



## **Network Participating Provider Manual**

**Texas Independence Health Plan**

**TOLL-FREE 1-800-405-9681 (TTY 711)**

ISSUER ID: H5015001

MEMBER ID: TX0000002

MEMBER: Test5 M Test6

RxBIN: 012312

RxPCN: PARTD

RxGRP: H5015001



**TEXAS INDEPENDENCE  
HEALTH PLAN**

**MedicareRx**  
*Prescription Drug Coverage*

CMS H5015 001

**ENROLLEE INFORMATION**

Member Services: 1-800-405-9681 (TTY 711)

We are open 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.

In emergency, call 911 or go to the nearest emergency room.

**IMPORTANT PROVIDER INFORMATION**

[www.Txindependencehealthplan.com](http://www.Txindependencehealthplan.com)

Provider Services: 1-800-405-9681 Pharmacists: 1-844-846-8007

Contracted and non-contracted providers may send claims to:

**Medical:**

Texas Independence Health Plan  
PO Box 24687  
Tampa, FL 33623  
EDI# 31403

**Pharmacy:**

EnvisionRxOptions  
2181 E. Aurora Road, Suite 201  
Twinsburg, OH 44087

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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 2020. The Texas service area includes the following counties: Aransas, Cameron, DeWitt, Fort Bend, Frio, Gregg, Guadalupe, Hidalgo, Jackson, Kendall, Kleberg, Lavaca, Nueces, Travis, Wharton.

### 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 in 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:

TIHP Providers: <https://www.txindependencehealthplan.com/providers/documents/>

## 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](http://www.txindependencehealthplan.com).

## Authorizations

TIHP requires authorization for certain services and procedures. Providers should use the authorization request form provided by the Plan and contact the Utilization Management (UM) team directly at 1-800-405-9681. Providers are encouraged to speak with the Member’s PCP or NP to ensure an appropriate care plan.

Medicare criteria, as well as healthcare guidelines, are used when reviewing authorization requests. The Medical Director makes all medical 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 in network specialists to assist with the peer review.

Authorization requests must be faxed to 1-844-593-6221. TIHP will review all requests and respond. If additional information is needed, TIHP staff will contact the requesting provider in order to obtain such documentation.

Once the review is completed and request approved, approval is granted. The authorization is valid for 90 days.

The requesting provider should use the TIHP authorization number, indicated in the confirmation letter, in the appropriate field of the CMS-1500 claim form.

If TIHP intends to deny the authorization request, an initial notification of pending denial will be faxed or telephonic to the requesting provider before the denial decision. The requesting provider may discuss the decision with a physician reviewer or request a copy of the criteria used to make the determination by replying to the pending denial communication from TIHP.

If a denial decision is made, the denial letter will contain all information necessary for an appeal to TIHP. A copy of the denial letter and appeal information is also sent to the Member.

## 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 12 months
Body Mass Index (BMI)	Once every 12 months
Prostate Cancer Screening	Once every 12 months
Colorectal Cancer Screening: Fecal Occult	Once every 12 months

## Chronic Conditions Measurements Table

### DIABETES/OBESITY:

Eye Exam	Once every 12 months
HgbA1C	Once every 6 months

	Microalbumin	Once every 12 months
<b>CHF:</b>		
	Ejection Fraction measurement	Once per lifetime
<b>CAD:</b>		
	LDL levels	Once every 12 months

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## 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 1-800-405-9681.

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 1-800-405-9681.

Once contracted, the provider may either submit the CAQH (Council for Affordable Quality Healthcare) provider identification number or fill out the applicable state-mandated credentialing application form and submit it to the Network Operations Department at the address listed below:

**Texas Independence Health Plan  
Attn: Credentialing & Network Operations Department  
101 West Goodwin, Suite 600  
Victoria, TX 77901**

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 initial and date the corrected information or update their CAQH profile.

## Credentialing Committee Review

Completed credentialing files are presented to the TIHP Credentialing Committee for review and final decision.

