Cox HealthPlans Medicare Advantage Provider Manual

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Introduction and plan offerings

Thank you for participating with Cox HealthPlans Medicare Advantage plans! This provider manual has been created to assist you and your office staff in partnering with us to help improve our beneficiary's health and wellbeing. It contains important information concerning our policies and procedures including claims payment and submission requirements, prior authorization and referral requirements and other helpful information. It also serves as an extension of your network participation agreement in which all providers are required to comply with it.

To the extent there is any inconsistency between the terms of this manual and your network participation agreement, the terms of your network participation agreement will control. This manual is also intended to help providers more effectively do business with Cox HealthPlans Medicare Advantage plans, so please make time to review it carefully.

The table below outlines things you need to know as you navigate through this manual.

Topic	What you need to know
Referrals	• Referrals are not required as long as the beneficiary is seeing in network providers.
Local network information	• The service area is comprised of Greene, Christian, Taney, Stone, Lawrence, Barry, Webster, Dallas, Dade, Polk, Cedar, Hickory, Crawford, Dent, Maries, Phelps, and Pulaski counties in Missouri. • Beneficiary identification cards provide high- level product/network information. Remember to contact the phone numbers on the card for assistance and follow guidance in order to verify eligibility, referral/no referral and authorization guidance.

Medicare Overview

Cox HealthPlans contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) plans.

Selection of a Primary Care Physician (PCP)	Beneficiaries are required to select a PCP. Beneficiaries are allowed to select a different PCP at any time.	

Referrals to specialists	We do not require referrals as long as the beneficiary is seeing an in-network provider.
ID card	The beneficiary's type of plan will be indicated at the top of the beneficiary's identification card.

Important Contact Information

Below is a list of frequently used key contacts. Our phone lines are open Monday through Friday 8 am to 12 pm and secure web portal messaging and chat is available 8 am to 5 pm.

Medicare Advantage Key Contacts	
Behavioral Health/substance use disorders	(Please call for authorizations) Call: 417.269.2900, option 5 Fax: 417.269.2949
Claims processing	Claims questions call 417.269.2900, option 5 Electronic first file claims and corrected claims may be submitted through: • Trizetto EDI (Payer ID: 00019 Professional, 00119 Institutional) Mail paper first file and corrected claims to: Cox HealthPlans PO Box 5750 Springfield, MO 65801-5750
Part C appeals	Appeals questions: 417.269.2900, option 5 | Fax: 417.269.2949 Mail Appeals to: Cox HealthPlans Attn: Appeals PO Box 5750 Springfield, MO 65801-5750

Compliance	To report potential fraud, waste or abuse please contact our compliance department. By email: compliancesiu@coxhealthplans.com By mail: Cox HealthPlans Attn: MA Compliance Officer PO Box 5750 Springfield, MO 65801-5750
Dental Benefits	For questions concerning supplemental benefits, please call Provider Services at 417.269.2900, option 5. Claims Mailing address: Dominion National PO Box 211424 Eagen, MN 55121 Electronic claims may be submitted using Payor ID DOM01.
Eligibility verification/ Co- payment information	Customer Service: 417.269.2900, option 5 | Provider Portal: Cox Health Plans Provider Portal (healthx.com)
Online Provider Portal	Your online solution for inpatient authorization inquiry, eligibility verification, and claims payment review.
Prior authorization (non-pharmacy)	Prior Authorization must be obtained for the following services: Inpatient and Elective Admission Notification and select Outpatient Services. Prior Authorization can be obtained by filling out our Prior Authorization form and faxing it to 417.269.2919.
Pharmacy	Prior Authorization Requests: Phone: 417.269.2900, option 5 Forms and Formulary Website: https://coxhealthmedicareadvantage.com/prescription-drug-search/ https://cmhmedicareadvantage.com/prescription-drug-search/ https://phelpshealthmedicareadvantage.org/prescription-drug-search/

Websites	https://coxhealthmedicareadvantage.com/ https://cmhmedicareadvantage.com/ https://phelpshealthmedicareadvantage.org/

Eligibility

All participating providers are responsible for verifying a beneficiary's eligibility at each visit. Please note that beneficiary data is subject to change. CMS retroactively terminates beneficiaries for various reasons. When this occurs, Cox HealthPlans' claim department will request a refund from the provider or offset the overpayment. The provider must then contact CMS Eligibility to determine the beneficiary's actual benefit coverage for the date of service in question.

Verify beneficiary eligibility

Please note: Cox HealthPlans should have the most up-to-date information that is available, however, Cox HealthPlans' eligibility information may not be completely accurate as CMS retroactively terminates beneficiaries for various reasons. You must call Cox HealthPlans to verify eligibility when the beneficiary cannot present identification or does not appear on your monthly eligibility list.

The table below outlines methods to verify beneficiary eligibility.

Method	Contact/Resource Information
Provider Services	Call 417.269.2900, option 5 Monday-Friday: 8 a.m. - 12 p.m. CST
Provider Web Portal	Cox Health Plans Provider Portal (healthx.com)
Beneficiary's Cox HealthPlans Identification Card	Review the identification card to determine the following: • Plan code • Copayment

Exchange of Electronic Data

Information protection requirements and guidance

Cox HealthPlans follows all applicable laws, rules, and regulations regarding the electronic transmittal and reception of beneficiary and provider information. As such, if an electronic connection is made to facilitate such data transfer, all applicable laws must be followed. Providers shall comply with submission of data, medical records and certify completeness and truthfulness. At all times, a provider

must be able to track disclosures, provide details of data protections, and respond to requests made by Cox HealthPlans regarding information protection.

Cox HealthPlans will engage with a provider's staff to appropriately implement the connection. Any files placed for receipt by provider staff must be downloaded in 24 hours, as all data is deleted on a fixed schedule. If the files are unable to be downloaded, then alternate arrangements for retransmission must be made. The provider and provider's staff must work collaboratively with Cox HealthPlans to ensure information is adequately protected and secure during transmission.

Credentialing

All practitioners and organizational applicants to Cox HealthPlans must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. These requirements are the same whether the provider is credentialed by Cox HealthPlans or another entity delegated by Cox HealthPlans to credential MA network providers. Cox HealthPlans' credentialing standards and processes are designed to comply with CMS regulations and applicable law.

Cox HealthPlans does not discriminate in terms of participation, reimbursement, or based on the population of beneficiaries serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. In order to participate in the Cox HealthPlans network, providers undergo a screening process before a contract can be extended to them.

Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the plan. No provider can be assigned a health plan effective date, be included in a provider directory, or have beneficiaries assigned without completing the credentialing and peer review process. All providers who have been initially approved for participation are required to recredential at least once every three years (i.e., every 36 months) in order to maintain participation status.

Practitioner and organizational selection criteria

Practitioner

Cox HealthPlans and credentialing delegates utilize specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to

- Holds appropriate, current and unrestricted licensure in the state of practice as required by state and federal entities.
- Holds a current, valid, and unrestricted federal DEA and state-controlled substance certificate as applicable.
- Is board-certified or has completed appropriate and verifiable training in the requested practice specialty.
- Physicians and practitioners must have and maintain malpractice insurance.
- Has a National Provider Identification number.
- Has not been excluded, suspended, precluded and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

• Is not currently opted out of Medicare.
• Has admitting privileges as applicable.

Organizational Provider

When assessing organizational providers for participation, Cox HealthPlans utilizes the following criteria:

• Must be in good standing with all state and federal regulatory bodies.
• Has been reviewed and approved by an accrediting body deemed by Medicare or recognized by Cox HealthPlans; and/or has received a passing score on Cox HealthPlans' credentialing site review.
• If not accredited, must provide a copy of a survey conducted by a state of federal agency within the 36 months prior to app submission which contains the corrective action plan for any identified deficiencies and proof of state/federal acceptance of the corrective action and/or current compliance with Medicare/Medicaid program requirements.
• Organizations that are not accredited or have not been surveyed by a state or federal regulatory body within the last 36 months may be subject to a health plan conducted site audit.
• Has not been excluded, precluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

Accreditation for DME, Orthotics, and Prosthetics Providers
All Durable Medical Equipment (DME) and Orthotics and Prosthetic providers are required by Medicare to be accredited by one of the 10 national accreditation organizations. The most current listing of these organizations can be found at: Cms.gov/Medicare/Provider-Enrollment- and-certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf

Nondiscrimination in the decision-making process
Cox HealthPlans', or their delegated entity's, credentialing program is compliant with all guidelines from Centers for Medicare and Medicaid Services (CMS) and state regulations as applicable. Through the universal application of specific assessment criteria, Cox HealthPlans and their delegates ensure fair and impartial decision-making in the credentialing process and does not make credentialing decisions based on an applicant's race, gender, age, ethnic origin, nationality, sexual orientation, gender identity or due to the type of beneficiaries or procedures in which the provider specializes

Appeals process and notification of authorities
If a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include: a) the reasons for the action, b) outline of the appeals process or options available to the provider, and c) the time limits for submitting an appeal. All appeals will be reviewed by a panel of the provider's peers. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of credentialing information
All information obtained during the credentialing and recredentialing process is considered and regulatory agencies. Confidential practitioner credentialing and recredentialing information will not be disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing monitoring
Cox HealthPlans and credentialing delegates conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions, OIG Exclusions, System for Award Management (SAM), CMS Preclusion and the CMS Opt Out list between credentialing cycles.

Participating providers who are identified as having been sanctioned, are the subject of a complaint review, or are under investigation for or have been convicted of fraud, waste, or abuse are subject to review by the Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider whose license has been revoked or has been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program or who has opted out of Medicare will be immediately and automatically terminated from the plan.

CMS preclusion list
CMS publishes a Preclusion List that lists providers and prescribers who are precluded from receiving payment for Medicare Advantage(MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

What is the impact?
CMS makes the Preclusion List available to Part D sponsors and the MA plans on a monthly basis. The preclusion list requirements are:
• Part D sponsors must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.

• MA plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

• Cox HealthPlans will terminate the network participation agreement of providers on the preclusion list.

Who is on the list?
Individuals or entities who meet the following criteria:
• Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

• Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

Provider Notification
CMS sends an email and letter to the provider or entity in advance of their inclusion on the

Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPPES) mailing address. The letter includes the reason for the preclusion, the effective date of the preclusion, and applicable rights to appeal. For more information on the preclusion list, visit: Cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List

Provider Directory and Requirements

To be included in Provider Directories or any other beneficiary communications, providers must be fully credentialed and contracted. Directory specialty designations must be commensurate with the education, training, board certification, and specialty(ies) verified and approved by the credentialing process. Any requests for changes or updates to the specialty information in the directory will only be approved once validated through the credentialing process. Cox HealthPlans utilizes a vendor to make quarterly outreaches to contracted practitioners.

If you move locations, change phone numbers or any other demographic information, update the information within 7 days of the change. Please do not wait for the quarterly update to make such a change. You can make the updates through your credentialing body.

As a contracted provider you are required to comply with the outreach request and supply updated information within the allotted timeframe. Failure to provide a response to the quarterly outreach will result in suppression from our provider directory or other action. Suppression from the directory means that beneficiaries and other providers will not be able to view you as a participating provider in the Cox HealthPlans network.

The accuracy of our directories directly impacts the beneficiaries we both serve. We take this compliance requirement very seriously and expect that you will cooperate fully with the attestation and validation process. If a provider fails to cooperate, we will take action, including suppression and potentially termination from participation from our Medicare Advantage plans.

Provider Termination

Cox HealthPlans is required to make good faith efforts to provide at least 45 calendar days advance for PCPs and behavioral health providers, 30 calendar days in advance for all others, written notice to impacted beneficiaries when a provider is being terminated or leaving the network.

