy or care, preventing redundant X-ray or lab tests, and reducing the length of stay.

TIHP's goal is to help reduce re-hospitalizations and avoid adverse events during the periods of transition. TIHP NPs and RNCCs work closely with facility staff and ask to be notified immediately when a transition of care is underway. Furthermore, upon arrival at their assigned facilities, RNCCs conduct rounds and attempt to "lay eyes on" each member which further enables the identification of hospitalized members, members who have returned to the facility and members who are at-risk for transition due to a change in condition.

Facility staff are responsible transferring necessary Member information to the hospital including face sheet, medication list, and Advanced Directives (i.e. Medical Orders for Life-Sustaining Treatment (MOLST), Physician Orders for Life-Sustaining treatment (POLST).

The NP and/or the RNCC follow up regularly with the hospital while the member is admitted.

Elective Admissions

To admit a Member for an elective admission, the admitting provider must receive prior authorization from TIHP as outlined in Section II, “Authorizations”. The admitting provider must work with the Plan’s Nurse Practitioner and/or the RN Case Coordinator (RNCC) and the hospital to schedule the admission and any pre-admission testing.

Pre-Admission Diagnostic Testing

Pre-admission diagnostic testing includes:

- Laboratory diagnostic tests
- Radiological diagnostic tests
- Other diagnostic tests, including electrocardiogram, pulmonary function and neurological function

All preadmission diagnostic testing conducted before a Member’s medically necessary surgery or admission to the hospital is covered when performed at an approved facility. Certain procedures require prior authorization.

Emergency Admissions

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

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

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

- Member name and TIHP ID number
- The name of the Member’s referring Provider (PCP, NP or the nursing facility), if applicable
- The name of the admitting Provider if different from the referring Provider or PCP
- Clinical documentation that supports the emergent admission and treatment plan

The hospital must notify the TIHP UM Intake department via fax at 1-877-235-1650 within one (1) business day of the emergency admission. The long-term care facility staff should notify the TIHP Nurse Practitioner (NP) or RN Care Coordinator (RNCC) immediately when a member experiences a transition of any kind.

Observation Status

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

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

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

As an Institutional Special Needs Plan (I-SNP), most Plan members reside in a long-term care nursing facility. The member's care needs, and subsequent care that may be provided at the facility where the member resides, should be discussed with the Plan's Nurse Practitioner (NP) or RN Case Coordinator (RNCC) to determine whether continued hospital level of care is required.

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

If a physician decides to admit a Member who is in observation status, the facility should notify the TIHP UM Intake department via fax at 1-877-235-1650 within one business day of the admission decision.

Admission Review

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

- The request does not appear to meet clinical guidelines and/or
- A Member's condition no longer meets criteria for an extended length of stay/level of care

If the request results in a potential denial, or adverse determination, the admitting Provider will have the opportunity to discuss the treatment plan and/or medical guidelines with the TIHP Medical Director through a Peer-to-Peer conversation facilitated by the Plan. The Provider may also contact the TIHP UM Intake department via fax at 1-877-235-1650.

TIHP communicates any decision, including any member and provider appeal rights, for initial admission non-approval via fax and mail.

The hospital is required to comply with all CMS requirements related to provision of the "Important Message from Medicare".

Notices of Non-Coverage/Denial

Per CMS requirements, the Plan must provide notice when it issues an adverse determination. The following forms are provided to the Member and a copy maintained by TIHP, including:

- Integrated Denial Notice (IDN): Notice of Denial of Medical Coverage/Notice of Denial of Payment (CMS 100003–NDMCP) – Used when the Plan denies a request for medical service (such as an authorization request), in whole or in part, or when denying a Member's request for payment of a service already received. The IDN informs the Member of the Plan's decision rationale and provides relevant appeal rights that may be pursued.

- Notice of Medicare Non-Coverage (CMS 10095-NOMNC) – Used when informing Members receiving skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services of the termination of services. For providers that offer these services, please refer to your contract which specifies responsibilities surrounding NOMNC generation and delivery. For providers who are responsible for the process, NOMNCs must meet CMS requirements and copies must be maintained within the Member's file and provided to the Plan upon request. The Plan maintains the right to audit a provider's NOMNC compliance.

Concurrent Review

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

Concurrent review includes:

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

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

Medicare Coverage Determinations, as well as InterQual® Healthcare Guidelines, are used when coordinating inpatient care. TIHP obtains clinical information on inpatient Members by coordinating with the utilization review staff at the facility. This may involve reviewing the medical record and/or interviewing attending physicians. TIHP will follow the same process as described above for inpatient stays if the services are not approved to facilitate discharge planning. If the services are approved to continue, the UM Intake team will notify the provider by fax or phone.

Transfers

The Member's Nurse Practitioner (NP) and/or RN Care Coordinator (RNCC) will help coordinate the transfer of any TIHP Member from an in-network hospital to another facility. Every effort should be made to maintain the use of in- network facilities. This helps to ensure a coordinated approach to the management of the Member and minimizes Member disruption.

Administrative Denials

An administrative denial is issued for those services for which the provider has not followed requirements set forth in their contract or the Plan's provider manual. An administrative denial may be issued for failure to follow prior authorization of an elective service, procedure or admission. It may also be issued for failure to notify the UM Department within one business day of an emergency service, procedure or admission

Situations that may result in an administrative denial include:

- Failure to obtain authorization pre-service for an elective service
- Failure to request authorization within one business day of determining the member has TIHP coverage, and extenuating circumstances do not exist
- Failure to follow the Plan's requests for clinical updates related to continuing care, such as SNF services.

In these circumstances, the member has begun, or completed service, so they are not involved in an administrative denial, as it is between the Plan and a contracted provider. Therefore, any denial notice, including appeal rights follow the policies as outlined in the Provider Manual and provider dispute (appeal) policy.

Members must be held harmless, and cannot be billed, for any service, except for relevant copayments and/or coinsurances, as required by CMS and the provider's contract.

Discharge Planning

The TIHP Nurse Practitioner (NP) and/or RN Case Coordinator (RNCC) works with the hospital staff, the long-term care facility where the member may reside, and internal UM staff, to coordinate discharge planning services. Additionally, the Plan NP conducts a post discharge clinical visit which may include:

- Assessing clinical stability and ordering of any new services that may be needed to avoid a readmission
- Medication reconciliation
- Confirmation that follow-up appointments are scheduled
- Care Plan revisions that may be required

Contact the UM department for members that may benefit from discharge planning services, as well as to confirm the member's actual discharge date.