TIHP staff will send a welcome letter to providers who are approved as providers in the TIHP Provider network. This letter will give the providers their effective date as in-network providers in TIHP.

Physicians are notified in writing if they are denied credentialing status. If a physician wishes to appeal a denial decision, the physician must submit a request in writing to the chair of the TIHP Credentialing Committee.

## 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 send an application for re-credentialing to providers six months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to return the completed reappointment application and supporting documentation 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.

## 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, the Healthcare Integrity and Protection Data Bank and/or applicable state licensing agency, the Credentialing Department shall promptly notify the affected provider by certified mail, return receipt requested.

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 1-800-405-9681.

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 1-800-405-9681.

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
<b>PRIMARY CARE PHYSICIAN</b>	
Chest pain	Same day
Mild respiratory symptoms >3 days	Next day
Routine physical examination	Within 30 days
<b>Obstetricians-Gynecologists</b>	

Urgent referral	Next day
Non-urgent referral	Within 2 weeks
Well-woman examination	Within 10 weeks
<b>SPECIALISTS</b>	
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:** [www.txindependencehealthplan.com](http://www.txindependencehealthplan.com)

**Provider Services:**

Phone: 1-800-405-9681  
(TTY for hearing impaired: 711)  
(8:00 a.m. to 8:00 p.m. Eastern Time)

E-mail: [info@txindependencehealthplan.com](mailto:info@txindependencehealthplan.com)

**Mailing Address:** **101 West Goodwin, Suite 600  
Victoria, TX 77901  
Attn: Provider Services**

**Authorization Department:** 1-800-405-9681

**Authorization Fax Number:** 1-844-593-6221

**Prior Authorization Department:**

Phone: 1-800-405-9681

**Medical Claims submissions:**

Mailing Address: Texas Independence Health Plan  
P.O. Box 24687  
Tampa, FL 33623

**Credentialing:**

To request a hearing: Texas Independence Health Plan (TIHP)  
Attn: Provider Relations  
101 West Goodwin, Suite 600  
Victoria, TX 77901

**Pharmacy:**

**Pharmacy Management Department:**

Email: [pharmacysupport@txindependencehealthplan.com](mailto:pharmacysupport@txindependencehealthplan.com)  
EnvisionRx Coverage Determination and Appeals:  
Phone: 1-844-846-8007  
Fax: 1-877-503-7231  
Web: [www.txindependencehealthplan.com](http://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](http://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 1-800-405-9681.

## 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](http://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	
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	

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Dental services	Exceptions include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician except as specifically stated in the Member's EOC. Tooth extractions for other reasons are not covered.
Foot care, routine	
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 Diabetes.

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

The EOC is provided to each member and states that every Member has the right to file an appeal. Members or their authorized representative must file an appeal within 60 calendar days of receiving notification of TIHP's denial decision or provide "good cause" for the delay in filing.

Examples of good-cause reasons include the following:

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

A Member may appoint an authorized representative or request that the Member's physician, ancillary practitioner or hospital represent him/her in the appeal or grievance. To be appointed, both the Member and the proposed representative (including attorneys) must sign, date, and complete the Appointment of a 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> or in the appendix

**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.

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.

There must be potential Member liability (e.g., an actual claim for services already rendered as opposed to an advance organization determination) in order for a provider to appeal utilizing the Member appeal process.

Certain Member or provider appeals (pre-service and payment) may require that TIHP obtain additional medical records from the rendering provider to adequately perform a fair and independent review. A plan representative, generally an Appeals Specialist, will request medical records. The Appeals Medical Director may also request a peer-to-peer review to address treatment or patient-specific information to assist in the plan's appeal determination.

A provider has the right to an appeal when a **denial of a service rendered** occurs, or upon receipt of an initial claim or Revised Payment Determination **that results in a zero payment** to the provider.