Impacted beneficiaries are those who are seen on a regular basis by the provider, have scheduled services with the provider or have recently received treatment or a service from the provider (within the past 90 calendar days). For behavioral health providers or members assigned to a PCP, notification will go to members seen within the past 3 years. Providers must provide advanced written notice (timeframe varies based on the provider services agreement) to Cox HealthPlans prior to terming their agreement or leaving the network (retiring, office closure, moving out of area, etc.). Reference your participating provider agreement for termination notification requirements.

Plan notification requirements for providers

Participating providers must provide written notice to Cox HealthPlans or the delegated credentialing body no less than 90 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to Cox HealthPlans by contacting your credentialing body:

- Practice address.
- Billing address.
- Fax or telephone number.
- Hospital affiliations.
- Practice name.
- Providers joining or leaving the practice (including retirement or death).
- Provider taking a leave of absence.
- Practice mergers and/or acquisitions.

Billing

Claims Submission

While Cox HealthPlans prefers electronic submission of claims, both electronic and paper claims are accepted. If you are interested in submitting claims electronically (EDI), contact Provider Services for assistance at 417-269-2900, option 5 or visit the website for provider portal and chat options.

Electronic submission

Electronic claims maybe submitted through:

- Trizetto EDI (Payer ID: 00019 Professional, 00119 Institutional).

Electronic remittance advice (ERA)/Electronic funds transfer(EFT) enrollment process

Contact ECHO Customer Service at 888-834-3511 to get enrolled for ACH.

Paper claims submission

Cox HealthPlans
Attn: Claims
PO Box 5750
Springfield, MO 65801-5750

Note: claims are not accepted via email or fax. Red and white paper claims are preferred.

Timely filing

As a Cox HealthPlans Participating Provider, you have agreed to submit all claims within the timeframes outlined in your provider agreement.

Claim format

The standard CMS required forms and data elements can be found in the CMS claims processing manual located at https://www.cms.gov/manuals/downloads/clm104c12.pdf. Appropriate forms and data

elements must be present for a claim to be considered a clean claim. Claims should be submitted using a red and white form to ensure claim processing accuracy.

Cox HealthPlans can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submissions. While Cox HealthPlans will attempt to inform the provider of claims errors, responsibility for claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same beneficiary by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their beneficiary in the same group.

Claim format standards

Cox HealthPlans pays clean claims according to contractual requirements and the Centers for Medicare and Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety and otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. A defect or impropriety includes, without limitation, lack of data fields required by Cox HealthPlans or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Cox HealthPlans, the claim is not considered clean.

Claim format preferences

Cox HealthPlans processes a maximum of 100 units per claim service line. If a service line should have more than 100 units, please bill on multiple service lines.

Claims Review

Cox HealthPlans reviews claims which may result in payments being classified as overpayments. This review includes, but is not limited to, itemized bills, clinical records or notes. If requested by Cox HealthPlans or our designee, providers must submit requested records within 30-days of notice for Cox HealthPlans to accurately adjudicate all claims in a timely manner.

Offsetting

Offsetting as a contracted Cox HealthPlans provider, you will be informed of any overpayments or other payments you may owe us. You will have thirty (30) days from receipt of our repayment demand to refund such amounts to us. We will provide you with the patient’s name, identification number, Cox HealthPlans’ claim number, your beneficiary account number, date of service, a brief explanation of the recovery request, and the amount or the requested recovery. If you have not refunded us within the thirty (30) day recovery period, we will offset the recovery amounts identified in the initial repayment demand, or in accordance with the terms of your agreement, unless an appeal or refund is received. Notwithstanding the foregoing, any CMS fee schedule or pricing changes will be automatically applied

and effective upon the date specified by CMS. Evidence of such adjustments shall be included in the explanation of payment/remittance advice.

Pricing

Original Medicare typically has market-adjusted prices by code (i.e., CPT or HCPCS) for services that Original Medicare covers. However, there are occasions where Cox HealthPlans offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, Cox HealthPlans will determine the price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Cox HealthPlans requests that you make every effort to submit claims with standard coding, failure to do so could delay processing. As described in this Manual and/or your agreement, you retain your rights to submit a Claim Disputes/Reconsideration you feel the reimbursement was incorrect. In the instance of an inpatient admission downgrade to observation, please submit an itemized bill including CPT and or HCPCS codes in order to expedite processing.

Claims Encounter Data

Providers who are paid under capitation agreements must submit claims in order to capture encounter data as required per your Cox HealthPlans Provider Agreement.

Explanation of payment (EOP)/Remittance advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by Cox HealthPlans. The statement provides a detailed description of how the claim was processed.

Prompt Payment

Cox HealthPlans will pay Participating Providers in accord with the applicable provisions of their agreement with Cox HealthPlans.

Non-payment/Claim Denial

Any denials of coverage or non-payment for services by Cox HealthPlans will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the beneficiary may not be billed for Covered Services denied by Cox HealthPlans. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the beneficiary, or the services are not covered, the EOP/RA will alert you to this and in some circumstances in some circumstances you may bill the beneficiary.

Pricing of Inpatient Claims

Unless the contract states otherwise, all outpatient services, including observation and emergency room services, furnished to a beneficiary by a hospital during an uninterrupted encounter (no discharge home) on the date of a beneficiary's inpatient admission or immediately preceding the date of a beneficiary's inpatient hospital admission, regardless of the number of uninterrupted days prior to the inpatient admission, will be paid under the applicable inpatient MS-DRG.

SNF Consolidated Billing (SNF CB)

Consolidated Billing Payment for the majority of services to beneficiaries in a Medicare -covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment to the SNF. The SNF must bill these bundled services in a consolidated bill. For services subject to consolidated billing (CB) and provided by entities other than the SNF, the entity looks to the SNF for payment and must not bill separately for those services.

CB RESOURCES: For more information, take the SNF CB web-based training course on the Medicare Learning Network® (MLN) Learning Management and Product Ordering System. To help determine how CB applies to specific services, refer to the flowcharts in the Skilled Nursing Facility Prospective Payment System educational product.

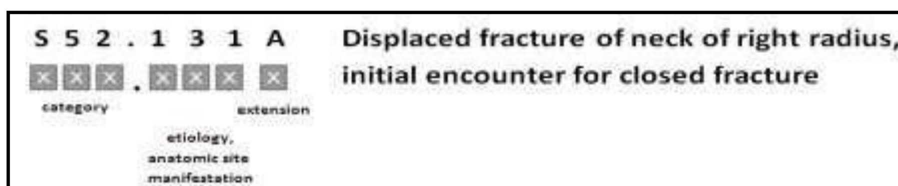
ICD-10 Diagnosis and Procedure Code Reporting

In January 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the use of International Classification of Diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding. The rule impacts the health care industry – including health plans, hospitals, doctors, and other health care professionals, as well as vendors and trading partners. Providers must be diligent about confirming the accuracy of their diagnoses and ensure that their diagnosis and coding practices comply with all applicable legal requirements

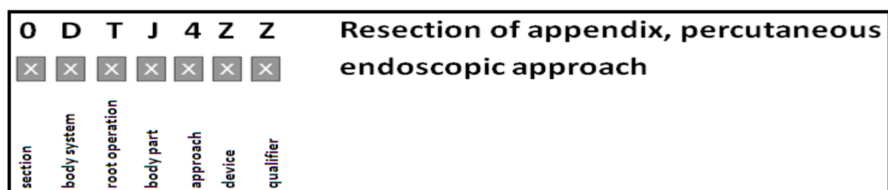
The U.S. Department of Health and Human Services released a rule on July 31, 2014 finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearing houses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

ICD-10 (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two parts:

1. ICD-10-CM for Diagnosis coding is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 characters instead of the 3 to 5 characters used with ICD-9-CM, adding more specificity.



2. ICD-10-PCS for Inpatient Procedure coding is for use in U.S. inpatient hospital settings only. ICD- 10-PCS uses 7 alphanumeric characters instead of the 3 or 4 numeric characters used under ICD-9-CM procedure coding. Coding under ICD- 10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.



Note: Procedure codes are only applicable to inpatient claims and not prior authorizations.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT or HCPCS coding for outpatient procedures.

Billable vs. Non-billable Codes

1. A billable ICD-10 code is defined as a code that has been coded to its highest level of specificity.

2. A non-billable or ICD-10 code is defined as a code that has not been coded to its highest level of specificity. If a claim is submitted with a non-billable code, the claim will be rejected.

3. The following is an example of a billable ICD-10 code with corresponding non-billable codes.

BILLABLE ICD-10 CODES	NON-BILLABLE ICD-10 CODES
M1A.3110 - Chronic gout due to renal impairment, right shoulder, without tophus	M1A.3 - Chronic gout due to renal impairment
	M1A.311 - Chronic gout due to renal impairment, right shoulder

Processing of Hospice Claims

When a Medicare Advantage (MA) beneficiary elects hospice care, but chooses not to dis-enroll from the plan, the beneficiary is entitled to continue to receive any MA benefits which are not the responsibility of the hospice through Cox HealthPlans. Under such circumstances the premium Cox HealthPlans receives from the Centers for Medicare and Medicaid Services (CMS) is adjusted to hospice status. As of the day the beneficiary is certified as hospice, the financial responsibility for that beneficiary shifts from Cox HealthPlans to Original Medicare. During a hospice election, Original Medicare covers all Medicare–covered services rendered with cost-sharing of Original Medicare. Cox HealthPlans will remain financially responsible for any benefits above Original Medicare benefits that are non- hospice related. Non-Medicare covered services, such as vision eyewear allowable, prescription drug claims, and medical visit transportation will remain the responsibility of Cox HealthPlans. Plan cost-sharing will apply to Cox HealthPlans covered services. If the beneficiary chooses original Medicare for coverage of covered, non-hospice-care, Original Medicare services and also follows MA plan requirements, then, the beneficiary pays plan cost-sharing and Original Medicare pays the provider. Cox HealthPlans will pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable. Plan rules must still be followed and apply for both professional and facility charges. An HMO beneficiary who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; A PPO beneficiary who receives services out of network and followed plan rules is only responsible for cost-sharing amounts applicable to their PPO plan. The beneficiary need not communicate to the plan in advance his/her choice of where services are obtained. When a beneficiary revokes hospice care, financial responsibility for Medicare-covered services will return to the plan on the first of the month following the revocation.

The following are the submission guidelines for Medicare Advantage beneficiaries enrolled in Hospice:

Hospice-related services

Medicare hospices bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage just as they do for beneficiaries, or beneficiaries, with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period and followed by claims with types of bill 81X or 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42 should be submitted as soon as possible so the beneficiary's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee -for-service contractors extends through the remainder of the month in which hospice is revoked. MA plan beneficiaries that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Non-hospice services

• For Part A services not related to the beneficiary's terminal condition, submit the claim to the fiscal intermediary using the condition code 07.

• For Part B services not related to the beneficiary's terminal condition, submit the claim to the Medicare carrier with a "GW" modifier.

• For services rendered for the treatment and management of the terminal illness by a non-hospice employed attending physician, submit the claim to the fiscal Intermediary/ Medicare carrier with a "GV" modifier.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320-Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for beneficiaries who have elected hospice coverage. The Medicare Claims Processing Manual, Chapter 11, Sections 40.2 and 50, and the CMS Program Memorandum AB-03-049 also outline payment responsibility and billing requirements for hospice services. This documentation is also available online at the CMS website: CMS.gov.

Coordination of Benefits

General Terms and Definitions

Term	Definition
Allowable expense	Any expense customary or necessary for health care services provided as well as covered by the beneficiary's health care plan.

