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Welcome to TexanPlus®, HMO and TexanPlus® HMO-POS

Who We Are

Welcome to TexanPlus®, part of the Universal American family of Medicare Advantage products. We are pleased to have you as a participating Provider in our Medicare-approved Health Maintenance Organization (HMO) and HMO Point-of-Service plan (HMO-POS). We hope that this manual will be helpful to you and your practice.

TexanPlus offers an array of plan options to people with Medicare, providing comprehensive medical and hospital coverage while offering health and wellness benefits. TexanPlus is designed to reduce the cost of healthcare by contracting with network doctors, hospitals, labs and specialists to provide care at a discounted rate for our Members.

This year, in addition to our TexanPlus HMO plan, we are also pleased to introduce our new Medicare Advantage Point-of-Service plan, TexanPlus HMO-POS. As a member of our contracted network, you are already a part of the TexanPlus HMO-POS network.

An HMO-POS plan requires a Member to choose a Primary Care Physician (PCP) who manages and coordinates care within the contracted network. HMO-POS plans also allow for the Member to use a Provider who is not in the contracted network yet participates in the Medicare program and still receive benefits for covered out-of-network services. However, utilizing out-of-network services for care will increase the cost to the Member.

> For more information see section About Our New TexanPlus® HMO-POS Plan, page 11.

There are distinctions between the TexanPlus HMO and TexanPlus HMO-POS plans which we have outlined in the above referenced Frequently Asked Questions. We also draw your attention to any differences in sections throughout this manual.

HMO and HMO-POS plans are offered through SelectCare of Texas, Inc., a member of a Universal American company that contracts with the federal government to provide Medicare Advantage health plans.

Universal American (NYSE: UAM) is dedicated to working collaboratively with healthcare professionals in order to reduce healthcare costs and improve the health and well-being of those we serve. Through our family of companies we provide services to Members in Medicare Advantage HMOs, HMO-POS plans, PPOs, PFFS, and network-based PFFS plans in 24 states.

Golden Triangle Physician Alliance

Golden Triangle Physician Alliance (GTPA) is the leading Independent Practice Association (IPA) in Southeast Texas. With its extensive network of family physicians and specialists, GTPA provides healthcare and services to more than 8,100 Members.

GTPA has local networks in Jefferson, Orange, Chambers and Hardin counties. These local networks have a variety of contracted facilities and specialists available to care for the region’s Medicare population.

Universal American

Universal American has been on the cutting edge of healthcare for nearly 20 years, pioneering innovative collaborations between patients, doctors and our company that produce healthy outcomes for all.

We believe there are great opportunities today to improve healthcare for patients, doctors, businesses and government. We are doing this by promoting better care and outcomes for patients; meeting the challenge of rising healthcare costs; and aligning the incentives of doctors, patients and our company so that all are working to keep patients in the best possible health while making healthcare more effective and affordable.

Through our family of healthcare companies, Universal American provides health benefits to people covered by Medicare and/or Medicaid in more than 30 states. Our Medicare Advantage plans serve approximately 120,000 Members.

For more information about Universal American, go to www.UniversalAmerican.com.

Provider Services

TexanPlus has a dedicated force of Provider Services Representatives. This team of highly trained Medicare Advantage specialists provides personalized support and service to Providers and serves as the primary liaison between Providers and TexanPlus.

The goals of the Provider Services Department are to educate Providers about TexanPlus and promptly resolve Provider issues.

To locate a regional Provider Services representative, call 1-888-800-0760.
About Our New TexanPlus® HMO-POS Plan

TexanPlus is pleased to introduce a new Medicare Advantage Point-of-Service plan, TexanPlus® HMO-POS, to our Members starting January 1, 2014.

An HMO Point-of-Service (POS) plan is a Medicare Advantage Health Maintenance Organization (HMO) plan with a Point-of-Service (POS) option. This type of plan allows Members to choose a Primary Care Physician (PCP) who manages and coordinates care within the contracted network.

HMO-POS plans also allow for the Member to use a Provider who is not in the LPO-contracted network yet participates in the Medicare program and still receive benefits for covered out-of-network services. However, utilizing out-of-network services for care will increase the cost to the Member.

HMO-POS plans provide your patients with comprehensive medical and hospital coverage, as well as prescription drug coverage.

Here are answers to some frequently asked questions about the HMO-POS network. If you have further questions about the TexanPlus HMO-POS plan, you may call your Provider Services Representative at 1-888-800-0760.

Am I part of the TexanPlus HMO-POS network?
Yes. Your contracted status with SelectCare of Texas covers all TexanPlus plans. All existing terms apply to TexanPlus HMO-POS members, including claims reimbursement rules and rates, authorization requirements and general provisions in the contract.

What are some of the general differences between the in-network and out-of-network benefits*?

<table>
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<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
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<tr>
<td>Can only see doctor in network</td>
<td>Can see any doctor who accepts Medicare</td>
</tr>
<tr>
<td>$0 Preventive Care Services</td>
<td>40% Copay for Preventive Care Services</td>
</tr>
<tr>
<td>Referrals/Authorizations required</td>
<td>No referrals or authorizations required</td>
</tr>
<tr>
<td>$3,400 Annual Out-of-Pocket Maximum</td>
<td>$10,000 Annual Out-of-Pocket Maximum</td>
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*Must be covered services that are medically necessary.

Do I need to get services authorized?
Yes. When you are providing services as an in-network Provider under the HMO component of the plan, any services that require prior authorization for Providers contracted with TexanPlus will require an authorization. Without an authorization, the claim may be denied payment if you are considered to be an in-network Provider for the Member for that service.
If you are a contracted Provider but are determined to be an out-of-network Provider for the Member due to your Local Physician Organization (LPO) affiliation being different than the
Member’s LPO, you will be providing services under the POS component of the plan and you do not need to obtain an authorization.

**What will be the claim reimbursement rate for services to TexanPlus HMO-POS Members?**
Claims reimbursement to TexanPlus HMO-POS Members will be the same as it is for TexanPlus HMO plans, the difference being in the Member cost-share. The terms and conditions of your existing contract apply.

**What are the Member cost-shares for the TexanPlus HMO-POS plan?**
Office visit copays are $0 for contracted Primary Care Physicians and $30 for contracted specialists.

**What referral network should I use when referring TexanPlus HMO-POS Members who are using their in-network HMO benefit?**
The referral network for TexanPlus HMO-POS is the same as the referral network for TexanPlus HMO plans when the Member is in-network within the LPO.

**What if a TexanPlus HMO-POS Member wants me to provide a referral to a Provider outside of the network?**
A TexanPlus HMO-POS Member does not need a referral to see a Provider outside of the network if they are using their out-of-network POS benefit. Please refer the Member to Member Services if they need help using the POS component of the plan.

**Are there restrictions on which Providers a Member may see when using the POS component of their plan?**
Members may choose to receive care from out-of-network Providers who participate in Medicare when using their out-of-network POS benefit. The plan covers services from out-of-network Providers, as long as the services are covered benefits under the POS and are medically necessary. Care received from an out-of-network Provider will be at a higher Member copayment or coinsurance, except in emergency or urgent care situations. Out-of-network Providers must choose to accept TexanPlus HMO-POS Members as patients.

Emergent Care, Urgent Care and Out-of-Area Dialysis are always covered under the HMO component of the plan and there is no cost share difference between in-network and out-of-network Providers for those services. Skilled Nursing, Home Health and Durable Medical Equipment (DME) are not covered under the POS benefit and are only covered services when obtained from an in-network Provider under the HMO benefit.

A Member who receives care from an out-of-network Provider who does not participate in Medicare will be responsible for the full cost of administered services, except if the care is emergent care.

**Where are out-of-network POS benefits available?**
Members may use the POS benefits with any Provider who participates in Medicare anywhere in
the United States. However, out-of-network Providers must choose to accept TexanPlus HMO-POS Members as patients.

Do Members have to get prior authorization to use the POS component of their plan?
No. POS services do not need to be authorized by the plan and do not require any referrals.

Can Members use non-LPO network Providers when seeking care within the plan’s service area?
Yes. They may see non-contracted Providers in their service area with their POS benefit. The Member will then be responsible for the higher cost share.

When or where is the POS benefit not available?
• If it is determined that services received from a non-LPO network Provider were not medically necessary, the plan may deny coverage and the Member will be responsible for the entire cost. If this occurs, the Member has a right to appeal.
• The out-of-LPO network Provider must participate in Medicare. A Member who receives care from an out-of-network Provider who does not participate in Medicare will be responsible for the full cost of administered services, except in an emergency.
• The POS benefit is not available outside the United States for plans in Houston and Beaumont. The POS benefit is available outside the United States for plans in Dallas-Fort Worth.
• Out-of-network Providers must choose to accept TexanPlus HMO-POS Members as patients.

Full details concerning covered services, Member cost shares, authorization guidelines and payment reimbursement policies can be found on the TexanPlus HMO-POS website at www.TexanPlusPOS.com or by contacting your Provider Services Representative at 1-888-800-0760.

TexanPlus HMO and TexanPlus HMO-POS Key Contacts

Provider Services 1-888-800-0760
8:00 a.m. – 8:00 p.m. Central Time, 7 days a week

Health Services 1-800-250-3487
Health Services Fax 1-877-218-4872

Member Services 1-866-230-2513

Pharmacy Services 1-866-386-1139
CVS Caremark (Authorizations) 1-855-344-0930
Authorizations Fax 1-855-633-7673

EDI Services 1-866-496-7826
EDI Services E-mail edi@UniversalAmerican.com
Behavioral Health (APS Healthcare)
1-877-907-9288
Behavioral Health (APS Healthcare) Fax
1-866-350-8131

Dental/Hearing:
Careington International Corporation
1-800-290-0523

Vision:
EYEMed Vision Care
1-866-723-0391

Websites
www.TexanPlus.com
www.TexanPlusPOS.com

ProviderLink
UAMProviderLink.UniversalAmerican.com

Emdeon Payment ID
72189
Emdeon Phone Number
1-800-845-6592

Paper Claims
Attn: TexanPlus Claims
SelectCare of Texas
P.O. Box 741107
Houston, TX 77274

Claims Disputes
Attn: Provider Dispute Dept.
P.O. Box 741107
Houston, TX 77274

Provider Services
2300 Highway 365, Suite 390
Nederland, TX  77627
Attn: Provider Services

Behavioral Health
APS Healthcare
P.O. Box 449
Linthicum, MD 21090?

Coding support:
CodingHelp@UniversalAmerican.com

Questions about Transition
From ICD-9 to ICD-10
ICD10Inquiries@UniversalAmerican.com

Fraud, Waste & Abuse Hotline:
1-800-388-1563

Report online:
www.tnwgrc.com/UniversalAmerican

Mailing address:
Universal American Corp.
Special Investigations Unit
P.O. Box 27869
Houston, TX 77277
Physician Standards and Procedures

Physician Rights and Responsibilities

TexanPlus 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, TexanPlus employees and contracted Providers shall:

• Treat all Members with respect and courtesy.
• Not discriminate against Members in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information and source of payment or other protected class.
• Respond promptly to Members’ questions and document communications with Members as appropriate.
• Protect Members’ rights by publicizing such rights to Members, employees and network Providers.
• Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to HMOs, 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 services, forgoing or withdrawing life-sustaining treatment, or participating in investigative studies or clinical trials. Healthcare Providers shall obtain informed consent as required by law.
• Inform Members of their rights to an appeal if a Provider chooses not to supply a service or treatment requested by the Member.
• Preserve the integrity and independence of clinical decision-making by network Providers. In making such decisions concerning a Member’s medical care, network Providers shall not allow themselves to be influenced by financial compensation to the Provider or Provider network that results from such decisions or by coverage of a particular treatment or course of care by the Member’s plan.
• Follow the guidelines of Provider marketing training as required by the Medicare Improvements for Patients and Providers Act (MIPPA).

See Medicare Improvements for Patients and Providers Act (MIPPA), Physician Standards and Procedures, page 38
The Role of the Primary Care Physician

Overview

The following specialties are considered Primary Care Physicians (PCPs):

- Family Practice
- General Practice
- Geriatrics
- Internal Medicine

All TexanPlus Members, whether they are enrolled in the TexanPlus HMO plan or the TexanPlus HMO-POS plan, must select a PCP from the list of participating primary care physicians in the TexanPlus Provider directories or the Provider look-up tool. Both are located at www.TexanPlus.com or www.TexanPlus_POS.com or available by calling Provider Services at 1-888-800-0760. The PCP’s name will also be noted on the Member’s health insurance plan identification (ID) card.

See Selecting a PCP, Member Administration, page 65

The scope of services to be provided by a PCP includes, but is not limited to:

- Office visits for illness, injury and prevention
- Diagnostic testing and treatment
- Injections and injectable substances
- Emergency department visits
- Hospital Care

Coordination of Care

The PCP has the primary responsibility for coordinating the Member’s overall healthcare and originating all Member communication and information exchanges among the Member’s various healthcare Providers. The PCP process is an effective system for reducing fragmented, redundant or unnecessary services and helps minimize costs. TexanPlus monitors referrals by PCPs to promote the use of network Providers, analyze referral patterns and assess medical necessity.

Coordination of Care for HMO-POS Member

The referral network for TexanPlus HMO-POS is the same as the referral network for TexanPlus HMO plans when the Member is in-network. Members in the HMO-POS plan are able to access care from out-of-network Providers without a referral or authorization from their PCP. However, the PCP may still need to coordinate care for the member if the out-of-network Provider directs them to a network facility or other Provider.

See Referrals by PCPs, Physician Standards and Procedures, page 19

1Only applicable where facilities do not have hospitalists.
PCPs, as well as all Providers, are expected to:
- Provide the appropriate level of care
- Maintain high quality
- Use healthcare resources efficiently
- Inform Members of their right to an appeal and refer them to Member Services if Members disagree with the Provider’s treatment plans
- Educate Members and document the presence or absence of an Advance Directive

See Advance Directives, Physician Standards and Procedures, page 24

Care Coordination requires communication. PCPs should communicate their desire for their Members’ care to specialists, therapists, hospitals, laboratories and other facilities in the Member’s network. In turn, those Providers should reciprocate by informing the referring physician of their findings and proposed treatment. Providers may share information by telephone, fax, letter or prescription. For HMO-POS members, this may involve communication with out-of-network Providers if a service is going to be performed at an in-network facility or by an in-network Provider at the referral of the out-of-network Provider.

Providers also need to supply TexanPlus with critical information needed to authorize certain types of care and process claims. A nurse is on call 24 hours a day, 7 days a week to assist with referrals, case management and other needs. Note, the referral network for TexanPlus HMO-POS is the same as the referral network for TexanPlus HMO plans when the Member is in-network.