Expedited appeals should be faxed to 1-844-593-6221. Standard appeals may be faxed to the same number or mailed to:

**Texas Independence Health  
Plan Attn: Member Appeals  
PO BOX 26289  
Tampa, FL 33623**

## **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 to 1-844-593-6221.

## Member Grievances

If a Member is dissatisfied with the services provided, such as any medical care, treatment, or care; sales, enrollment or service processes, the Member has the right to file a grievance with the plan. TIHP will review the grievance, take corrective action as appropriate and notify the Member. A grievance does not involve an appeal or coverage determination. Members may file a written or oral grievance at any time.

For more information about the appeals and grievances policies and procedures, please contact Customer Service at 1-800-405-9681.

# IV. Hospitalization Guidelines

## Overview

TIHP strives to deliver a coordinated care approach to providing care for our Members. This coordination is led by the NP working in conjunction with the PCP and the Member's ICT. The Member's ICT may include community-based providers, facility-based providers and the facility staff.

It is through this coordinated approach that services are delivered in the most effective and efficient manner. Therefore, TIHP has incorporated certain authorization processes as described in the Authorizations section.

TIHP urges all providers to use the services of an in-network hospital. This will assure the most appropriate cost sharing for the Members. The MOC emphasizes appropriate care at the most clinically appropriate setting. Whenever appropriate, unnecessary hospitalization should be avoided to minimize Member disruption and the risk of infections.

## 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 at least 14 calendar days in advance of the admission for a standard request and three calendar days before the admission for an expedited request.

The admitting provider must work with the NP and/or the 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:

- The name of the Member's PCP
- 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
- Nursing Facility Residence

The hospital should notify the TIHP UM Intake department via fax at 1-844-593-6221 within 48 hours or next business day following the emergency admission.

The facility staff should notify the TIHP NP or 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 in order 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.
- The Member's condition or diagnosis is not sufficiently clear to allow the Member to leave the hospital.

If a physician wants to admit a Member who is in observation status, the physician should notify the TIHP UM Intake department via fax at 1-844-593-6221.

## Admission Review

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

- An admission request does not appear to meet guidelines upon initial review 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 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. TIHP will send a letter of non-authorization the same day by messenger, fax or mail, including our appeals process.

TIHP Providers have the right to an immediate Peer Review Organization (PRO) review of a denial. The Provider should contact the TIHP UM Intake department via fax at 1-844-593-6221.

If after PRO review, the denial remains, the provider has the option of a second level of clinical review with another Medical Director. To request this level of review, the Provider should contact the TIHP UM Intake department via fax at 1-844-593-6221.

Regardless of whether the provider initiates an immediate PRO, the Member retains the right to appeal through the regular appeal process and should contact Member Services.

To appeal an adverse determination, the Member or authorized representative must make such a request in writing or by telephone by calling Member Services at 1-800-405-9681 (TTY users call 711) by noon on the next business day following receipt of the notice of non-coverage.

## Notices of Non-Coverage/Denial

In February 2011, CMS revised its mandated forms regarding denials and appeals. As of February 28, 2011, TIHP must use these forms when it makes an adverse determination. The following forms are provided to the Member and a copy is maintained by TIHP.

Those updated forms include:

- Integrated Denial Notice: Notice of Denial of Medical Coverage/Notice of Denial of Payment (CMS 100003–NDMCP) – When denying a request for medical service, in whole or in part, or when denying a Member's request for payment of a service already received
- Notice of Medicare Non-Coverage (CMS 10095-NOMNC) – When informing Members receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services of the termination of services. (TIHP must provide the service termination date to the provider no later than two days before the termination of services.)

## Concurrent Review

Concurrent review is performed to assess the appropriateness of continued inpatient care in a hospital or skilled nursing facility.

Concurrent review includes:

- Review of medical necessity
- Determination of the next review date
- Discharge planning
- Research/coordination of alternatives to inpatient care, such as home healthcare.

The review is conducted on Members in acute, rehabilitation, skilled nursing, and psychiatric facilities.

Medicare criteria, as well as InterQual<sup>®</sup> 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 continue. If the services are approved to continue, the UM Intake team will notify the provider by fax or by phone call.

## Transfers

The Member's NP and/or 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.