Transplant Management

The TIHP care management team helps providers interpret transplant benefits for Members and choose a facility from the national transplant network. Each transplant facility is selected based upon its level of expertise and standards of care using an established set of criteria.

Transplant coverage includes pre-transplant, transplant and post-discharge services, as well as the treatment of complications after transplantation. Providers should contact the TIHP UM Intake department via fax at 1-877-235-1650 as soon as they feel transplant services may be necessary and before evaluation for transplant services.

A claim for a transplant may be reviewed for medical necessity to ensure coverage for qualified Medicare benefits.

V. Claims and Reimbursements - Billing Guidelines

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

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

- National Provider Identifier
- The Member's identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.)

Providers who are paid based on interim rates should include with the claim a copy of the current interim rate letter if the interim rate has changed since the previous claim submission.

Billing questions and/or problems should be directed to Provider Services at 833-471-8447.

Filing a Claim for Payment

Electronic Submissions

TIHP is contracted with RAM Technologies, Inc.. RAM Technologies, Inc. is able to forward claims to TIHP.

Electronic Payer ID for Texas Independence Health Plan HMO SNP is 31403.

Filing claims electronically reduces administrative costs, speeds claims payment and improves payment accuracy. To begin submitting claims electronically, contact RAM Technologies, Inc. as follows:

833-471-8447

For questions regarding electronic claims (EDI) billing, contact Provider Services1-833-471-8447.

Paper Submissions

Providers who prefer to submit claims by mail should send them to the following address:

Texas Independence Health Plan
P.O. Box 25738
Tampa, FL 33622

Filing Deadlines

Timely filing requirements are specified within the applicable Provider Participation Agreement. For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, or the patient is admitted for care.

Failure to comply with timely filing requirements will result in claim denial, unless documented extenuating circumstances exist.

Key Points

Here are some key points to consider when filing claims:

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

Clean vs. Unclean Claims

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

Under CMS guidelines, a “clean” claim is a claim with no defects or improprieties. An “unclean” claim may include:

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

TIHP will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

National Provider Identifier

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

The purpose of the NPI is to uniquely identify a healthcare Provider in standard transactions, such as healthcare claims. The NPI may also be used to identify healthcare Providers on prescriptions, in internal files to link proprietary Provider identification numbers, in coordination

of benefits between health plans, inpatient medical record systems and in program integrity files.

The NPI is the only healthcare Provider identifier that can be used for identification purposes in such transactions.

Reimbursements

TIHP complies with Medicare's prompt payment of claims requirements for all clean claims. Claims must be submitted within the time frame specified in the provider's contracts. TIHP processes all error-free claims (known as clean claims) for covered services provided to a Member within 30 calendar days of receipt by the plan.

Special Circumstances

For certain Medicare-approved providers, TIHP pays as follows:

- Eligible hospitals are reimbursed according to CMS Inpatient Prospective Payment System (IPPS) Diagnosis-Related Group (DRG) reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under original Medicare based on rates published on the CMS website (www.CMS.gov). The payment is added to the IPPS. However, because Fiscal Intermediaries are responsible for operating IME and Direct Graduate Medical Education (DGME), TIHP does not reimburse those components of the DRG.

- TIHP reimburses qualifying Disproportionate Share Hospitals (DSH) the same capital exception payments and add-on payments for operating DSH that they would have received under original Medicare. The payment is added to the PPS rate. TIHP reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.

- TIHP does not reimburse facilities for bad debt incurred as a result of Members not paying their cost-sharing amounts (if any), unless specified in a provider's contract.

- TIHP does not enter into the annual cost settlement process with providers, contracted or non-contracted. Providers who have treated TIHP Members should contact Medicare or their Fiscal Intermediary regarding their cost settlements.

Billing for Non-Covered Services

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

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

For those members who are dually eligible, providers should bill Medicaid for relevant services that may be covered. Please also refer to the section on "Balance Billing Provisions".

Balance Billing Provisions

A provider may collect only applicable plan cost-sharing amounts from TIHP Members and may not otherwise charge or bill Members. Balance billing is prohibited by providers who furnish plan-covered services to TIHP Members.

Per CMS guidance, Billing Prohibition for Qualified Medicare Beneficiaries (QMBs):

All original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – cannot charge QMBs for Medicare cost sharing for Covered Parts A and B Services. (Note: QMBs cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay.)

- Medicare Remittance Advice notices clearly indicate if a beneficiary is a QMB and show the beneficiary's deductible, copayment, and coinsurance cost-sharing is zero.

- If a provider bills a QMB for Medicare cost-sharing, or turns a bill over to collections, the provider must recall it. If the provider collects any cost-sharing money from a QMB the provider must refund it.

- A provider may be subject to sanctions if it bills a QMB for amounts above the total of all Medicare and Medicaid payments (even when Medicaid does not fully pay the Medicare cost-sharing).

For more information, see the Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program MLN Matters® article.

Additional Billing Requirements for Dually Eligible Beneficiaries:

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

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

For more information, see the ABN Form and Instructions available on the Medicare website.

Provider Remittance Advice Form

TIHP sends Providers a Provider Remittance Advice Form (PRAF) once it has received and paid a claim.

Questions regarding the PRAF may be addressed to TIHP at 833-471-8447 from 8 AM to 5 PM (local time zone), Monday-Friday a week.

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

- National Provider Identifier (NPI)
- Claim number in question
- Member's name
- Date of service
- Member's date of birth
- Issue requiring review
- Member's ID number
- Copy of claim (if available)

Coordination of Benefits

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

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

For a provider who accepts Medicaid and who treats a TIHP Member who is a Medicaid patient, TIHP will pay the Medicare portion of the claim. The provider must then submit the claim to the appropriate state Medicaid entity for the Medicaid portion of the claim.

The following types of situations, not an exhaustive list, will prevent payment by TIHP as the primary payer:

- Employer Group Health Plan (EGHP): These Members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse's age is not material to the determination of primary coverage, only the qualification of the EGHP.

- Disabled Beneficiaries Employer Group Health Plans: These Members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member's employment. LGHP is defined by at least one of the employers having at least 100 employees.

- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either

respiratory or pulmonary diseases. TIHP is the primary payer for all other care and service needs.

- Workers' Compensation: The Workers' Compensation carrier is responsible for all injuries and illnesses that result from employment. TIHP pays only when the Workers' Compensation benefits are exhausted or the services/care were not covered by the Workers' Compensation carrier but are Medicare benefits.

- Veterans Administration (VA) Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. TIHP may supplement VA payment when the Member files a claim for Part B services that were not fully reimbursable by the VA.

Provider Payment (Claim) Dispute (Appeal) Resolution Process

If a contracted provider believes a clean claim should have been paid differently, they have the right to dispute the payment. Initially, the provider may contact the Provider Services Call Center to discuss the claim with a specialist. If the specialist cannot reprocess the claim (i.e. they believe the claim processed correctly under Plan rules), providers must address disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments or the amount of the claim) in writing. Providers may direct any questions to Provider Services at 833-471-8447.

To file a payment dispute, providers should submit a written request for dispute resolution along with any supporting documentation. Providers are encouraged to include a cover sheet outlining the reason for the requested review along with the claim. TIHP will respond to all written disputes regarding claims within 30 calendar days. If TIHP agrees with the reason for the payment dispute, TIHP will issue a new Explanation of Payment (EOP) and pay any additional amount that is owed, including interest due.

Claims that denied related to medical necessity, must be reviewed by the UM department prior to any payment. Should an administrative denial be overturned, the case is reviewed for medical necessity before a decision is communicated.

TIHP will inform providers in writing if the decision is unfavorable and no additional payment is allowed.

Claims must be disputed within 120 days from the date payment/denial is initially received by the provider. In cases where TIHP re-adjudicates a claim, providers have an additional 120 days from the notification date in which to dispute the adjustment.

TIHP will inform providers in writing if the decision is unfavorable and no additional payment is allowed.

VI. Medicare Risk Adjustment

What is Risk Adjustment?

Risk adjustment promotes quality care and improved outcomes leading to increased patient satisfaction. Designed as an actuarial tool that adjusts funding for the care of the patient based on the severity of illness, it's rooted in early detection, intervention, and consistent care of chronic conditions. Each patient is assigned a risk adjustment score that identifies their illness burden and predicts expected cost of care and utilization. A risk score is the numeric value an enrollee in a risk adjustment program is assigned each calendar year based on demographics and diagnoses (HCCs).

The risk score of an enrollee resets every January 1 and is officially calculated by CMS overseeing the risk adjustment program the member is enrolled in. Another term for risk score is Risk Adjustment Factor (RAF)..

Physician/Provider Roles

Providers play an important role in risk adjustment. While many conditions necessitate routine monitoring and frequent visits throughout the year for optimal management, risk adjustment requires an annual assessment of each condition. Providers drive the risk adjustment score for each patient by:

- Assessing and treating the patient's chronic conditions
- Documenting the patient's condition(s) to the highest level of specificity during each visit
- Reporting each condition accurately and specifically
- All claims and/or encounters submitted for risk adjustment consideration are subject to federal and/or TIHP internal audit. Audits may come from CMS, HHS, or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please give us any requested medical records quickly. Please provide all available medical documentation for the services rendered to the member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

How Does Risk Adjustment Impact Physicians and Members?

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

- ✓ Primary diagnoses, to the highest level of specificity

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

With your help in providing accurate and timely coding for risk adjustment, we can avoid unnecessary and costly administrative revisions, and provide your patients and our members with superior customer service.

Why is Medical Record Documentation Important for Risk Adjustment?

- Defines patient health status – Medical records provide a comprehensive account of a patient's health, include their active and chronic conditions, beyond what is captured on claims alone. Drives risk scoring – Risk adjustment uses information from medical records to assign Hierarchical Condition Categories (HCCs) and calculate a Risk Adjustment Factor (RAF). A higher RAF indicates a patient with more complex and costly conditions. Determines reimbursement – Higher risk scores,, validated by detailed documentation, lead to higher reimbursement rates for healthcare plans and providers. Supports Care Management – Accurate documentation helps identify patients who could benefit from specialized programs, such as chronic care and case management, improving health outcomes.
- Ensures coding accuracy – Documentation provides the detailed evidence necessary for your coders to select the most specific ICD-10-CM codes, which directly impacts the assigned RAF.

Best Documentation Practices for Diagnosis Coding

Documentation should be clear, concise, and described to the highest level of specificity. It facilitates:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely healthcare provider payment for furnished services
- Legibility

- The entire medical record must be legible.
- If it is not documented, it was not done.
- If it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and that appropriate medical services were performed.

- Patient demographics
    - Each page should include the date of service and the patient's name and date of birth.
    - Include the patient's identification number, if applicable.
- Page numbering
    - Each page for each date of service should be numbered so that, if pages are separated, they may be easily reassembled in proper order
- Healthcare provider signature and credentials
    - Only authorized personnel may document in the medical record and must be clearly identified by a printed, legible provider's name and credentials.
    - Each encounter must document date of service and be signed in a timely manner by the rendering provider.
    - Signature method shall be handwritten or electronic signature. Stamped signatures are not acceptable. CMS allows stamped signatures, on handwritten records, only when the provider can show proof of physical disability that renders them unable to sign the record.
- Abbreviations and acronyms
    - Limit the use of abbreviations and acronyms or avoid them altogether.
    - Use only industry-standard abbreviations and acronyms.
    - Some standard abbreviations and acronyms have multiple meanings and can often be determined based on context, but is not always true.
- Dates and timelines – Specific dates and timelines provide important information and can affect diagnosis code assignment.
    - Post-hospitalization or post-operative follow-up office visits:
        - Vague: "Patient is here for hospital follow-up."
        - Specific: "Patient was discharged from the hospital on 1/15/20xx after admission for an exacerbation of congestive heart failure."
- Historical versus Current – Do not use descriptor "history of" to describe a current or chronic condition that is still present, active, or ongoing. In diagnosis coding, "history of" means a condition occurred in the past and is no longer a current problem.
    - To describe a current condition that is in remission document the condition as "in remission" and not historical. For example:
        - Patient with a history of prostate cancer that was eradicated in the past, presents to the office for evaluation, examination, and 6-month follow up PSA lab test to monitor for prostate cancer reoccurrence.