Best Practices

TexanPlus uses the following “Best Practices” guidelines to aid PCPs and their staff in servicing Members:
- Do not refer a Member to the emergency department due to limited office access
- Make sure Members who recently were discharged from the hospital or emergency department have timely follow-up visits
- Notify Health Services at 1-800-250-3487 if Members require special needs, e.g., chronic conditions, behavioral problems that influence care and socioeconomic issues that jeopardize the Member’s health
- Send newly effective Members welcome letters encouraging them to schedule get-acquainted visits

The Role of the Specialist

Specialty care is defined as services that PCPs are not trained to provide and/or have not been approved to provide by the Credentialing Committee. TexanPlus monitors referrals to specialists to promote the use of network Providers, analyze referral patterns and assess medical necessity.

See Referrals by Specialists, Physician Standards and Procedures, page 19
Specialists must have a referral from the TexanPlus Member’s Primary Care Physician or an approved and completed referral/authorization request form before treating a Member. This form may be valid up to 180 days and up to six visits. TexanPlus HMO-POS Members do not need a referral to see a Provider outside of the network if they are using their out-of-network POS benefit. Please refer Members to Member Services at 1-866-230-2513 if they need help using the POS component of the plan.

See Referral/Authorization Request Form, Appendix 95

With some limitations, specialists must provide written reports to referring PCPs regarding actions taken with HMO Members and HMO-POS Members who require outpatient and inpatient procedures.

Specialists are able to refer to other specialists within the Member’s network. These referrals may be submitted directly to Health Services through the referral/authorization request form. Specialists also may call Health Services at 1-800-250-3487 for additional information.

See Referral/Authorization Request Form, Appendix page 95

Well-Woman Examinations

Female Members may self-direct visits to a network gynecologist or their PCP for a well-woman examination. Referrals are not required. A TexanPlus HMO-POS Member may see an out-of-network gynecologist, although the cost will generally be higher than if the Member visits an in-network gynecologist.

Network gynecologists must verify the Member’s eligibility before rendering services.

Referrals and Authorizations

Referrals

TexanPlus monitors referrals to specialists to promote the use of network Providers, analyze referral patterns and assess medical necessity. The referral network for TexanPlus HMO-POS is the same as the referral network for TexanPlus HMO plans when the Member is in-network.

When a TexanPlus HMO-POS Member uses an out-of-network Provider:

TexanPlus HMO-POS Members also have the option of using out-of-network Providers, usually at a greater cost to the Member. A TexanPlus HMO-POS Member does not need a referral to see a Provider outside of the network if they are using their out-of-network POS benefit. POS Services do not need to be authorized by the plan and do not require any referrals.
Referrals by PCPs

To keep Members’ costs to a minimum, PCPs should coordinate care with other specialists, therapists, hospitals, laboratories and facilities within the Member’s network (if the member is using the TexanPlus HMO benefit). Network Providers are responsible for determining the type of care needed and the Provider or facility best able to administer that care.

TexanPlus requires that Providers use a referral/authorization request form for all referrals to in-network Providers. A sample form is in the appendix and may be copied. Additional forms also are available by calling Provider Services at 1-888-800-0760.

> See Referral/Authorization Request Form, Appendix page 95

Referrals by Specialists

All referrals for TexanPlus HMO members must be to contracted Providers. (TexanPlus HMO-POS Members may see non-contracted Providers in their service area with their POS benefit. The Member will then be responsible for the higher cost share). If a specialty is not represented in the TexanPlus Provider Directory, the referring specialist should call Health Services at 1-800-250-3487 to coordinate the referral. Additional Provider directories are available by calling Provider Services at 1-888-800-0760 or going online to www.TexanPlus.com or www.TexanPlusPOS.com.

Authorizations

TexanPlus has divided referrals into two main categories:
- Services not requiring authorization
- Services requiring TexanPlus authorization

Authorization requirements are the same for contracted Providers whether they are providing service to an HMO member or an HMO-POS member.

Providers should contact Health Services to determine specific treatments and/or services requiring authorization of any kind.

Services Requiring TexanPlus HMO Authorization

For services requiring TexanPlus HMO authorization, Providers should attach all pertinent information, such as office notes or laboratory results, to support the request and check the appropriate box on the referral request form.
Providers should indicate the urgency of the request by marking the appropriate box on the referral request form. The Health Services Department will review all referral requests in the order received and follow Medicare guidelines for processing as follows:

- Routine/standard requests – Up to fourteen (14) calendar days. Under certain circumstances in a standard request an additional fourteen (14) calendar days may be needed to process the referral and requires a fourteen (14) day extension letter in that situation.
- Expedited requests – Within 72 hours of receipt, but as expeditiously as the Member’s condition warrants.

**Note:** As of January 2015, Providers are required to utilize the new pre-authorization fax form that will represent both ICD-9 and ICD-10 codes for any requests that include dates of service taking place in both September and October 2015.

**Procedures have been put in place for pre-authorizations requested that span both September and October 2015 dates of service (see page 52 for more information)**

TexanPlus reviews referral requests in a consistent manner using Medicare coverage criteria and InterQual care guidelines. Those guidelines are available upon request to network Providers on a case-by-case basis.

![ALERT—Additional Information Requests]

If additional information is required, the Health Services Department will make three attempts over a five-day period to compile the missing information. If the requested information is not received or when the appropriate clinical protocol is not met, the case is sent to the Medical Director for a review and determination.

Once the review is completed and the request approved, a confirmation letter will be sent via fax to the requesting Provider and the requested Provider.

The authorization may be valid for up to 180 days from the date of approval and delineates the Provider and services that are approved.

The letter will indicate, at a minimum, the following:

- A TexanPlus authorization number
- The Member’s name and effective date with TexanPlus
- The date services were approved
- The expiration date of the authorization
- The quantity and description of services, with applicable copayments
- The Member’s PCP
- The requested Provider

The requested Provider should use the TexanPlus authorization number, indicated in the confirmation letter, in the authorization field (box 23) of the CMS-1500 claim form.
CLOSER LOOK
If additional information is required, the Health Services Department will make three attempts over a five-day period to compile the missing information. If the requested information is not received or when the appropriate clinical protocol is not met, the case is sent to the Medical Director for a review and determination.

Out-of-Network Requests for TexanPlus HMO Members

Providers should make every attempt to send TexanPlus HMO Members to network Providers, hospitals and facilities. Under extenuating circumstances, however, Providers may use out-of-network specialists, therapists, laboratories and hospitals, but they must seek prior authorization from Health Services at 1-800-250-3487 before doing so. The requesting Provider must give the reason for the out-of-network referral, as well as the reason why a network Provider is not able to perform the service or treatment.

ALERT—Out-of-Network Requests
TexanPlus will deny any claim for an out-of-network referral for a TexanPlus HMO Member that does not have prior authorization from the Health Services Department.

Out of Network Requests for TexanPlus HMO-POS Members

TexanPlus HMO-POS Members may see out-of-network Providers without a Provider referral. Out-of-network Providers are Providers who are contracted with a different network, not contracted with TexanPlus at all, or who are located in a different service area. The plan covers services from out-of-network Providers as long as the services are covered benefits under POS and are medically necessary. Care received from an out-of-network Provider will be at a higher member copayment or coinsurance, except in emergency or urgent care situations. Out-of-network Providers must choose to accept TexanPlus HMO-POS Members as patients.

Authorization Denials for TexanPlus HMO Members

The Medical Director makes all medical and out-of-network denial decisions and is available for consultation with network practitioners. The Medical Director also may contact network specialists to assist with the peer review.

In the event of an adverse determination the requesting Provider may request a peer-to-peer to discuss the decision with a physician reviewer or request a copy of the criteria used to make the determination by calling Health Services at 1-800-250-3487. If a denial decision is made, the denial letter will contain all information necessary for appeal to TexanPlus. A copy of the denial letter and appeal information is also sent to the member.
Notices of Non-Coverage/Denial

In February 2011, the Centers for Medicare & Medicaid Services (CMS) revised its mandated forms regarding denials and appeals. As of February 28, 2011, the health plan must use these forms when it makes an adverse determination.

If a Provider makes a recommendation for care and the Member does not agree, the Member must be given his/her appeals rights, which requires the Member to call the health plan and dispute the recommended services. Once the Member has filed a grievance, the health plan will process the request for services accordingly. If the decision results in a denial, the health plan will send out the appropriate form.

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. (The health plan must provide the service termination date to the Provider no later than two days before the termination of services.)

Accessibility Standards and Office Requirements

Practice Information

At the time of credentialing and re-credentialing, TexanPlus will verify important demographic details about a Provider’s practice to help ensure the accuracy of information such as claims, payments and Provider directories.

ALERT—Changes in Practice Information

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

Mail all Provider changes to Provider Services at:

TexanPlus HMO
4888 Loop Central Drive, Suite 300
Houston, TX 77081
Attn: Provider Services
Office Hours

All network Providers must have the hours of operation clearly posted in the office.

Coverage on Leave or Vacation

While on vacation or a leave of less than 30 days, a network Provider must arrange for coverage by another TexanPlus Provider. If a Provider goes on a leave of 30 days or longer, the Provider must notify Provider Services at 1-888-800-0760.

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 TexanPlus 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 as set forth in this manual

24-Hour On-Call Coverage

All network Providers are required to provide 24-hour on-call coverage. If a Provider delegates this responsibility, the covering Provider must participate in the TexanPlus network and be available 24 hours a day, 7 days a week.

In-Office Services

Providers should bill TexanPlus for all services performed 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 the network Provider’s contract for reimbursement rates and terms.

Radiology

A licensed radiology technician may perform in-office radiology services. However, a radiologist must review all X-rays. The American College of Radiology must certify radiology facilities.

Laboratory

Offices that perform laboratory services must meet all regulatory guidelines, including, but not limited to, participation in a Proficiency Testing Program and certification by the Clinical Laboratory Improvement Amendments (CLIA).
Culturally Competent Services

TexanPlus 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 1-888-800-0760.

Guidelines Regarding Advance Directives

All healthcare Providers who participate in the Medicare Advantage 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 takes 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.

**Guidelines for Medical Record Documentation**

TexanPlus requires network Providers to maintain medical records for their Members in a manner that is:
- Accurate and timely,
- Well-organized, readily accessible and confidential,
- Designed to permit prompt and systematic retrieval of information, and
- Maintained in a secure location that can be locked and protected when not in use.

**Credentialing and Termination**

**Provider Credentialing**

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

**Application**

Physicians who wish to be credentialed as a TexanPlus Provider may either submit the Council for Affordable Quality Healthcare (CAQH) Provider identification number or request a state-mandated credentialing application form from **Provider Services at 1-888-800-0760**.

The Provider should fill in all of the requested information, sign and date the application and return it with any requested documents for initial processing to:

*TexanPlus HMO*
*4888 Loop Central Drive, Suite 300*
*Houston, TX 77081*
*Attn: Provider Services*

TexanPlus requires that network Providers be re-credentialed every three years.

**Notification**

TexanPlus follows CMS 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 on the application to the primary source data. If TexanPlus notes any discrepancies, it notifies the physician in writing and gives the physician two weeks to forward the correct information to the Credentialing Department supervisor.
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 TexanPlus Credentialing Committee reviews it. The physician must initial and date the corrected information.

**Credentialing Committee Review**
Completed credentialing files are presented to the TexanPlus Credentialing Committee for review and deliberation. TexanPlus will send a welcome letter to physicians who are approved as Providers in the TexanPlus Provider network. This letter will include the effective date for plan participation.

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 TexanPlus Credentialing Committee chairperson.

› See Credentialing Denials and Appeals, Physician Standards and Responsibilities, page 27

**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 also are evaluated on their professional performance, judgment and clinical competence.

Criteria used for this evaluation may include, but are not limited to, the following:
- Compliance with TexanPlus policies and procedures
- TexanPlus sanctioning related to utilization management, administrative issues or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

TexanPlus 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 requested deadline may result in termination from the network.

**Board Certification**
TexanPlus prefers that PCPs and specialists be board certified in their respective specialty by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
Depending on the availability of qualified, board-certified physicians, the following exceptions may apply:
- Physicians who meet all other qualifications but began practicing a specific scope of medical practice before the availability of board certification in their particular specialty. Such physicians must have active admitting privileges at a network hospital and maintain 50 hours of Category I CMEs per year in their practice focus.
- Physicians who are within five years of completion of an approved residency or fellowship in the specialty in which they practice.

**Malpractice Insurance**
TexanPlus requires Providers to carry minimal professional liability insurance. Providers should contact Provider Services to verify those amounts.

**Credentialing Denials and Appeals**
The TexanPlus Credentialing Committee chairperson will send to a Provider who has been denied credentialing a letter that includes the following:
- The specific reason for the denial
- The Provider’s right to request a hearing
- A summary of the Provider’s right in the hearing
- The deadline for requesting a hearing
- The Provider has 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, the health plan 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 TexanPlus is informed of such representation at least seven days before the hearing.

**Requests for hearings should be sent to:**

**TexanPlus HMO**  
4888 Loop Central Drive, Suite 300  
Houston, TX 77081  
Attn: Credentialing Department Chairperson
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**

**Overview**
The relationship between a Provider and TexanPlus may be terminated for several reasons. TexanPlus may initiate the action, or the Provider may initiate the action.

In all cases, if a Provider began treating a Member before the termination, the Provider should continue the treatment until the Member can, without medically injurious consequences, be transferred to the care of another participating Provider. The terminating Provider will be compensated for this treatment according to the rates agreed to in the Provider’s contract.

Should the terminating Provider note special circumstances involving a Member – such as treatment for an acute condition, life-threatening illness, disability or pregnancy beyond 24 weeks – the Provider should ask TexanPlus for permission to continue treating that Member.

In such cases, TexanPlus 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 the TexanPlus network. The Provider also is to abide by the determination of the applicable grievance and appeals procedures.

**Termination by TexanPlus**
TexanPlus may recommend termination of a Provider contract to include, but not be limited to, the following reasons:
  • Provider is noncompliant with the insurance 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 Medicare or Medicaid

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 Databank (NPDB) or Healthcare Integrity Protection Data Bank (HIPDB) and 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 of 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 his 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 the Provider’s 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 Credentialing Committee chairperson. 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.

Termination by the Provider
Providers must give at least 90 days written notice to TexanPlus before voluntarily leaving the network. Providers also must supply copies of medical records and facilitate a Member’s transfer of care to another Provider at no charge to TexanPlus or the Member.

For terminations by PCPs, TexanPlus will notify affected Members in writing and ask them to select a new PCP. If a Member does not select a PCP, TexanPlus 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, TexanPlus will notify all Members who have visited the specialist in the past 6 months. This notification will alert the Member of the Provider’s forthcoming termination and allow for transition of care to another contracted Provider.

The medical record must express the evaluation and treatment of the Member in a legible and detailed manner to assist communication, coordination and continuity of care, and to promote efficient and effective treatment. Consistent and complete documentation in the medical record is an essential component of quality care.

