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Welcome

Today’s Options PPO – New York and Maine

Welcome to Today’s Options® PPO, part of the Universal American (UAM) family of Medicare Advantage (MA) products. We are pleased to have you as a participating provider, and hope this manual will be helpful to you and your practice.

We know good health begins when you have a strong voice in your patients’ healthcare decisions. That’s why we’re committed to working with you to help deliver exceptional care to your patients. We also give you the right tools to manage your patients’ care and your relationship with us.

Please note that members enrolled in our Today’s Options PPO plan must reside in our service area. The plan is designed to give members the flexibility to see providers in- and out-of-network; we cover a portion of the cost for both in- and out-of-network services. However, members will typically pay more out-of-pocket when they receive care from out-of-network providers, with the exception of emergencies or urgent care. Additionally, Today’s Options PPO members may see a specialist without a referral. Limitations, copays and restrictions may apply.

This 2015, Today’s Options PPO Provider Manual includes detailed information on a broad range of topics including Physician Standards and Procedures, Claims and Reimbursement, Medicare Risk Adjustment, Legal and Compliance, as well as Member Administration. For more information about our plans, please visit www.TodaysOptionsPPO.com.

About Universal American

Universal American has been on the cutting edge of healthcare for over two decades, pioneering innovative collaborations between patients, doctors and our company that produce healthy outcomes for all. We call this A Healthy Collaboration®.

We have built our business model around the concept that Primary Care Physicians (PCPs) are in the best position to drive significant improvements in the cost and quality of healthcare. Our job is to enable them by providing a structure that offers appropriate incentives for such improvements and actionable information that helps them achieve these goals. This concept underlies our long-term success in serving the needs of people with Medicare and/or Medicaid.

Our TexanPlus® and Today’s Options® Medicare Advantage brands extend to a range of coverage options in Texas, New York and Maine. These include Medicare Advantage HMO (Health Maintenance
Organization), HMO-POS (Point of Service), PPO (Preferred Provider Organization), and PFFS (Private Fee-for-Service) plans.

Universal American is a publicly traded healthcare company listed on the New York Stock Exchange.

**Live Healthy Program**

Our free and voluntary Live Healthy program offers members of our plans additional health and wellness services not covered by Original Medicare. These beneficial services are designed to support the care and treatment already being provided by each member’s Primary Care Physician (PCP). Services include annual House Calls, Wellness Calls, Preventive Screenings, Healthy at Home and Care Coordination support, and more.

Live Healthy is a way of life at Today’s Options PPO. With the Live Healthy program, our members have access to services that help them live healthy, be active and stay independent. In turn, you will have added support in caring for your patients.

**Provider Relations**

Today’s Options PPO has a dedicated team of Provider Relations 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 Today’s Options PPO.

The goals of the Provider Relations Department are to educate providers about working with our plans and promptly resolve provider issues.

To locate a regional Provider Relations representative, call 1-866-422-5009.

**Medicare Advantage Provider Resource Center**

Find everything you need to help your Today’s Options PPO Medicare Advantage patients at our Provider Resource Center. You’ll find training resources, reference materials and forms, claims and administration information and quick reference guides, all in one convenient location.

Visit our Provider Resource Center homepage and click on “Providers” to learn more.


Additionally, our secure ProviderLink portal enables you to conduct self-service transactions and inquiries online, including:

- Provider level demographic detail
- Member eligibility and benefit summary
- Claims detail
- Authorizations submission and validation
Contacting Today’s Options PPO

Providers may contact Today’s Options PPO staff 7 days a week from 8:00 a.m. to 8:00 p.m. in your local time zone at the numbers or website addresses listed below:

**Website:**  [www.Todays OptionsPPO.com](http://www.Todays OptionsPPO.com)

**ProviderLink:**  UAMProviderLink.UniversalAmerican.com

**Provider Services:**

Phone:  1-866-422-5009,  
8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week  
(TTY for hearing impaired: 711)

Mailing Address:  Today’s Options PPO  
4888 Loop Central Drive, Suite 300  
Houston, TX 77081  
Attn: Provider Relations

**Pharmacy:**

*Today’s Options PPO Pharmacy Management Department:*

Phone:  1-866-386-1139  
E-mail:  [PharmacySupport@UniversalAmerican.com](mailto:PharmacySupport@UniversalAmerican.com)

*CVS Caremark Clinical Prior Authorization Department:*

Phone:  1-855-344-0930  
Fax:  1-855-633-7673  
Web:  [www.TodaysOptions PPO.com](http://www.TodaysOptions PPO.com)

**24-hour Pharmacist Access:**

Phone:  1-800-875-0867

**Automatic Refills:**

Web:  [www.Caremark.com](http://www.Caremark.com)

**Mail-order Forms and Mail-order Information:**

Phone:  1-800-378-5697  
Web:  [www.TodaysOptions PPO.com](http://www.TodaysOptions PPO.com)

**Behavioral Health (Optum):**

Phone:  1-877-907-9288  
Fax:  1-866-350-8131
**Claims submissions:**
Mailing Address: Today’s Options PPO  
P.O. Box 742568  
Houston, TX 77274-1107  
Attn: Claims Department

**Appeals:**
Fax: 1-800-817-3516  
Mailing Address: Today’s Options PPO  
P.O. Box 742608  
Houston, TX 77274  
Attn: Member Appeals

**Emdeon Claims Code:** 48055  
**Emdeon Support:** 1-800-845-6592

**Credentialing:**
To request a hearing: Today’s Options PPO  
4888 Loop Central Drive, Suite 300  
Houston, TX 77081  
Attn: Credentialing Committee Chairperson

**Refunds for overpayments:**
Mailing Address: Today’s Options PPO  
Cost Containment Unit  
P.O. Box 505057  
St. Louis, MO 63150-2127  
Attn: Cost Containment Unit

**Coding Support:**
E-mail: CodingHelp@UniversalAmerican.com

**Questions about Transition from ICD-9 to ICD-10:**
E-mail: ICD10Inquiries@UniversalAmerican.com

**Fraud Waste & Abuse Hotline:**
Universal American Special Investigation Unit:  
Phone: 1-800-388-1563  
Report online: www.tnwgrc.com/UniversalAmerican  
Mailing Address: Universal American Corp. Special Investigations Unit  
P.O. Box 27869  
Houston, TX 77227
Treating a Today’s Options PPO Member

The Role of the Primary Care Physician

The following specialties are considered Primary Care Physicians (PCPs):
- Family practice
- General practice
- Geriatrics
- Internal medicine

The scope of services to be provided by the PCP may include, but is not limited to, the following:
- Office visits for illness, injury and prevention
- Diagnostic testing and treatment
- Injections and injectable substances

All Today’s Options PPO Members are encouraged to select a PCP from the list of participating PCPs in the Today’s Options PPO Provider Directory or the provider look-up tool. Both are located at www.TodaysOptionsPPO.com or available by calling Provider Services at 1-866-422-5009. The PCP’s name will be noted on the Member’s ID card.

See Member ID Cards, page 12

Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month. Today’s Options PPO will send a new Member ID card to the Member.

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. Today’s Options PPO monitors the use of network providers, analyzes referral patterns and assesses medical necessity.

PCPs, as well as all providers, are expected to:
- Maintain high quality
- Provide the appropriate level of care
- Make accommodations for 24-hour, 7-day-a-week access to care
• 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, page 40

Coordination of care 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.

Providers also need to supply Today’s Options PPO 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.

**Verifying Member Eligibility**

Possession of a Member ID card is not a guarantee of benefits. Providers should photocopy the card and check it for any change of information, such as address and eligibility date.