        - Assessment section should not state “prostate cancer” but rather “history of prostate cancer.”
        - Related plan is best stated as “continue to monitor PSA every six months to check for prostate cancer reoccurrence.”
- Consistency – Use caution when using record templated or electronic health records (EHRs) that might introduce conflicting or contradictory information. Example:
    - Chief complaint states the patient presents for evaluation of chest pain, and the final assessment states acute angina. However, the ROS states, “patient denies any episodes of chest pain.”
- Specificity – Avoid vague diagnosis descriptions, e.g., “other” or “unspecified”. Describe each final diagnosis to the highest level of specificity, such as:
    - With or without exacerbation and/or complications
    - Primary, secondary, recurrent, in remission (partial or full)
    - Acute, chronic, acute-on-chronic
    - Severity – mild, moderate, severe
    - Current stage
    - Location or site, including laterality and specific site with a body part (upper outer quadrant, lower inner quadrant, etc.) distal, proximal, etc.
- Causal Relationship –
    - Medical record documentation should clearly link conditions like diabetes mellitus to related complications by using linking terms such as “due to,” “secondary to,” “caused by,” and “associated with.” These linking terms confirm the cause-and-effect relationship (versus the two conditions simply co-existing).
    - Avoid use of punctuation marks (e.g., slashes and commas) to separate conditions, as this may not clearly indicate a causal relationship.
- Confirmed versus Uncertain – ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.H. directs us to avoid use of terms that imply uncertainty (such as “probable,” “apparently,” “likely,” or “consistent with”) to describe diagnoses or conditions that are confirmed. Rather document the signs and symptoms in the absence of a confirmed diagnosis in the outpatient setting.
- Status conditions – Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant).
- Assessment/Impression/Plan – This portion of a medical record is where the provider compiles their medical decision-making for the encounter and documents their visit diagnoses, treatment plan or referrals and any other plans for the encounter.
    - There should only be one final assessment.
    - Should document to highest level of specificity of the following:
        - A final diagnosis for all conditions, including how each condition was evaluated and managed during the encounter.

- All comorbid or coexisting conditions that impacted patient care, treatment or management for that encounter.
- Status of each condition that currently exists (not historical), such as improved, stable, worsening, in remission, etc.

- Electronic Health Records (EHR) issues –
  - Some EHRs insert ICD-10-CM codes with descriptions into the medical record to represent the final diagnosis and are vague descriptions and incomplete diagnoses.
  - Mismatch between final diagnosis and EHR-inserted diagnosis code with description. Example:
    - **Assessment: Ischemic cardiomyopathy**

      I42.0 Dilated cardiomyopathy (correct diagnosis)

      The final **bold** diagnosis in the Assessment is "Ischemic cardiomyopathy," which codes to I25.5. The EHR-inserted diagnosis code with description that follows, however, is I42.0, Dilated cardiomyopathy, which causes confusion regarding which diagnosis is correct. Often documentation found elsewhere in the record does not provide clarity.
  - To ensure accurate diagnosis code assignment, the provider's final diagnosis must either:
    - Match the code with description, or
    - It must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.
- Supporting documentation – The medical record should provide supporting documentation for each condition or diagnosis listed, such as:
  - Related signs and symptoms and physical exam findings.
  - Medication lists should document the drug name, dosage with times and/or frequency and clear linkage to the condition(s) for which the drug has been prescribed.
  - For chronic conditions impacting patient care, treatment and management and are being followed by a different provider, supporting documentation would be notation to that effect.
- Treatment plan – The current plan of treatment for each diagnosis should be clearly documented and specific and can include:
  - Dietary recommendations
  - Medication changes (linked to the diagnosis)
  - Orders for lab/diagnostic testing
  - Specific patient education or counseling provided
  - Continued monitoring
  - Other factors that affect diagnosis

- Problem lists – Problem lists are a common element in medical records, especially EHRs. There is no universally accepted definition of the naming, content or use of a problem list across all EHRs. Problem lists may contain both active and historical conditions, but they are not equivalent to a past medical history or final assessment/plan. The problem list should be maintained and updated, by the healthcare provider, documented at every visit. This avoid confusion and questions about the status of the conditions in the list and possibly the medical record in its entirety.

Requests for Medical Records

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

Texas Independence Health Plan
Attn: Medical Records for Risk Adjustment
1908 N. Laurent Street
Suite 250
Victoria, TX 77901
Phone: 833-471-8447 | Fax 1-866-805-8447
Email: TIHPRiskAdjustment@txihp.com

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

CMS Risk Adjustment Data Validation helps ensure the integrity and accuracy of risk-adjusted payment. It is the process of verifying that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member. Medicare Advantage Plans are selected for data validation audits annually. It is important for physicians and their office staff to be aware of risk adjustment data validation activities because medical record documentation may be requested. As previously stressed, accurate risk-adjusted payment relies on the diagnosis coding derived from the member's medical record..

Data Process for Risk Adjustment

1. Physician documents member visit in the medical record; the office codes the claim from the medical record.
2. TIHP submits diagnosis data from claims to CMS for risk adjustment calculation and payment.
3. CMS conducts annual risk adjustment data validation audit on selected plans.

Hierarchical Condition Category (HCC) Model

Hierarchical Condition Category (HCC) coding is a risk-adjustment model originally designed to estimate future healthcare costs for patients. The Centers for Medicare and Medicaid Services (CMS) HCC model was initiated in 2004 and is becoming increasingly prevalent as the environment shifts to value-based payment models.

HCC coding relies on ICD-10-CM coding to assign risk scores to patients. Each HCC is mapped to an ICD-10-CM code. Along with demographic factors such as age and gender, MA plans use HCC coding to assign patients a risk adjustment factor (RAF) score. Using algorithms, MA plans can use a patient's RAF score to predict costs. For example, a patient with multiple chronic conditions would be expected to have higher care utilization and costs.

Purpose – to adjust payments to MA plans based on the expected health costs and risk of their enrollees. Mechanism – the model uses demographic factors and Hierarchical Condition Categories (HCCs), which are groupings of medical codes linked to specific diagnoses.