Conclusion	COB is applying the NAIC rules to determine which plan is Primary, secondary or tertiary when alternate insurance coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations. Medicare Secondary Payer (MSP) provisions apply for Medicare beneficiaries under certain conditions.
Coordination of Benefits (COB)	Coordination of Benefits (COB) is the process of determining and reconciling individual payor liability for reimbursement when a beneficiary is eligible for benefits under more than one insurance company or other payor type (e.g., Medicare / Medicaid). Terms and conditions within the Summary of Benefits for each plan will generally dictate which payor is primary, secondary or tertiary and any mathematical formula associated for calculating each pay portion of coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.
Order of benefit determination rule	Rules which, when applied to a particular beneficiary covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for the beneficiary. A plan will be determined to have primary secondary or tertiary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.
Medicare Secondary payer (MSP)	MSP refers to situations where Medicare does not have primary payment responsibility, specifically Medicare pays second, and another entity or insurance company has responsibility to pay Medicare.
Primary	The primary carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.
Secondary	The secondary carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Common Situations of Primary vs. Secondary Payer Responsibility

The following list identifies some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

If the beneficiary/beneficiary:	The below condition exists:	The below Program pays first:	The below program pays secondary:

Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family beneficiary's current employment	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more employees	The Group Health Plan (GHP) pays primary	Cox HealthPlans /Medicare pays secondary
Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family beneficiary's current employment	The employer has less than 20 employees	Cox HealthPlans/ Medicare pays primary	Group Health Plan (GHP) pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family beneficiary's current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	The Large Group Health Plan (LGHP) pays primary	Cox HealthPlans/ Medicare pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family beneficiary's current employment	The employer employs less than 100 employees	Cox HealthPlans/ Medicare pays primary	Large Group Health Plan (LGHP) pays secondary
Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	Cox HealthPlans / Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	Cox HealthPlans / Medicare pays primary	COBRA pays secondary
Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD	The Group Health Plan (GHP) pays primary for the first 30 months	Cox HealthPlans / Medicare pays secondary (after 30 months Cox HealthPlans pays primary)

Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD and then retired	The Retirement Insurance pays primary for the first 30 months	Cox HealthPlans /Medicare pays secondary (after 30 months Cox HealthPlans pays primary)
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the beneficiary drops the COBRA coverage	Cox HealthPlans / Medicare pays secondary (after 30 months Cox HealthPlans pays primary)
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	The Large Group Health Plan (LGHP) pays primary	Cox HealthPlans / Medicare pays secondary (after 30 months Cox HealthPlans pays primary)
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks COBRA coverage	COBRA insurance would pay primary for the first 30 months or until the beneficiary drops the COBRA coverage	Cox HealthPlans / Medicare pays secondary (after 30 months Cox HealthPlans pays primary)

Basic Processing Guidelines for COB

For Cox HealthPlans to be responsible as either the primary or secondary carrier, the beneficiary must follow all HMO/PPO rules (i.e. pay copays and follow appropriate referral process as applicable). Cox HealthPlans or their delegate will pay claims using the Medicare guidelines for COB.

When Cox HealthPlans is the secondary insurance carrier:

• All Cox HealthPlans guidelines must be met in order to reimburse the provider (i.e., pre- certification, referral forms, etc.).
• The provider collects only the copayments required.
• Be sure to have the beneficiary sign the "assignment of benefits" sections of the claim form. Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of Cox HealthPlans for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When Cox HealthPlans is the primary insurance carrier:

• The provider collects the copayment required under the beneficiary's Cox HealthPlans plan.
• Submit the claim to Cox HealthPlans first
• Be sure to have the beneficiary sign the assignment of benefits sections of the claim form.
• Once payment and/or Remittance Advise (RA) has been received from Cox HealthPlans, submit a copy of the claim with the RA to the secondary carrier for adjudication.
• Please note: Cox HealthPlans is a total replacement for Medicare.
• Medicare cannot be secondary when beneficiaries have Cox HealthPlans.
• Medicaid will not pay the copay for Cox HealthPlans beneficiaries.

When Cox HealthPlans is the tertiary carrier:
• Tertiary insurance coverage is a third policy.
• All requirements listed above when Cox HealthPlans is primary or secondary must be met in order for Cox HealthPlans to pay as the tertiary carrier.

Worker's Compensation

Cox HealthPlans does not cover worker's compensation claims. When a provider identifies medical treatment as related to an on-the-job illness or injury, Cox HealthPlans must be notified. The provider will bill the worker's compensation carrier for all services rendered, not Cox HealthPlans.

Dual Eligible

Dual Eligible Individuals

Many beneficiaries may have Cox HealthPlans as their primary insurance payer and Medicaid as their secondary payer. You must coordinate the benefits of these "dual eligible" Cox HealthPlans beneficiaries by determining whether the beneficiary should be billed for the deductibles, copayments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB-Plus individual for Cox HealthPlans copayments, coinsurances, and/or deductibles. Medicaid is the payer of last resort when dual eligibility applies.

Providers can accept Cox HealthPlans' payment as payment in full or seek additional payment from the appropriate state source. Additional information concerning Medicaid provider participation is available at state specific Medicaid website.

Providers are prohibited from billing, charging, collecting a deposit, seeking compensation or remuneration from, or having any recourse against any Cox HealthPlans beneficiary for fees that are the responsibility of Cox HealthPlans.

Medicaid eligibility can be obtained by using the Medicaid Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid agency for additional information.

Please note: Each state varies in their decision to cover the cost-share for populations beyond QMB and QMB-Plus.

Medicaid Coverage Groups

Qualified Medicare Beneficiary (QMB Only)
A "QMB" is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed three times the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments (except for Part D). QMBs who do not qualify for any additional Medicaid benefits are called "QMB Only". Providers may not assess a QMB for Cox HealthPlans deductibles, copayments, or coinsurances.

Qualified Medicare Beneficiary Plus (QMB+)
A "QMB+" is an individual who meets standards for QMB eligibility and also meets criteria for full Medicaid benefits in the state. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or through spending down excess income to the Medically Needy level.

Specified Low-Income Medicare Beneficiary (SLMB Only)
An "SLMB" is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed three times the SSI limit. The only Medicaid benefit for which a SLMB is eligible is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called "SLMB Only."

Specified Low-Income Medicare Beneficiary Plus (SLMB+)
A "SLMB+" is an individual who meets the standards for SLMB eligibility, but who also meets the criteria for full state Medicaid benefits. Such individuals are entitled to payment of the Medicare Part B premium, as well as full state Medicaid benefits. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

Qualifying Individual (QI)
A "QI" is an individual who is entitled to Medicare Part A, has income that is at least 120% FPL but less than 135% FPL, resources that do not exceed three times the SSI limit, and who is not otherwise eligible for Medicaid. A QI is similar to an SLMB in that the only benefit available is Medicaid payment of the Medicare Part B premium; however, expenditures for QIs are 100% federally funded and the total expenditures are limited by statute. QIs are not otherwise eligible for full Medicare coverage.

Other Full Benefit Dual Eligible (FBDE)
An "FBDE" is an individual who is eligible for Medicaid either categorically or through optional coverage groups such as Medically Needy or special income levels for institutionalized or home and community-based waivers, but who does not meet the income or resource criteria for QMB or SLMB.

Qualified Disabled and Working Individual (QDWI)
A "QDWI" is an individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. QDWIs are eligible only for Medicare.

Appeals

Provider Appeals

An appeal is a request for Cox HealthPlans to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. Cox HealthPlans offers participating providers one level of appeal. The following should be considered when requesting an appeal:

- You must receive a notice of denial, or remittance advice before you can submit an appeal
- Do not submit your initial claim in the form of an appeal.

- An appeal must be submitted based on what is stated in your provider agreement.
- **With your appeal request, you must include**: an explanation of what you are appealing along with the rationale for appealing, a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay, or office visit, and a copy of the insurance verification completed on the date of service. If necessary medical records are not submitted, the request will be returned without action until the medical records are submitted and must be received within the timeframe for which the provider must submit their request for appeal. An appeal form is available on our website.
- Appeals can take up to 60 days for review and determination.
- Timely filing requirements are not affected or changed by the appeal process.
- If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the Cox HealthPlans agreement.
- You may appeal a previous decision not to pay for a service. For example, claims denied for no authorization or no referral, including a decision to pay for a different level of care; this includes both complete and partial denials.
    - Examples of partial denials include: denials of certain levels of care, isolated claim line items not related to claims reconsideration issues, or a decreased quantity of office or therapy visits not related to claims reconsideration issues.
    - Total and partial denials of payment may be appealed using the same appeal process. Your appeal will receive an independent review by a Cox HealthPlans representative not involved with the initial decision.
- Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision.
- You may appeal a health services or Utilization Management denial of a service not yet provided, on behalf of a beneficiary. The beneficiary must be aware that you are appealing on his or her behalf. This may be done through an Appointment of Representative Form.

Submit an appeal

1. To request an appeal, complete the Medicare Advantage Appeals and Claims Disputes form.
2. Attach Medical Records
3. Submit your appeal in one of the following ways:
    a. You may mail to Attn: Appeals PO Box 5750 Springfield, MO 65801-5750
    b. Fax to Attn: Appeals at 417-269-2949

Beneficiary Appeals

Beneficiary Appeals are processed according to Medicare guidelines. Please visit the resources page on our website for more information.

Claim disputes/reconsiderations

You have up to 180 days from claim payment date to request a reconsideration. You may request claim reconsideration if you feel your claim was not processed appropriately according to the Cox HealthPlans claim payment policy or in accordance with your provider agreement. A claim dispute/reconsideration

request is appropriate for disputing denials such as coordination of benefits, timely filing, or missing information.

Payment retractions, underpayments/overpayments, as well as coding disputes should also be addressed through the claim dispute/reconsideration process. Cox HealthPlans will review your request, as well as your provider record, to determine whether your claim was paid correctly.

Provider Information, Roles and Responsibilities

Access and Availability Standards for Providers

Cox HealthPlans meets CMS requirements for network adequacy. Cox HealthPlans also requires the following access standards:

Access Standards		
Practitioner Type	**Standard**	**Source of data/goal**
Medical Care		
Regular and routine care	An appointment within 30 days	**CAHPS Q7**: 90% of members reported that they "always" or "usually" get an appointment for a check-up or routine care at a doctor's office or clinic as soon as they needed it. Review of Member Complaints
Routine, symptomatic care	An appointment within one (1) week or five (5) business days	**CAHPS Q5**: 90% of members reported they "always" or "usually" get an appointment for health care at a doctor's office or clinic as soon as they needed it. Review of Member Complaints
Urgent care	An appointment within 24 hours	**CAHPS Q5**: 90% of members reported they "always" or "usually" get an appointment for health care at a doctor's office or clinic as soon as they needed it. Review of Member Complaints
Obstetrical care	An appointment within one (1) week for enrollees in the first or second trimester of pregnancy and within three (3) days for enrollees in the third trimester	Review of member complaints

After-hours care	After- hours care is available to members through later clinic hours and walk-in clinics	90% on after-hours call audit Review of member complaints
Behavioral Health		
Routine care	Within 10 business days	Review of hours for behavioral health, review of member complaints
Urgent care	Within 48 hours	Review of hours for behavioral health and urgent care, review of member complaints
Non-life-threatening emergency care	Within 6 hours	Immediate ER Access, review of member complaints
Life-threatening emergency care	24 hours/ 7 days per week	Immediate ER access
Plan Customer Services		
Telephone access to customer services	Call answered within 30 seconds; Call abandonment less than 5%	Telephone system reports

After-hours access standards

1) Cox HealthPlans members can obtain after-hours, urgent and emergency care.
   a) For emergency care, members are instructed to go directly to the nearest emergency room.
   b) Cox HealthPlans has contracts with urgent care centers, including hospital-based urgent care centers for immediate care for conditions that are not life-threatening.
   c) Walk-in Clinics with extended hours
   d) Virtual Visits are offered Monday through Friday 8 am – 8 pm and Saturday and Sunday 10 am – 4 pm.

2) Cox HealthPlans informs members of how to access after-hours, urgent and emergency care.
   a) Provider Directory – identifies Cox HealthPlan providers
   b) “Right Care/ Right Now” Flyer is provided to members and posted on the Cox HealthPlan website to help members identify ways to access care 24/7, including lists of urgent care centers.