TexanPlus has adopted certain standards for medical record documentation. To meet these guidelines, a Provider should do the following:
Basic Information

- Place the Member’s name or ID number on each page of the record
- Include the marital status and address along with name of the Member’s employer and the Member’s home and work telephone numbers
- Include the author’s identification in all entries in the medical record; the author identification may be a handwritten signature, unique electronic identifier or initials
- Date all entries
- Ensure the record is legible to someone other than the writer

Medical History

- Indicate significant illnesses and medical conditions on the problem list; if the patient has no known medical illnesses or conditions, the medical record should include a flow sheet for health maintenance
- Prominently note medication allergies and adverse reactions in the record; if the patient has no known allergies or history of adverse reactions, note this in the record
- Document in an easily identifiable manner past medical history (for Members seen three or more times), including serious accidents, operations and illnesses
- Note the use of cigarettes, alcohol and controlled substances for Members; Providers should query substance abuse history from Members they have seen at least three times
- In the history and physical exam, identify appropriate subjective and objective information pertinent to the Member’s complaints
- Maintain an updated immunization record for children or add appropriate history for adults
- Include evidence that the Provider offered preventive screening and services in accordance with TexanPlus practice guidelines; these guidelines are available upon request
- Include, when applicable, summaries of emergency services, hospital admissions, operative procedures and reports on any excised tissue
- Discuss Advance Directives and, if completed, maintain a copy of the directive in the medical record

Treatment

- Provide an indication that laboratory and other studies are ordered, as appropriate
- Provide an indication that working diagnoses are consistent with findings
- Provide an indication that treatment plans are consistent with diagnoses
- Document progress notes, treatment plans and any change in the treatment plan, including drugs prescribed
- Document prescriptions telephoned to a pharmacist
- Address unresolved problems from previous office visits in subsequent visits
**Notations**

- Include on encounter forms or notes a notation regarding follow-up care, calls or visits; note the specific time of return in weeks, months or as needed
- Keep documentation of follow-up for any missed appointments or no-shows
- Include a note from the consultant in the medical record when a consultation has been requested
- Place initials on reports filed in the chart to signify review of consultations, laboratory and imaging work. (Review and signatures by other professionals, such as a nurse practitioner or physician assistant, do not meet this requirement; consultation, abnormal lab results and imaging study results must have an explicit notation in the record of follow-up plans.)

**Accessibility Standards**

TexanPlus follows accessibility requirements set forth by applicable regulatory and accrediting agencies as well as standards to be met for services within Providers’ offices. The purpose of these standards is to make sure services are available and accessible to Members in a timely fashion. TexanPlus monitors compliance with these standards annually.

The following table describes sample types of services within Providers’ offices and their respective standards:

**Table 1: Accessibility Standards**

<table>
<thead>
<tr>
<th>REASON FOR APPOINTMENT</th>
<th>COMPLIANCE STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY CARE PHYSICIAN</strong></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Same day</td>
</tr>
<tr>
<td>Mild respiratory symptoms &gt; 3 days</td>
<td>Next day</td>
</tr>
<tr>
<td>Routine physical examination</td>
<td>Within 30 days</td>
</tr>
<tr>
<td><strong>OBSTETRICIANS-GYNECOLOGISTS</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent referral</td>
<td>Next day</td>
</tr>
<tr>
<td>Non-urgent referral</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Well-woman examination</td>
<td>Within 30 days</td>
</tr>
<tr>
<td><strong>SPECIALISTS</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>Same day</td>
</tr>
<tr>
<td>Urgent referral</td>
<td>Next day</td>
</tr>
<tr>
<td>Routine referral</td>
<td>Within 2 weeks</td>
</tr>
</tbody>
</table>
Provider and Member Satisfaction Surveys

Satisfaction surveys provide TexanPlus with feedback on performance relating to:
- Access to care and/or services
- Overall satisfaction with TexanPlus
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

ProviderLink

ProviderLink is a secure, web-based application that allows Providers to perform a wide range of self-service transactions and inquiries. The easy-to-use portal offers accurate access to various types of information and increases the timeliness of that information.

Features of ProviderLink include:
- Plan benefit descriptions and benefit details
- Member eligibility information and Member inquiries
- Claim information and payment status
- Authorization submissions and referral information

Providers may use a single-step setup procedure that is available 24 hours a day from any Internet-accessible computer.

To get started:
- Contact Provider Services at 1-888-800-0760 to receive a 12-digit PIN number. Provider Services is available every day from 8 a.m. to 8 p.m.
- Visit ProviderLink at https://UAMProviderLink.UniversalAmerican.com
- Click on “Register” to set up an account.
- Start using ProviderLink immediately.

Provider Role in HIPAA Privacy Regulations

TexanPlus policies and procedures include regulatory information to make sure TexanPlus 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 TexanPlus.

Throughout its business areas, TexanPlus 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. TexanPlus 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.

TexanPlus 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, TexanPlus Providers should complete, sign and return the referral/authorization form to TexanPlus.

See Authorization Request Form, Appendix, page 95

All Members receive TexanPlus’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 TexanPlus’s precautions to conceal individual health information from employers.

TexanPlus’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 1-888-800-0760.

Provider's Role in 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. TexanPlus requires that network Providers’ offices or facilities comply with these aforementioned statutes/laws.

The ADA and Section 504 require that Providers’ offices have the following modifications:
• the office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs
• patient rest rooms should be equipped with grab bars
• 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.
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. The National Health Care Anti-Fraud Association (NHCAA) website reports that healthcare loss due to fraud, waste and abuse has an impact on patients, taxpayers and the government because it leads to higher healthcare costs, insurance premiums and taxes. Healthcare fraud often hurts patients who may receive unnecessary or unsafe healthcare procedures or who may be the victims of identity theft.

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

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

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

Universal American’s Commitment

Universal American is committed to fighting healthcare fraud, waste and abuse through a dedicated Special Investigations Unit (SIU) whose mission is to protect employees, Members and Providers, as well as first-tier, downstream and related entities.

The SIU works diligently to investigate all allegations, correct known offenses, recover lost funds and partner with federal and state agencies to prosecute violators to the fullest extent of the law.

Examples of healthcare fraud occur when:

* A healthcare Provider bills for medical services, supplies or items that were not provided, also referenced as providing services not rendered
* A healthcare Provider bills for a more expensive service or procedure than what was actually provided or performed, also known as upcoding

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.
• A healthcare Provider performs medically unnecessary services to obtain the insurance payment
• A healthcare Provider misrepresents a non-covered service as medically necessary to obtain the insurance payment
• A healthcare Provider or pharmacy charges a beneficiary a price over the copayment amount
• A healthcare Provider or pharmacy waives the patient’s copayment amount and overbills the insurance plan to recoup the cost
• A beneficiary or policyholder misrepresents his/her personal information, such as identity, eligibility or medical condition, in order to illegally receive a benefit
• A beneficiary or policyholder allows a third party to use his/her benefit information to obtain medication and/or medical services

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 Medicare Advantage Plans. This may affect the person’s health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

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

Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse may be reported anonymously to the Universal American Special Investigation Unit at 1-800-388-1563. You may also report suspected fraud, waste and abuse online at www.tnwgrc.com/Universal American.com or by regular mail by writing to:

Universal American Corp.
Special Investigations Unit
P.O. Box 27869
Houston, TX 77227

Additional Information is available at the following websites:
• www.insurancefraud.org
• www.stopmedicarefraud.gov
• www.ssa.gov/oig
• www.nhcaa.org
Office of the Inspector General (OIG) Exclusion Listing

Federal law prohibits individuals on the Office of the Inspector General’s (OIG) Listing of Excluded Individuals and Entities (LEIE) from receiving Federal or Medicare funds.

Because Providers in TexanPlus networks are recipients of applicable Federal funds, TexanPlus is required to perform monthly OIG exclusion checks for all contracted network Providers. TexanPlus also performs OIG exclusion checks on non-contracted Providers (post-pay).

In turn, Providers are responsible for making sure all other associated clinical (e.g., nurses, physician assistants, etc.) and non-clinical (e.g., billing, administrative, etc.) staff also are not on the OIG’s LEIE by performing monthly exclusion checks.

During the plan’s annual delegated entity review process, the plan may ask for evidence that this requirement is being met and retained for review.

To perform an exclusion check:
- Visit the OIG website at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp
- Download the "List of Excluded Individuals/Entities" (LEIE)
- Check the list for the names of possible new hires and current employees
- Keep the list for reference

TexanPlus will validate performance of these exclusion checks during the Provider’s annual review.

Questions about the OIG exclusion list may be directed to Provider Services at 1-888-800-0760.

Frequently Asked Questions Regarding the OIG Exclusion List

These are a few of the most frequently asked questions regarding the OIG Exclusion List.

**Q: What is the LEIE?**
**A:** The Office of Inspector General’s (OIG) List of Excluded Individuals and Entities (LEIE) database provides information to the healthcare industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal healthcare programs. Individuals and entities who have been reinstated are removed from the LEIE.

**Q: Why am I required to perform this exclusion check?**
**A:** As a delegated entity of TexanPlus, your organization is a recipient of Federal funds and required under contract to adhere to all CMS regulations and requirements.

**Q: What is the frequency at which this exclusion check must be performed?**
**A:** The CMS guidance states that the exclusion check must be performed each time the exclusion list is updated. The OIG typically updates the database monthly. The sites are generally updated in the middle of the month. The updates include all actions taken during the prior month.
Q: What is the effect of exclusion?
A: No payment will be made by any Federal healthcare program for any items or services furnished, ordered or prescribed by an excluded individual or entity. Federal healthcare programs include Medicare, Medicaid and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

Q: What activities can result in an individual or entity being excluded?
A: The following acts by individuals or entities will result in mandatory exclusions:
- Conviction of program-related crimes
- Conviction relating to patient abuse
- Felony conviction relating to healthcare fraud
- Felony conviction relating to controlled substance

The following acts by individuals or entities may result in permissive exclusions. (This is not an all-inclusive listing. For a complete list of activities that could result in permissive exclusions, refer to Section 1128A (b) of the Social Security Act):
- License revocation or suspension
- Fraud, kickbacks or other prohibited activities
- Entities controlled by a sanctioned individual
- Default on health education loan or scholarship obligation
- Making false statements or misrepresentation of material facts

Q: Where can I find the list of individuals and entities excluded?
A: The List of Excluded Individuals and Entities (LEIEs) is available on the OIG website (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp).

Once you access the OIG website, your organization may sign up to receive e-mail notifications from the OIG when the list is updated. The OIG allows for individual searches to be performed on its website. Additionally, OIG also provides a downloadable LEIE database.

The database format provided is compatible with Microsoft Access and Microsoft Excel. However, the downloadable database does not contain Social Security Numbers (SSNs) or Employee Identification Numbers (EINs). If your organization is using the database and identifies a potential match, further research will need to be performed utilizing the OIG website.

Q: How will Universal American validate that this review has been performed during my annual delegation audit?
A: Validation will be performed by reviewing the entity’s policies and procedures governing how the exclusion check is performed. The entity’s policies and procedures should, at a minimum, provide the following level of detail:
- The responsible party within the organization that performs the check
- If your organization’s IT department is automating the exclusion check, documentation
- Supporting the download of the LEIE and the manner in which the LEIE and Human Resources data is compared will be requested
- Proof that the check is being performed monthly
For small organizations, printouts of search results should be retained. For larger organizations, methods such as attestation by a senior management executive that the search has been performed, the date the search was performed and the results may be more efficient. The manner in which your organization notifies TexanPlus upon identifying an excluded individual or entity. The manner in which your organization addresses an instance in which an excluded individual or entity has been identified. The submission of monthly attestations from an officer in the organization that the excluded listings are verified pursuant to any contractual obligations.

Medicare Improvements for Patients and Providers Act (MIPPA)

Rules Related to Marketing Medicare Advantage Plans

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

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

Providers may:
- Provide the names of plan sponsors with which they contract and/or participate (See Medicare 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.

Please note that per Universal American (UAM) policy, all Provider affiliation communication materials must be submitted to the UAM Compliance Department to be filed and approved by CMS.

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 encourage patients to seek other sources of information for assistance with Medicare questions, such as the State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, the state Medicaid office, the local Social Security Administration office, **1-800-MEDICARE (24 hours a day, 7 days a week)**, or **www.medicare.gov**. Providers should also encourage patients who are members of TexanPlus and have plan-specific questions, to call TexanPlus **Member Services at 1-866-230-2513**.

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

Providers must not make available sales or plan promotional Medicare Advantage materials that are not CMS-approved (CMS-approved material would have a footer in the lower left 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 1-888-800-0760.

# Hospitalization Guidelines

## Admissions

### Overview

TexanPlus HMO strives to deliver a coordinated approach to the utilization of services. This coordination includes community-based Providers, facility-based Providers and the facilities themselves. It is through this coordinated approach that services are delivered in the most effective and efficient manner. Communication is a key ingredient in this coordination; therefore, TexanPlus has incorporated certain authorization processes.

TexanPlus HMO urges all Providers to use the services of a network hospital. This will help ensure Members receive the highest level of benefits.

**TexanPlus HMO-POS members may opt to utilize an out-of-network hospital under their POS benefit, but the cost share will be higher.**

If a Provider sends a Member to the hospital as a direct admission, the Provider should contact TexanPlus Health Services Direct Admissions at 1-800-250-3487 and the hospitalist.
Elective Admissions

To admit a Member for a future elective admission, the admitting Provider should obtain prior authorization from Health Services by submitting supporting clinical information to the Pre-Certification Department via fax to 1-877-218-4872 at least seven business days before the admission.

An HMO-POS member who is under the care of an out-of-network Provider will still need to have admissions to an in-network hospital authorized.

The admitting Provider must work with the hospital to schedule the admission and any pre-admission testing.

Emergency Admissions

TexanPlus 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, if applicable
- The name of the admitting Provider if different from the referring Provider or PCP

CLOSER LOOK at Notification for Emergency Admissions

The hospital or facility must notify Health Services at 1-800-250-3487 within 24 hours or on the next business day following the emergency admission to inpatient or observation status. Also, hospitals must contact network hospitalists, if applicable, when admitting TexanPlus members.

Observation Status

Observation status applies to patients for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when:

- The Member's condition is expected to be evaluated and/or treated within 24 to 48 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 admitting physician should notify the hospital staff, who in turn should fax notification to Health Services at 1-877-218-4872. A nurse is available 24 hours a day, 7 days a week to handle authorizations.

**Out-of-Network Hospitals**

**For TexanPlus HMO Members**
When a TexanPlus HMO Member is admitted to an out-of-network hospital for an emergency medical condition, facility staff should contact the Member Services number on the back of the Member’s identification card. A TexanPlus Care Coordinator may coordinate a transfer to a contracted hospital when the member is medically stable.