Context – The implementation of the HCC model was tied to the creation of the Medicare Advantage program, which was introduced by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

Helpful CMS Webpages

- Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements: Medicare Claims Processing Manual
- Medicare Program Integrity Manual Chapter 3-section 3.3.2.4 – Signature Requirements: Medicare Program Integrity Manual
- Medicare Billing: 837P and Form CMS-1500: Medicare Billing: CMS-1500 & 837P
- Medicare Billing: 837I and Form CMS-1450: Medicare Billing: CMS-1450 & 837I

Frequently Asked Questions

These are a few of the most frequently asked questions regarding Medicare Risk Adjustment:

***Q:** How often does the diagnosis have to be addressed to be counted for risk adjustment?*

A: The diagnosis must be addressed and documented at least once a calendar year.

***Q:** Is a "typed" signature on a report acceptable for office consultation notes, a discharge summary and hospital consultations?*

A: No. The provider who dictated the report must sign it, regardless of the record type, and

add his/her credentials. Electronic signatures are acceptable but must be accompanied by words such as “electronically signed by,” “authenticated by” or “signed by.”

Q: *Are medical records containing dictated progress notes that are dated but not signed acceptable for medical review?*

A: No. Medical record documentation should be signed and dated by the physician.

Q: *If providers submit an unsigned medical record, will TIHP return the record to the provider for a signature?*

A: Yes, as long as it is within 30 days. Otherwise, providers must submit either an attestation with the rendering providers signature and credentials or an addendum to the medical record .

Example: Signature Attestation Statement

https://med.noridianmedicare.com/documents/10546/2911943/Signature+Attestation+Statement.pdf

Q: *Can a pathology report alone substantiate a risk adjustment assignment?*

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

***Q:** Can a radiology report alone substantiate a risk adjustment assignment?*

A: Radiology is not an acceptable source to report diagnoses for risk adjustment because it generally does not have a documented diagnosis but instead provides an impression of the findings.

***Q:** How often should providers document chronic conditions, such as an old myocardial infarction (MI)?*

A: Yearly, or as often as the diagnosis factors into the medical decision making.

VII. Pharmacy – Part D Services

Overview

The TIHP Pharmacy Department manages the administration of pharmacy benefits.

For formulary and/or coverage-related questions, you can contact the TIHP pharmacy team at pharmacysupport@txindependencehealthplan.com.

TIHP partners with MedImpact, a Pharmacy Benefit Manager (PBM), to administer the prescription programs for TIHP Members.

The TIHP formulary may be viewed by going online to www.txindependencehealthplan.com/

- Click on "Providers" and then select "Texas TIHP Provider Documents"
- Under the Pharmacy Information and Authorization section, you can:
  - Search the formulary online using the "2026 Formulary (Prescription Drugs) Search Tool"
  - Download and print the comprehensive formulary and/or utilization management criteria using the respective links

Pharmacy Policies

Generics

The formulary includes both generic and brand name medications. There may be instances where only the brand is covered. As generics become available during the year, TIHP may immediately substitute coverage of the generic over the brand medication.

Formulary

Physicians and clinical pharmacists on the PBM's Pharmacy and Therapeutics Committee develop and maintain the formulary for TIHP.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits include prior authorizations, quantity limits, and/or step therapy.

To request coverage for a drug that has additional requirements, call 1-866-213-1594 or visit www.txindependencehealthplan.com/providers/documents/ for a link to make the request electronically or download a form that can be faxed to the PBM for review.

Excluded Medications

Medicare has excluded certain medication classes from coverage by Part D Medicare programs. These classes include all drugs (brand and generic) and combination drugs that contain a medication within these classes:

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

Alert – No Appeal for Excluded Medications

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

Discontinuing, Changing or Reducing Coverage

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

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

Notification of Formulary Changes

If TIHP removes drugs from the formulary or adds coverage restrictions, such as prior authorizations, quantity limits, and/or step therapy requirements on a drug, TIHP must notify affected Members and providers of the change at least 60 days before it becomes effective.

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

Transition Policy

TIHP will provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. TIHP will cover up to a one month (30-day, or 31-day for residents of long-term care facilities) supply within the enrollee's first 90 days of Membership, during which time the provider should initiate the same "coverage determination" process outlined previously.

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

Pharmacy Network

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

In-network pharmacies include community-based pharmacies, pharmacies that serve long-term care facilities, specialty pharmacies (home infusion pharmacies) and pharmacies owned by Indian tribal councils.

Mail Order Services

TIHP offers mail order services to our Members. Some of the benefits to the Members include:

- Free delivery
- Online convenience: save time and set up automatic refills or order any time of day or night at www.birdirx.com/mail-order

To get mail order forms and information about ordering prescriptions for your patients through mail order, go to www.birdirx.com/for-prescribers or call 877- 269-1159.

VIII. Pharmacy – Part B Services

Definition of Part B Coverage

Medicare Part B originally was designed to help people with Medicare pay for their medical costs but not for their medications.

Over the years, though, Congress added benefits to treat specific diseases, including medications used to treat those diseases. The Part B benefit does not apply to specific medications (Exceptions may apply for IPPB solutions and some diabetic supplies) but rather to the treatment of certain diseases.

Medicare Part B covers a limited number of prescription drugs. These Part B drugs generally fall into three categories:

- Drugs furnished incident to a physician's service
- Drugs used in conjunction with durable medical equipment (DME)
- Certain statutorily covered drugs, including:
  - Immunosuppressive drugs for beneficiaries with a Medicare-covered organ transplant
  - Hemophilia blood clotting factor
  - Certain oral anti-cancer drugs
  - Oral anti-emetic drugs
  - Pneumococcal, influenza and hepatitis vaccines (for intermediate to high-risk individuals)
  - Antigens
  - Erythropoietin for trained home dialysis patients
  - Certain other drugs separately billed by End-Stage Renal Disease (ESRD) facilities (e.g., iron dextran, vitamin D injections)
  - Home infusion of intravenous immune globulin for primary immune deficiency

Medicare Part B drug coverage has not been changed by implementation of the new Medicare Part D drug program. Drugs that were covered by Medicare Part B before the Part D prescription drug program became operational continue to be covered under Medicare Part B.

Copayments for each category are as follows:

- Part A – Generally No copayment (part of the Hospital payment)

- Part B – Generally No coinsurance (varies by plan and/or product)
- Part D – Generally No Member copayment (varies by plan and/or product and/or by tier level)

Part B Medication Authorizations and Claims

Drugs furnished incident to physician's services follow the same authorization and claim procedures as other physician services. For prescription medications dispensed by a pharmacy, the TIHP pharmacy claims system is able to adjudicate Part B claims. Some prescription medications may require Part B vs. D coverage determination review.