3) Significant medical advice or direction given to a member, either online, via telephone, after hours, or during other such activities, is recorded in the member’s clinical record.

4) Cox HealthPlans monitors member’s access to after-hour care through member satisfaction surveys, reviewing hours of after-hour care facilities, and patient complaints.

Primary Care and Specialist Responsibilities

All contracted, credentialed providers participating with Cox HealthPlans are listed in the Provider Directory, which is provided to beneficiaries and made available to the public via the online provider directory at:

https://coxhealthmedicareadvantage.com/find-a-physician/
https://cmhmedicareadvantage.com/find-a-physician/
https://phelpshealthmedicareadvantage.org/find-a-physician/

Role of the PCP

Cox HealthPlans beneficiaries must select a participating PCP at the time of enrollment. The PCP is responsible for managing all the health care needs of the beneficiary as follows:

• Manage the health care needs of the beneficiaries who have chosen the physician as their PCP.
• Ensure that each beneficiary receives treatment as frequently as is necessary based on the beneficiary's condition.
• Develop an individual treatment plan for each beneficiary.
• Submit accurate and timely claims and encounter information for clinical care coordination.
• Comply with Cox HealthPlans' pre-authorization and referral procedures, as applicable.
• Refer beneficiaries to appropriate Cox HealthPlans Participating Providers.
• Comply with Cox HealthPlans' Medical Management, Quality Improvement and Utilization Management programs.
• Use appropriate designated ancillary services.
• Comply with emergency care procedures.
• Comply with Cox HealthPlans' access and availability standards as outlined in this manual, including after-hours care.
• Bill Cox HealthPlans on the current CMS 1500 claim form or electronically in accordance with Cox HealthPlans billing procedures.
• Ensure that, when billing for services provided, coding is specific enough to accurately capture the acuity and complexity of a beneficiary's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
• Comply with Preventive Screening and Clinical Practice Guidelines.
• Adhere to Cox HealthPlans' medical record standards as outlined in this manual.

Role of the Specialist

Each Cox HealthPlans beneficiary is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a beneficiary as follows:

• Provide specialty health care services to beneficiaries as needed.
• Collaborate with the beneficiary's Cox HealthPlans Primary Care Physician to enhance continuity of health care and appropriate treatment.
• Provide consultative and follow-up reports to the referring physician in a timely manner.
• Comply with access and availability standards as outlined in this manual including after-hours care.
• Comply with Cox HealthPlans' pre-authorization and referral process, as applicable
• Comply with Cox HealthPlans' Quality Management and Utilization Management programs.
• Bill Cox HealthPlans on the CMS 1500 claim form in accordance with Cox HealthPlans' billing procedures.
• Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a beneficiary's condition and ensure that the codes submitted are supported by proper documentation in the medical record.

• Refer beneficiaries to appropriate Cox HealthPlans Participating Providers.
• Submit encounter information to Cox HealthPlans accurately and timely.
• Adhere to Cox HealthPlans' medical record standards as outlined in this manual.

Administrative, Medical and Reimbursement Policy Changes

From time to time, Cox HealthPlans may amend, alter or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards and modification of Covered Services. Specific Cox HealthPlans policies and procedures may be obtained by calling our Provider Services at 417.269.2900, option 5.

Cox HealthPlans will communicate changes to the Provider Manual through the use of a variety of methods including but not limited to:
• Annual Provider Manual updates
• Letter
• Facsimile
• Email
• Provider newsletters
• Website updates

Providers are responsible for the review and inclusion of policy updates in the provider manual, periodically checking Cox HealthPlans' website for updates, and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Communication Among Providers

• The PCP should provide the Specialist Physician with relevant clinical information regarding the beneficiary's care.
• The Specialist Physician must provide the PCP with information about his/her visit with the beneficiary in a timely manner.
• The PCP must document in the beneficiary's medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Continuity of Care

CHP will notify and assist MA members in transferring to new provider if the member's current provider terminates from the provider network.

All CHP Medicare Advantage (MA) members will have their health care needs assessed and coordinated within 90 days of enrollment. As part of the assessment and coordination, there is a minimum 90-day transition period for any active course(s) of treatment when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a MA plan and enrollees new to Medicare. CHP will not reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days. Approval of a prior authorization request for a course of treatment will be valid for as long as medically necessary to avoid

disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation.

Cox HealthPlans will abide by any state or federal regulations pertaining to continuity of care.

Beneficiary Assignment to new PCP

Cox HealthPlans Primary Care Physicians have a limited right to request a beneficiary be assigned to a new Primary Care Physician. Such requests cannot be based solely on the filing of a grievance, appeal or the request for a secondary review or other action by the beneficiary. A provider may request to have a beneficiary moved to the care of another provider due to the following behaviors:

• Fraudulent use of services or benefits.
• The beneficiary is disruptive, unruly, threatening, or uncooperative to the extent that beneficiary seriously impairs Cox HealthPlans' or the provider's ability to provide services to the beneficiary or to obtain new beneficiaries and the aforementioned behavior is not caused by a physical or Behavioral Health condition.
• Threats of physical harm to a provider and/or office staff.
• Non-payment of required copayment for services rendered.
• Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
• Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
• The beneficiary steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).
• Other behavior, which results in serious disruption of the beneficiary/physician relationship.

The provider should make reasonable efforts to address the beneficiary's behavior, which has an adverse impact on the beneficiary/physician relationship, through education and counseling, and if medically indicated, coordination with appropriate Specialists.

If the beneficiary's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP must notify Provider Services at (417)269-2900, option 5. Provider Services will research the concern and document all actions taken by the provider and Cox HealthPlans to cure the situation. This may include beneficiary education, counseling or re-assignment. A Cox HealthPlans PCP cannot request a disenrollment based on adverse change in a beneficiary's health status or utilization of services medically necessary for treatment of a beneficiary's condition.

Procedure

1. Once the physician has determined that the physician/beneficiary relationship has been irreparably harmed, the physician should contact Provider Services and provide details and documentation to support their decision.
2. The physician is required to send the beneficiary a notice informing them of their decision to terminate the physician/beneficiary relationship. The notice must be sent to the beneficiary at least 30 calendar days in advance of discharging a beneficiary from a practice.

3. The physician is required to continue beneficiary care for at least 30-45 days or longer to allow the beneficiary time to select and be assigned a new PCP.
4. The physician will transfer, at no cost, a copy of the medical records of the beneficiary to the new PCP, if necessary, and will cooperate with the beneficiary's new PCP in regard to transitioning care and providing information regarding the beneficiary's care needs.
5. A beneficiary may also request a change in PCP for any reason. The PCP change that is requested by the beneficiary will be effective the first (1st) of the month following the receipt of the request.

Provider Delegation

• Delegation is a formal process by which Cox HealthPlans enters into a written contract with an entity to provide administrative or health care services for beneficiaries on Cox HealthPlans' behalf.
• The decision of what function may be considered for delegation is determined by the type of participation agreement a provider group has with Cox HealthPlans, as well as the ability of the provider group to perform the function.
• Although Cox HealthPlans can delegate the authority to perform a function, it cannot delegate the responsibility.
• Delegated providers must comply with the responsibilities outlined in their Provider Agreement and Cox HealthPlans policies and procedures.

Non-Discrimination and Cultural Competency

Participating providers shall provide health care services to all beneficiaries, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

Participating providers shall provide covered services in a culturally competent manner to all beneficiaries by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

Cox HealthPlans offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) beneficiaries. Providers can call Provider services at (417-269-2900, option 5 to assist with translator and TTY services if these services are not available in their office location.

Physician Rights and Responsibilities

In addition to the rights and responsibilities outlined in your agreement with Cox HealthPlans, Physicians have the following rights and responsibilities:

• Cox HealthPlans encourages your feedback and suggestions on how service may be improved within the organization.
• If an acceptable beneficiary-physician relationship cannot be established with a Cox HealthPlans beneficiary who has selected you as his/her Primary Care Physician, you may request that Cox HealthPlans have that beneficiary removed from your care.
• You may request claims reconsideration on any claims submissions in which you feel are not paid according to payment policy.
• You may request an Appeal on any claims submission in which you feel are not paid in keeping with the level of care rendered or Clinical Practice Guidelines.
• You may request to discuss any referral / authorization request with the Medical Director or Chief Medical Officer at various times in the review process.

Physician responsibilities
• You must treat Cox HealthPlans beneficiaries the same as all other beneficiaries in your practice, regardless of the type or amount of reimbursement.
• Primary Care Physicians shall use best efforts to provide beneficiary care to new beneficiaries within four (4) months of enrollment with Cox HealthPlans.
• Primary Care Physicians shall use best efforts to provide follow-up beneficiary care to beneficiaries that have been in the hospital setting within ten (10) days of hospital discharge.
• Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization. (HMO)
• All providers are required to code to the highest level of specificity necessary to accurately and fully describe a beneficiary’s acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
• Specialists must coordinate the referral process (i.e., obtain authorizations) for further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the beneficiary is under the direction of the Specialist.
• In the event you are temporarily unavailable or unable to provide beneficiary care or referral services to a Cox HealthPlans beneficiary, you must arrange for another physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room.
• You must provide continuity of care upon termination in accordance with your contract.
• You must utilize Cox HealthPlans’ participating physicians/facilities when services are available and can meet your beneficiary’s needs. Approval prior to referring outside of the contracted network of providers may be required.
• You must participate in Cox HealthPlans’ peer review activities as they relate to the Quality Management/ Utilization Review program.
• You must cooperate with Cox HealthPlans’ Quality Improvement (QI) activities to improve the quality of care and services and the beneficiaries’ experience to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization’s QI programs.
• You must allow Cox HealthPlans to use your performance data; including the collection, evaluation and use of data in the participation of data for quality improvement activities.
• You must maintain beneficiary information and records in a confidential and secure manner.

• As a practitioner or provider of care you affirm to freely and openly discuss with beneficiaries all available treatment options regardless of whether the services may be covered services under the beneficiary's benefit plan. This includes all treatment options available to them, including medication treatment options, regardless of benefit limitations.
• You may not balance bill a beneficiary for providing services that are covered by Cox HealthPlans. This excludes the collection of standard copays. You may bill a beneficiary for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the Claims section of this manual.
• All claims must be received within the timeframe specified in your contract.

Provider Participation

Providers must be contracted with and credentialed by Cox HealthPlans or its delegates to participate in the Cox HealthPlans Medicare Advantage provider network.

Emergency or Disaster Situations

In the event of a Presidential emergency declaration, a Presidential major disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Cox HealthPlans is responsible for ensuring beneficiaries have access to providers, services and medications during disasters and emergencies to avoid significant disruption.

When a Presidential state of emergency proclamation or executive order is received, a notice is posted on the Cox HealthPlans online provider portal.

In order to ensure impacted beneficiaries have access to the services needed as of declaration effective date, Cox HealthPlans:
• Waives the 30-day notification requirement to beneficiaries as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the beneficiary;
• Allows Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR § 422.204(b)(3), be furnished at Medicare certified facilities).

Cox HealthPlans maintains the above in effect until the declaration is lifted or expires.

Provider Directory Update Requirements

CMS requires all Medicare Advantage Organizations (MAOs) to outreach to contracted providers on a quarterly basis in order to verify provider's demographic data published in the Cox HealthPlans Provider Directories. CMS also requires MAOs to update Provider Directories within 30 days of receipt of new or revised demographic information.

Cox HealthPlans utilizes the Council for Affordable Quality Healthcare (CAQH) to make quarterly outreaches to contracted practitioners. For all other provider types, Cox HealthPlans, or their delegate, reaches out via email and provides instructions to complete the quarterly attestation process.

If you move locations, change phone numbers or any other demographic information, update the information within seven days of the change. Please do not wait for the quarterly update to make such a change. If you are a practitioner, visit the CAQH site to make the updates. If you are a facility/ancillary provider, submit your changes by visiting Chsproviderdatavalidation.com/.