Texan Plus HMO Members should not be admitted to out-of-network hospitals for non-emergencies unless the medically necessary service is not available in network and prior authorization has been obtained from Health Services. Except for emergency services, TexanPlus HMO will not pay for services received by Members at non-contracted hospitals.

**For TexanPlus HMO-POS Members**
Texan Plus HMO-POS Members may receive services at an out-of-network hospital without an authorization or referral. The member will be responsible for a higher cost-share.

**Inpatient Management**

**Hospitalist Program**
At some hospitals, TexanPlus uses the services of hospitalists. Their role is to:
- Oversee and coordinate care for hospitalized patients
- Work with hospital-based physicians
- Support network PCPs

Because these physicians specialize in inpatient care, they can closely supervise the care of the patients and improve their outcomes. The hospitalist coordinates care with a TexanPlus Care Coordinator and communicates all relevant information to the Member’s PCP and any consulting Providers.

**For TexanPlus HMO Members**
If a Texan Plus HMO Member requires consultation with a specialist, the hospitalist should refer the Member to a network specialist. If care requires the use of an out-of-network Provider, the hospitalist should coordinate care with the Care Coordinator assigned to the admission.
For TexanPlus HMO-POS Members
If a Texan Plus HMO-POS Member requires consultation with a specialist, the hospitalist should refer the Member to a network specialist so that the Member can pay the lowest possible cost share. However, the Member can select an out-of-network specialist under their POS benefit. If an out-of-network Provider is required or requested, the hospitalist should coordinate care with the Care Coordinator assigned to the admission.

In the absence of a hospitalist program, the PCP or admitting physician should carry out these duties.

Pre-Admission Diagnostic Testing
Pre-admission diagnostic testing includes:
- Laboratory diagnostic tests
- Radiological diagnostic tests
- Other diagnostic tests, including electrocardiogram, pulmonary function and neurological

All pre-admission diagnostic testing conducted before a Member's medically necessary surgery or admission to the hospital is covered when performed at the approved facility. Some procedures may require prior authorization.

Concurrent Review
Care coordination for concurrent review is implemented to monitor the level, duration and medical necessity of the care provided to a member during inpatient hospitalization, in a skilled nursing facility or while receiving inpatient rehabilitation services.

Concurrent review includes:
- Review of medical necessity, using appropriate guidelines
- Determination of the next review date
- Discharge planning
- Research/coordination of alternatives to inpatient care, such as home healthcare

A licensed Care Coordinator conducts the review daily on all acute care patients and at least once a week on all rehabilitation and skilled nursing facility inpatients to determine whether the severity of illness and intensity of service are appropriate for the level of current care.

InterQual® healthcare guidelines and Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are used when coordinating inpatient care.

TexanPlus obtains clinical information about inpatient Members by coordinating with the utilization review staff at the facility, reviewing the medical record and/or interviewing attending physicians.
Transfers and Discharge Planning Transfers

Transfers

The Care Coordinator and attending physician will coordinate the transfer of any TexanPlus Member from a network hospital to another facility.

Every effort is made to maintain the use of contracted facilities. If a Member is approved to be sent to an out-of-network facility, the Care Coordinator will complete the proper authorization.

HMO-POS Members may opt to transfer to an out-of-network hospital, but they will be responsible for the higher cost share.

For HMO-POS Members, Skilled Nursing Facilities (SNFs) and (Long-Term Acute Care) LTAC are only covered under the HMO benefit of the plan and only for in-network Providers.

Discharge Planning

Health Services staff work with participating hospitalists, attending physicians, and the facility’s utilization review staff to coordinate discharge planning. A TexanPlus Care Coordinator is available to help coordinate follow-up care, ancillary services and other appropriate services.

Health Services staff also may place a post-discharge call to Members who are high-risk or have unresolved discharge needs. The call may include:

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

Admission Review

The Member and attending physician are notified immediately and the case referred to the TexanPlus Medical Director if:

- An admission request does not appear to meet guidelines upon initial review and/or
- A patient’s condition no longer meets criteria for an extended length of stay/level of care

The requesting Provider will have the opportunity to discuss the treatment plan and/or medical guidelines with the TexanPlus Medical Director. If a request results in a denial or adverse determination, TexanPlus will make every attempt to communicate non-authorization the same day but no later than the next business day. This communication includes the appeals process.
Medicare members have the right to an immediate appeal. If the Member does not choose to initiate an immediate appeal, the Member retains the right to do so through the regular appeal process and should contact Member Services at 1-866-230-2513 by noon on the next business day following receipt of the notice of non-coverage.

# Medical Management

## Care Coordination Services

Care coordination is the coordination of the delivery of care for Members through an integrated and systematic process. This collaborative effort provides Members with continuity of care, thereby improving quality, access and value.

Care coordination goals are to support Members and Providers across the continuum by:

- Helping Members make transitions safely
- Making sure Members get appropriate treatment at all levels of care
- Facilitating and supporting close connections to their PCP
- Providing an ongoing nursing plan of care when care coordination is needed

The care coordination process includes:

- Identifying and grouping each Member into health risk levels
- Assessing and monitoring Member-specific care plans
- Evaluating Members with chronic conditions to optimize their outcomes
- Providing assistance to Members with acute-care and post-hospitalization needs

All utilization review criteria, care coordination guidelines, educational materials and other relevant clinical material are consistent with nationally accepted clinical practice guidelines. The utilization process does not include any bonus or other incentive for denials of medically necessary services. Utilization management staff uses recognized medical criteria to determine appropriate place of service and length of stay for inpatient stays.

When conducting routine prospective, concurrent and retrospective utilization review, the staff makes all reasonable efforts to gather only information necessary to authorize the admission, procedure, treatment length of stay and/or frequency and duration of services.

Criteria used to support utilization management decisions include the following:

- National and local Medicare coverage guidelines from CMS, Novitas Solutions and Durable Medical Equipment Regional Carrier (DMERC) websites
- McKesson’s InterQual® Clinical Decision Support Criteria (licensed for online use with multiple users; copies of criteria available to print on request)
• Health plan specific coverage criteria developed and approved by the Medical Policy Committee
• Hayes Health Technology

The Member’s adherence to the medical treatment plan is measured by analyzing:
• Claims data, including laboratory and pharmacy information
• Health risk assessments
• Member-reported information
• Case coordination notes

Care coordination services are available to all TexanPlus Members who require a multidisciplinary approach to their care. Nurses and social workers assist Members with needs spanning various aspects of social services and the medical community.

A Care Coordinator may telephone or make home visits to Members who have certain diseases, conditions and situations and ask permission to be involved in their care. Once Members grant this permission, the Care Coordinator will contact the Providers involved in the Member’s care.

Some of these diseases and situations are:
• Chronic Obstructive Pulmonary Disease (COPD)
• Congestive Heart Failure (CHF)
• Coronary Artery Disease (CAD)
• Diabetes
• Transplant management
• Complex medical conditions

CLOSER LOOK at Diseases and Situations
This list is, by no means, all-inclusive. If a Provider believes a Member would benefit from care coordination, the Provider should call Health Services at 1-800-250-3487 and refer the Member to the program.

Preventive Screenings and Disease Management

TexanPlus requests that PCPs evaluate each Member annually, addressing the Member’s specific healthcare needs and conducting appropriate preventive screenings.

Preventive requirements to be addressed include, but are not limited to:
• Screening for colorectal cancer
• Mammography (females)
• Influenza vaccine administration
• Pneumonia vaccine administration
• Glaucoma Screening
Gaps in Member healthcare screenings and management may require appropriate intervention to improve and meet recommended goals. Either the health plan’s staff or the Member’s physician may provide this intervention. The Medical Management Department is able to assist both parties by providing reports to physicians and documenting attempts to support Members.

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

**Table 1: Prevention Measurements**

<table>
<thead>
<tr>
<th>GENERAL PREVENTIVE CARE:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia Vaccine</td>
<td>Once per lifetime =&gt;65 years</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Colorectal Cancer Screening:</td>
<td></td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>

**Table 2: Chronic Conditions Measurements**

<table>
<thead>
<tr>
<th>REASON FOR APPOINTMENT</th>
<th>COMPLIANCE STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES/OBESITY</strong></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>HgbA1C</td>
<td>Once every 6 months</td>
</tr>
<tr>
<td>Microalbumin</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>LDL levels</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Blood pressure checks</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td><strong>CHF</strong></td>
<td></td>
</tr>
<tr>
<td>Ejection Fraction measurement (MUGA scan, echocardiogram and cardiac catheterization)</td>
<td>Once per lifetime</td>
</tr>
<tr>
<td><strong>CAD AND OTHER CARDIOVASCULAR CONDITIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>LDL levels</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td><strong>HTN</strong></td>
<td></td>
</tr>
<tr>
<td>Blood pressure checks</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>
Transplant Management

The TexanPlus Health Services staff 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. A transplant coordinator will assist in the transplantation workup. The coordinator also will follow the Member through the transplant period and for one year post transplant.

Providers should contact Health Services at 1-800-250-3487 as soon as they feel transplant services may be necessary. Providers are asked to contact Health Services before evaluation for transplant services.

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

Quality Improvement

Overview

TexanPlus’s approach to quality improvement is built on a model that involves the entire organization and related operational processes. The Quality Improvement program incorporates information from all of TexanPlus departments and encourages Providers to participate in quality improvement initiatives.

The Quality Improvement model employs a cycle of continuous improvement and a “Plan-Do-Check-Act” methodology. Opportunities for improvement are identified through qualitative and quantitative reviews of Member care and services.

Quality improvement is a shared responsibility between TexanPlus and its contracted networks and other delegated entities. The Quality Improvement department oversees and directs many of the activities that support continuous quality improvement, including:

- Identifying processes that require improvement
- Organizing work groups and committees, such as the Quality Improvement Committee
- Identifying best practices
- Developing and implementing improvements
- Collecting data to evaluate the results of the improvements
Member satisfaction and quality of care and service are regularly subjected to scrutiny under the quality improvement cycle outlined above. The CMS Star program results and Quality guidelines serve as ongoing indicators for the Quality Improvement work plan.³

Participation in the collection, review, and submission of CMS Five-Star quality rating system performance data is one means by which TexanPlus evaluates the quality of Member services, care and satisfaction.

In addition, TexanPlus 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 cardiovascular disease. Program development is also underway to further develop and expand our tobacco use cessation strategies, medication adherence initiatives, blood pressure reduction and cholesterol management activities.

The TexanPlus Quality Improvement program includes initiatives related to the CMS-mandated Quality Improvement Project (QIP) which is focused on reducing the incidence of readmissions within 30 days.

Numerous strategies have been implemented as part of our Live Healthy program, which is designed to help Members manage and improve their health. Live Healthy is the umbrella name for a range of free services that TexanPlus offers to Members to promote healthy behavior and a healthier lifestyle. For example, the Live Healthy House Calls service offers scheduled in-home visits from nurse practitioners who provide check-ups to Members and share the results of the visit with the Member’s primary care physician. Other Live Healthy services include free flu shots, reminders to take prescribed medications, and a Rewards program to encourage prevention and healthy choices.

The expectation is that these ongoing activities will improve quality of care, provide for better health outcomes for Members and increase Member and Provider satisfaction with TexanPlus.

**Provider and Member Satisfaction Surveys**

Satisfaction surveys provide TexanPlus with feedback on performance relating to:
- Access to care and/or services
- Overall satisfaction with TexanPlus
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

³HEDIS and CAHPS are sets of measurements developed and defined by the National Committee for Quality Assurance (NCQA) as a basis for comparing quality, resource utilization and Member satisfaction across health plans. The submission of HEDIS and CAHPS data is required by CMS for Medicare Advantage health plans that meet specific organization and enrollment criteria. Health plans are rated against Stars indicators which are set by CMS and derived from HEDIS, CAHPS, the health outcomes survey, and additional administrative measures.
ICD-10

TexanPlus is committed to being compliant with ICD-10 by the new compliance date that would require the use of ICD-10 beginning October 1, 2015. TexanPlus will continue to work towards ICD-10 readiness and will move forward with remediation that can or should be completed by the new compliance date for ICD-10. We will continue to monitor CMS guidance regarding the implementation of ICD-10. Please refer to our website for further information.

Questions should be directed to ICD10Inquiries@UniversalAmerican.com.

Claims Procedures

Overview

TexanPlus pledges to provide accurate and efficient claims processing. To this end, TexanPlus requests Providers submit claims promptly and include all necessary data elements. A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims.

Providers should bill all Medicare-covered services in accordance with the Centers for Medicare & Medicaid Services (CMS) rules, standards and guidelines applicable to Parts A and B. Also, Providers should use applicable CMS billing forms (i.e., UB-04/CMS1450, CMS1500, or such successor forms) and follow all CMS-required coding conventions.

Key Points

- Type paper claim forms or submit them electronically. Corrections may not be handwritten. In addition, claims with eraser marks, white-out corrections or any alterations will be returned.
- Include Provider’s NPI number on all claims.
- If a mistake is made on a claim, submit a new claim. Claims must be submitted by established filing deadlines or they will be denied.
- Services for the same patient with the same date of service may not be unbundled.
- Only clean claims containing the required information will be processed within the required time limits. Rejected claims—those with missing or incorrect information—may not be resubmitted. A new claim form must be generated for resubmission.
- Use proper CMS place of service codes and CMS code sets (procedure, HCPCS, revenue, modifiers, diagnosis, etc.) for all claims.
- Submit only one payee address per tax identification number.
- Submit all appeals in writing within 90 business days of receipt of the notice indicating the claim was denied.

4Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.
• Bill diagnosis codes to the highest specificity.
  – Dates of service on or before September 30, 2015 should be billed to applicable ICD-9 codes.
  – Dates of service on or after October 1, 2015 should be billed to applicable ICD-10 codes.

Filing Methods and Policies

Electronic

TexanPlus is contracted with Emdeon clearinghouse. Providers who have existing relationships with this clearinghouse can transmit claims in the format produced by their billing software.

The clearinghouse is then responsible for reformatting these claims to meet HIPAA standards and passing the claims on to TexanPlus.

For all Electronic Data Interchange (EDI) submissions, submit the National Provider Identifier number and the Member’s TexanPlus identification number. When care is coordinated, the referring Provider’s name and address also are required.

Closer Look at Payer ID Numbers

Emdeon has a payer code of “76045.” Providers who are contracted with another clearinghouse should ask their clearinghouse to add another carrier. For questions regarding EDI billing, contact the EDI Services Department at 1-866-496-7826 or e-mail edi@UniversalAmerican.com.

Paper Claim Forms

CMS-1500 form

These forms are for professional services performed in a Provider’s office, hospital or ancillary facility. (Provider-specific billing forms are not accepted.)

UB-04 (CMS-1450) form

These forms are for outpatient and inpatient hospital services or ancillary services performed in the hospital. (Hospital-specific billing forms are not accepted.)

Deadlines

TexanPlus accepts new claims for services up to the filing time specified in the contract.