Providers should verify Member eligibility before each office visit by registering or logging in to ProviderLink at UAMProviderLink.UniversalAmerican.com. Providers may verify Member eligibility in ProviderLink. To view information about a Member’s eligibility, providers need either the Member’s name or identification number. The database then reveals the Member’s coverage, effective dates and PCP.

➤ See ProviderLink, page 35

Providers may also verify eligibility by calling the telephone number listed on the back of the Member’s ID card or by calling Provider Services at 1-866-422-5009.

**Member ID Cards**

An example of a Today’s Options PPO Member ID card follows. Various products may have different logos, but the general information on the card is similar. Refer to the Today’s Options PPO website at www.TodaysOptionsPPO.com for information about specific benefits and Member cost-sharing.

A Member ID card contains vital information such as:
• The Member’s name
• The product name
• The plan name
• Member identification number
Member Benefits and Copayments/Coinsurance

Today’s Options PPO covers the same benefits as Original Medicare as well as additional benefits that include preventive services.

Providers should collect the appropriate copayment at the time of service. For a list of benefits and their respective cost-sharing amounts, refer to the Today’s Options PPO website at www.TodaysOptionsPPO.com.

Today’s Options PPO receives a capitated payment from CMS and, in turn, reimburse physicians, hospitals and other ancillary providers on a Fee-for-Service basis. This payment is the equivalent of the current Medicare allowable fee schedule less any applicable copayments or coinsurance.

Members continue to pay their Medicare Part B premium and are responsible for the Today’s Options PPO plan premiums, plus any cost-sharing amounts.

A claim may be reviewed for medical necessity to ensure coverage for qualified Medicare benefits. Providers may contact Provider Services at 1-866-422-5009 to request a review for benefit coverage prior to a service or treatment.
**Benefit Exclusions**

The following list indicates some, but not all, of the services not covered by Medicare or Today’s Options PPO:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Ambulance is covered only if transportation in any other vehicle would endanger the Member’s life. Air ambulance is paid only in emergency situations. If land ambulance would not seriously endanger the Member’s health, Medicare will reimburse land ambulance rates only.</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Exception: Manual manipulation of the spine to correct subluxation.</td>
</tr>
<tr>
<td>Contraceptives</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Exception: Reconstructive surgery is a covered benefit, as it is primarily intended to improve bodily function, relieve symptoms or improve appearance altered by disease, trauma or previous therapeutic processes (e.g., when breast reconstruction is performed following a mastectomy), or exists because of congenital or developmental abnormality.</td>
</tr>
<tr>
<td>Custodial care or respite care</td>
<td></td>
</tr>
<tr>
<td>Dental services</td>
<td>Exceptions include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician except as specifically stated in the Member’s EOC. Tooth extractions for other reasons are not covered.</td>
</tr>
<tr>
<td>Foot care, routine</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment and medical supplies that do not meet Medicare coverage criteria</td>
<td>Examples include shower chairs, safety tubs, stair lifts and blood pressure monitors.</td>
</tr>
<tr>
<td>Exercise programs</td>
<td></td>
</tr>
<tr>
<td>Experimental or investigative procedures</td>
<td></td>
</tr>
<tr>
<td>Eye surgery for refractive defects</td>
<td>Exception: Veterans Administration hospitals and military treatment facilities are considered for payment according to current legislation.</td>
</tr>
<tr>
<td>Government treatment</td>
<td>Same as above.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>NOTE</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hearing aids</td>
<td></td>
</tr>
<tr>
<td>Homemaker services</td>
<td></td>
</tr>
<tr>
<td>Naturopath services</td>
<td></td>
</tr>
<tr>
<td>Obesity treatment</td>
<td>Exception: This exclusion does not apply to surgical obesity treatment if treatment is necessary to treat another life-threatening condition involving obesity or if providers document that non-surgical obesity treatments have failed.</td>
</tr>
<tr>
<td>Optometric services or supplies</td>
<td>Exception: First pair of contact lenses or eyeglasses is covered after cataract surgery.</td>
</tr>
<tr>
<td>Orthodontia</td>
<td></td>
</tr>
<tr>
<td>Orthopedic shoes, unless part of a leg brace</td>
<td></td>
</tr>
<tr>
<td>Personal comfort items</td>
<td></td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Exception: If Today's Options PPO determines that such services are medically necessary before service is rendered</td>
</tr>
<tr>
<td>Sex transformation</td>
<td></td>
</tr>
<tr>
<td>Work-related conditions</td>
<td></td>
</tr>
</tbody>
</table>

**Referrals**

Members may see specialists without any prior authorization or referral, and female Members may see network gynecologists or their PCP for a well-woman examination without any prior authorization or referral.

To maximize their benefits and reduce out-of-pocket costs, Members are encouraged to see network specialists; however, Members have an out-of-network benefit that allows them to see out-of-network specialists at a higher cost-share.

**Authorizations**

Today's Options PPO requires authorization for certain services and procedures. Providers must complete a prior authorization request form, a sample of which is in the Appendix. You may also download the form by going to the Provider Resource Center at [http://ProviderResourceCenter:UniversalAmerican.com/](http://ProviderResourceCenter:UniversalAmerican.com/). You may also call 1-866-422-5009.

- See Authorization Guidelines, Appendix, page 75
- See Referral/Authorization Request Form, Appendix, page 77
Note, our 2014 Referral/Authorization Request form allows providers to include both ICD-9 codes (for dates of service taking place on or before September 30, 2015) and ICD-10 codes (for dates of service taking place on or after October 1, 2015). Procedures have also been put in place for pre-authorization requests for dates of service that include both September and October 2015.

For more information, see Transition from ICD-9-CM to ICD-10-CM, page 56

Decisions are made with consideration of the medical necessity and clinical urgency of the situation, in accordance with regulatory standards. Members covered under a Medicare Advantage health plan will be handled in accordance with CMS coverage guidelines.

The time period for deciding authorization requests depends on the level of urgency. Standard requests are decided within 14 business days. Expedited requests are decided in a timely fashion appropriate to the nature of the Member’s condition, but not to exceed 72 hours.

These timelines are the maximum turnaround time for requests and are based on the receipt of all documentation needed for a complete medical review. If additional information is needed, Today’s Options PPO staff will contact the requesting provider in order to obtain such documentation.

If Today’s Options PPO is not able to act on a request within the designated time frame, an extension will be implemented with a time frame of no later than 14 calendar days from the request in order to get additional documentation. Causes for such an extension may include, but are not limited to:

- Lack of reasonable and necessary information requested
- Required consultation by an expert reviewer
- Need for additional examination or test, consistent with good medical practice

Once the review is completed and the request approved, the authorization is issued and is valid for 180 days.

A confirmation letter is faxed to the provider. Questions regarding issued authorizations may be directed to the toll-free telephone number in the confirmation letter.

Medicare criteria, in conjunction with InterQual® healthcare guidelines, are used when reviewing authorization or referral requests. In addition, Today’s Options PPO will review past referral requests and/or claims history to avoid duplication of services as well as to ensure appropriate utilization.

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

An initial notification of pending denial will be communicated to the requesting provider before the denial decision. The requesting provider may discuss the decision with a physician reviewer.
or request a copy of the criteria used to make the determination by calling Provider Services at 1-866-422-5009.

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

**Care Coordination**

**Hospitalization Guidelines**

Today's Options PPO 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, Today's Options PPO has incorporated certain authorization processes.

Today's Options PPO urges all providers to use the services of a network hospital. This will help ensure Members receive the highest level of benefits.

**Elective Admissions**

To admit a Member for an elective admission, the admitting provider must notify Today's Options PPO Provider Services at 1-866-422-5009 at least two business days before the admission.