Part B vs. D Coverage Determination for Prescription Medications Dispensed by a Pharmacy

While the use of some medications is assumed to fall under Part B coverage, others require additional clinical information before coverage can be determined. Therefore, certain prescription medications are subject to prior authorization for Part B vs. Part D coverage determination. The intent is not to establish clinical grounds for approval but to determine the circumstances of the claim for payment purposes.

TIHP will allow payment as a Part D benefit only when it can establish appropriate coverage. Otherwise, coverage is redirected as a Medicare Part B claim.

In addition:

- Some medications could be covered under Part B (medical) or Part D (prescription) depending on several issues, including the diagnosis, residential status of the Member or route of administration.
- Part B and D drugs have different copayments, and Part B drugs do not apply to True Out-of-Pocket costs (TrOOP).
- The process to determine if the drug is to be covered as Part B or Part D is the same process outlined previously for "coverage determination."

IX. Physician Rights, Responsibilities and Roles

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

As such, TIHP employees and in-network providers shall:

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

Provider Role in HIPAA Privacy Regulations

Like TIHP, participating providers are covered entities under HIPAA and are required to keep Protected Health Information (PHI) confidential. A major goal of the Privacy Rule is to ensure that an individual's PHI is properly protected, while still allowing the flow of health information needed to provide and promote high-quality care, as well as to protect the public's health and well-being.

TIHP policies and procedures include regulatory information to ensure TIHP complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach- Bliley Act. Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations – as is the staff at TIHP.

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

TIHP developed its referral/authorization request form in accordance with the core elements and required statements contained in the HIPAA privacy rules. To determine pre-service medical necessity, providers should complete, sign and return the referral/authorization form to TIHP.

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

TIHP's Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. To view the Privacy Statement and Notice of Privacy Practices, contact Provider Services at 833-471-8447.

This information regarding HIPAA privacy compliance is provided as a courtesy to Plan Providers and is designed for educational purposes only. It should not be used as a substitute for legal or other professional advice. For more detailed information regarding confidentiality and accuracy of enrollee records, please see regulations under 42 CFR §422.118.

Complying with the Americans with Disabilities Act

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Offices are required to adhere to the Americans with

Disabilities Act (ADA) guidelines and any of its amendments, Section 504 of the Rehabilitation Act of 1973 (Section 504), and other applicable state or federal laws.

TIHP requires that in-network providers' offices or facilities comply with these aforementioned statutes/laws.

The ADA and Section 504 require that providers' offices have the following modifications: (i) the office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs; (ii) patient rest rooms should be equipped with grab bars; and (ii) handicapped parking must be available near the provider's office and be clearly marked. These aforementioned requirements are not an exhaustive list of the standards or access requirements mandated by the ADA, Section 504, or any other applicable state or federal law.

Anti-Kickback Statute

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

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

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

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

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

The Scope of Fraud, Waste and Abuse on the Healthcare System

During Fiscal Year (FY) 2021, the Federal government won or negotiated over $5 billion in healthcare fraud judgments and settlements.[1] The National Health Care Anti-Fraud Association (NHCAA) website reports that healthcare loss due to fraud, waste and abuse has an impact on patients, taxpayers and the government because it leads to higher healthcare costs, insurance premiums and taxes. Healthcare fraud often hurts patients who may receive unnecessary or unsafe healthcare procedures or who may be the victims of identity theft.

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

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

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

Medical Identity Theft

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

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

[1] The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2021.

Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse (FWA) may be reported anonymously to the **Compliance Department at 1-888-418-1566** 24 hours a day/7 days a week. Suspected or detected non-compliance or FWA concerns can also be reported to the TIHP Compliance Officer at: tgifford@txihp.com.

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

Texas Independence Health Plan
1908 N. Laurent Street
Suite 250
Victoria, TX 77901

All reports are treated confidentially to the fullest extent possible. Results of investigations may be shared with law enforcement or regulatory authorities in certain instances.

Additional Information is available at the following websites:

- www.insurancefraud.org
- www.medicare.gov/basics/reporting-medicare-fraud-and-abuse
- www.ssa.gov/oig
- www.nhcaa.org

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

Rules Related to Marketing Medicare Advantage Plans

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

In general:

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

Providers may:

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

- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.

Plan Affiliations

Providers may:

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

Providers should not:

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

Plan Benefits

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

Contact Information

When requested, providers may provide the plan's contact information to a beneficiary so that the beneficiary may contact the plan directly regarding an expressed interest in enrolling in a plan in which the provider participates.

However, for marketing purposes, providers shall not release a beneficiary's contact information to a plan or an agent unless the beneficiary requests that the plan contact him or her.

Sales Presentations

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

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

Marketing Materials

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

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

Distributing Information

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

Providers may provide links on their website to all plan enrollment applications and/or provide downloadable enrollment applications to all plans with which they participate.

Providers must not perform health screening when distributing plan sponsor information to patients. This is prohibited under MIPPA.

Providers are encouraged to participate in educational events, including health fairs. However, they must not engage in marketing activities at such events.

Providers must not accept enrollment applications from beneficiaries or offer scope of

appointment forms to beneficiaries.

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

Questions should be directed to Provider Services at 833-471-8447.

XII. Legal and Compliance

Overview

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

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

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

TIHP Compliance & Ethics Program

TIHP has established a comprehensive Compliance & Ethics Program that focuses on proactive monitoring, training, evaluation, detection, and prevention of violations of CMS Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Program regulations, guidelines, and applicable federal and state laws. TIHP works collaboratively with State and Federal regulatory agencies and, our contracted business partners to ensure business practices are conducted lawfully, ethically, and in manner conducive to the achievement of mutual goals and to deliver quality services and health care to our members

Our Compliance Plan, Codes of Conduct and compliance policies and procedures promote a culture of compliance by establishing guidelines, requirements and expectations for all employees, Board Members and contracted business partners including our First Tier, Downstream and Related Entities (FDRs).