When TexanPlus is the secondary payer, claims are accepted with the explanation of benefits (EOB) from the primary carrier. Unless the Provider’s contract states otherwise, this claim must be received within 60 days of the primary EOB remittance date or up to the new claim timely filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing. Members cannot be billed for claims submitted after these deadlines.
**Claims Addresses**

Providers should submit claim forms to the following address:

**TexanPlus HMO**  
P.O. Box 741107  
Houston, TX 77274-1107  
Attn: Claims

**Diagnosis Codes**

Providers must submit claims with a diagnosis code, indicating the Member’s medical condition or circumstances necessitating evaluation or treatment. These diagnosis codes must correlate to the documentation contained within the Member’s medical record and reflect or support the reason services have been provided. Providers are able to submit up to eight diagnosis codes for professional services when submitting claims via EDI.

**Key Points**

Follow these guidelines to avoid the most common claims coding problems:

- The diagnosis should be coded using the most updated standard diagnostic code set (ICD-9 or ICD-10 as applicable).
- Make sure the diagnosis code is valid and complete (i.e., includes all digits).
- The primary diagnosis should describe the chief reason for the Member’s visit to the Provider.
- When a specific condition or multiple conditions are identified, the Provider should code these conditions and report them as specifically as possible.
- For coding of services provided on an outpatient basis, do not code the diagnosis as “rule out” “suspect,” or “probable” until the condition is confirmed. Code the condition to the highest degree of certainty, such as symptoms, signs or abnormal test results.
- When addressing both acute and chronic conditions, assign codes to all conditions for which the Member is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.
- In coding Diabetes Mellitus, identify the current status of the Member’s condition as Type I or Type II, controlled or uncontrolled, referring to the standard diagnostic code set guidelines.
- Use caution in coding injuries, identifying each as specifically as possible.
- Refer to standard diagnostic code set guidelines for “late effect” coding and sequencing.
- “Well” vs. “sick” visits: If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as “preventive.” The condition(s) for which the Member is being treated should be coded as a secondary diagnosis.
- Specific codes are used for circumstances affecting a Member’s health status or involving contact with health services that are not classified under ICD-9-CM or ICD-10-CM codes as applicable. In general, they do not represent primary disease or injury conditions and should not be used routinely. Diagnostic codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure. Diagnostic codes that pertain to mental health, learning disorders or social conditions are not covered.
Claims Resubmission

Providers may resubmit claims within 45 days of the initial submission if TexanPlus has not paid or denied the claim. These claims can be a photocopy or a reprinted claim, with the original submission date clearly noted.

Claims Documentation

Clean vs. Unclean Claims

Under CMS guidelines, a “clean” claim is a claim with no defects or improprieties. An “unclean” claim may include, but is not limited to:

- Lack of required substantiating documentation, such as an NPI number
- 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

Only clean claims containing the required information will be processed in a timely manner.

Alert—Rejected Claims

Rejected claims – those with missing or incorrect information – cannot be resubmitted. Providers must generate a new claim form for resubmission.

National Provider Identifier

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

The purpose of the National Provider Identifier 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, in patient medical record systems and in program integrity files.
Codes and Modifiers

Claims Coding
TexanPlus generally reimburses Providers and ancillary service Providers on a fee-for-service basis. Network Providers agree to accept the network contracted reimbursement, less deductibles, copayments and co-insurance, as payment in full for covered services.

**Alert—Balance Billing**
Providers are not permitted to balance bill members for the difference between the Provider’s charge and the TexanPlus reimbursement.

TexanPlus annually updates all fee schedules with CPT-4 and HCPCS code additions and deletions. Coverage policy follows Centers for Medicare & Medicaid Services (CMS) guidelines whenever appropriate. All Provider claims are subject to coding review edits based on CMS Correct Coding Initiative (CCI) guidelines or TexanPlus payment policies.

Coding Practices Subject to Review
The following practices are considered improper and inappropriate and will be subject to TexanPlus system edits:

- **Fragmenting**—Breaking down a multitask service and coding each task of the service or procedure separately.
- **Unbundling**—Reporting separate codes for related services when a single code exists to identify all of the services.
- **Downcoding**—Selecting two or more lower-level codes to identify a service that could have been identified with a single higher-level code.
- **Upcoding**—Selecting a code at a higher level than was actually provided for the sake of higher reimbursement.
- **Surgical Field Separation**—Separately identifying the surgical approach from the major surgical service when the major surgical service code includes the approach or exploration of the surgical field.

Unlisted Codes

Procedures
When appropriate, a Provider may need to bill for a procedure that does not have an existing CPT/HCPCS code. The Provider should use the “miscellaneous” or “not otherwise classified” codes that most closely relate to the service provided. When billing for “unlisted” or “not otherwise classified” codes, Providers will be asked to supply supporting documentation.
**Medications**

“Unlisted” or “not otherwise classified” drugs must be submitted with applicable HCPCS codes. The claim must include a description of the item/drug supplied, correct dosage and the National Drug Classification Code (NDC) number.

**Physician Modifiers**

Frequently used modifiers are listed in the following table. For a complete list of modifiers, refer to the CPT or HCPCS manual.

**Table 2: Physician Modifiers**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual procedure</td>
</tr>
<tr>
<td>23</td>
<td>Unusual anesthesia</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated EM service during post-op period</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable EM service by the same Provider on the same date of service as procedure/service</td>
</tr>
<tr>
<td>26</td>
<td>Professional services</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedure(s)</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
</tr>
<tr>
<td>62</td>
<td>Co-surgeons</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (no resident available)</td>
</tr>
<tr>
<td>TC</td>
<td>Technical services</td>
</tr>
</tbody>
</table>

**Reimbursement**

**Overview**

TexanPlus processes all clean claims within 45 days from the date TexanPlus receives the claim or as indicated by the filing period stated in an individual Provider’s contract. According to the Centers for Medicare and Medicaid Services, a claim is paid when TexanPlus mails the check or electronically transfers funds.

Note: Claims reimbursement to TexanPlus HMO-POS Members is the same as it is for TexanPlus HMO plans. Differences will be in the Member cost share. The terms and conditions of your existing contract apply.
**Multiple Payee Addresses**

TexanPlus does not honor multiple payee addresses. Providers are required to submit a single payee address per tax ID number.

**Process for Refunds or Returned Checks**

TexanPlus accepts overpayments two ways; Providers may refund additional money directly to TexanPlus or TexanPlus will take deductions from future claim payments.

**Refunds**

If TexanPlus has paid in error, Providers may return the TexanPlus check or write a separate check from their account for the full amount paid in error.

Providers should include a copy of the Explanation of Payment (EOP), supporting documentation noting the reason for the refund and the EOP from other insurance carriers, if applicable.

Refunds should be sent directly to the Cost Containment Unit at the following address:

**TexanPlus HMO**
P.O. Box 505057
St. Louis, MO 63150-2127
Attn: Cost Containment Unit

**Overpayment**

If TexanPlus has paid in error and the Provider has not sent a refund or returned the TexanPlus check, TexanPlus will send Providers a request for the overpayment. If Providers still fail to return the payment, TexanPlus will deduct money from future claim payments. The related claim information will be shown on the EOP as a negative amount.

TexanPlus is permitted to pursue overpayments made within a three-year calendar period of the original payment, special contractual provisions notwithstanding.

**Claims Follow-Up**

Providers may view claims status online at ProviderLink at UAMProviderLink.UniversalAmerican.com.

Providers who have not registered or not know how to use ProviderLink should contact Provider Services at 1-888-800-0760.

To check the status of a claim without going online, Providers may call Provider Services from 8 a.m. to 5 p.m. Central Time, Monday through Friday.
Claims Reconsideration

Providers occasionally may disagree with the adjudication of a claim. If so, they may dispute the decision by filing a request for reconsideration. Providers must submit such reconsideration requests in writing within 90 business days of receipt of the notice of the denied claim. 

See Provider Dispute Resolution Request Form, Appendix, page 96

The following procedure outlines the claim reconsideration process:

1. The Provider sends a written request for reconsideration to TexanPlus

The Provider sends the request to TexanPlus at the address below stating the reason for the reconsideration, a copy of the explanation of payment and any relevant documentation, including the member’s medical record, to support the Provider’s belief that the claim should be reconsidered.

TexanPlus HMO
P.O. Box 741107
Houston, TX 77274-1107
Attn: Provider Disputes

2. The Provider Dispute Coordinator reviews the reconsideration request

The Provider Dispute Coordinator reviews and decides reconsideration requests. In some cases, the Provider Dispute Coordinator may need additional information from other departments, such as authorization, to make a final determination. Every effort is made to make a final determination within 30 days.

Alert—Claims Resubmissions or Corrections

Correcting or resubmitting a claim is not a request for reconsideration. Corrections or resubmissions of claims should be sent to the standard claims address at:

TexanPlus HMO
P.O. Box 741107
Houston, Texas, 77274-1107
Medicare Risk Adjustment

Hierarchical Condition Category (HCC) Model

Overview

CMS previously reimbursed Medicare Advantage plans based on a Member’s demographics. Now, however, CMS also considers a Member’s chronic health conditions. This reimbursement method is called Medicare Risk Adjustment.

Under risk adjustment, health plans receive higher compensation for chronically ill Members in anticipation of the cost of paying for their care. Payments are calculated by the diagnoses on each Member’s claims for the previous year.

TexanPlus reviews all claims to identify conditions that yield varying reimbursement rates. To determine the reimbursement rate associated with the diagnosis codes that Providers submit, the risk adjustment process relies on a model called “Hierarchical Condition Category” or HCC.

The HCC model is a list of standard diagnostic codes (ICD-9-CM up until September 30, 2015; ICD-10- CM starting on October 1, 2015) that have been separated into clinically related groups. The model identifies chronic diseases and conditions that may have a corresponding disease management program. The reimbursement also is based on the severity of each qualifying condition.

A qualifying diagnosis must appear on a Member’s medical record at least once a calendar year to be counted for risk adjustment. In addition, the physician who dictated or documented the Member’s condition must sign the record and note their credentials, regardless of the type of medical record.

Hierarchical Condition Categories

The following chart gives a few examples of diagnosis conditions and their corresponding HCC category. (Note: These codes may change from year to year.)
Table 3: HCC to ICD-9-CM Corresponding Category Chart

*Note, these codes are for illustrative purposes only. All ICD-9-CM codes are in effect until September 30, 2015. This chart does not include corresponding ICD-10-CM codes for these conditions, which go into effect on October 1, 2015.

<table>
<thead>
<tr>
<th>HCC</th>
<th>HCC DESCRIPTION</th>
<th>ICD-9 –CM CODE</th>
<th>ICD-9-CM DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>042</td>
<td>HIV Disease</td>
</tr>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>07953</td>
<td>HIV-2 Infection, viral and chlamydial</td>
</tr>
<tr>
<td>2</td>
<td>Septicemia/Shock</td>
<td>03810</td>
<td>Staphylococcal Septicemia, Unspecified</td>
</tr>
<tr>
<td>2</td>
<td>Septicemia/Shock</td>
<td>0389</td>
<td>Septicemia Unspecified</td>
</tr>
<tr>
<td>8</td>
<td>Lung, Upper Digestive Tract, &amp; Other</td>
<td>1502</td>
<td>Malignant Neoplasm – Abdomen/Esophagus</td>
</tr>
<tr>
<td></td>
<td>Severe Cancers</td>
<td>1519</td>
<td>Malignant Neoplasm Stomach NOS</td>
</tr>
<tr>
<td>9</td>
<td>Lymphatic, Head &amp; Neck, Brain &amp; Other</td>
<td>1410</td>
<td>Malignant Neoplasm – Tongue Base</td>
</tr>
<tr>
<td></td>
<td>Major Cancers</td>
<td>1411</td>
<td>Malignant Neoplasm – Dorsal Tongue</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
<td>25001</td>
<td>Diabetes Mellitus Type 1 Uncomplicated, Not stated as uncontrolled</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
<td>25000</td>
<td>Diabetes Mellitus Type 2 Uncomplicated, Not stated as uncontrolled</td>
</tr>
<tr>
<td>21</td>
<td>Protein-Calorie Malnutrition</td>
<td>261</td>
<td>Nutritional Marasmus</td>
</tr>
<tr>
<td>26</td>
<td>Cirrhosis of Liver</td>
<td>5712</td>
<td>Alcohol Cirrhosis Liver</td>
</tr>
<tr>
<td>26</td>
<td>Cirrhosis of Liver</td>
<td>5713</td>
<td>Alcohol Liver Damage</td>
</tr>
<tr>
<td>80</td>
<td>Congestive Heart Failure</td>
<td>42831</td>
<td>Acute Diastolic Heart Failure</td>
</tr>
<tr>
<td>80</td>
<td>Congestive Heart Failure</td>
<td>42832</td>
<td>Chronic Diastolic Heart Failure</td>
</tr>
<tr>
<td>104</td>
<td>Vascular Disease with Complications</td>
<td>41511</td>
<td>Iatrogenic Pulmonary Embolism/Infarction</td>
</tr>
<tr>
<td>104</td>
<td>Vascular Disease with Complications</td>
<td>41519</td>
<td>Other Pulmonary Embolism/Infarction</td>
</tr>
</tbody>
</table>
Provider’s Role in Risk Adjustment

Overview

The Provider’s role is critical in the risk adjustment process because payments from CMS rely exclusively on complete medical record documentation and the submission of accurate diagnostic coding. The accuracy and quality of the medical record depend on thorough documentation and coding by Providers and their staffs.

Providers must sign, add their credentials after their signature and date all medical record information, including but not limited to notes, diagnostic results and reports received from specialists. A signature indicates that the Provider has acknowledged and reviewed this information.