It is the admitting provider’s responsibility to work with the hospital to schedule the admission and any pre-admission testing.

**Emergency Admissions**

Today's Options PPO 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
The hospital or facility must notify Health Services via fax, portal or at 1-866-422-5009 within 24 hours of the emergency admission.

**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 physician should notify the hospital staff. The facility then is to contact Health Services via fax, portal or at 1-866-422-5009. A nurse is available 24 hours a day, 7 days a week to handle authorizations.

**Pre-Admission Diagnostic Testing**

Pre-admission diagnostic testing includes:

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

Certain procedures require prior authorization; please refer to the 2015 Authorization Guidelines for a list of applicable services.

▶ See Authorization Guidelines, Appendix, page 75

Today’s Options PPO covers all medically necessary pre-admission diagnostic testing conducted before a Member’s medically necessary surgery or admission.

**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
- 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 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.

Medicare criteria, in conjunction with InterQual® healthcare guidelines, are used when coordinating inpatient care.

Today’s Options PPO obtains clinical information about inpatient Members by coordinating with the utilization review staff at the facility. This may involve reviewing the medical record and/or interviewing attending physicians.

**Transfers and Discharge Planning**

The Today’s Options PPO Care Coordination staff should be notified of all pre-admissions, transfers and discharges. This allows the staff to provide optimal care coordination with the provider and Member in a timely manner, use resources efficiently and conduct preadmission/discharge planning care needs for the Member.

**Transfers**

A Today’s Options PPO Care Coordinator is available to help coordinate the transfer of any Today’s Options PPO Member from a network hospital to another facility (inpatient rehabilitation, long-term acute care or skilled nursing facility). Every effort is made to maintain the use of contracted facilities. This helps to ensure a coordinated approach to the management of the patient. If a Member is sent to an out-of-network facility, providers should notify Today’s Options PPO so that case management may be involved, if needed. Authorization is required at least one business day prior to transfer or admission from Acute Care, an observation unit or a home setting.

**Discharge Planning**

Health Services staff members work with participating hospitalists, attending physicians and the facility’s staff to coordinate discharge planning. A Today’s Options PPO discharge planner is available to help coordinate follow-up care and ancillary or other appropriate services.

Health Services staff may also 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 Today's Options PPO 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 Today's Options PPO Medical Director. If a request results in a denial or adverse determination, Today's Options PPO will communicate non-authorization the same day. This communication includes the appeals process.

Members have the right to an immediate Peer Review Organization (PRO) review of a denial. The Member or the Member's representative must make such a request in writing or by telephone as instructed, when notified of the denial by noon on the next business day following receipt of the notice of non-coverage.

If the Member does not choose to initiate an immediate PRO, the Member retains the right to appeal through the regulatory appeal process as directed in the Member's appeal rights.

[See Member Appeals and Grievances, page 23](#)

**Notices of Non-Coverage/Denial**

In February 2011, 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:

- **Notice of Denial of Medical Coverage (CMS 100003-NDMC)** – When denying a request for medical service in whole or in part
- **Notice of Denial of Payment (CMS 10003-NDP)** – 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.)
Healthy at Home

The Healthy at Home team coordinates the delivery of care for Members through an integrated and systematic care coordination 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 care continuum by:
- Helping Members make transitions safely
- Making sure Members get treatment appropriate to stage of life and place 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 Members’ care needs
- Assessing and monitoring Member-specific care plans
- Evaluating Members with chronic care conditions to optimize their outcomes
- Providing assistance to Members with acute care and pre/post-hospitalization needs

The Healthy at Home program is based on national and Medicare guidelines, identifying key indicators for care compliance.

The Member’s adherence to the medical treatment plan is measured by analyzing:
- Claims data, including laboratory and pharmacy information
- Personal Health Assessment, which tracks changes in the Member’s medical conditions
- Member-reported information
- Case management notes

In addition, providers may contact Provider Services at 1-866-422-5009 to request a review for benefit coverage prior to a service or treatment.

Care Coordination

To enable a multidisciplinary approach to the Member’s healthcare, care coordination services are available to all Today’s Options PPO Members and providers. Our Care Management Program is called Healthy at Home which are Nurses and Social Workers that assist Members and providers with needs spanning various aspects of social services and the medical community.

A Care Coordinator will call or visit 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 may contact the appropriate providers.
Some of the diseases and conditions are:
- Chronic Obstructive Pulmonary Disease (COPD)
- Complex medical conditions
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Transplant management

This list is, by no means, all inclusive. If a provider believes a Member would benefit from care coordination, the provider should call Provider Services at 1-866-422-5009.

**Transplant Management**

The Today’s Options PPO Care Coordination 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. Providers should contact Provider Services at 1-866-422-5009 as soon as they feel transplant services may be necessary and before evaluation for transplant services.

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

**Preventive Screenings and Disease Management**

Today’s Options PPO requests an annual evaluation of each Member to address the Member’s specific needs and conduct appropriate preventive screenings.

Preventive guidelines to be addressed include, but are not limited to:
- Screening for colorectal cancer
- Mammography (females)
- Influenza vaccine administration
- Pneumonia vaccine administration

Gaps in Member healthcare screenings and management may require appropriate intervention to improve and meet recommended goals. Either Today’s Options PPO staff or the Member’s physician may provide this intervention. The Today’s Options PPO Care Coordination 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>
</tbody>
</table>

Table 2: Chronic Conditions Measurements

<table>
<thead>
<tr>
<th>REASON FOR APPOINTMENT:</th>
<th>COMPLIANCE STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIABETES/OBESITY</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>CHF</td>
<td></td>
</tr>
<tr>
<td>Ejection Fraction measurement</td>
<td>Once per lifetime</td>
</tr>
<tr>
<td>(MUGA scan, echocardiogram and</td>
<td></td>
</tr>
<tr>
<td>cardiac catheterization)</td>
<td></td>
</tr>
<tr>
<td>CAD</td>
<td></td>
</tr>
<tr>
<td>LDL levels</td>
<td>Once every 12 months</td>
</tr>
</tbody>
</table>

Member Appeals and Grievances

Today's Options PPO Members and their authorized representatives have the right to file appeals and grievances with Today’s Options PPO when they have concerns or problems related to coverage or care. Members may also request that providers act on their behalf in the appeal process.

Members may appeal a decision made by Today's Options PPO 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 Today's Options PPO 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 Today's Options PPO website at www.TodaysOptionsPPO.com. For more information on the Member appeals and grievances process, providers also may call Provider Services at 1-866-422-5009.

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 80

A Member's treating physician or non-physician provider may file a standard pre-service appeal on the Member's behalf without representation documentation. Medicare regulations require that the physician notify the Member that the appeal is being filed. However, if the appeal request comes from the member’s primary care physician in the Health plan's contract network, no member notice verification is required. If the appeal request comes from either an in-network (contract) physician or a non-contract physician, and the member's records indicate he or she visited this physician at least once before, the Health Plan may assume that the physician has informed the member about the request and no further verification is needed. If this appears to be the first contact between the physician requesting the reconsideration and the enrollee, the Health plan will undertake reasonable efforts (i.e. calling the physician; calling the member to ask if he/she has knowledge of the request; obtaining a written statement from the physician attesting that
they are acting on the member’s behalf with the member’s knowledge and approval) to confirm
the physician has given the enrollee appropriate notice.

For post-service (claim payment) appeals, 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 of
the appeal by submitting a completed and a signed Waiver of Liability (WOL) form.

➤ See CMS Waiver of Liability Statement Form, Appendix, page 84

Today’s Option PPO 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 Today’s Options
PPO 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 which 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:

Today’s Options PPO
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 that may include an independent second level provider dispute review.