As a Medicare Advantage plan sponsor, TIHP must ensure that FDRs performing delegated administrative or health care service functions related to its Medicare Advantage program are familiar and comply with General Medicare Compliance Program and Fraud, Waste and Abuse (FWA) requirements described in the TIHP Compliance Plan and Code of Conduct. In order to fulfill General Medicare Compliance Program requirements, our contracted FDRs must:

- Adopt and comply with TIHP's Code of Conduct and Compliance Policies and Procedures (P&Ps) or have their own materially similar versions
- Ensure that the TIHP Code of Conduct and Medicare Compliance Program documents or their own materially similar versions are distributed to all personnel involved with TIHP's Medicare Advantage business (including downstream entity personnel, when applicable) within 90 days of contracting, upon revision and annually thereafter
- Ensure all personnel assigned to perform TIHP Medicare Advantage services know how the compliance program operates and, how to identify and report issues of non-compliance and FWA concerns
- Ensure all personnel receive general compliance training and FWA training within 90 days of hire, and annually thereafter
- Complete and submit TIHP FDR Compliance Attestation annually
  Provide evidence of distribution of a Code of Conduct and Compliance P&Ps to TIHP upon request

TIHP maintains ultimate responsibility for fulfilling the terms and conditions of its contract with CMS. CMS may hold TIHP accountable for the failure of its FDRs to comply with Medicare Part C and Medicare Part D program requirements.

Regulatory Compliance

Regulatory compliance is not an option, but it is a requirement. The TIHP Compliance Program is led by the Compliance Officer (CO) and addresses all aspects of regulatory compliance, including, but not limited to:

- Utilization Management
- Coverage Determinations
- Formulary Administration
- Appeals and Grievances
- Claims Processing
- Enrollment/Disenrollment
- Credentialing/Recredentialing
- Marketing and Sales
- Compliance Education and Training
- FDR Monitoring and Oversight
- Compliance Risk Assessments
- Exclusion and Debarment Screenings
- Conflicts of Interest
- Compliance Investigations

Every operational area at TIHP is responsible for the compliance of its functions. The TIHP Compliance and Regulatory Committee (CRC) supports the Compliance Officer in the development, monitoring and assessment of the Compliance Plan. The Compliance Plan operates under the authority and oversight of the Boards of Directors for Texas Independence Health Plan.

XIII. Federal & State Regulations

Overview

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

These regulations include, but are not limited to:

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

Health Information Portability & Accountability Act (HIPAA)

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

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

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

Information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards. Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all "providers of services" (e.g., institutional providers such

as hospitals) and “providers of medical or health services” (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Medicare Improvements for Patients and Providers Act (MIPPA)

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

False Claims Act and Fraud Enforcement Recovery Act

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

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

Physician Self-Referral Law (Stark Law)

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

The Omnibus Budget Reconciliation Act of 1993 (“OBRA 1993”), known as “Stark II,” extended the ban, effective January 1, 1995, to an additional list of services and applied it to Medicaid at

the same time. CMS has issued a series of implementing regulations. CMS issued “Phase III” of the final regulations September 5, 2007.

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

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

Anti-Kickback Statute

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

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

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

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

Exclusion Law and Civil Monetary Penalties (CMP) Law

The Exclusion Law (42 U.S. Code § 1320a–7) excludes individuals or entities convicted of criminal offense relating to patient abuse or neglect, a felony offense related to health care fraud, or a felony offense related to controlled substances from participation in any Federal health care program for a minimum of five years. If there is one prior conviction, the exclusion will be for 10 years, and the exclusion will be permanent if there are two prior convictions. The Civil Monetary Penalties Law authorizes the Secretary of Health and Human Services Office of Inspector General (OIG) to impose civil monetary penalties for a variety of conduct and different amounts penalties and assessments may be imposed the type of violation at issue. Penalties can range up to $50,000 per violation. Violators are also subject to three times the amount of renumeration offered, paid, solicited or, received.

Fraud, Waste and Abuse

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

The HITECH Act

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

Title XIII of Division A and Title IV of Division B of the Act are referred to as the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The HITECH Act includes a number of measures designed to broaden the scope and increase the rigor of HIPAA compliance. The HITECH Act expands the reach of HIPAA data privacy and security requirements to include the Business Associates of those entities (healthcare providers, pharmacies, and the like) that are subject to HIPAA. Business Associates are companies such as accounting firms, billing agencies, law firms or others that provide services to entities covered under HIPAA.

Under the HITECH Act, companies are now directly subject to HIPAA security and privacy requirements as well as to the same civil and criminal penalties that hospitals, pharmacies and other HIPAA-covered entities face for violations. Before HITECH came into force, Business

Associates that failed to properly protect patient information were liable to the covered entities via their service contracts, but they did not face governmental penalties.

The HITECH Act specifies that Business Associates will be subject to the same civil and criminal penalties previously imposed only on covered entities. As amended by the HITECH Act, civil penalties range from $100 to $50,000 per violation with caps of $71,162 to over $2.1 million for all violations of a single requirement in a calendar year. Criminal penalties include fines up to $250,000 and imprisonment for up to ten years. In some instances, fines are mandatory.

State Regulations

Many state regulations also have an impact on the Plan's day-to-day operations. Many of these regulations relate to Medicaid and/or relationships existing between governmental entities and TIHP.

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

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

XIV. Glossary and Abbreviations

Glossary of Healthcare Terms

Abuse
Incidents inconsistent with accepted medical or business practices, improper or excessive, resulting in unnecessary costs to the program, beneficiaries, or third parties.

Advance Directive
A written document that states how and by whom a Member wants medical decisions to be made if that Member loses the ability to make such decisions for himself or herself. The two most common forms of Advance Directives are living wills and durable powers of attorney.

Ancillary Services
Healthcare services that are not directly available to Members but are provided as a consequence of another covered healthcare service, including, but not limited to radiology, pathology, laboratory and anesthesiology.

Benefit plan
The schedule of benefits establishing the terms and conditions pursuant to which Members enrolled in TIHP receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment, coinsurance, deductible and/or out-of-pocket maximum amounts; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Board-Certified
Term describing a practitioner who has completed residency training in a medical specialty and has passed a written and oral examination established in that specialty by a national board of review.

Care Team
Term describing the group including the Member's PCP, Plan NP, Plan RN care coordinator and Plan account managers who work together to form the Member's care plan.

Claim
A request by a healthcare Provider for payment for services rendered to a Member.

Clean Claim
A claim that is free from defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term shall not include a claim from a healthcare Provider who is under investigation for fraud and abuse regarding that claim.