Capturing Chronic Conditions

To ensure accurate payment, Providers should consider the following steps to assist in capturing all chronic conditions that qualify under the HCC model:

- All PCPs should have at least one annual face-to-face visit with each Member assigned to their panel.
- At each visit, Providers must document appropriately. This includes recording all conditions and diseases, indicating the Member’s name and date of service on each page of the medical record and signing and dating each entry, making sure to indicate the Provider’s credentials. The Provider’s name and credentials must be legible, and a reviewer must be able to determine the identity of the signee.
- Electronic signatures also are acceptable as long as they include a statement such as “electronically signed by,” “authenticated by” or “approved by” in addition to the Provider’s name, credentials and date of signature.
- As of Jan. 1, 2009, CMS no longer accepts signature stamps for office visit notes.
- Providers should choose a documentation style and be consistent with that style. Methods of documentation include “SOAP notes” or 1997 E/M Coding Documentation.
- SOAP notes include Subjective data, Objective data, Assessment and plan.
- The 1997 E/M Coding Documentation must include chief complaint, history of current illness, review of systems, family and social history, exam and medical decision making.
- Providers should code a visit based on the documentation in the medical record.
- Providers should code to the highest known specificity for all conditions at the time of the visit.
- Providers should report all of a Member’s chronic conditions, using the most updated standard diagnostic coding guidelines.
- Providers should submit the ICD-9-CM (for dates of service up until September 30, 2015) or ICD-10-CM (for dates of service starting October 2015, the new ICD-10 compliance date) diagnostic data to TexanPlus via a CMS-1500 claim form or electronic claim. Note: The CMS-1500 only allows for four standard diagnostic codes; an electronic submission allows for eight standard diagnostic codes. If a Member has more chronic conditions than provided for on the form, Providers should call Provider Services at 1-888-800-0760 so the codes may be manually entered into the system.
TexanPlus Role in Risk Adjustment

The payments received by TexanPlus are adjusted according to the severity of each Member’s condition. To guarantee that compensation correctly reflects the Member’s current health status, TexanPlus must:

- Educate all contracted physicians. To do so, TexanPlus will provide the following:
  - A biannual Provider and office manager meeting
  - Individual meetings with Providers and their staffs, as requested
- Provide updated and accurate reports. TexanPlus has created several reports for use by Providers and their staffs to make sure Providers capture correct diagnoses. To review these reports, Providers may contact Provider Services at 1-888-800-0760.
- Provide coding support. TexanPlus has created coding tools to help contracted Providers. To obtain these tools, Providers may contact Provider Services at 1-888-800-0760 or e-mail codinghelp@UniversalAmerican.com.
- Conduct chart reviews. TexanPlus will conduct periodic reviews and educate Providers and their staffs regarding the importance of capturing correct and full diagnoses. These reviews will be coordinated with the Provider’s office staff.
- Submit the encounter data/claims detail to CMS. TexanPlus must submit all encounter data and/or claims detail to CMS in a timely manner.

CLOSER LOOK at Submitting Encounter Data

Providers who have difficulty submitting encounter data to TexanPlus should contact Provider Services at 1-888-800-0760 as soon as possible.

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 has to appear at least once a calendar year.

Q: Is a “typed” signature on a report acceptable for office consultation notes, a discharge summary and hospital consultations?
A: No. The Provider who dictated the report must sign it, regardless of the record type. Electronic signatures are acceptable but must be accompanied by such words as “electronically signed by,” “authenticated by” or “signed by” and must indicate the Provider’s credentials.

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 TexanPlus 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: Are there any available data on linking standard diagnostic codes to the HCC level?
A: Yes. Providers who need assistance may contact Provider Services at 1-888-800-0760 or e-mail codinghelp@UniversalAmerican.com.

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: May Providers use ICD-9-CM code 412 (or ICD-10-CM code 125.2) if the only documentation of an old myocardial infarction (MI) is an EKG report?
A: No the EKG report cannot be used as a source until the procedure has been interpreted and documented in the medical record.

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

Member Administration

Member ID Cards

This is an example of a TexanPlus Member ID card. Various products may have different logos, but the general information on the card should be similar. Refer to the TexanPlus website at www.TexanPlus.com or www.TexanPlusPOS.com for information about benefits, Member copayments/coinsurance and product logos.

The information below is for sample purposes only. Please verify benefits at the time of visit.
Typical Member ID Card

![Typical Member ID Card]

**Selecting a Primary Care Physician (PCP)**

All TexanPlus HMO and HMO-POS Members must select a PCP from the list of participating PCPs in the TexanPlus HMO Provider Directory. The PCP’s name will also be noted on the Member’s ID card. (Provider directories are available at [www.TexanPlus.com](http://www.TexanPlus.com) or by calling **Provider Services at 1-888-800-0760**.

If a Member does not select a PCP, TexanPlus will assign a PCP based on geographic access.

The PCP has the primary responsibility for coordinating the Member’s overall healthcare and originating all Member communication and information exchange among the Member’s various Providers.

A PCP, with an open panel, is not permitted to refuse services to an eligible Member.

Members may change PCPs by contacting **Member Services at 1-866-230-2513**. The change becomes effective on the first day of the following month. TexanPlus will send a new Member ID card to the Member.
Verifying Member Eligibility

Possession of an identification card is not a guarantee of benefits. Providers should photocopy the card and check it for any change of information, such as copayments, claims mailing address and eligibility date.

Providers may verify Member eligibility online at ProviderLink at UAMProviderLink.UniversalAmerican.com.

Providers also may verify eligibility by calling the Provider Services telephone number listed on the back of the Member’s health plan identification card.

PCP offices also may refer to the monthly capitation report to note Member’s participation; however, the report is not a guarantee of benefits.

Determining Primary Insurance Coverage

These guidelines will help Providers determine primary insurance coverage for their Members. Typical scenarios Providers may encounter include the following:

If a TexanPlus Member has any type of Medicaid coverage...
...TexanPlus is primary to the Medicaid coverage. Members may transfer in or out of this “dual-eligibility” status month to month. Providers should not collect copayments from these Members for any services, including prescription services. The Provider is permitted to collect the Medicaid copayment, if applicable, for any service that is covered by Medicaid.

If a TexanPlus Member presents an Original Medicare card and a TexanPlus identification card...
...TexanPlus is primary. Members need to show the Provider only the TexanPlus identification card, not both identification cards.

If a TexanPlus Member is 65 or older and also covered by a group health plan because of current employment or spouse’s current employment...
...TexanPlus is primary if the employer has fewer than 20 employees. The group health plan is primary if the employer has 20 or more employees.

If a TexanPlus Member is covered under workers’ compensation because of a job-related illness or injury...
...workers’ compensation is primary for all workers’ compensation-related services.
If a TexanPlus plan Member has been in an accident where no-fault or liability insurance is involved...
...no-fault or liability insurance is primary for all accident-related services.

Member Transfers

If an acceptable patient-physician relationship cannot be established, the PCP may request that TexanPlus remove the Member from the PCP’s panel.

Providers should give specific details for such a request in a letter to TexanPlus sent to the following address:

TexanPlus HMO
4888 Loop Central Drive, Suite 300
Houston, TX 77081
Attn: Provider Services

The request should be based on one of the following:
• Inability to establish and/or maintain a satisfactory relationship with the Member
• Chronic failure of the Member to pay the copayment
• Noncompliant, abusive or threatening behavior

After a review, TexanPlus will contact the Member for any additional information, if necessary. TexanPlus then will notify the Provider and the Member of its decision.

**ALERT—Continued Care**
The PCP must continue to provide care for the Member for 30 days or until a new PCP is selected.

Member Appeals and Grievances

TexanPlus Members and their authorized representatives have the right to file appeals and grievances with TexanPlus when they have concerns or problems related to coverage or care. Members also may request that Providers act on their behalf in the appeal process.

Members may appeal a decision made by TexanPlus to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members also have the right to file a request for an organization determination if their Provider refuses to supply a requested service or treatment.
Members may file a grievance for all other types of complaints not related to the provision or payment for healthcare, such as sales, enrollment or complaints related to the quality of service or quality of care they receive.

The TexanPlus Member Evidence of Coverage (EOC) provides more detailed information about the Member appeal and grievance process. The Plan’s EOC documents are posted on the “Plan Documents” page on the TexanPlus website at www.TexanPlus.com or www.TexanPlusPOS.com. For more information on the Member appeals and grievances process, Providers also may call Provider Services at 1-888-800-0760.

**Member Appeals**

Members or their authorized representative must file an appeal within 60 calendar days of receiving notification of the health plan’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.

Documentation completed, signed and dated by both the Member and the Member’s proposed representative is required. The Appointment of a Representative (AOR) form (CMS1696 form) is available on the Centers for Medicare & Medicaid Services (CMS) website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf or in the appendix.

➤ See Appointment of Representative Form (CMS1696), Appendix, page 97

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. If the physician is a non-contracted Provider, he or she must formally agree to waive any right to payment from the Member regardless of the outcome by submitting a completed and a signed Waiver of Liability (WOL) form.

➤ See CMS Waiver of Liability Statement Form, Appendix, page 101
TexanPlus 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 TexanPlus obtain additional medical records from the treating 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 1-800-817-3516. Standard appeals may be faxed to the same number or mailed to:

TexanPlus HMO  
P.O. Box 742608  
Houston, TX 77274  
Attn: Member Appeals

The above type of appeal is not to be confused with a physician’s right to non-contract Provider payment dispute resolution. CMS guidance provides that non-contract and deemed Providers have payment dispute rights, which may include the CMS Independent Review Entity (IRE) process.  
  ➔ See Provider Payment Dispute Resolution Process, page 98

**CMS Timeliness Standards Regarding Member Appeals**

CMS regulations require that TexanPlus 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 TexanPlus within five calendar days so that the Medicare Advantage health plan 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.
TexanPlus must make a determination for expedited appeal requests within 72 hours of receipt. Providers must respond to the plan’s requests for information regarding expedited pre-service appeals within 24 hours to ensure timely resolution. (Post-service (payment) appeals cannot be processed as expedited.)

Expedited appeals should be faxed to 1-800-817-3516.

**TexanPlus Member Grievances**

If a Member is dissatisfied with TexanPlus sales, enrollment or service processes or with the Provider or the Provider’s office, the Member or their appointed or authorized representative has the right to file a grievance. If the grievance involves a Provider, TexanPlus will contact the Provider for an explanation (which may include the request for medical records) to ensure a balanced investigation of all the facts before responding to the Member, or their appointed representative. Providers must respond to such a request within five (5) calendar days in order for that response to be included in the investigation.

**CMS Timeliness Standards Regarding Member Grievances**

CMS timeliness standards require that TexanPlus respond to the Member with the results of the investigation within 30 calendar days. A Provider’s quick response to investigative inquiries will ensure that TexanPlus complies with CMS regulations.

The deadline for a response to a grievance may be extended by 14 calendar days if doing so is in the interest of the Member.

**Providing Members with Notice of Their Appeal Rights – Requirements for Hospitals, SNFs, CORFs and HHAs**

Hospitals must notify patients with Medicare who are hospital inpatients about their inpatient hospital discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: [http://www.cms.gov/Medicare/Medicare-General-information/BNI/HospitalDischargeAppealNotices.html](http://www.cms.gov/Medicare/Medicare-General-information/BNI/HospitalDischargeAppealNotices.html).

Skilled Nursing Facilities (SNFs), home health agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) must notify patients with Medicare about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. The enrollee must receive a NOMNC at least two days in advance of the proposed service termination date. For copies of the form and the notice instructions, go to: [http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNCInstructions.pdf](http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNCInstructions.pdf) and [http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNC.pdf](http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNC.pdf).
If a Member or authorized representative notifies the Quality Improvement Organization (QIO) that the he/she wishes to appeal a decision regarding a hospital discharge or termination of HHA, CORF, or SNF, TexanPlus will provide Members with a detailed explanation of why services are no longer covered upon notification by the QIO within the time frames specified by law.

**Pharmacy**

**Part D Pharmacy Services**

**Overview**

The TexanPlus Pharmacy Management Department helps manage healthcare dollars spent on prescription medications. In addition, the department works with Health Services to coordinate Member care regarding medications.

TexanPlus partners with CVS Caremark, a Prescription Benefits Manager (PBM), to administer the prescription programs for TexanPlus Members.


- Click on “Part D/pharmacy – coverage information”
- Click on “Formulary Information”
- On the next page, you can:
  - Search the formulary online
  - Download and print the comprehensive formulary
  - Download and print an update (addendum) to the comprehensive formulary

You may also access the formulary on ProviderLink at [UAMProviderLink.UniversalAmerican.com](http://UAMProviderLink.UniversalAmerican.com).

**Formulary Key Points**

Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for TexanPlus. These Medicare Advantage prescription drug plans include the following features:

- Tiered copayments based on the type and use of medications
- Clinical programs to ensure appropriate use of medications
- Services for “specialty” medications that require extra information, handling, storage and use instructions
- In some plans, elimination of the Member’s Part D deductible
• In some plans, coverage of certain medications within the standard Part D coverage gap
• 90-day supply of medications available for pick up at network pharmacies
• Mail-order services through CVS Caremark Mail Service
• A staff clinical pharmacist is available to do the following:
  • Answer medication-related questions from Providers and network pharmacies
  • Assist in educating Providers and network pharmacies about pharmacy changes
  • Serve as a clinical resource for contracted Providers and their staffs
  • Work with pharmacy benefit managers to develop medication utilization review point-of-service edits

The TexanPlus Pharmacy Management Department may be contacted by telephone at
**1-866-386-1139** or by e-mail at pharmacysupport@UniversalAmerican.com.

The CVS Caremark Clinical Prior Authorization Department may be contacted at:

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<th>PHONE</th>
<th>1-855-344-0930</th>
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<td>(TTY users call 1-866-236-1069)</td>
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<td>FAX</td>
<td>1-855-633-7673</td>
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<td>MAIL</td>
<td>P.O. Box 52000, Phoenix, AZ 85072-2000</td>
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**Pharmacy Policies**

**Generics**

All formularies include the concept of generic medications as the preferred use medication. Copayments for most generic medications are lower than copayments for brand-name medications.

**Five-Tier Formulary**

Most medications, unless they are benefit exclusions or non-formulary, are reimbursed under this program. This allows for accessibility of all medication classes required by the Centers for Medicare & Medicaid Services (CMS) and permits Providers to determine the most appropriate medication.
Tier 1: *(Preferred Generic Drugs)*
This is the lowest-cost Generic tier and includes preferred generic drugs. Generic drugs contain the same active ingredients as brand drugs and are equally safe and effective.

Tier 2: *(Non-Preferred Generic Drugs)*
This is the higher-cost Generic tier and includes non-preferred generic drugs and sometimes some preferred brand drugs. Some Tier 2 drugs have lower-cost Tier 1 alternatives.

Tier 3: *(Preferred Brand Drugs)*
This is the middle-cost tier, and includes preferred brand drugs and sometimes non-preferred generic drugs. Some Tier 3 drugs have lower-cost Tier 1 or 2 alternatives.

Tier 4: *(Non-Preferred Brand Drugs)*
This is the higher-cost tier and includes non-preferred brand drugs and sometimes non-preferred generic drugs. Some Tier 4 drugs have lower-cost Tier 1, 2, or 3 alternatives.

Tier 5: *(Specialty Tier Drugs)*
The Specialty tier is the highest-cost tier. A Specialty Tier drug is a very high cost or unique prescription drug that may require special handling and/or close monitoring. Specialty drugs may be brand or generic.

**Coverage Determination**
TexanPlus has several processes that help ensure the effective and efficient use of medications under the prescription benefit offered to Members. TexanPlus refers to these processes collectively as “coverage determination.”