➤ See Provider Payment Dispute Resolution Process, page 79

**CMS Timeliness Standards Regarding Member Appeals**

CMS regulations require that Today’s Options PPO 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 Today’s Options PPO 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.

Today’s Option PPOs 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.

**Today’s Options PPO Member Grievances**

If a Member is dissatisfied with Today’s Options PPO 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, Today’s Options PPO 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 Today’s Options PPO respond to the Member with the results of the investigation within 30 calendar days. A provider’s quick response to investigative inquiries (including requests for medical records) will ensure that Today’s Options PPO 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 best interest of the Member. Delays in obtaining documentation from contract providers may not justify the Plan invoking a 14 day extension.

**Providing Members with Notice of Their Appeals 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: www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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:

www.cms.hhs.gov/MMCAG/Downloads/NOMNC.pdf and

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, Today’s Options PPO 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.

Provider Standards and Procedures

Credentialing and Termination

Provider Credentialing

Credentialing of providers may be conducted internally by Today’s Options PPO staff or delegated to an external entity. If delegated, Today’s Options PPO will conduct both pre-delegation and annual audits to ensure credentialing standards are maintained throughout the network. The standards below outline the overall approach to credentialing by Today’s Options PPO. The delegated entity’s standards may differ slightly. If there are any questions, please contact Provider Services at 1-866-422-5009.

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

Providers who would like to participate in the Today’s Options PPO network should request a “Request for Participation” form from Provider Services at 1-866-422-5009.

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

Today’s Options PPO
4888 Loop Central Drive, Suite 300
Houston, TX 77081
Attn: Provider Relations
Today's Options PPO requires that network providers be re-credentialed every three years. Today’s Options PPO 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 Today’s Options PPO notes any discrepancies, it notifies the physician in writing and gives the physician two weeks to forward the correct information to the Credentialing Department.

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 Today’s Options PPO Credentialing Committee reviews it. The physician must initial and date the corrected information.

**Credentialing Committee Review**

Completed credentialing files are presented to the Today’s Options PPO Credentialing Committee for review and deliberation. Today’s Options PPO staff will send a welcome letter to physicians who are approved as providers in the Today’s Options PPO provider network. That 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 chairperson of the Today’s Options PPO Credentialing Committee.

**Re-credentialing Process**

All physicians must be re-credentialed within three years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except that physicians 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 Today’s Options PPO policies and procedures
- Today’s Options PPO 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

Today’s Options PPO or its designee will send an application for re-credentialing to providers six months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to return the completed reappointment application and supporting documentation by the deadline may result in termination from the network with no appeal rights.
**Credentialing Denials and Appeals**

The Today’s Options PPO Credentialing Department 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 right 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 Today’s Options PPO is informed of such representation at least seven days before the hearing.

Requests for hearings should be sent to:

Today’s Options PPO  
4888 Loop Central Drive, Suite 300  
Houston, TX 77081  
Attn: Credentialing Committee 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**

**Termination by Today’s Options PPO**

The relationship between a provider and Today’s Options PPO may be severed for several reasons, which may include any of the following:
- Provider is non-compliant 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

Today's Options PPO 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 Today’s Options PPO for permission to continue treating that Member. In such cases, Today’s Options PPO 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 Today’s Options PPO’s network. The provider also is to abide by the determination of the applicable grievance and appeals procedures.

When the Credentialing Committee decides to terminate a provider’s agreement or impose a corrective action that will result in a report to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and/or applicable state licensing agency, the Credentialing Department shall promptly notify the affected provider by certified mail, return receipt requested.

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

A provider shall have 30 days following receipt of notice to file a written request for a hearing. Requests shall be hand delivered or sent by certified mail, return receipt requested, to the chairperson of the Credentialing Committee. If such a hearing is requested, the Credentialing Committee shall follow the steps as defined by the Credentialing Department’s policies and procedures. (Copies of such policies and procedures are available upon request.)
A provider who fails to request a hearing within the time and in the manner specified in this policy waives any right to a hearing. Such a waiver shall constitute acceptance of the action, which then becomes the final decision of the Credentialing Committee and is not subject to appeal.

**Termination by the Provider**

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

For terminations by PCPs, Today’s Options PPO will notify affected Members in writing and ask them to select a new PCP. If a Member does not select a PCP, Today’s Options PPO 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, Today’s Options PPO will notify all Members who have visited the specialist in the past 90 days. This notification will alert the Member of the provider’s forthcoming termination and allow for transition of care to another contracted provider.

**Accessibility Standards and Office Requirements**

**Practice Information**

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

Providers should notify Today’s Options PPO 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 Relations at:

Today’s Options PPO
4888 Loop Central Drive, Suite 300
Houston, TX 77081
Attn: Provider Relations

All network providers must have the hours of operation clearly posted in their 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 Today’s Options PPO provider. If a provider goes on a leave of 30 days or longer, the provider must notify Provider Services at 1-866-422-5009.
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 Today’s Options PPO 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 Today’s Options PPO’s network and be available 24 hours a day, 7 days a week.

In-Office Services

Providers should bill Today’s Options PPO 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.

Malpractice Insurance

Today’s Options PPO requires providers to carry minimal professional liability insurance. Please refer to the provider’s contract or contact Provider Relations to verify those amounts.

Culturally Competent Services

Today’s Options PPO 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 may also 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 1-866-422-5009.
Accessibility Standards

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

Today’s Options PPO sets standards to be met for services within providers’ offices. The next table describes sample types of services and the respective standards to be followed:

Table 3: 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>Obstetricians-Gynecologists</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 10 weeks</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 30 days</td>
</tr>
</tbody>
</table>

Quality Improvement

Overview

Today’s Options PPO’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 Today’s Options PPO 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 Today’s Options PPO 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 initiatives
- 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 Medicare Star program results and Quality guidelines serve as ongoing indicators for the Quality Improvement work plan.¹

Participation in the collection, review, and submission of Star quality rating system performance data is one means by which Today’s Options PPO evaluates the quality of Member services, care and satisfaction.

In addition, Universal American (UAM) 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 UAM 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.

Through our Live Healthy program, we help members take better control of their health. To learn more about our Live Healthy offerings, see page 8.

**Provider and Member Satisfaction Surveys**

Satisfaction surveys provide Today’s Options PPO with feedback on performance relating to:

- Access to care and/or services
- Overall satisfaction with Today’s Options PPO
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

¹HEDIS 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 Medicare Star indicators which are set by CMS and derived from HEDIS, CAHPS, the health outcomes survey, and additional administrative measures.
Quality Collaboration Program

In selected markets, Today’s Options PPO offers a performance-based compensation program to encourage providers to support Today’s Options PPO’s goal of providing accessible, high-quality care as efficiently as possible. This program recognizes physician networks that embrace evidence-based medicine in the daily coordination of patient care while increasing quality of care and improving patient outcomes.

The goals of the quality compensation program are to improve health outcomes for Members, thereby reducing costs associated with chronic conditions; to link health quality and provider performance in a manner that is equitable for payers and providers; and to decrease the variation in care provided.

The program also is designed to:
- Support care coordination initiatives and efforts to manage chronically ill high-risk populations while increasing Member satisfaction
- Support emerging CMS policies pertaining to performance-based compensation
- Demonstrate the credibility of the Today’s Options PPO provider-oriented pay-for-performance compensation programs
- Compensate providers for their efforts to improve health outcomes and Member compliance

The program’s measurements were carefully considered. The metrics that were selected for inclusion were intended to meet HEDIS specifications and were approved by the Physician Advisory Committee.