## Discharge Planning

The TIHP NP and/or RNCC work with hospital staff, attending physicians, PCP's, and the nursing facility's staff to coordinate discharge planning. A TIHP clinical team member helps coordinate follow-up care, ancillary services and other appropriate services.

The TIHP NP will conduct a post-discharge visit and HRA within two business days of the Member's return to the facility. The visit may include:

- Confirmation that follow-up appointments are made
- Verification that prescriptions are filled
- Confirmation that discharge services are completed
- Identification of symptoms or complications that may require readmission
- Care Plan revisions

## 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 1-866-990-8059 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 1-800-405-9681.



## Filing a Claim for Payment

### Electronic Submissions

TIHP is contracted with Beacon Health Services. Beacon Health Services 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 Beacon Health Services as follows:

1-800-405-9681

For questions regarding electronic claims (EDI) billing, contact Provider Services 1-800-405-9681.

### Paper Submissions

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

Texas Independence Health Plan  
P.O. Box 24687  
Tampa, FL 33623

### Filing Deadlines

For services furnished after January 1, 2010, Section 6404 of the Patient Protection and Affordable Care Act of 2010 amended the timely filing requirements to reduce the maximum time period for submission of all Medicare claims to one calendar year following the date of service.

Many providers have agreed to a shorter filing deadline in their applicable Provider Participation Agreement and should be consulted for specific applicable deadlines.

For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, not the date treatment begins, or the patient is admitted for care.

## Key Points

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](http://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, and
- The Member has agreed, in writing, to pay for the services.

## 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.

## 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 1-800-405-9681 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 Dispute Resolution Process

If a provider believes a clean claim should have been paid differently, providers have the right to dispute the payment.

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 1-800-405-9681.

To file an official payment dispute, providers should submit a Provider Dispute Resolution Request form along with any supporting documentation. Providers may include a cover sheet outlining the reason for the requested review along with the claim and PRAF.

TIHP will respond to all written disputes regarding claims within 30 business days.

If TIHP agrees with the reason for the payment dispute, TIHP will issue a new Explanation of Payment (EOP) and pay the additional amount that is requested, including any interest due.

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

Claims must be disputed within 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.

## VI. Medicare Risk Adjustment

### What is Risk Adjustment?

Risk adjustment is the process by which CMS reimburses MA Plans based on the member age, gender and health statuses throughout the plan year.

TIHP, contracts with CMS to offer MA plans. The risk of the member is determined by the ICD-10 diagnosis codes included on the encounters, claims submitted to TIHP and passed to CMS.

## Physician/Provider Roles

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

- To comply with risk adjustment guidelines, specific ICD-10-CM codes are required.
- Medical records must support all dx conditions coded on the claims and encounters you submit using clear, complete and specific language.
- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment or management.
- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify if conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member's condition and pertinent history at the time of the visit. *Do not code conditions that no longer exist.*
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member's condition.
- Check the diagnosis code against the member's gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted for risk adjustment consideration are subject to federal and/or 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?

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

## Medical Record Documentation

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



*It is important for the physician's office(s) to fully code each encounter; the claim should report the ICD-10-CM code of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed. Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses that were addressed were reported.*

## 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 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  
101 West Goodwin, Suite 600  
Victoria, TX 77901  
Phone: 1-800-405-9681 | Fax 1-844-593-6221  
Email: [TIHP@txindependencehealthplan.com](mailto:TIHP@txindependencehealthplan.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 Data Validation 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 by. 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 data validation audit on selected plans.

## Hierarchical Condition Category (HCC) Model

CMS implemented the Hierarchical Condition Categories (HCC) model in 2004 to adjust capitation payments to Medicare Advantage plans for the health expenditure risk of their enrollees.

In the U.S. Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) risk adjustment model, a value is assigned to each diagnosis code that falls into the payment model. The ICD-10-CM codes are then grouped into an HCC. Unlike hospital diagnosis-related groups (DRGs), HCCs are cumulative: Each additional HCC in an unrelated disease category is factored into the risk profile.