The following list includes the various types of coverage determination requests:
- Formulary exception – Coverage for a Part D medication that is not on the formulary
- Prior authorization – Coverage for certain formulary prescription drugs that require specific clinical criteria
- Step therapy – Coverage for certain formulary prescription drugs that first require the trial and failure of other formulary alternatives
- Quantity limits – Coverage for certain medications that have quantity limits to ensure compliance with FDA guidelines and appropriate use of medications
- Tier exception – Coverage for a Non-Preferred Tier drug at a lower, Preferred Tier copayment
Each of these various types of coverage determinations has its own respective request form, which Providers may access by calling the CVS Caremark Clinical Prior Authorization Department at:

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<td>MAIL</td>
<td>P.O. Box 52000, Phoenix, AZ 85072-2000</td>
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Forms may be accessed in the section titled “Part D/pharmacy – coverage information” under “Formulary information – Materials and Forms.”

### 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 TexanPlus Member is taking a formulary drug that was covered at the beginning of the year, TexanPlus will continue coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or when adverse information about the safety or effectiveness of a drug is released.
Other types of formulary changes, such as removing a drug from the formulary, will not affect Members currently taking the drug and will remain available at the same cost-sharing for the remainder of the coverage year.

**Notification of Formulary Changes**

If TexanPlus 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, TexanPlus must notify affected Members and Providers of the change at least 60 days before it becomes effective.

Providers may access these notifications at www.TexanPlus.com or www.TexanPlusPOS.com.
- Click on “Part D/pharmacy – coverage information”
- Click on “Formulary information” under “Upcoming formulary changes”

This information is also available at ProviderLink at UAMProviderLink.UniversalAmerican.com.

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

**Transition Policy**

TexanPlus may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. TexanPlus 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.

➤ See Coverage Determination, Pharmacy, page 73

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

Participating 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

TexanPlus now offers mail-order services to our Members. Some of the benefits to the Members include:

- Save money: mail-order refills can save your patients up to 60% in costs and always come with no shipping cost for standard shipping.
- Personal service: 24-hour access to a pharmacist by calling 1-800-875-0867.
- Online convenience: save time and set up automatic refills or order any time of day or night at www.caremark.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 websites at www.TexanPlus.com or www.TexanPlusPOS.com or call 1-800-378-5697.

Part B Pharmacy 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\(^5\) 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 as a supply to 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

\(^5\)Exceptions may apply for IPPB solutions and some diabetic supplies.
-- 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 – No copayment (part of the Hospital payment)
• Part B – Generally a Member coinsurance (varies by plan and/or product)
• Part D – Generally a 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 TexanPlus 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.

TexanPlus 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.”
Legal and Compliance

Overview

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

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

The Compliance Program

Universal American Corp. (UAM) has established a comprehensive Compliance Program and is committed to ensuring that all organizational areas of UAM are, and remain, compliant with applicable State and Federal regulatory requirements. UAM’s 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. UAM 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.

UAM designed the Compliance Program and all efforts surrounding this program to establish a culture within UAM 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, UAM’s Compliance Program and the UAM Code of Conduct effectively articulate and demonstrate the Plan’s commitment to legal and ethical conduct. The UAM Compliance Program applies to all of UAM’s Medicare Advantage plan types (e.g., HMO, HMO-POS, PPO, PFFS and SNP).
Responsibilities

The UAM Compliance Program has responsibilities among three teams:
- Medicare Advantage Operational Compliance
- Monitoring & Delegated Entity Oversight (MDO) and
- Compliance – Sales Oversight (CSO)

See the following three sections for details of each team’s responsibilities

Medicare Advantage Operational Compliance

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

Compliance Monitoring & Delegation Oversight (MDO)

Compliance Monitoring & Delegation Oversight is responsible for the following:
- Annual and routinely monitoring the activities of UAM delegated entities and the UAM Business Areas
- Assignment and oversight of the Internal Corrective Action Plan process
- Validation of the timely implementation of regulatory mandates which may impact current processes and protocols
- Annual Risk Assessment (in collaboration with Internal Audit)
- 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 Oversight (CSO)

Compliance – Sales & Marketing Oversight is responsible for the following:
- Investigating allegations of agent misconduct
- Ensuring appropriate Agent training and certification
- Market Event Surveillance activities (i.e., event secret shopping)
- The Compliant registration of agent marketing/sales events with CMS
- Agent Quality at Universal American (AQUA), 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

UAM’s Corporate Compliance Program fulfills all of the requirements as provided by the Office
of Inspector General (OIG), 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 UAM establish and maintain an effective Compliance
Program to prevent, detect and correct FWA and potential Medicare program non-compliance.

In accordance with these elements, UAM requires all Providers to acknowledge in writing UAM’s
Code of Conduct.

TexanPlus Providers and contractors are defined by CMS as “first tier, downstream and related
entities” (FDRs), which are individuals or entities that furnish services to Medicare Advantage
Members under written agreement with UAM or contracted entities. UAM is obligated under its
CMS contracts to ensure that all these entities receive and acknowledge Universal American’s Code of Conduct.

The attestation page should be executed by the sole Provider or by the primary partner/manager of group practices and returned to Delegation Oversight via e-mail, fax or regular mail.

▶ See Code of Conduct and Ethics, Appendix, page 102

E-mail: DelegationOversight@UniversalAmerican.com
Fax: 713-838-3508
Mail: Universal American
P.O. Box 740446
Houston, TX 77274
Attn: Delegation Oversight

Federal Regulations

Overview

There are a number of Federal Regulations that affect the day-to-day operations of Universal American. 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.

Medicare Improvements for Patients and Providers Act (MIPPA)

Congress introduced this act in 2008 to enhance the quality of healthcare, expand access to care and provide coverage for certain preventative services.
For more information on MIPPA, see page 38.

**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.6

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 applies for false claims presented to Medicare Advantage plans). FERA strengthened whistleblower protection, relaxed the standard for False Claims Act violations, and made retention of overpayments made to a Provider a violation of the False Claims Act.

**Physician Self-Referral Law (Stark Law)**

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

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

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

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

6Department of Justice, December 20, 2013, “Justice Department Recovers Nearly $3.8 Billion in False Claims Act Cases in Fiscal Year 2013”
Anti-Kickback Statute

TexanPlus is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, TexanPlus must ensure that all Providers adhere to the Federal Anti-Kickback Statute and state equivalents (the “Anti-Kickback Policy”), which apply 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. You may also visit:

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.

For more information on Fraud, Waste and Abuse, see page 34.

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 day-to-day operations of Universal American. Many of these regulations relate to Medicaid and/or relationships existing between governmental entities and Universal American.

In addition, many states now have enforceable regulations related to HIPAA, the False Claims Act and Patient Anti-Brokering or Anti-Referral Acts, which mirror the Federal regulations and, rather than being pre-emptive, are in addition to the Federal mandates under which UAM 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 UAM’s relationship with Providers.
Glossary and Abbreviations

Glossary of Healthcare Terms

A

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, such as radiology, pathology, laboratory and anesthesiology.

B

Benefit plan
The schedule of benefits establishing the terms and conditions pursuant to which Members enrolled in TexanPlus products 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.

C

Claim
A request by a healthcare Provider for payment for services rendered to a Member.
Clean Claim
A claim that has no 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 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.

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

D

Deductible
Amount Member must pay for covered services before the health plan 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 patient 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 network Providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.
**H**

**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. 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.

**M**

**Medicare Advantage 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. Medicare Advantage Plans (called 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).

**N**

**National Provider Identifier**
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**
Group of physicians, hospitals, laboratories and other healthcare Providers who participate in a health plan’s healthcare delivery system. The Providers agree to undergo the health plan’s credentialing process, follow the health plan’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 the health plan’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 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

A
ADA—Americans with Disabilities Act
ASA—American Society of Anesthesiologists

C
CAD—Coronary Artery Disease
CAHPS—Consumer Assessment of Health plan Survey
CCI—Correct Coding Initiative
CDC—Centers for Disease Control
CHF—Congestive Heart Failure
CLIA—Clinical Laboratory Improvement Amendments
CME—Continuing Medical Education (credits)
CMS—Centers for Medicare & Medicaid Services
COPD—Chronic Obstructive Pulmonary Disease
CPT—Current Procedural Terminology
CRNA—Certified Registered Nurse Anesthetist
CRNP—Certified Registered Nurse Practitioner

D
DO—Doctor of Osteopathy
DME—Durable Medical Equipment
DPM—Doctor of Podiatric Medicine

E
EAP—Employee Assistance Program
EDI—Electronic Data Interchange
E&M—Evaluation and Management
EPO—Exclusive Provider Organization
EOB—Explanation of Benefits
ESRD—End-Stage Renal Disease

F
FDA—Food and Drug Administration

H
HCC—Hierarchical Condition Category
HCFA—Health Care Financing Administration
HEDIS—Health plan Employer Data Information Set
HIPAA—Health Insurance Portability and Accountability Act
**HMO**—Health Maintenance Organization

**I**
ID—Identification
IPA—Independent Practice Association

**L**
LPO—Local Physician Organization

**M**
MD—Medical Doctor
MI—Myocardial Infarction
MRA—Medicare Risk Adjustment

**N**
NCQA—National Committee for Quality Assurance
NDC#—National Drug Classification Code number
NPI—National Provider Identifier
NSAIDs—Non-Steroidal Anti-Inflammatory Drugs

**O**
OB-GYN—Obstetrician-Gynecologist
OTC—Over-the-Counter

**P**
PA—Certified Physician Assistant
PCP—Primary Care Physician
PRO—Peer Review Organization
PSA—Prostate Specific Antigen

**Q**
QICC—Quality Improvement Compliance Committee

**T**
TrOOP—True Out-Of-Pocket

**U**
UB—Uniform Billing code
UPIN—Universal Provider Identification
Appendix

Authorization Guidelines
Referral/Authorization Request Form
Provider Dispute Resolution Request Form
CMS Appointment of Representative Form (CMS 1696)
CMS Waiver of Liability Statement Form
Code of Conduct and Ethics
Code of Conduct and Ethics Acknowledgement Form
CMS Medicare Advantage Program Requirements
This authorization guide applies to contract providers with the Golden Triangle Physician Alliance.

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*Referral/Authorization Program Guide (GTPA)*

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## Service Level Authorization Rules*

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<td></td>
<td>Wound Care</td>
</tr>
</tbody>
</table>

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*For specialities and services not defined above:*

- Procedures with billed amounts less than $200 **do not** require an authorization.
- Procedures with billed amounts greater than or equal to $200 **do** require an authorization.

### NOTES:

- Network specialists are able to refer to additional network specialists without the PCP’s intervention, as long as the member’s diagnosis remains the same. The referring specialist would need to complete an authorization form and receive an authorization number. If the member’s diagnosis changes, the PCP will need to begin the referral process. In addition, providers should verify the member’s benefits with the respective health plan.

- If additional procedures need to be included under an authorization, the specialist is able to request the additions directly from Care Coordination.

- If the time limits of an authorization need to be extended, the referring provider should contact Care Coordination (use the Provider Services phone number provided below).

- Referrals for members with chronic conditions can be extended beyond the normal 60-day limit upon request by the specialist; continued verification of eligibility is the responsibility of the requesting provider.

For questions, call TexanPlus® HMO or TexanPlus HMO-POS® Provider Services at 1-800-230-2513.
Authorization Request Form

☐ ROUTINE
☐ EXPEDITED* - based on the urgency of the **member's health condition**

*The referring provider or member believes that an expedited determination is warranted when the standard decision time frame may jeopardize the member's health or ability to regain maximum functioning.

Patient Name:  
DOB:  
PCP:  
Member ID#:  
Member Phone #:  
Member Address:  
City, State:  
Zip:  

**Referral Type:**
- ☐ Inpatient Admit
- ☐ Outpatient Surgery
- ☐ Home Health (SN/ST/PT/OT)
- ☐ DME
- ☐ OP Therapy (ST/PT/OT)
- ☐ Consultation
- ☐ Follow-up Visit
- ☐ Consult & 1 Follow-up
- ☐ Other:  

**Diagnostic Procedure:**  
☐ CT/CTA
☐ MRI/MRA
☐ PET Scan

**Referring Physician:**  
Specialty:  
Address:  
City, State:  
Zip:  
Phone #:  
Fax #:  
Contact Person:  

**Requested Provider/Facility:**  
Phone #:  
Fax #:  
Address:  
City, State  
Zip

If Referring Out-of-Network/POD Please State Reason: (A Peer to Peer may be necessary)

**Requested Procedure Description:**  
CPT Code:  
Requested Procedure Date:  

Additional Procedure(s):  
CPT Code(s):  
Primary Diagnosis/Rule Out:  
ICD-9 Code:  
Date of Last Office Visit:
Secondary Diagnosis(es):  
ICD-9 Code(s):  
Primary Diagnosis/Rule Out: Only required if DOS is after 9-30-14.  
ICD-10 Code:  
Secondary Diagnosis(es): Only required if DOS is after 9-30-14.  
ICD-10 Code(s):  

**Determination Date:**  
Expiration Date:  
Authorization Number:  
Reviewer:

___  

**ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS**

ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.

Send Claims to: SelectCare of Texas, P.O. Box 741107, Houston, TX 77274

Privacy Notification: This facsimile and any accompanying documents may contain confidential and/or proprietary information, which should not be viewed or used by anyone other than the individual to whom the fax is sent and other authorized individuals as appropriate. The reader is hereby notified that any unauthorized copying, dissemination, or distribution of this fax is prohibited. If you have received this fax by mistake, please telephone (collect if necessary) the sender and notify the person that you have received the fax by mistake and that the document has been destroyed.

Y0067_MM_AUTHREQ_1113_JA 12/02/2013 HMO_Beaumont
Provider Dispute Resolution Request Form

Instructions:
Please fully complete the form. Information with an asterisk (*) is required.
Be specific when completing the Description of Dispute and Expected Outcome.
Please provide supporting documentation to support your appeal.

Mail the completed form to: TexanPlus – Provider Dispute Resolution
P.O. Box 741107
Houston, TX 77274-1107

Or fax the complete form to: 1-877-656-1728

Provider Name: Provider Tax ID#/Medicare ID#:

Address:

Provider Type:
☐ MD ☐ DME ☐ Mental Hospital ☐ Hospital ☐ ASC ☐ SNF
☐ DME ☐ Home Health ☐ Rehab ☐ Ambulance ☐ Other

(Please specify)

Claim Information
☐ Single ☐ Multiple “LIKE” Claims (Please provide listing)
Number of claims

*Patient Name: *Date of Birth:

*Health Plan ID #: Patient Account Number: Original Claim ID Number (if multiple cases provide separate listing):

*Service From/To Date: Original Claim Amount Billed: Original Claim Amount Paid:

Dispute Type:
☐ Claim ☐ Seeking Resolution of Billing Determination
☐ Appeal of Medical Necessity ☐ Other
☐ Requirement for Reimbursement of Overpayment

*Description of Dispute:

*Expected Outcome:

Contact Name (Please Print) ______________________ Title ______________________ (___) ______ Phone Number

Contact Name (Please Print) ______________________ Title ______________________ (___) ______ Phone Number

☐ Check if additional information is attached.