Measures that are calculated into the Medicare Star ratings received a high priority for inclusion in the program. The measurements that are selected support current practice patterns for chronic conditions and target health screening and prevention in all populations. Data used to determine compensation are gathered from a variety of sources, including administrative claims, laboratory results, pharmacy use, physician reports and information from patients.

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.

Enhancements and Features of ProviderLink
- Enter authorization requests directly with an expedited option
- Start an authorization request, save and return at later date to complete
- Check status of authorization requests (pended/approved/denied/voided)

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.
• Attach relevant documentation directly to requests
• View member eligibility and benefits including copays, coinsurance and maximum out-of-pocket (MOOP) in the Member Search section
• Review claim status quickly and easily

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 1-866-422-5009** to receive a 12-digit PIN number. Provider Services is available every day from 8:00 a.m. to 8:00 p.m.
• Visit ProviderLink at [https://UAM.ProviderLink.UniversalAmerican.com](https://UAM.ProviderLink.UniversalAmerican.com)
• Click on “Register” to set up an account.
• Start using ProviderLink immediately.

**Physician Rights, Responsibilities and Roles**

Today’s Options PPO 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, Today’s Options PPO 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 health maintenance organizations, their employees and their network providers.
• Provide Members with information concerning the benefits available to them so they may avail themselves of such benefits as appropriate.
• Make sure Members have reasonable access to the services to which they are entitled under their plans.
• Give Members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Healthcare providers shall obtain informed consent as required by law.
• Inform Members of their rights to an appeal if a provider chooses not to supply a service or treatment requested by the Member.
• Preserve the integrity and independence of clinical decision 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 guidance 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), page 42

Medical Records Confidentiality and Access

• Providers must follow these procedures for any medical records or other health or enrollment information maintained for Today’s Options PPO Members.
• Safeguard the privacy of any information that identifies a particular Member (Information from, or copies of, records may be released only to authorized individuals. Be sure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas).
• Maintain the records and information in an accurate and timely manner.
• Provide Members timely access to their records and information that pertains to them in accordance with federal and state regulations.
• Abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records and other health and Member information.

Guidelines for Medical Record Documentation

Today’s Options PPO recommends that providers 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.

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 patient care.

Today’s Options PPO has adopted certain standards for medical record documentation. To meet these guidelines, a provider should do the following tasks regarding the Member’s basic information, medical history, treatment and notations:
Basic Information

- Place the Member’s name and ID number on each page of the record.
- Include marital status and address along with name of the member’s employer (if applicable) 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), which may include 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 Today’s Options PPO 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, does not meet this requirement. Consultation, abnormal lab results and imaging study results must have an explicit notation in the record of follow-up plans.)

Provider Role in HIPAA Privacy Regulations

Today’s Options PPO policies and procedures include regulatory information to make sure Today’s Options PPO 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 Today’s Options PPO.

Throughout its business areas, Today’s Options PPO 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. Today’s Options PPO 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.

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

› See Authorization Request Form, Appendix, page 77

All Members receive Today’s Options PPO’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 Today’s Options PPO’s precautions to conceal individual health information from employers.
Today’s Options PPO’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 1-866-422-5009.

**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.

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

**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.

Anti-Kickback Statute

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

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

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

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

In general:
Doctors and office staff may not encourage patients to enroll in the plan in any way; doing so is considered “steering.”

- CMS draws no distinction between exclusive and non-exclusive groups when it comes to regulations on steering.
- Providers may make available to their 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 continuing communication need to state that the provider may also contract with other plans.
• 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 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 Today’s Options PPO and have plan-specific questions, to call Today’s Options PPO Member Services at 1-866-422-5009.

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 Today’s Options PPO 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 1-866-422-5009.

**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.

**Commitment to Fighting Fraud**

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.

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3The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.
Examples of healthcare fraud occur when:
- A healthcare provider bills for medical services, supplies or items that were not provided, also referred to 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
- 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](http://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](http://www.insurancefraud.org)
- [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
- [www.ssa.gov/oig](http://www.ssa.gov/oig)
- [www.nhcaa.org](http://www.nhcaa.org)
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 Today’s Option’s PPO networks are recipients of applicable Federal funds, Today’s Options PPO is required to perform monthly OIG exclusion checks for all contracted network providers. Today’s Options PPO also performs OIG exclusion checks on non-contracted providers (post-pay).

In turn, providers are responsible for making sure all other associated clinical (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

Today’s Options PPO 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 1-866-422-5009.

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 Universal American, 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 Universal American 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

**ICD-10**

Today’s Options PPO 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. Today’s Options PPO 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 and Reimbursements

Billing Guidelines

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

Diagnosis codes should be billed to the highest level of specificity. The following information should be included on claims:
- National Provider Identifier
- The Member’s identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.)

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

Billing questions and/or problems should be directed to Provider Services at 1-866-422-5009.

Filing a Claim for Payment

Electronic Submissions

Today’s Options PPO is contracted with Emdeon Clearinghouse. Emdeon Clearinghouse is able to forward claims to Today’s Options PPO.

Providers who have existing relationships with Emdeon can transmit claims in the format produced by their billing software. This clearinghouse is then responsible for reformatting these claims to meet HIPAA standards and passing the claims on to Today’s Options PPO.

Filing claims electronically reduces administrative costs, speeds claims payment and improves payment accuracy. To begin submitting claims electronically, reference the contact and payer identification information in the following table.
Providers who use a different clearinghouse should contact their clearinghouse or software vendor to determine if they are able to pass claims to Today’s Options PPO using Emdeon.

Providers who would like to be enrolled with Emdeon should contact the clearinghouse’s support line at the number listed above.

For questions regarding electronic claims (EDI) billing, contact EDI Services at 1-866-496-7826 or by e-mail at edi@UniversalAmerican.com.

**Paper Submissions**

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

**Today’s Options PPO**
P.O. Box 742568
Houston, TX 77274-1107
Attn: Claims Department

**Filing Deadlines**

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

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

**Key Points**

Here are some key points to consider when filing claims:

- Do not bill the Medicare carrier or fiscal intermediary. Doing so will delay payment and Medicare will not process the claim.
- Providers must include their NPI number on all claims.
- Durable medical equipment suppliers must use a 10-digit DME Medicare supplier number.
- Laboratories must use their 10-digit CLIA number.
- Providers should submit claims to Today’s Options PPO as soon as possible after the service is rendered.
- Submit claims using the same coding rules as original Medicare and use only Medicare-approved CPT codes and defined modifiers.
• Bill diagnosis codes to the highest specificity.
  – 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.
 › For more information ICD-9 and ICD-10 procedures and coding, see page 56

**Clean vs. Unclean Claims**

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

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

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

Today’s Options PPO will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

**Billing for Non-Covered Services**

Providers may not bill a Member if Today’s Options PPO denies payment because the service was not covered unless:

• The provider has informed the Member in advance that the service may not be covered, and
• The Member has agreed, in writing, to pay for the services.

**Reimbursements**

**Payment for Covered Services**

Today’s Options PPO reimburses providers at 100% of the current Medicare-approved amount for all Medicare-covered services, less any member cost-sharing amounts (copayments or coinsurances), according to CMS guidelines.

Note: Contracted providers may have specific reimbursement methodologies included in their contract with Today’s Options PPO. Please refer to those documents for provider-specific compensation parameters.
Today's Options PPO sends providers a Provider Remittance Advice Form, or PRAF, once it has received and paid a claim.

See Provider Remittance Advice Form (PRAF), Appendix, page 85

Questions regarding the PRAF may be addressed to Provider Services by calling 1-866-422-5009.

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

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

Process for Refunds or Returned Checks

Today's Options PPO accepts overpayments two ways – providers may refund additional money directly to Today's Options PPO or Today's Options PPO will take deductions from future claims.