As a contracted provider, you are required to comply with the outreach request and supply updated information within the allotted timeframe. Failure to provide a response to the quarterly outreach will result in suppression from our Provider Directory.

Suppression from the Directory means that beneficiaries and other providers will not be able to view you as a Participating Provider in the Cox HealthPlan networks. If you were removed from the Directory and you are a practitioner, visit the CAQH site to update/attest to your demographic information. If you are a facility/ancillary provider, submit your attestation by visiting www.chsproviderdatavalidation.com/.

The accuracy of our Directories directly impacts the beneficiaries we both serve. We take this compliance requirement very seriously and expect that you will cooperate fully with the attestation and validation process. If a provider fails to cooperate, we will take action, including suppression and potential termination from participation from our Medicare Advantage plans.

Provider Communications and Marketing

Participating Providers must adhere to CMS marketing provisions. The information below is a general guideline to assist Cox HealthPlans providers who have contracted with multiple Medicare Advantage plans and accept Medicare FFS beneficiaries to determine what beneficiary outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limited number of plans, based on the financial interest of the provider or agent. Providers should remain neutral parties when assisting beneficiaries with enrollment decisions.

Providers can:

- Mail/call their beneficiary panel to invite beneficiaries to general educational events run by Cox HealthPlans to learn about the Medicare and/or Medicare Advantage program. This is not a sales/marketing meeting. No sales or plan materials can be distributed. Sales representative cards can be provided upon request.
- Have additional mailings (unlimited) to beneficiaries about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify beneficiaries in a letter of a decision to participate in Cox HealthPlans sponsored programs.
- Utilize a provider/beneficiary newsletter to communicate information to beneficiaries on a variety of subjects.
- Provide objective information to beneficiaries on specific plan formularies, based on a beneficiary's medications and health care needs.

• Refer beneficiaries to other sources of information, such as the State Health Insurance Assistance Program(SHIP), Cox HealthPlans marketing representatives, state Medicaid, or 1-800-Medicare to assist the beneficiary in learning about the plan and making a health care enrollment decision.
• Display and distribute Cox HealthPlans plan marketing materials in common areas of provider offices. The office must display or offer to display materials for all participating MA plans.
• Notify beneficiaries of a physician's decision to participate exclusively with Cox HealthPlans for Medicare Advantage or to close panel to original Medicare FFS if appropriate.
• Display promotional and educational items with the Cox HealthPlans logos; however, promotional items cannot be displayed in areas where care is being delivered.
• Allow Cox HealthPlans to have a room/space in provider offices completely separate from where beneficiaries are receiving care, to provide beneficiaries' access to a Cox HealthPlans Medicare Advantage sales representative.

Providers cannot:
• Urge or steer patients towards any specific plan or limited set of plans.
• Accept or collect Medicare scope of appointment or enrollment applications.
• Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
• Conduct health screenings for potential enrollees as a marketing activity.
• Expect or accept compensation directly or indirectly from a plan for any marketing or enrollment activities.
• Call patients who are dis-enrolling from the health plan to encourage re-enrollment in a health plan.
• Mail marketing materials to patients on behalf of a health plan.
• Call patients to invite them to sales activities for a health plan.
• Advertise using Cox HealthPlans' name without Cox HealthPlans' prior consent.

The information contained in this section should not be construed as legal advice.
Providers should consult the Medicare Communication and Marketing Guidelines
Published by CMS to learn more about CMS's requirements regarding provider outreach.

Medical Record Standards

Cox HealthPlans requires the following items in beneficiary medical records:

• Identifying information of the beneficiary.
• Identification of all providers participating in the beneficiary's care and information on services furnished by these providers.
• A problem list, including significant illnesses and medical and psychological conditions.
• Presenting complaints, diagnoses and treatment plans.
• Prescribed medications, including dosages and dates of initial or refill prescriptions.
• Information on allergies and adverse reactions (or a notation that the beneficiary has no known allergies or history of adverse reactions).
• Information on advanced directives, documented in a prominent place in the medical record.
• Past medical history, physical examinations, necessary treatments, and possible risk factors for the beneficiary relevant to the particular treatment.

Note: Unless otherwise specifically stated in your provider services agreement, medical records shall be provided promptly and at no cost to Cox HealthPlans and Cox HealthPlans beneficiaries. Failure to respond quickly to medical record requests may impact your future participation with us.

Pharmacy

Pharmacy Prescription Benefit

Part D drug formulary

Detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, any plan year negative changes, and most recent plan formularies is available here:
https://coxhealthmedicareadvantage.com/prescription-drug-search/
https://cmhmedicareadvantage.com/prescription-drug-search/
https://phelpshealthmedicareadvantage.org/prescription-drug-search/

Cox HealthPlans utilizes a customized classification system defined by the Pharmacy and Therapeutics (P&T) Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. Cox HealthPlans includes all or substantially all drugs in protected classes, as defined by The Centers for Medicare and Medicaid Services (CMS). The Pharmacy and Therapeutics (P&T) Committee reviews all formularies for clinical appropriateness, including the utilization management edits placed on formulary products. Cox HealthPlans submits all formulary changes to CMS according to the timelines designated by CMS.

A Part D drug is a drug that meets the following criteria:

- May be dispensed only by prescription
- Approved by the FDA
- Used and sold in the US
- Used for a medically accepted indication
- Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex and American Hospital Formulary Service Drug Information (AHFS-DI). On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication.
- National Comprehensive Cancer Network (NCCN), Clinical Pharmacology, and Lexicomp, as well as peer-reviewed literature are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.
- Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems not otherwise covered under Medicare Part B).

Drugs excluded under Part D include the following:

- Drugs for which payment as so prescribed or administered to an individual is available for that individual under Part A or Part B

• Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (with the exception of smoking cessation products)
• Drugs for anorexia, weight loss or weight gain
• Drugs to promote fertility
• Drugs for cosmetic purposes and hair growth
• Drugs for symptomatic relief of coughs and colds
• Vitamins and minerals (except for prenatal vitamins and fluoride preparations)
• Non-prescription drugs
• Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
• Agents used for treatment of sexual or erectile dysfunction (ED) (except when prescribed for other FDA-approved indications such as pulmonary hypertension)

Part D Utilization Management

Cox HealthPlans formularies include utilization management requirements that include Prior Authorization, Step Therapy and Quantity Limits. The Part D utilization management is available here:
https://coxhealthmedicareadvantage.com/prescription-drug-search/
https://cmhmedicareadvantage.com/prescription-drug-search/
https://phelpshealthmedicareadvantage.org/prescription-drug-search/

Prior Authorization (PA)

For a select group of drugs, Cox HealthPlans requires the beneficiary or their physician to get approval for certain prescription drugs before the beneficiary is able to have the prescription covered at their pharmacy. A PA requirement is placed on certain drugs to gather necessary information to determine if the drug should be covered under the beneficiary's Medicare Part B or Part D benefit. Another common reason for a drug's PA requirement is to ensure that a drug is being used for a medically accepted or Part D allowed indication as defined above. Finally, some drugs may have more detailed PA criteria that also require submission of medical information, such as lab results, and current and/or past medication history.

Step Therapy (ST)

For a select group of drugs, Cox HealthPlans requires the beneficiary to first try and fail certain drugs/drug classes to treat their medical condition before covering another drug for that condition.

Quantity Limits (QL)

For a select group of drugs, Cox HealthPlans limits the amount of the drug that will be covered without prior approval.

How to File a Coverage Determination (CD)

A coverage determination (CD) is any decision that is made by or on behalf of a Part D plan sponsor regarding payment or benefits to which a beneficiary believes he or she is entitled.
Coverage determinations may be received orally or in writing from the beneficiary (or appointed representative), the beneficiary's prescribing physician.

Requests for prior authorization can be submitted using the online forms available on our website.

For standard requests, the prescriber will receive the outcome of a coverage determination via phone, fax or a letter placed in USPS mail no later than seventy-two (72) hours after the initial request was received or receipt of the supporting statement. For urgent requests, the prescriber will receive the outcome notification via phone, fax or a letter placed in USPS mail no later than twenty-four (24) hours after the initial request was received or receipt of the supporting statement. If the request is regarding payment for a prescription drug the beneficiary already received, an expedited request is not permitted, patients can request reimbursement and Cox HealthPlans will provide a decision and written notice no later than fourteen (14) calendar days from the date the request was received.

The following information will be provided:

Decided Outcome of the Case	
Denied	1. The specific reason for the denial taking into account the beneficiary's medical condition, disabilities and special language requirements, if any; 2. Information regarding the right to appoint a representative to file an appeal on the beneficiary's behalf; and 3. A description of both the standard and expedited redetermination processes and timeframes including conditions for obtaining an expedited redetermination and the appeals process.
Approved	1. The duration of an approval; 2. Limitations associated with an approval; and/or any coverage rules applicable to subsequent refills.

How to File a Part D Appeal

A Part D appeal, or redetermination, must be filed within 60 calendar days from the date printed/written on the coverage determination denial letter and can be received orally or in writing from a beneficiary, beneficiary's representative, beneficiary's prescribing physician or other physician. For a standard Part D appeal, Cox HealthPlans will provide a decision and written notice no later than seven (7) calendar days from the date the request was received. For an expedited/ urgent Part D appeal, Cox HealthPlans will provide a decision no later than seventy-two (72) hours after receiving the appeal. Requestors may request an expedited appeal in situations where applying the standard time frame could seriously jeopardize the beneficiary's life, health or ability to regain maximum function. Forms and more detailed information regarding a Request for Redetermination of Medicare Prescription Drug Denial are available on our website.

If the request is regarding payment for a prescription drug the beneficiary already received, an expedited appeal is not permitted and patients can request prescription drug claim reimbursement.

Such requests must be received in writing. Cox HealthPlans will provide a decision and written notice no later than fourteen (14) calendar days from the date the request was received.

Part D Appeals Contact Information:
• Phone: 855.476.5985 TTY 711
• Fax: 877.503.7231

Pharmacy Quality Improvement (PQI)

The Cox HealthPlans Quality Department maintains clinical programs that meet or exceed CMS and NCQA standards, drive improvements in CMS STAR ratings and NCQA HEDIS metrics, and continually strive to improve quality of pharmacy care and prevent under- or overutilization of medication therapy among our members. These programs include, but are not limited to:
• Medication Therapy Management (MTM)
• Opioid Drug Management Program(DMP)
• Case Management Pharmacy Referral Programs
• Clinic-Based Pharmacists
• Population Health: Pharmacy and Medical Integration
• Drug Utilization Review (DUR)
• Pharmacy Stars Support Programs

A description of each program is included below.

Medication Therapy Management (MTM)

Cox HealthPlans' Medication Therapy Management (MTM) program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing medication adherence, and recognizing potential cost savings opportunities. The program is designed for patients that satisfy certain criteria provided by CMS.

Eligible members are automatically enrolled into the program and sent a welcome letter encouraging each beneficiary to call to complete their Comprehensive Medication Review (CMR) before their annual wellness visit with their provider. A comprehensive medication review is a personal review of prescriptions, OTC medications, herbal therapies, and dietary supplements with a clinical pharmacist. After the completion of the CMR, any potential drug therapy problems (DTPs) that were identified are sent to the prescribing provider and/or primary care provider by mail or fax. Along with DTPs, the provider also receives an updated list of the beneficiary's medication history through the previous 4 months. An individualized letter, which includes a personal medication record of all medications discussed and a medication action plan, is also mailed to the beneficiary.

In addition to the CMR, beneficiaries also receive targeted medication reviews (TMRs) quarterly. The TMRs are generated using the MTM software to review for specific drug therapy problems (DTPs). If any DTPs are identified, a letter may be mailed or faxed to the prescribing provider and/or primary care provider.