Coinsurance
A cost-sharing requirement under a health insurance plan that provides that a Member will assume responsibility for payment of a fixed amount or percentage of the cost of a covered service, where the cost is generally the allowed amount under the fee schedule.

Complaint
A dispute or objection regarding a Provider or the coverage, operations, or management policies of a managed care plan that has not been resolved by the managed care plan and has been filed with the plan or with the appropriate state Department of Insurance. A complaint is not the same as a grievance.

Comprehensive Health Record
Document that combines the history and physical (H&P) and the Health Risk Assessment (HRA)

Coordination of Benefits (COB)
The process to prevent duplicate payment of medical expenses when two or more insurance plans or government benefits plans provide coverage to the same person. The rules that determine which insurer provides primary or secondary coverage are governed by healthcare industry standards and, in some instances, by applicable regulatory agencies.

Copayment
Cost-sharing arrangement in which the Member pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

Covered Services
Healthcare services for which a health plan is responsible for payment according to the benefit package purchased by the Member.

Credentialing
TIHP's review procedure in which potential or existing network Providers must meet certain standards to begin or continue participation in the network of TIHP. The credentialing process may include examination of a Provider's certifications, licensures, training, privileges and/or professional competence.

Deductible
Amount Member may be required to pay for covered services before TIHP begins to pay for such services.

Disenrollment
Process of termination of a Member's coverage.

Durable Medical Equipment (DME)
Medical equipment owned or rented, that is placed in the home of a Member to facilitate treatment and/or rehabilitation.

Emergency Services
Any healthcare service provided to a Member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the Member (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service, if the condition of the Member is as described above.

Encounter Data
Data relating to treatment or service rendered by a Provider to a Member regardless of whether the Provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

Enrollment
Process by which a health plan signs up groups and individuals for Membership.

Explanation of Benefits (EOB)
Statement that explains the benefits provided; the allowable reimbursement amounts; any deductibles, coinsurance or other adjustments taken; and the net amount paid.

Fraud
The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit.

Grievance
A type of complaint you make about us or one of our in-network Providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Maintenance Organizations (HMO)
Sometimes called “managed care organizations,” HMOs contract with doctors and hospitals who agree to accept their payments. In an HMO, you receive your care from the doctors, hospitals, and other Providers who contract with the HMO.

Healthcare Effectiveness Data and Information Set (HEDIS)
A core set of performance measures developed and managed by the National Committee for Quality Assurance (NCQA) to assist employers and other purchasers in evaluating health plan performance. HEDIS measures are also used by government agencies to monitor quality of care provided or arranged by health plans.

Health Insurance Portability and Accountability Act (HIPAA)
Regulations regarding the use and disclosure of certain information held by "covered entities" (generally, healthcare clearinghouses, employer sponsored health plans, health insurers, and medical service Providers that engage in certain transactions.). Establishes regulations for the use and disclosure of Protected Health Information (PHI), which is any information held by a covered entity concerning health status, provision of healthcare or payment for healthcare that can be linked to an individual.

Medicare Advantage (MA) Plan
Medicare Advantage Plans are health plan options offered by private insurance companies that are approved by Medicare. If you join one of these plans, you generally get all of your Medicare- covered healthcare through that plan. MA Plans combine Part A (hospital insurance) and Part B (medical insurance) together in one plan, and they can also be combined with Part D prescription drug coverage (called MA-PD Plans).

National Provider Identifier (NPI)
The number used to identify healthcare Providers in standard transactions, such as healthcare claims. The NPI is the only healthcare Provider identifier that can be used for identification purposes in standard transactions by covered entities. It eliminates UPIN numbers – multiple Provider numbers assigned by Medicare, Medicaid and private payers.

Network
Contracted groups of physicians, hospitals, laboratories and other healthcare Providers who participate in a health plan's healthcare delivery system. The Providers agree to undergo TIHP's credentialing process, follow TIHP's policies and procedures, submit to monitoring of their practices and provide services to Members at contracted rates.

Out-of-Area Care
Care for illness or injury that is delivered to Members traveling outside the designated service area.

Out-of-Network Care
Care performed by Providers who do not participate in TIHP's network.

Out-of-Pocket Expenses
Payments toward eligible expenses that a Member funds for himself/herself and/or dependents, including copayments, coinsurance and deductibles.

Participating or In-Network Provider
Facility, hospital, doctor or other healthcare Provider that has been credentialed by and has a contract with a health plan to provide services.

Primary Care Physician (PCP)
A healthcare practitioner who, within the scope of his/her practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide healthcare services to a Member,

initiates Member referral for specialist care and maintains continuity of care for enrolled Members of an HMO.

Specialist
Provider or practitioner who specializes in a particular branch of medicine, such as cardiology, dermatology, orthopedics or surgery.

Waste
The over-utilization of services or other practices that result in unnecessary costs.

Abbreviations

ADA—Americans with Disabilities Act
ANOC—Annual Notice of Change
BMI—Body Mass Index
CAD—Coronary Artery Disease
CAHPS—Consumer Assessment of Healthcare Providers and Systems
CAQH—Council for Affordable Quality Healthcare
CCIP—Chronic Care Improvement Program
CHF—Congestive Heart Failure
CPT—Current Procedural Terminology
DME—Durable Medical Equipment
EOB—Explanation of Benefits
EOC—Evidence of Coverage
FDR—First Tier, Downstream and Related Entities
FWA—Fraud, Waste and Abuse
HCC—Hierarchical Condition Category
HEDIS—Healthcare Effectiveness Data and Information Set
HIPAA—Health Insurance Portability and Accountability Act
HITECH—Health Information Technology for Economic and Clinical Health Act
HMO—Health Maintenance Organization
LDL—Low-Density Lipoprotein
LIS—Low-Income Subsidy
MLP—Mid-Level Practitioner
NCQA—National Committee for Quality Assurance
NP—Nurse Practitioner
NPI—National Provider Identifier
OEC—Online Enrollment Center
OIG—Office of Inspector General
PCP—Primary Care Physician
PDSA—Plan-Do-Study-Act
PHI—Protected Health Information
POA—Power of Attorney
PRAF—Provider Remittance Advice Form
PRO—Peer Review Organization
QIP—Quality Improvement Project
RNCC—Registered Nurse Care Coordinator
SDRP—Self-Referral Disclosure Protocol
TrOOP—True Out-Of-Pocket
UPIN—Universal Provider Identification Number