If Today's Options PPO has paid in error, providers may return the 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:

Today's Options PPO
P.O. Box 505057
St. Louis, MO 63150-2127
Attn: Cost Containment Unit

If Today's Options PPO has paid in error and the provider has not sent a refund or returned the check, Today's Options PPO will send providers a request for the overpayment. If providers still fail to return the payment, Today's Options PPO will deduct money from future claims paid. The related claim information will be shown on the EOP as a negative amount.

According to the Medicare Financial Management Manual, Today's Options PPO is permitted to pursue overpayments made within a three-year calendar period of the original payment, special contractual provisions notwithstanding.
Coordination of Benefits

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

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

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

The following types of situations will prevent payment by Today’s Options PPO as the primary payer:

- Elderly Workers Employed Group Health Plan (EGHP): These Members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse’s age is not material to the determination of primary coverage, only the qualification of the EGHP.
- Disabled Beneficiaries Employer Group Health Plans: These Members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member’s employment. LGHP is defined by at least one of the employers having at least 100 employees.
- End-Stage Renal Disease (ESRD): A policy and procedure is available by calling Provider Services at 1-866-422-5009.
- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either respiratory or pulmonary diseases. Today’s Options PPO is the primary payer for all other care and service needs.
- Workers’ Compensation: The Workers’ Compensation carrier is responsible for all injuries and illnesses that result from employment. Today’s Options PPO pays only when the Workers’ Compensation benefits are exhausted or the services/care are not covered by the Workers’ Compensation carrier but are Medicare benefits.
- Third-Party Liability: See the policy and procedure covering Third-Party Liability, which is available by calling Provider Services at 1-866-422-5009.
- Veterans Administration Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. Today’s Options PPO may supplement VA payment when the Member files a claim for Part B services that are not fully reimbursable by the VA.
Provider Payment Dispute Resolution Process

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

Providers must address disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments or the amount of the claim) in writing. Providers may direct any questions to Provider Services at 1-866-422-5009.

To file an official payment dispute, providers should submit a Provider Dispute Resolution Request form along with any supporting documentation. Providers may include a cover sheet outlining the reason for the requested review along with the claim and Provider Remittance Advice Form, or PRAF. See Provider Dispute Resolution Request Form, Appendix, page 79


Those documents should be faxed to 1-877-656-1728 or mailed to:
- Today’s Options PPO
- P.O. Box 741107
- Houston, TX 77274-1107
- Attention: Provider Dispute Department

Today’s Options PPO will respond to all written disputes regarding claims within 30 business days.

If Today’s Options PPO agrees with the reason for the payment dispute, Today’s Options PPO will issue a new Explanation of Payment (EOP) and pay the additional amount that is requested, including any interest due. Today’s Options PPO will inform providers in writing if the decision is unfavorable and no additional amount is owed, as well as supply information regarding the provider’s appeal rights.

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

Hierarchical Condition Category (HCC) Model

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.

Today’s Options PPO 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 until September 30, 2015; ICD-10-CM starting October 1, 2015) codes 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.

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 5: HCC to ICD-9 Corresponding Category  *Note, these codes are for illustrative purposes only. All ICD-9 codes are in effect until September 30, 2015. This chart does not include corresponding ICD-10 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>
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<td>HCC</td>
<td>HCC DESCRIPTION</td>
<td>ICD-9-CM CODE</td>
<td>ICD-9-CM DESCRIPTION</td>
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<tr>
<td>-----</td>
<td>------------------------------------</td>
<td>---------------</td>
<td>-----------------------------------------------------------------</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>2</td>
<td>Septicemia/Shock</td>
<td>0380</td>
<td>Streptococcal Septicemia</td>
</tr>
<tr>
<td>8</td>
<td>Lung, Upper Digestive Tract, &amp; Other Severe Cancers</td>
<td>1502</td>
<td>Malignant Neoplasm – Abdomen / Esophagus</td>
</tr>
<tr>
<td>8</td>
<td>Lung, Upper Digestive Tract, &amp; Other 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 Major Cancers</td>
<td>1410</td>
<td>Malignant Neoplasm – Tongue Base</td>
</tr>
<tr>
<td>9</td>
<td>Lymphatic, Head &amp; Neck, Brain &amp; Other 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>21</td>
<td>Protein-Calorie Malnutrition</td>
<td>2639</td>
<td>Protein Calorie Malnutrition, NOS</td>
</tr>
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<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>
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<td>80</td>
<td>Congestive Heart Failure</td>
<td>42831</td>
<td>Acute Diastolic Heart Failure</td>
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<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>Iatrogen Pulmonary Embolism/Infarction</td>
</tr>
<tr>
<td>104</td>
<td>Vascular Disease with Complications</td>
<td>41519</td>
<td>Pulmonary Embolism/Infarction, Other</td>
</tr>
</tbody>
</table>
Provider’s Role in Risk Adjustment

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 staff.

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.

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 and provide their credentials. This includes recording all conditions and diseases, indicating the Member’s name on each page of the medical record and signing and dating each entry, making sure to identify the provider’s credentials.
- 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 code set guidelines.

Providers should submit the ICD-9-CM diagnostic data (for dates of service up to September 30, 2015) or ICD-10-CM diagnostic data (for dates of service starting October 1, 2015) to Today’s Options PPO via a CMS-1500 claim form or electronic claim.

If a Member has more chronic conditions than provided for on the form, call Provider Services at 1-866-422-5009 or e-mail codinghelp@UniversalAmerican.com so the codes may be manually entered into the system.

Today’s Options PPO’s Role in Risk Adjustment

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

- Educate all contracted physicians – To do so, Today’s Options PPO will provide the following:
  - A biannual provider and office manager meeting.
  - Individual meetings with providers and their staffs, as requested
  - Educational materials upon request.
• Provide updated and accurate reports – Today’s Options PPO 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 1-866-422-5009.

• Provide coding support – Today’s Options PPO has created several coding tools to help contracted providers. To review these tools, providers may contact Provider Services at 1-866-422-5009 or e-mail codinghelp@UniversalAmerican.com.

• Conduct chart reviews – Today’s Options PPO 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 – Today’s Options PPO must submit all encounter data and/or claims detail to CMS in a timely manner. Providers who need assistance submitting encounter data to Today’s Options PPO should contact Provider Services at 1-866-422-5009 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, and add his/her credentials. Electronic signatures are acceptable but must be accompanied by such words as “electronically signed by,” “authenticated by” or “signed by.”

**Q:** Are medical records containing dictated progress notes that are dated but not signed acceptable for medical review?
**A:** No. Medical record documentation should be signed and dated by the physician.

**Q:** If providers submit an unsigned medical record, will Today’s Options PPO 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 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.

Pharmacy

Part D Pharmacy Services

Overview

The Today's Options PPO 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.

Today’s Options PPO partners with CVS Caremark, a Prescription Benefits Manager (PBM), to administer the prescription programs for Today’s Options PPO Members.

The Today’s Options PPO formulary may be viewed by going online to www.TodaysOptionsPPO.com or on ProviderLink at UAMProviderLink.UniversalAmerican.com.