There is no additional cost for participation in the MTM program. MTM Program CMR completion rate is a Part D Star rating based off the percentage of beneficiaries who meet eligibility criteria for MTM program and who receive a CMR.

Opioid Drug Management Program (DMP)

Cox HealthPlans' Opioid DMP is designed to identify patterns of inappropriate opioid utilization with the goal to enhance patient safety through improved medication use. Quarterly reports are generated using an algorithm aligned with CMS criteria that identifies beneficiaries who may be potentially at risk of opioid overutilization. Members are identified either based on the number of prescribers, pharmacies, and calculated morphine milligram equivalent (MME) per day or having a history of an opioid-related overdose and recent opioid utilization. Individuals who have active cancer-related pain, sickle cell disease, are receiving hospice or palliative care, or are a resident of a LTC facility are excluded from the program.

Clinical staff review claims data of all identified members who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will fax written notification letters to the prescribers involved in the beneficiary' 's care, requesting information pertaining to the medical necessity and safety of the current opioid regimen. Cox HealthPlans clinical staff may reach out to discuss the case with the patient's opioid prescriber(s) in an attempt to reach a consensus regarding the patient's opioid regimen.

If clinical staff is able to engage with prescribers, then action will be taken based on an agreed upon plan. In the most severe cases, clinical staff may collaborate with the prescriber(s) to implement member-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may apply to opioid and/or benzodiazepine medications and may require members to use only selected pharmacies or prescribers for selected medications or limit the amount of opioid or benzodiazepine medication covered by the health plan. If Cox HealthPlans does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multi-disciplinary team according to CMS requirements.

As part of our ongoing partnership with providers to reduce unnecessary use and diversion of controlled substances, Cox HealthPlans encourages prescribers and pharmacists to fully utilize their state's prescription drug monitoring program (PDMP). You can locate your state's PDMP at https://www.pdmpassist.org/state .

Population Health: Pharmacy & Medical Integration

Cox HealthPlans' Population Health pharmacy team develops and/or coordinates initiatives to reduce medical and pharmacy costs, improve patient health outcomes and increase pharmacy-related quality ratings. The team also provides pertinent pharmacy benefits and services education to internal and external stakeholders, including providers and provider office support staff.

Drug Utilization Review (DUR)

Drug Utilization Review (DUR) is a structured, ongoing review of prescribing, dispensing and use of medication to identify potential drug therapy problems (DTPs) that could result in adverse drug events. Retrospective Drug Utilization Review (rDUR) evaluates prescription drug claims data (after the medications have been dispensed to the patient), and concurrent Drug Utilization Review (cDUR) is typically performed at the point-of-sale, or point of distribution, by automated checks that are integrated in the pharmacy claims processing system (before the medications have been dispensed to the

patient). Cox HealthPans clinical staff tracks and trends all DUR data on a monthly or quarterly basis. Types of DTPs that are identified and addressed through Cox HealthPlans' DUR programs include, but are not limited to:

- Underutilization or failure to refill prescribed medications
- Drug-drug and drug-disease interactions
- Overutilization or duplicate therapy
- Narcotic safety including potential abuse or misuse
- Use of medications classified as high risk for use in the older population

Cox HealthPlans' rDUR is conducted through various channels. As a part of Cox HealthPlans' rDUR programs, prescribers are alerted of DTPs through mail, fax, or electronic health record (EHR) integrated messaging solution (where available).

Cox HealthPlans' cDUR program aligns with CMS requirements for cDUR opioid safety edits. Safety controls will be implemented at point-of-sale, including "soft" and "hard" cDUR edits, which will both reject opioid claims that meet certain utilization criteria. The dispensing pharmacy may override a "soft" rejection by entering the appropriate pharmacy professional service (PPS) codes upon consulting the prescriber and/or determining safe and appropriate use of the medication. "Hard" rejections may not be overridden at point-of-sale, and in order to request coverage of the medication(s), a coverage determination must be initiated.

Listed below are the **current opioid cDUR drug safety edits**, which align with CMS guidance on required and recommended utilization management of opioid prescriptions:

- Opioid prescriptions are limited to a maximum of a 1-month supply OR a 7-day supply in opioid naïve beneficiaries. Cox HealthPlans defines "opioid naïve" as beneficiaries who have not had an opioid medication filled within the past 120 days. This is a "hard" cDUR edit and will require a coverage determination for coverage under the beneficiary's part D plan if a day supply exceeding these limits is needed. However, if the member meets a specific exemption (including not being truly opioid-naïve, palliative care, cancer, long-term care, and sickle cell anemia), the dispensing pharmacist may use pharmacy professional service (PPS) codes to override this "hard" rejection.

- Opioid prescriptions for beneficiaries who have claims exceeding a total of 90 morphine milligram equivalents (MME) per day AND have 2 or more opioid prescribers will receive a "soft" rejection at point-of-sale. A coordination of care between the prescriber and dispensing pharmacist is encouraged.

Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use pharmacy professional service (PPS) codes to override the “soft” rejection.

• Opioid prescriptions will “soft” reject at point-of-sale if an interaction with a benzodiazepine from a different prescriber is detected. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides beneficiary counseling, and/or determines that it is safe to dispense the medication(s).

• Opioid prescriptions for long-acting opioid medications will “soft” reject at point-of-sale if a duplication of therapy is detected between 2 or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides beneficiary counseling, and/or determines that it is safe to dispense the opioid medication(s).

Pharmacy Stars Support Programs

Cox HealthPlans has multiple programs to specifically target pharmacy-related Part C & D metrics. These programs help support the following Medicare Part C & D Star measures:
• Statin Use in Persons with Diabetes
• Statin Therapy for Patients with Cardiovascular Disease
• Medication Adherence for Diabetes Medications
• Medication Adherence for Hypertension (RAS Antagonists)
• Medication Adherence for Cholesterol (Statins)
• Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)
• Concurrent Use of Opioids and Benzodiazepines (COB)

Low Income Subsidy Program

The Federal Medicare “Extra Help” program, also known as the Low Income Subsidy (LIS) program, provides extra help to assist with Medicare prescription drug costs for individuals who have limited income and resources. Although most beneficiaries who are eligible for Low Income Subsidy benefits will automatically qualify for this program, there are many others who may qualify by applying for this valuable benefit. As a result, many individuals may not even know they are eligible. The Extra Help program has many benefits for qualified individuals including:

• Low or no monthly Part D premiums
• Low or no initial Part D deductible
• Coverage in the Donut Hole or Coverage Gap
• Greatly reduced costs for prescription drugs that are covered by the Medicare Part D plan and/or
• 90-day supply of Medicare Part D covered drugs for the same cost as a 30 -day supply (applies to most but not all beneficiaries who quality for Extra Help)

Eligibility

To be eligible for the Extra Help program individuals must reside in one of the 50 states or the District of Columbia and meet certain income and resource limits. Resources include items like savings, stocks and money in checking/savings accounts, but will not include an individual’s home or car. Income limits, set

by the federal government, are used to determine eligibility for the Extra Help program and are based on the Federal Poverty Level (FPL) published by Department for Health & Human Services (DHHS).

Applying For Extra Help

Individuals with limited income and resources may qualify for Extra Help to reduce their out -of- pocket costs. Applying for Extra Help is easy. Cox HealthPlans beneficiaries can choose from the following options:

- Phone call to the Social Security Administration (SSA) at 800.772.1213 (TTY 800. 325.0778) to apply over the phone or to request a paper application
- Apply online at SocialSecurity.gov/extrahelp

If an individual does not qualify for the Extra Help Program, state programs may be available to help pay for prescription drug cost. Cox HealthPlans encourages all beneficiaries to inquire about these Federal and State Programs.

Pharmacy Networks

Cox HealthPlans provides access to pharmacies throughout the country. This extensive network gives our beneficiaries – your patients – convenient access to many pharmacies in their area to choose for their unique pharmacy needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, mail order/home delivery pharmacy options are available, as well.

Preferred Pharmacy Network

There are also a large number of pharmacies in our preferred pharmacy network, which offer lower copays on most prescriptions. Large national and regional chains in the preferred pharmacy network include CVS, Walmart, and other pharmacies. A more detailed list of preferred pharmacies is available on our website along with the full listing of the provider directories, which include network pharmacy providers. Patients can choose to use a pharmacy in either the standard or preferred network according to their needs, but only preferred pharmacies can offer reduced cost sharing on prescription drugs. This can often result in significant total savings over the course of a year, especially for beneficiaries that take multiple prescription medications.

Home Delivery Pharmacy

One of the most important ways to improve the health of your beneficiaries is to make sure they receive and take their medications as you prescribe.

Your patients can receive a three-month supply of their medications through mail order, making it easier for the beneficiary as they only fill their script four times per year. Using preferred mail order may lower their costs, sometimes to as low as $0, and improve their adherence. Talk to your patients about home delivery. We contract with network pharmacies throughout the country, including major retail pharmacy chains and independent pharmacies. A complete listing can be found on our website.

Medical Health Services

Overview

Cox HealthPlans' Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the beneficiary.

Cox HealthPlans will provide a full range of customary utilization review and care management services, and except in the case of an Emergency Medical Condition, pre-authorize those services if required by the beneficiary's Benefit Plan, including hospital inpatient stays or confinement. You are responsible to participate in and comply with Cox HealthPlans' utilization management program requirements, and provide medical records and other information, including access to electronic medical records, as requested.

Cox HealthPlans Utilization Management staff base their utilization-related decisions on the clinical needs of beneficiaries, the beneficiary's Benefit Plan, well-established clinical decision-making support tools, the appropriateness of care, CMS Guidelines, health care objectives, and scientifically based clinical criteria and treatment guidelines in the context of provider and/or beneficiary-supplied clinical information and other such relevant information.

Cox HealthPlans in no way rewards or incentivizes, either financially or otherwise, practitioners, Utilization Reviewers, clinical care managers, physician advisers or other individuals involved in conducting Utilization Review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the beneficiary's health plan benefits.
- To monitor utilization practice patterns of Cox HealthPlans' contracted physicians, hospitals, ancillary services, and specialty providers.
- To provide a system to identify high-risk beneficiaries and ensuring that appropriate care is accessed.
- To provide Utilization Management data for use in the process of re-credentialing providers.
- To educate beneficiaries, physicians, contracted hospitals, ancillary services, and specialty providers about Cox HealthPlans' goals for providing quality, value-enhanced managed health care.
- To improve utilization of Cox HealthPlans' resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Departmental functions

- Prior Authorization
- Concurrent Review
- Discharge Planning
- Care Management and Disease Management

• Continuity of Care

Prior authorization

Cox HealthPlans requires authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. The authorization is typically obtained by the ordering provider, but may also be requested by the rendering provider.

Participating providers are responsible for requesting Prior Authorization on behalf of the beneficiary when required. Prior Authorization submission is recommended at least fourteen (14) Business days in advance of the admission, procedure, or service when possible. Requests must include all pertinent clinical information to support the medical necessity of the services requested. The beneficiary may also request a determination prior to delivery of services. In this event, Cox HealthPlans will contact you for clinical information to support the request.

If prior authorization cannot be timely obtained, Cox HealthPlans and the appropriate participating provider must be notified, as applicable, as soon as possible, but no later than twenty-four (24) hours after providing the covered services, or ordering the covered services, or on the next working day.

Please refer to the Authorization Requirements located in your provider portal here: Cox Health Plans Provider Portal (healthx.com). If you are uncertain about the precertification requirement for a specific procedure, you may also outreach to our Provider Service from at 417.269.2900, option 5.

Precertification request forms can be found on our website. Using the forms when faxing a Precertification Request provides the team with needed information to complete the request. Please include clinical information to support your request at time of submission.

Requirements will be routinely updated on a quarterly basis due to program or CPT/HCPCS coding changes. It is recommended that you check the authorization requirements via the provider portal frequently and prior to delivering planned services. Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status, and benefits at the time the service is rendered.

The presence or absence of a service or procedure on the list does not determine coverage or benefits.