ProvDispute_NTX_SETX_020614
# Appointment of Representative

**Section 1: Appointment of Representative**

*To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):*

I appoint this individual, ____________________________ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the “Act”) and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

<table>
<thead>
<tr>
<th>Signature of Party Seeking Representation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Section 2: Acceptance of Appointment**

*To be completed by the representative:*

I, ____________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ____________________________

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

<table>
<thead>
<tr>
<th>Signature of Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

**Section 3: Waiver of Fee for Representation**

*Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation.*

I waive my right to charge and collect a fee for representing ____________________________ before the Secretary of the Department of Health and Human Services.

| Signature | Date |

**Section 4: Waiver of Payment for Items or Services at Issue**

*Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)*

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

| Signature | Date |
Charging of Fees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative’s fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Authorization of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1855.

Form CMS-1696 (Rev 06/12)
Nombramiento de un Representante

Nombre del Participante | Numero de Medicare o identificador Nacional del Proveedor

Sección 1: Nombramiento de un Representante
Para ser completado por el participante que busca representación (por ejemplo, el beneficiario de Medicare, el proveedor o suplidor):

Yo nombro a ______________________________ para actuar como representante en relación con mi reclamación o derecho en virtud del título XVIII de la Ley del Seguro Social (la “Ley”) y sus disposiciones relacionadas al título XI de la Ley. Autorizo a este individuo a realizar cualquier solicitud; presentar o obtener información sobre apelaciones conseguir pruebas; obtener información sobre apelaciones y recibir toda notificación sobre mi apelación, en mi representación. Entiendo que podría divulgarse al representante indicado a continuación, la información médica personal sobre mi apelación.

Firma del que designa a su representante | Fecha
Dirección: | Numero de teléfono (con código de área)
Ciudad | Estado | Código Postal

Sección 2: Aceptación del Nombramiento
Para ser completado por el representante:

Yo, ______________________________, acepto por la presente el nombramiento antes mencionado. Certifico que no se ha descalificado, suspendido o prohibido mi desempeño profesional ante el Departamento de Salud y Servicios Humanos; que no estoy en calidad de empleado actual o pasado de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación de la Secretaría.

Me desempeño como ______________________________
(Situación profesional o relación con el participante, por ejemplo: abogado, pariente, etc.)

Firma del representante | Fecha
Dirección: | Numero de teléfono (con código de área)
Ciudad | Estado | Código Postal

Sección 3: Renuncia al Cobro de Honorarios por Representación
Instrucciones: El representante debe completar esta sección si se lo requieren o si renuncia al cobro de honorarios por representación. (Los proveedores o suplidores que representen a un beneficiario y le hayan brindado artículos o servicios no pueden cobrar honorarios por representación y deben completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a ______________________________ ante el Secretario(a) del Departamento de Salud y Servicios Humanos.

Firma | Fecha

Sección 4: Renuncia al Pago por Artículos o Servicios en Cuestión
Instrucciones: Los proveedores o suplidores que actúan como representantes de beneficiarios a los que les brindaron artículos o servicios deben completar esta sección si la apelación es por un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley. (En la sección 1879(a)(2) en general se aborda si un proveedor, abastecedor o beneficiario no tenía conocimiento o no se podía esperar que supiera que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

Renuncio a mi derecho de cobrar al beneficiario un honorario por los artículos o servicios en cuestión en esta apelación si está pendiente una determinación de responsabilidad bajo la sección 1879(a)(2) de la Ley.

Firma | Fecha
Cobro de Honorarios por Representación de Beneficiarios ante el Secretario(a) del Departamento de Salud y Servicios Humanos

Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del Departamento de Salud y Servicios Humanos (DHHS en inglés) (por ejemplo, una audiencia con un Juez de Derecho Administrativo (ALJ en inglés), una revisión con el Consejo de Apelaciones de Medicare o un proceso ante un ALJ o el Consejo de Apelaciones de Medicare como resultado de una orden de remisión del la Corte de Distrito Federal) debe, por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, “Solicitud para obtener un honorario por concepto de representación” se recaba la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ o revisión del Consejo de Apelaciones de Medicare.

La aprobación de honorarios para el representante no es necesaria si: (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal del honorario en cuestión; (3) el honorario es por representación del beneficiario ante la corte de distrito federal; o (4) el honorario es por representación del beneficiario en una redeterminación o reconsideración. Si el representante desea renunciar al cobro de un honorario, puede hacerlo. La sección 3 en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

Autorización de Honorarios

El requisito para la aprobación de honorarios garantiza que el representante recibirá una remuneración justa por los servicios prestados ante DHHS en nombre de un beneficiario y brinda al beneficiario la seguridad de que los honorarios sean razonables. Para la aprobación de un honorario solicitado, el ALJ o el Consejo de Apelaciones de Medicare considera la naturaleza y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

Conflicto de Interés

Las secciones 203, 205 y 207 del título XVIII del Código de Estados Unidos consideran como un delito penal cuando ciertos funcionarios, empleados y antiguos funcionarios y empleados de los Estados Unidos prestan ciertos servicios en temas que afectan al Gobierno, ayudan o asisten en el procesamiento de reclamaciones contra los Estados Unidos. Los individuos con un conflicto de interés quedarán excluidos de ser representantes de los beneficiarios ante DHHS.

Dónde Enviar este Formulario

Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: (1) apelación si está solicitándola, (2) queja, (3) determinación o decisión inicial si está solicitando una determinación inicial o decisión. Si necesita ayuda, comuníquese con su plan de Medicare o llame al 1-800-MEDICARE (1-800-633-4227).

De acuerdo con la Ley de Reducción de Papeleo de 1995, no se le requiere a ninguna persona responder a una recopilación de información a menos de que presente un número de control válido OMB. El número de OMB para esta recopilación es 0938-0950. El tiempo requerido para completar este formulario es de 15 minutos por notificación, incluyendo el tiempo necesario para seleccionar el formulario pre-impreso, completar y entregarlo al beneficiario. Si tiene comentarios sobre el tiempo estimado para completarlo o sugerencias para mejorar este formulario, favor de escribir a: CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Formulario de CMS-1696 (Rev 06/12) Spanish
WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee’s Name

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further Appeal under 42 CFR 422.600.

Signature

Date

Y0067_PR_WOL_0512 IA 05/29/2012
Code of Conduct: Overview

Universal American Corp. (the “Company”) is committed to conducting business in a legal and ethical manner. The Code of Conduct contains the Company’s expectations of each employee, officer or director to ensure their job is done in an honest, ethical and lawful way to protect not only the Company, but also you. Below is an overview of the Company Code of Conduct. It is not meant to cover all of the information in the Code of Conduct. For more information, please review the Company’s Code of Conduct located on the Company intranet.

It is difficult to anticipate every decision or action an employee, officer or director may face, therefore if you have doubts about the right ethical or legal choice, consult an appropriate manager, supervisor, Medicare Compliance Officer and/or Corporate Compliance Officer to receive proper guidance.

Conflict of Interest
A conflict of interest occurs when the personal or private interests of an employee, officer or director, or a member of his or her family, conflicts, or appears to conflict, with the interests of the Company. Every employee, officer or director should take care about the appearance of a conflict. Even if there is no actual conflict, the appearance might cause lack of confidence or may harm the reputation of the Company.

Company Assets
Every employee, officer or director has a personal duty to protect the physical and intangible assets of the Company and ensure their efficient use. Each employee, officer or director may not take for themselves, personally, opportunities that are discovered through the use of Company property, data or position. These opportunities may not be shared with a third party or invested in without first offering it to the Company.

Network Use
The Company reserves the right to monitor or review any information on an employee’s, officer’s or director’s computer or electronic device. Internet activity, email and other electronic communication is also subject to monitoring and review without prior notice. These tools may not be used to commit illegal acts or break Company policies such as, discrimination, harassment, pornography or solicitation. To guard network security, passwords may not be shared and software may not be put on computers without Information Technology (IT) approval. No employee, officer or director should take part in the illegal use, copying, distribution or modification of computer software. This includes software from outside sources or developed internally. All software Terms of Use must be followed.
Confidential Information/Privacy
Current or previous employees, officers or directors may not use confidential information for their own personal use or share that data with others outside of the Company. Confidential Information is any non-public data that might be of use to competitors, of interest to the press or harmful to the Company or its customers.

Relationships with Customers & Vendors
Each employee, officer or director should deal fairly with the Company's suppliers, customers and competitors. Employees, officers or directors should not discuss prices, costs, products, services or other non-public data with a competitor. To ensure compliance with the Federal False Claims Act, employees, officers or directors are not allowed to knowingly submit false claims to a government program.

Compliance with Other Laws, Rule & Regulations
The Company requires each employee, officer or director to comply with all applicable laws, rules and regulations. To ensure compliance, the Company has created various policies and procedures and Company governance documents. Employees, officers or directors whose day to day work is directly impacted by certain laws have a duty to understand them well enough to be aware of potential issues and know when to seek advice. When there is any doubt as to the lawfulness of any proposed activity, seek advice from the Company's Corporate Compliance Officer or other appropriate Compliance Officer.

Inquiries from the Media and Public
Employees, officers or directors are not allowed to answer questions from the media, analysts, investors or other members of the public. If you should receive a question, record their name and contact data and provide it immediately to the Corporate Compliance Officer.

Maintaining a Safe, Healthy and Affirmative Workplace
The Company is committed to a workplace that is free from sexual, racial or other harassment and from threats or acts of violence. The Company will not tolerate offensive materials on company property, computers or other equipment. The Company is committed to a drug-free work environment. Illegal possession, distribution or use of any controlled substance is not allowed on Company property or at Company functions. This includes reporting to work under the influence of any illegal drug, alcohol or abusing medications.
Accounting Practices, Books & Records and Record Retention

It is the policy of the Company to fully and fairly disclose the financial condition of the Company according to all applicable accounting principles, laws, rules and regulations. The Company makes full, fair, accurate, timely and understandable information in its periodic reports filed with the Securities and Exchange Commission and in other communications to securities analysts, rating agencies and investors.

Record Retention

Employees, officers or directors must follow the Company’s Records Retention procedures. Documents related to any pending or possible legal action, investigation or audit shall not be destroyed for any reason. Destroying or altering a document with the intent to impair it, is a crime. Employees, officers or directors will accurately complete all records used to determine compensation or expense reimbursement.

Duty to Report Violations

Each employee, officer or director has a duty to report violations of this Code. Retribution against any employee, officer or director, reporting in good faith, is not permitted. Suspected policy violations may be reported to the any of the other people listed below either orally by phone, email or letter. Confidential or anonymous reporting may be done using the hotlines listed below.

Chief Ethics and Corporate Compliance Officer
Robert Hayes, 44 South Broadway, Suite 1200, White Plains, NY 10601; 914-597-2990

Medicare Compliance Officer
Tyrina Blomer, 4888 Loop Central Drive, Suite 300, Houston, TX 77081; 713-314-1664

Fraud, Waste & Abuse Hotline 1-800-388-1563

Compliance & Ethics Hotline 1-800-388-1563

Every effort will be made to research confidential and anonymous reports. However, the research will be limited to the information given.

Violations of this Code of Conduct

Violations of this Code of Conduct may result in suspension of work duties, removal of responsibilities, demotion, termination and/or financial penalties. Self-reporting a violation will not excuse the violation itself. However, the extent and quickness of reporting will be considered in determining appropriate actions.
ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

This document evidences receipt of Universal American’s Code of Conduct and my organization’s acknowledgement and responsibilities for the following:

__________
Initial  I attest that I am a Corporate, Executive Level Officer within my organization and fully authorized to bind my company to the requirements and obligations contained in Universal American’s Code of Conduct and Conflict of Interest Policies.

__________
Initial  I have reviewed and understand Universal American's Code of Conduct and Conflict of Interest polices.

__________
Initial  As a contracted first-tier, downstream or related entity of Universal American, my organization's employees are required to have compliance training and attest to no Conflicts of Interest regarding the business we conduct with Universal American.

__________
Initial  I understand that training of my employees on Universal American's Code of Conduct will be validated when Universal American conducts annual or ad-hoc reviews.

_________________________________________________   ______________________________________
Signature                                              Date

_________________________________________________
Printed Name

_________________________________________________
Title

_________________________________________________
Organization Name

Y0067_CoCSumAttest2_0311 IA 03/22/2011
CMS Medicare Advantage Program Requirements

As a contracted Medicare Advantage plan with CMS, TexanPlus HMO provides for members and fulfills its obligations to CMS for the following requirements.

These requirements may be viewed in their entirety at the following website: [http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr422_06.html](http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr422_06.html)

<table>
<thead>
<tr>
<th>CMS MEDICARE ADVANTAGE PROGRAM REQUIREMENTS</th>
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<tbody>
<tr>
<td>Safeguard privacy and maintain records accurately and timely</td>
<td>422.118</td>
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<tr>
<td>Permanent “out of area” members to receive benefits in continuation area</td>
<td>422.54(b)</td>
</tr>
<tr>
<td>Prohibition against discrimination based on health status</td>
<td>422.110(a)</td>
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<tr>
<td>Pay for emergency and urgently needed services</td>
<td>422.110(b)</td>
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<tr>
<td>Pay for a renal dialysis for those temporarily out of service area</td>
<td>422.110(b)(1)(iv)</td>
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<td>Direct access to mammography and influenza vaccinations</td>
<td>422.110(g)(1)</td>
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<tr>
<td>No copayment for influenza and pneumococcal vaccines</td>
<td>422.110(g)(2)</td>
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<tr>
<td>Agreements with providers to demonstrate “adequate” access</td>
<td>422.112(a)(1)</td>
</tr>
<tr>
<td>Direct access to women’s specialists for routine and preventive services</td>
<td>422.112(a)(3)</td>
</tr>
<tr>
<td>Services available 24 hrs/day, 7 days/week</td>
<td>422.112(a)(7)</td>
</tr>
<tr>
<td>Adhere to CMS marketing provisions</td>
<td>422.80(a), (b), (c)</td>
</tr>
<tr>
<td>Ensure services are provided in a culturally-competent manner</td>
<td>422.112(a)(8)</td>
</tr>
<tr>
<td>Maintain procedures to inform members of follow-up care or provide training in self care as necessary</td>
<td>422.112(b)(5)</td>
</tr>
<tr>
<td>Document in a prominent place in medical record if individual has executed advance directive</td>
<td>422.128(b)(1)(ii)(E)</td>
</tr>
<tr>
<td>Provide services in a manner consistent with professionally recognized standards of care</td>
<td>422.504(a)(3)(iii)</td>
</tr>
<tr>
<td>Continuation of benefits provisions (may be met in several ways, including contract provision)</td>
<td>422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)</td>
</tr>
</tbody>
</table>
Call today at 1-866-230-2513
8:00 a.m. to 8:00 p.m. Central Time, 7 days a week

www.TexanPlus.com
www.TexanPlusPOS.com