- 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

Formulary Key Points

Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for Today’s Options PPO. 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 Today’s Options PPO 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:

<table>
<thead>
<tr>
<th>PHONE</th>
<th>1-855-344-0930</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(TTY users call 1-866-236-1069)</td>
</tr>
<tr>
<td></td>
<td>8:00 a.m. to 8:00 p.m. in your local time zone</td>
</tr>
<tr>
<td></td>
<td>October-February, 7 days a week</td>
</tr>
<tr>
<td></td>
<td>March-September, Monday- Friday</td>
</tr>
<tr>
<td>FAX</td>
<td>1-855-633-7673</td>
</tr>
<tr>
<td>MAIL</td>
<td>P.O. Box 52000, Phoenix, AZ 85072-2000</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.Caremark.com">www.Caremark.com</a></td>
</tr>
</tbody>
</table>

**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

Today’s Options PPO has several processes that help ensure the effective and efficient use of medications under the prescription benefit offered to Members. Today’s Options PPO 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**:

| PHONE       | 1-855-344-0930  
|            | (TTY users call 1-866-236-1069)  
|            | 8:00 a.m. to 8:00 p.m. in your local time zone  
|            | October-February, 7 days a week  
|            | March-September, Monday- Friday  
| FAX        | 1-855-633-7673  
| MAIL       | P.O. Box 52000, Phoenix, AZ 85072-2000  

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 Today’s Options PPO Member is taking a formulary drug that was covered at the beginning of the year, Today’s Options PPO 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 Today’s Options PPO 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, Today’s Options PPO must notify affected Members and providers of the change at least 60 days before it becomes effective.

Providers may access these notifications at [www.TodaysOptionsPPO.com](http://www.TodaysOptionsPPO.com).

- Click on “Part D/pharmacy – coverage information”
- Click on “Formulary information” under “Upcoming formulary changes”

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

**Transition Policy**

Today’s Options PPO may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. Today’s Options PPO 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 66

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

Today’s Options PPO offers mail-order services to our Members. Some of the benefits to the Members include:

- 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.

To get mail-order forms and information about ordering prescriptions for your patients through mail order, go to our website www.TodaysOptionsPPO.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 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
  - 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

\(^4\)Exceptions may apply for IPPB solutions and some diabetic supplies.
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 Today’s Options PPO 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.

Today’s Options PPO 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 (i.e., 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 Compliance
Operational Oversight

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

Compliance Monitoring & Delegation Oversight (MDO) 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 & Marketing Oversight

Compliance – Sales & Marketing Oversight (CSO) 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, 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.

Today’s Options PPO 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 87**
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 42.

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.\(^5\)

Generally, only the Relator who is the first to file a lawsuit can receive a reward for reporting the fraud. Even if one person uncovers the fraud, someone else can file the lawsuit first and bar the first whistleblower from sharing in any recovery.

Congress strengthened and broadened the scope of the False Claims Act by passing the Fraud Enforcement and Recovery Act (FERA) of 2009. FERA extends the liability for False Claims Act violations to claims not directly submitted to the government (e.g., the False Claims Act attaches for false claims presented to 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 to medical facilities in which they 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.

**Anti-Kickback Statute**

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

\(^5\)Department of Justice, December 4, 2012, “Justice Department Recovers Nearly $5 Billion in False Claims Act Cases in Fiscal Year 2012”
The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties such as being debarred from participation in federal programs.

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

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

**Fraud, Waste and Abuse**

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

➤ For more information on Fraud, Waste and Abuse, see page 45

**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.

**Duty to Report**

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

**Medicare Compliance Officer**

Celeste Panaro – 713-558-7164  
4888 Loop Central Drive, Suite 300,  
Houston, TX 77081

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.
Appendix:

Authorization Guidelines

Referral/Authorization Request Form

Provider Dispute Resolution Request Form

Appointment of Representative Form (CMS 1696)

CMS Waiver of Liability Statement Form

Provider Remittance Advice Form (PRAF)

UAM 2015 Annual Provider –Physician Compliance Materials Attestation

Code of Conduct and Ethics Acknowledgement Form

CMS Medicare Advantage Program Requirements
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Inpatient Hospital Admissions</strong> (Elective/Emergent)</td>
<td><strong>Servicing Facility:</strong> Authorization request required at least two (2) business days prior to admission, but no later than 24 hours following emergency admission</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation</strong></td>
<td><strong>Servicing Facility:</strong> Authorization request required at least one (1) business day prior to transfer/admit from Acute, Observation Units or home setting</td>
</tr>
<tr>
<td><strong>Long-Term Acute Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Procedures:</strong></td>
<td><strong>Ordering Provider:</strong> Authorization required at least two (2) business days prior to services being rendered (non-emergent)</td>
</tr>
<tr>
<td>CTA</td>
<td><strong>Servicing Provider:</strong> Must confirm procedure has been authorized prior to rendering service</td>
</tr>
<tr>
<td>CT Scan</td>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
</tr>
<tr>
<td>MRI</td>
<td></td>
</tr>
<tr>
<td>MRA</td>
<td></td>
</tr>
<tr>
<td>PET Scan</td>
<td></td>
</tr>
<tr>
<td>*Sleep Studies</td>
<td></td>
</tr>
<tr>
<td>*Molecular and Genetic Testing</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiology Imaging, including:</strong></td>
<td><strong>Ordering Provider:</strong> Authorization required at least two (2) business days prior to services being rendered (non-emergent)</td>
</tr>
<tr>
<td>Nuclear Stress</td>
<td><strong>Servicing Provider:</strong> Must confirm procedure has been authorized prior to rendering service</td>
</tr>
<tr>
<td>Echo Stress</td>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
</tr>
<tr>
<td>Echo Cardiography</td>
<td></td>
</tr>
<tr>
<td>Cardiac PET Scan</td>
<td></td>
</tr>
<tr>
<td>Cardiac MRI</td>
<td></td>
</tr>
<tr>
<td>Coronary CT</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Heart Catheterization</td>
<td></td>
</tr>
<tr>
<td>*Cardiac Implantables</td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
<td></td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy Drugs</strong></td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
<td></td>
</tr>
<tr>
<td><strong>Interventional Pain Procedures</strong></td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
<td></td>
</tr>
<tr>
<td><strong>Spinal Surgery including Decompression and Fusion Procedures</strong></td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>(* Subject to Authorization Program administered by CareCore National)</td>
<td></td>
</tr>
<tr>
<td>CATEGORY</td>
<td>REQUIREMENT</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arthroscopic Procedures including joint replacement*</td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td></td>
<td>(*) Subject to Authorization Program administered by CareCore National</td>
</tr>
<tr>
<td>Physical Therapy*/Occupational Therapy*/Speech Therapy</td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered beyond the initial evaluation</td>
</tr>
<tr>
<td>(including outpatient and in-home services; specialty types, such as</td>
<td>(*) Physical and Occupational Therapy subject to Authorization Program administered by CareCore National</td>
</tr>
<tr>
<td>aqua-therapy, pulmonary rehab, cardiac rehab, and vestibular therapy)+A81</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>DME/Orthotics/Prosthetics:</td>
<td><strong>Servicing Provider:</strong> Authorization required at least two (2) business days prior to services being rendered</td>
</tr>
<tr>
<td>Purchase price &gt; $750</td>
<td></td>
</tr>
<tr>
<td>Rental price &gt; $250</td>
<td></td>
</tr>
<tr>
<td>Cosmetic and/or Reconstructive Procedures</td>
<td><strong>Servicing Provider:</strong> Authorization required at least five (5) business days prior to services being rendered</td>
</tr>
<tr>
<td>Including but not limited to:</td>
<td></td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td></td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td></td>
</tr>
<tr>
<td>Gastroplasty/Gastric Bypass</td>
<td></td>
</tr>
<tr>
<td>Lipectomy or Excess Fat Removal</td>
<td></td>
</tr>
<tr>
<td>Uvulopalatopharyngoplasty</td>
<td></td>
</tr>
<tr>
<td>Sclerotherapy/Varicose veins</td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td><strong>Servicing Provider:</strong> Authorization required at least five (5) business days prior to services being rendered</td>
</tr>
</tbody>
</table>

*All authorization services are administered by Today’s Options PPO unless indicated by * that the services are administered by CareCore National.*

**Contact Information:**

Services Administered by Today’s Options PPO
Fax: 1-800-349-3548
ProviderLink: uamproviderlink.UniversalAmerican.com

Services administered by CareCore National
Phone: 1-800-792-8814
Online: www.carecorenational.com
Authorization Request Form

DATE:  
IPA/LPO

Authorization for Medical Services is NOT a Guarantee of Eligibility or Payment.