Log in to your Provider Portal or contact Provider Services to verify benefits, coverage, and beneficiary eligibility. Authorization requests may be submitted by phone, fax, the chat feature on our website, or by mail 24 hours a day, 7 days a week. After confirming a beneficiary's eligibility and the availability of benefits, providers should submit all supporting documentation with the organization determination request via our Provider Portal, Fax or phone. Contact information for Fax and phone are:

Phone: 417.269.2900, option 5
Fax: 417.269.2919

The Medical Management Department, under the direction of licensed nurses, clinical pharmacists, and medical directors, documents and evaluates requests for prior authorization, including:

• Confirmation that the beneficiary is eligible for services with Cox HealthPlans at the initial start of care
• Verification that the requested service is a covered benefit under the beneficiary's benefit package
• Determination of the appropriateness of the services (medical necessity)
• Validation that the service is being provided by the appropriate provider and in the appropriate setting.
• The Prior Authorization Department documents and evaluates requests using CMS guidelines and nationally recognized criteria to make a determination of coverage. The provider may be notified electronically, orally, or in writing within the regulated CMS timeframes.

Examples of information required for a determination include, but are not limited to:
• Beneficiary name and identification number
• Location of service (e.g., hospital or ambulatory care setting)
• Primary Care Physician name along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
• Servicing/attending physician name including National Provider Identifier (NPI)
• Date of service
• Diagnosis
• Service/procedure/surgery description and CPT or HCPCS code
• Clinical information supporting the need for the service to be rendered

In order to provide optimal service to our providers and beneficiaries, submission of clinical information at the time of the request is essential. Cox HealthPlans may outreach to you for necessary information in order to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory timeframes as CMS rules require that appropriate information be requested before decisions are rendered. See below for details regarding decision and notification timeframes.

For beneficiaries who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

Medical Management Department

The Medical Management department consists of nonclinical and clinical support staff trained to receive requests via portal, fax, telephone and mail. Pertinent information will be requested in order to efficiently and accurately process the medical necessity determination. Upon submission of the request, please be prepared with all necessary information noted above inclusive of accurate diagnosis, CPT/HCPCS coding, and rendering provider information.

As necessary, requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity, appropriateness of provider and place of service. Requests that

cannot be approved utilizing CMS and nationally recognized, evidence -based criteria will be forwarded to a Pharmacist or Medical Director for review.

Approval notification may be delivered electronically, orally, or in writing.
Denials for medical necessity are issued only by appropriately licensed personnel such as a Medical Director or Pharmacist depending on the type of service request.

He/she may also make a decision based on administrative guidelines. The Medical Director or Pharmacist, in making the decision, may suggest alternative covered services to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Cox HealthPlans notifies the facility or providers office of the denial. Such notice is issued to the beneficiary and the provider when appropriate, documenting the original request that was denied, the rationale for the decision, the approved service if applicable, and the process for appeal.

Denial rationale will include the specific clinical criteria or benefits provision used in the determination of the denial. Written notifications are sent in accordance with CMS and AAAHC requirements to the provider and/or beneficiary. Upon request, the provider or beneficiary may receive a copy of the clinical criteria used in the decision. To request clinical criteria, visit our website or call provider services at 417.269.2900, option 5.

Cox HealthPlans provides opportunity for providers to discuss adverse determinations with the medical director who made the decision.

After a decision is rendered, a peer-to peer conversation can occur with the purpose of allowing the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide additional clinical information that may be helpful, prior to initiating a formal appeal. Cox HealthPlans will advise the treating provider of the availability of this process when notification of the authorization denial is given Cox HealthPlans in no way rewards or incentivizes, either financially or otherwise, clinical practitioners, utilization staff beneficiaries, clinical care managers, physician advisers or other individuals involved in conducting reviews, for issuing denials of coverage or service or inappropriately restricting care.

Prior authorization requests and timeframes Emergency

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

• Serious jeopardy to the life or health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
• Serious impairment to bodily functions;
• Or, serious dysfunction of any bodily organ or part.

Prior authorization is not required for an emergency medical condition.

Expedited

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the beneficiary's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined and notification will occur within 72 hours of receipt of the request or as soon as the beneficiary's health condition requires. For Part B Drugs, the determination and notification will occur within 24 hours. Please use the appropriate level when submitting organization determinations.

In order to assist us in best meeting our beneficiary’s urgent needs, it is recommended that expedited requests be reserved for services meeting the above criteria and not utilized as a convenience due to a scheduled service.

An expedited request may not be requested for cases in which the only issue involves a claim for payment for services that the beneficiary has already received.

Routine

A routine or standard Prior Authorization request will be determined and notification will occur as expeditiously as the beneficiary’s health condition requires, but no later than 14 calendar days after receipt of the request.

Medical Necessity

Criteria hierarchy for Medical Necessity.

The hierarchy of decision the service must:
- Be a covered benefit in the Member’s Evidence of Coverage;
- Be a benefit that is not otherwise excluded; and
- Be appropriate and Medically Necessary.

The hierarchy of references includes:
- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC)
- MCG, most recent edition available
- Cox HealthPlans Internal Policies
- Additional Medical Director Resources:
- Hayes
- Wolters Kluwer Clinical Drug Information Lexi-Drugs (Up to Date)
- Medical Inquiry Database

Denial or Adverse Organization Determination

An Advanced Beneficiary Notice (ABN) may not be used to hold beneficiaries liable for services unless a preservice adverse organization determination has already been rendered and communicated in writing

via an Integrated Denial Notice (IDN), Applicable Integrated Plan Coverage Decision Letter or the beneficiary's EOC clearly excludes the service from covered services.

Retrospective Review

Retrospective Review is the process of determining coverage for clinical services by applying guidelines/ criteria to support the claim adjudication process after the opportunity for precertification or concurrent review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:
• Authorizations for claims billed to an incorrect carrier.
• As long as you have not billed the claim to Cox HealthPlans and received a denial, you can request a retro authorization from Health Services within 2 business days of receiving the RA from the incorrect carrier.
• If the claim has already been submitted to Cox HealthPlans and you have received a denial, the request for retro authorization then becomes an appeal and you must follow the guidelines for submitting an appeal.
• Cox HealthPlans will retrospectively review any medically necessary services provided to Cox HealthPlans beneficiaries after hours, holidays, or weekends. Cox HealthPlans does require the retro-authorization request and applicable clinical information to be submitted to the Health Services department within 1 business day of the start of care.
• In accordance with Cox HealthPlans policy, retrospective requests for authorizations not meeting the scenarios listed above will not be accepted and claims may be denied for payment.

Drugs/Biologics Part B (medical benefit)

Drugs/Biologics Part Bare covered under the medical benefit in accordance with Medicare Benefit Policy Manual, Chapter 15 and Medicare Managed Care Manual, Chapter 4. Requests for Drugs/Biologics Part B precertification are processed in accordance with Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Precertification requirements for Drugs/Biologics Part Bare available on our Medicare provider facing website.

Precertification requirements ensure appropriate drug utilization by following Centers for Medicare and Medicaid Services (CMS) guidelines according to National Coverage Determinations, Local Coverage Determinations, Medicare Benefit Policy Manual and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Part B Criteria Hierarchy for Medical Necessity: The hierarchy of decision the service must:
• Be a covered benefit in the Member's Evidence of Coverage;
• Be a benefit that is not otherwise excluded; and
• Be appropriate and Medically Necessary.

The hierarchy of references includes:
• National Coverage Determinations (NCD)
• Local Coverage Determinations (LCD)

- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC)
- MCG, most recent edition available
- Cox HealthPlans Internal Policies
- Additional Medical Director Resources:
- Hayes
- Wolters Kluwer Clinical Drug Information Lexi-Drugs (Up to Date)

Convenient ways to obtain precertification for Part B:
- Cox HealthPlans Provider Portal
- By calling the Drugs/Biologics Part B Provider Services department at 417.269.2900, option 5
- By faxing the Drugs/Biologics Part B Medical Management department at 417.269.2919

Home Health Services

Cox HealthPlans requires authorization of home health services and utilizes CMS guidelines and nationally accepted, evidence-based review criteria to conduct medical necessity review of services. Following the completion of the initial assessment by the home health agency (HHA), the HHA has 7 calendar days from the initial visit to establish the care plan and must include all visits needed to establish the plan of care specific to the beneficiary’s needs when requesting authorization. Timely receipt of clinical documentation supports the clinical review process. Failure to comply with notification timelines or failure to provide timely clinical documentation to support the need for home health services or continuation of home health services could result in an adverse determination.

A Medical Director reviews all home health services that do not meet medical necessity criteria and issues a determination. If the Medical Director deems that the services are not medically necessary, the Medical Director will issue an adverse determination (a denial).

The Prior Authorization Nurse will notify the provider and beneficiary verbally and in writing of the adverse determination via notice of denial.

Cox HealthPlans will issue a NOMNC to the home health provider when an adverse determination is rendered resulting in an end to all skilled disciplines in the home. It is the Home Health Provider’s responsibility to deliver the written Notice of Medicare Non- Coverage (NOMNC) provided by Cox HealtlhPlans in accordance with CMS guidelines. The home health provider is responsible for delivering the notice to the beneficiary or their authorized representative/power of attorney (POA) at least 2 calendar days prior to the end date of the currently approved authorization, or the second to last day of service if care is not being provided daily. For services less than 2 calendar days in duration the provider is responsible to issue the NOMNC on the initial visit. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. The provider is responsible for ensuring the beneficiary, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on beneficiary's rights to file a fast-track appeal.

The home health provider is required to send a copy of the signed NOMNC back to Cox HealthPlans promptly in order to ensure the beneficiary’s rights to file a fast-track Appeal are preserved. Receipt of

the NOMNC will be monitored. Cox HealthPlans validates the appropriate receipt of the NOMNC back from home health providers in accordance with CMS guidelines.

Concurrent Review

Concurrent review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of care during inpatient (acute, long term acute care, rehabilitation) and skilled nursing facility admissions in order to ensure:

- Reasonable and necessary covered services or supplies are being provided at the appropriate level of care by a physician, hospital, or other health care provider licensed by the appropriate state or federal agency, or as otherwise approved by Cox HealthPlans.
- Services are not experimental or investigational, are consistent with the symptoms or diagnosis of the beneficiary's condition, disease, ailment or injury.
- Services are not primarily for the personal comfort or convenience of the beneficiary or their family, physician, hospital, or other health care provider.
- Services are the most appropriate supply or level of services that can safely be provided to the beneficiary consistent with standards of good medical practice.
- Services are being administered according to the individual facility contract

All requests for inpatient level of care, are subject to medical necessity review. The fact that a provider has prescribed, performed, ordered, or coordinated a service or course of treatment does not, in and of itself, mean it is medically necessary. In making determinations as to whether a particular covered service is medically necessary, Cox HealthPlans shall consider the terms of the beneficiary's Benefit Plan, Medical National and Local Coverage Guidelines (as applicable), scientifically based clinical criteria, treatment guidelines and decision-making tools, and the beneficiary's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. No service is a covered service unless it is medical necessary.

Cox HealthPlans requires admission notification for the following:

- Elective admissions
- ER and Urgent observation and acute admissions
- Intent to Transfer to Acute Rehabilitation, LTAC and SNF as those admissions require pre-authorization
- Observation and Acute admissions following outpatient procedures

Emergent or urgent admission notification must be received via fax or phone within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled.

Cox HealthPlans' preferred method for Concurrent review is electronic medical record access. Concurrent review documentation can also be received via fax. Live dialogue between our Concurrent review nursing staff and the facilities' UM staff is encouraged to assist with discharge planning and needs. Admission notification and clinical information should be received within 24 hours of admission or observation status. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information Cox HealthPlans has available.

Skilled Nursing Facility Care and Levels

Unless otherwise specifically stated in your provider services agreement, patient level classification varies based upon presenting condition of the patient in conjunction with authorized services/medical necessity.