Under the risk adjustment model, physicians/providers should document, and coders should report all present, relevant diagnoses. ICD-10 guidelines instruct us to choose a primary diagnosis (to describe the main reason for the member visit on the encounter), and to “list additional codes that describe any coexisting conditions.”

Providers should code for all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. Co-existing conditions include chronic, ongoing conditions, such as diabetes, congestive heart failure, atrial fibrillation, COPD, etc. These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient’s health when treating co-existing conditions for all but the most minor of medical encounters. Co-existing conditions also include ongoing conditions such as multiple sclerosis, hemiplegia, rheumatoid arthritis, and Parkinson’s disease.

HCCs are given a severity ranking, the higher medical risk to the patient, the higher the ranking. It is important to follow normal coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a visit must be documented. The medical record documentation must support the diagnosis was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the CMS instructions for Risk Adjustment implementation. In addition, the diagnosis must be coded according to ICD-10-CM Guidelines for Coding and Reporting. Codes with a higher HCC ranking result in more “credit.”

## Helpful CMS Webpages

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

## 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 appear to be counted for risk adjustment?*

**A:** The diagnosis must appear at least once a calendar year.

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

**A:** No. The provider who dictated the report must sign it, regardless of the record type, and add his/her credentials. Electronic signatures are acceptable but must be accompanied by such words as “electronically signed by,” “authenticated by” or “signed by.”

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

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

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

**A:** Yes, as long as it is within 30 days. Otherwise, providers must submit a new medical record with the provider’s signature to substantiate the HCC.

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

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

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

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

**Q:** 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.

A TIHP clinical pharmacist and team members are available to answer formulary and/or medication-related questions. You can contact the TIHP pharmacy team at [pharmacysupport@txindependencehealthplan.com](mailto:pharmacysupport@txindependencehealthplan.com).

TIHP partners with EnvisionRx, a Prescription Benefits Manager (PBM), to administer the prescription programs for TIHP Members.

The TIHP formulary may be viewed by going online to [www.txindependencehealthplan.com](http://www.txindependencehealthplan.com)

- Click on “Prospective Members” and then select “Formulary”
- On the next page, you can:
  - Search the formulary online Download and print the comprehensive formulary

### Pharmacy Policies

#### Generics

All formularies include both brand name and generic medications. The formulary also includes the preferred use medication. The preferred use medication may or may not be the generic medication.

#### Formulary

Physicians and clinical pharmacists on the 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: 1-844-846-8007**

## 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; adds coverage determinations, such as prior authorizations, quantity limits, and/or step therapy restrictions on a drug; or moves a drug to a higher cost-sharing tier, 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 may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. TIHP may grant a temporary 30-day 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 now offers mail-order services to our Members. Some of the benefits to the Members include:

- Personal service: 24-hour access to a pharmacist.
- Online convenience: save time and set up automatic refills or order any time of day or night at [www.orchardrx.com](http://www.orchardrx.com)

**\*Please note:** Members who used our “Automatic Refill” service in the past automatically received drug refills when our records indicated that they were about to run out. As of January 2014, Members need to provide permission to have their drugs refilled by mail.

To get mail-order forms and information about ordering prescriptions for your patients through mail order, go to our website [www.txindependencehealthplan.com](http://www.txindependencehealthplan.com) or call 1-800-405-9681.

## 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

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 1-800-405-9681.

## **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 (iii) 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) 2012, the Federal government won or negotiated over \$3 billion in healthcare fraud judgments and settlements.<sup>1</sup> 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

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<sup>1</sup> The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.

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.

## Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse may be reported anonymously to the **Compliance Department at 1-833-213-0636**.

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

**Texas Independence Health Plan  
101 West Goodwin, Suite 600  
Victoria, TX 77901**

Additional Information is available at the following websites:

- [www.insurancefraud.org](http://www.insurancefraud.org)
- [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
- [www.ssa.gov/oig](http://www.ssa.gov/oig)
- [www.nhcaa.org](http://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 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. Providers must make new affiliation announcements within the first thirty (30) days of the new contract agreement. However, new affiliation announcements that name only one plan may occur only once when using direct mail and/or e-mail. Additional communications must include all plans with which the provider contracts.
- 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 particular plan.
- Suggest that a particular 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, waiting rooms, 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](http://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. In the alternative, providers may feel free to offer a link to the CMS Online Enrollment Center (OEC).