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

Referral Type:

- Inpatient Admit
- Outpatient Surgery
- Consultation
- Follow-up Visit
- Diagnostic Procedure:
  - CT/CTA
  - MRI/MRA
  - OP Therapy(ST/PT/OT)

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):
- Primary Diagnosis/Rule Out:
- Secondary Diagnosis(es):
- Primary Diagnosis/Rule Out:
- Secondary Diagnosis(es):

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Y0067_PR_AUTHREQ_0814_IA 08/14/2014
ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.
Send Claims to: Today’s Options® PPO, P.O. Box 741107, Houston, TX 77274
Note, once this document is formatted, these two lines should appear above the privacy notification.

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Y0067_FR_AUTHREQ_0814_IA 08/14/2014
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 documentation to support your appeal.

Mail the completed form to: Today’s Options PPO – 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
- Other
- Mental Hospital
- Home Health
- Hospital
- ASC
- SNF
- Rehab
- Ambulance
- Other

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
- Appeal of Medical Necessity
- Requirement for Reimbursement of Overpayment
- Seeking Resolution of Billing Determination
- Other

*Description of Dispute:

*Expected Outcome:

___________________________________________  (_____)  _____________
Contact Name (Please Print)  Phone Number

☐ Check if additional information is attached.
Appointment of Representative

<table>
<thead>
<tr>
<th>Name of Party</th>
<th>Medicare or National Provider Identifier Number</th>
</tr>
</thead>
</table>

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. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

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

<table>
<thead>
<tr>
<th>Nombre del Participante</th>
<th>Numero de Medicare o identificador Nacional del Proveedor</th>
</tr>
</thead>
</table>

### 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 nombo 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 u 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.

<table>
<thead>
<tr>
<th>Firma del que designa a su representante</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección:</td>
<td>Numero de teléfono (con código de área)</td>
</tr>
<tr>
<td>Ciudad</td>
<td>Estado</td>
</tr>
</tbody>
</table>

### 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.)

<table>
<thead>
<tr>
<th>Firma del representante</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección:</td>
<td>Numero de teléfono (con código de área)</td>
</tr>
<tr>
<td>Ciudad</td>
<td>Estado</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Firma</th>
<th>Fecha</th>
</tr>
</thead>
</table>

### 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.

<table>
<thead>
<tr>
<th>Firma</th>
<th>Fecha</th>
</tr>
</thead>
</table>

Formulario de CMS-1696 (Rev 06/12) Spanish
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 entregárselo 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
**Today's Options - PPO**

P.O. Box 722568
Houston, TX 77274

---

**Return Service Requested**

---

**For questions please call:** (866) 422-5009

---

**Payment Summary**

- **Paid To:**
- **Provider #:**
- **Payment Date:**
- **Check #:**
- **Check Amount:**
- **Reference #:**
- **Prior Overpayment:** 0.00
- **Overpayment Incurred This Period:** 0.00
- **Recovered This Check:** 0.00
- **Outstanding Overpayment:** 0.00

---

**Explanation of Payment**

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Rev</th>
<th>Proc</th>
<th>Unit</th>
<th>Amount Billed</th>
<th>Allowed</th>
<th>Prog Resp</th>
<th>COB Applied</th>
<th>Net Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/14-11/16/11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>297.00</td>
<td>149.10</td>
<td>57.90</td>
<td>809</td>
<td>149.10</td>
</tr>
<tr>
<td>11/15-11/17/11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>142.00</td>
<td>75.21</td>
<td>66.79</td>
<td>809</td>
<td>75.21</td>
</tr>
<tr>
<td>11/16-11/18/11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>86.00</td>
<td>60.61</td>
<td>27.39</td>
<td>809</td>
<td>60.61</td>
</tr>
</tbody>
</table>

**Claim Totals:** 445.00  292.92  152.08

- **Interest Amount:** 0.00
- **Prompt Pay Discount:** 0.00
- **Subscriber Payment:** 0.00
- **Net Payment:** 292.92

**Provider Group Summary Totals**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Amount Billed</th>
<th>Allowed</th>
<th>Prog Resp</th>
<th>Patient Resp</th>
<th>Member OOP</th>
<th>COB Applied</th>
<th>Net Amount</th>
<th>Interest Amount</th>
<th>Prompt Payment Discount</th>
<th>Subscriber Payment</th>
<th>Prior Paid</th>
<th>Overpayment</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>445.00</td>
<td>292.92</td>
<td>152.08</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>292.92</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>292.92</td>
</tr>
</tbody>
</table>

**Totals:** 445.00  292.92  152.08

- **Amounts Recovered:** 0.00
- **Check Amount:** 292.92
- **Remaining Balance:** 0.00

**Remark Explanations and Clinical Edits**

**Claim ID** | **Line** | **Code** | **Explanation**
---|---|---|---
809 | | | Reimbursement Based on Medicare's Allowable
*** | | | If you have any questions please contact our Customer Service Department.

**Today's Options is now accepting EDI claims from Emedon.**

The Emedon payer ID is 48055. In order to enroll, please contact Emedon support at (800) 845-6592.

---

**Reference #:**
MEMORANDUM

TO: Universal American Providers and Physicians
FROM: Mariko Hoffman, Compliance – Monitoring & Delegation Oversight
DATE: 2015
SUBJ: UAM Compliance Materials

UAM is requesting your acknowledgement on the review and receipt of the following materials located at:

https://uamproviderlink.universalamerican.com

- 2015 UAM Code of Conduct
- Compliance Program 2015
- DO.PNP.005 Effective Lines of Communication
- CO-069 Delegation Oversight
- MDO-PNP-003 Monitoring Delegation Oversight Risk Assessment
- CO-005 – Compliance Training & Education
- CO-008 Investigating Potential Compliance Issues
- PHI and PII Data Security and Handling (SCAMS.0803)
- Y0067_DO_2015FDRComplianceTraining_0715

Once completed please fax this acknowledgement to (713) 838-3580. Should you have further questions, please do not hesitate to send your inquiry to.
FDRComplianceTraining@UniversalAmerican.com

Thank you in advance for your responsiveness.

_______________________________________________________________
COMPANY NAME

_______________________________________________________________
NAME & TITLE

_______________________________________________________________
SIGNATURE & DATE
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, Today’s Options PPO 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

<table>
<thead>
<tr>
<th>CMS MEDICARE ADVANTAGE PROGRAM REQUIREMENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard privacy and maintain records accurately and timely</td>
<td>422.118</td>
</tr>
<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>
</tr>
<tr>
<td>Pay for emergency and urgently needed services</td>
<td>422.110(b)</td>
</tr>
<tr>
<td>Pay for a renal dialysis for those temporarily out of service area</td>
<td>422.110(b)(1)(iv)</td>
</tr>
<tr>
<td>Direct access to mammography and influenza vaccinations</td>
<td>422.110(b)(1)</td>
</tr>
<tr>
<td>No copayment for influenza and pneumococcal vaccines</td>
<td>422.110(g)(2)</td>
</tr>
<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)(ii); 422.504(g)(2)(iii); 422.504(g)(3)</td>
</tr>
</tbody>
</table>
Call today at 1-866-422-5009,
8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week

www.TodaysOptionsPPO.com