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 1-800-405-9681.

## **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.

### **The Compliance Program**

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

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

In practice, the Compliance Program and the Code of Conduct effectively articulate and demonstrate the Plan's commitment to legal and ethical conduct.



## Responsibilities

The Compliance Program has responsibilities in three functional areas:

- MA Operational Compliance;
- Monitoring & Delegated Entity Oversight and
- Compliance – Sales Oversight

The following three sections detail of each areas responsibilities:

## Medicare Advantage Compliance Operational Oversight

Operational Oversight includes but is not limited to:

- Managing regulatory affairs
- Ensuring operational and technical compliance across all operations and clinical areas via internal monitoring and audits and open lines of communications
- Enforcing disciplinary and corrective actions for compliance violations and deficiencies
- Ensuring the development and maintenance of operational and corporate policies and procedures
- Building and maintaining relationships with CMS

## Compliance Monitoring & Delegation Oversight

Monitoring and Delegation Oversight includes:

- Annual and routine monitoring of the activities of delegated entities and the various Business Areas
- Annual Risk Assessment
- Ensuring the appropriate and timely management of activities to prevent, detect and correct fraud, waste and abuse
- Providing oversight for the Health Information Portability and Accountability Act (HIPAA)

## Compliance Sales & Marketing Oversight

Sales and Marketing Oversight includes:

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

commissions and sales quality

## Seven Elements of an Effective Compliance Program

The Compliance Program fulfills all of the requirements as provided by the OIG, Department of Health and Human Services (HHS) and CMS for a comprehensive Compliance Program.

The seven elements of an effective Compliance Program are as follows:

1. Written policies and procedures
2. Designated Compliance Officer and Compliance Committee
3. Effective training and education
4. Effective lines of communication
5. Internal monitoring and auditing
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Prompt response to detected problems through corrective actions

The Compliance Program, as part of each of these elements, addresses the prevention, detection and correction of potential compliance issues as well as the on-going oversight of Fraud, Waste and Abuse (FWA) by plan sponsors. Throughout the Compliance Program there are provisions for interpretive rules and guidance to help establish and maintain an effective Compliance Program to prevent, detect and correct FWA and potential Medicare program non-compliance.

TIHP providers and contractors are defined by CMS as “first tier, downstream and related entities,” (FDRs) which are individuals or entities that furnish services to MA members under written agreement with the Plan or contracted entities. TIHP is obligated under its CMS contracts to ensure that all these entities receive the Code of Conduct.

## 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
- 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 False Claims Act (31 U.S.C. Sections 3729-33) allows a private individual or "whistleblower,"

with knowledge of past or present fraud on the Federal government, to sue on behalf of the government to recover stiff civil penalties and triple damages. The person bringing the suit was

formally known as the “Relator.” The False Claims Act is also called the “Qui Tam statute.” The Department of Justice saw a record 647 qui tam suits filed in fiscal year 2012 and recovered a record \$3.3 billion in suits filed by whistleblowers during that period.<sup>2</sup>

Generally, only the Relator who is the first to file a lawsuit can receive a reward for reporting the fraud. Even if one person uncovers the fraud, someone else can file the lawsuit first and bar the first whistleblower from sharing in any recovery. 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](mailto:1877CallCenter@cms.hhs.gov) or call **410-786-4568**.

## 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”),

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<sup>2</sup> Department of Justice, December 20, 2013, “Justice Department Recovers Nearly \$3.8 Billion in False Claims Act Cases in Fiscal Year 2013”

which applies to all covered persons.

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

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

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

## **Fraud, Waste and Abuse**

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

## **The HITECH Act**

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

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

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

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

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

## State Regulations

Many state regulations also have an impact on 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-Broking 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.

**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.

### **Health Plan Employer Data 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**

Acting with gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit.

## Abbreviations

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