Standard services, which are included in all levels of care, are as follows:

- Semi-Private room
- Meals
- Provisions of enteral and parenteral nutrition
- 24-hour Nursing care and rehabilitation nursing services
- Pharmacy
- Routine Medication
- Supplies
- Pharmacy Consultation
- Standard DME (durable medical equipment)
- Routine Oxygen
- Routine medical and surgical supplies
- Routine Laboratory Services (i.e.,) PT, PTT, CDC, UA, C & S, SMA 7 and blood glucose
- Chest x-rays, up to one per week
- Routine Doppler Studies
- Discharge planning
- Teaching, training observation by skilled nursing or rehabilitation staff
- Case Management
- Recreational Therapy
- Social Services

SNF Notice of Medicare Non-Coverage (NOMNC)

A Cox HealthPlans or the reviews all ongoing skilled nursing services that do not meet medical necessity criteria and issues a determination. If the Medical Director deems that continued stay is not medically necessary, the Medical Director will issue an adverse determination (a denial).

Cox HealthPlans will issue a NOMNC to the skilled nursing facility with adverse organization determinations/denials when it is determined that services will end and discharge is anticipated in accordance with CMS guidelines. The skilled nursing provider is responsible for delivering the notice to the beneficiary or their authorized representative/power of attorney (POA) at least 2 calendar days prior to the end date of the currently approved authorization. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. The provider is responsible for ensuring the beneficiary, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on beneficiary's rights to file a fast-track appeal.

Adverse determinations – concurrent review Rendering of adverse determinations (denials)
The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits, or eligibility. Every effort is made to obtain all necessary information, including pertinent clinical information and original documentation from the treating provider to allow the Medical Director to make appropriate determinations.

Only a Medical Director may render an adverse determination (denial) based on medical necessity. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to limit an admission or deny an extension of stay, Cox HealthPlans notifies the requesting provider of partial approval of service, documenting the original request that was denied and if applicable, the alternative approved service, along with the process for appeal. If the Medical Director makes a determination to deny an admission, Cox HealthPlans notifies the requesting provider and beneficiary of the denial of service, documenting the denial rationale, along with the process for appeal.

Cox HealthPlans provides opportunity for providers to discuss adverse determinations with the medical director who made the decision.

The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide additional clinical information that may be helpful, prior to initiating a formal appeal.

Cox HealthPlans will advise the treating provider of the availability of this process when notification of the authorization denial is given.

The provider may initiate the peer-to-peer discussion by calling the number listed on the denial notification. The provider has three (3) business days following discharge to initiate and complete a peer-to-peer review. We will make the peer-to-peer conversation available after receiving a timely request. If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case.

If the peer-to-peer conversation or review of additional information results in an approval, the physician reviewer informs the provider of the approval. If the conversation does not result in an approval, the physician reviewer informs the provider of the right to initiate an appeal, and explains the procedure.

Cox HealthPlans employees are not compensated for denial of services. The PCP or attending physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (denials)

The reason for each denial, including the specific Utilization Review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and beneficiary as applicable. Written notifications are sent in accordance with CMS and AAAHC requirements to the provider and/ or beneficiary as follows:

- For non-urgent pre-service/standard decisions: within 14 calendar days of the request.
- For urgent pre-service/expedited decisions: *within 72 hours of receipt of the request.
- For urgent concurrent decisions: *within 24 hours of the request.
- For post-service decisions: within 30 calendar days of the request.

*Cox HealthPlans complies with CMS requirements for written notifications to beneficiaries, including rights to appeal and grievances.

Discharge Planning

Discharge planning is a critical component of the process that begins with an early assessment of the beneficiary's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the beneficiary and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Cox HealthPlans' Concurrent Review staff will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan.

Care Management

Care Management Program Goals

Cox HealthPlans may publish and maintain a detailed set of program objectives available upon request in our care management program description. The objectives will be clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Plan demographic and epidemiologic data, and survey data may be used to select program objectives, activities, and evaluations.

Care Management Approach

Cox HealthPlans care management program will be part of the broader population health management strategy and may have a comprehensive multidisciplinary approach to the management of beneficiaries across the spectrum of care with chronic, complex and disease specific care needs. Key components of the Care Management Program are to provide early identification and intervention for beneficiaries with medical, pharmaceutical or behavioral health needs who would benefit from:

- Improved self-management skills
- Referrals to adjunct programs
- Complex Care Management
- Assistance with coordinating plan benefits and/or community resources
- Reduction in the frequency and/or intensity of a chronic illness exacerbation
- Closure of gaps in preventive care measures

Beneficiaries may be stratified and identified for specific programs that meet their needs through a variety of mechanisms including referrals, data analysis for health resource patterns and predictive modeling. Prevalence rates and co-morbidities in each individual market's population of beneficiaries may be evaluated for needed services. Beneficiaries may also be referred for evaluation based on their Health Risk Assessment (HRA) results or by the beneficiary's PCP, specialist, inpatient review nurse or other ancillary services practitioner. Claim or encounter data, pharmacy data, laboratory results, data from the care management/UM process or care management (SNP) process, information from electronic medical records (EMR), and member self-referral may also be used to identify beneficiaries for disease-specific programs. The Care Management Program content includes all information and

interventions that the organization directs at members or practitioners to improve management of a condition or health maintenance (e.g., materials, member reminders, scripts for phone calls).

How to Use Services

Patients that may benefit from care management are identified in multiple ways, including but not limited to: Utilization Management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a Cox HealthPlans beneficiary for care management/care coordinator services, please contact Care Management.

In addition, our beneficiaries have access to information regarding the program via website and may self-refer. The beneficiary has the right to opt out of the program. Once enrolled, an assessment may be completed with the beneficiary and a plan of care with goals, interventions, and needs is established.

Coordination with Network Providers

Cox HealthPlans offers beneficiaries' access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, and alcohol and substance use disorder specialists, as well an ancillary care network. Each beneficiary receives a provider directory annually giving in- depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP (if required), conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the beneficiary's provider leaves the network. A toll-free Customer Service telephone number is provided, and beneficiaries with questions are asked to reach out to the plan. Patients also have access to a series of web-based provider materials.

Our website allows beneficiaries to search the provider directory for doctors, facilities, and pharmacies. Our care management staff will work with you and your staff to meet the unique needs of each beneficiary. Care managers may work with beneficiaries and providers to schedule and prepare for beneficiary visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care.

Program Evaluation

Cox HealthPlans continually monitors the program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the program are accompanied by policy and procedure revisions and staff training as required. The program operates under the umbrella of the plan's Quality Improvement Committee. It is reviewed and updated annually in collaboration with the Quality Improvement Department. The plan's Medical Director, also reviews the program and its Clinical Practice Guidelines at certain intervals and provides improvement recommendations.

Quality Programs

Under the direction of the Centers for Medicare and Medicaid Services the Quality Improvement Organization (QIO) program allows a Beneficiary and Family-Centered Care (BFCC) QIO contractor to improve the quality of care and health outcomes delivered to individuals with Medicare. The BFCC-QIO

contactor will focus on conducting quality of care reviews, discharge and termination of service appeals, and other areas of required review.

Method	The Livanta BFCC – QIO Program (Missouri's Quality Improvement Organization) – Contact Information
CALL	1(888)755-5580 (in Missouri) Monday - Friday 9:00 a.m. – 5:00 p.m. (local time)
TTY	1(888)985-9295 (in Missouri) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Quality Care Management Program

Overview

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage organizations to have an ongoing Quality Improvement (QI) program to ensure health plans have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The requirements for the QI program are based in regulation at 42 CFR§ 422.152.

Cox HealthPlans' QI program is dedicated to improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

Goals and Objectives

The MA QI Program is designed to optimize the quality of the health care to CHP MA plan members with the implementation of CMS Quality of Care elements. This is accomplished by working closely with providers to actively pursue opportunities for improvement through systematic monitoring and evaluation of services.

The MA QI Program goals are to:
• Provide timely access to high-quality healthcare for CHP MA plan members
• Systematically monitor and evaluate the quality and appropriateness of health care and services
• Pursue opportunities to improve safety of health care services by fostering a culture of safety and harm prevention/minimization in patient settings
• Foster effective communication and coordination of care
• Promote effective prevention and treatment of chronic disease
• Make care cost-effective and affordable as possible
• Improve processes to reduce inappropriate and unnecessary care

• Update QI program to reflect focus on Stars performance
• Help patients and their families become active participants in their care
• Educate and offer help to communities to help people lead healthier lives
• Develop, compile, evaluate, and report specific measures and other information to CMS, plan enrollees, and the community.
• Report cost of operations and patterns of utilizations of services to CMS, as well as the availability, accessibility, and acceptability of Medicare approved and covered services.
• Maintain ongoing AAAHC accreditation.

To achieve these goals, the MA QI program focuses on the following objectives:
• Establish and maintain member rights and responsibilities and ensure members are treated with respect, consideration, and dignity
• Ensure members have access/availability to qualified health care practitioners and providers
• Adopt, promote, and monitor evidence based clinical and preventive health guidelines
• Ensure appropriate utilization of services
• Ensure the provider network and health programs are designed to meet the needs of members, including cultural and linguistic considerations
• Make available case and disease management services to members with chronic conditions and complex health care needs
• Regularly review and analyze member and provider data for demographic information and care needs
• Promote health education and wellness among CHP MA plan members
• Conduct health risk appraisals (HRAs) and incorporate the results into the development of member resources and disease management programs
• Monitor and benchmark clinical and service performance indicators and work with delegates to improve care
• Incorporate peer review activities in credentialing and recredentialing
• Conduct ongoing monitoring of provider network regarding quality, sanctions, and licensure issues
• Investigate and ensure timely response to all complaints, grievances and appeals and analyze trends that need to be addressed
• Provide oversight and ongoing monitoring of all delegated activities
• Evaluate the impact and effectiveness of quality improvement activities and the overall Program at least annually
• Communicate results from quality improvement activities with members, providers, and employees
• Ensure adequate resources are dedicated to quality improvement activities.

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the Cox HealthPlans' organization, its affiliates, and delegated entities.

The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and services provided to enrollees for both their physical and behavioral health. The program also defines the health plan's methodology for identifying improvement opportunities and for developing and implementing initiatives to impact opportunities identified.

Scope

The MA QI program encompasses a wide range of clinical and service quality initiatives affecting members and providers, as well as internal stakeholders throughout CHP and Providers. Key areas of focus include:

- Access and availability of network providers
- Behavioral Health Care and Service
- Complaint, appeal, and grievance management
- Continuity, coordination, and transition of care
- Credentialing/Re-credentialing
- Peer review
- Delegation oversight (oversight of entities to which CHP delegates selected functions)
- Health Education and Wellness
- Health Risk Appraisal
- Medical records review and provider facility site reviews
- Member rights and responsibilities
- Member/Provider satisfaction
- Patient safety
- Utilization management of inpatient and outpatient services
- QI initiatives addressing specific focus areas
- Care Coordination and Care management
- Risk Management

Quality Improvement Committee (QIC)

The QIC has oversight authority for Quality Improvement activities across the organization and is responsible for ensuring the development and implementation of Cox HealthPlans' QI program Description, the Annual QI/UM/CM Work Plans, review and approval of Health Service Policies; monitoring credentialing, delegation oversight, beneficiary Appeal activity, and reviewing clinical and service quality initiatives.

To monitor and facilitate implementation of the QI program, the QIC has established appropriate sub-committees that provide oversight of the functions and activities within the scope of the organization's Quality Improvement program. The QIC may also appoint and convene ad hoc work groups as indicated.

Health Care Plan Effectiveness Data and Information Set (HEDIS)

HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) supplemental data (EMR/vendor data), and medical record review data. HEDIS includes measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Controlling High Blood Pressure, Breast Cancer Screening, Medication Reconciliation Post Discharge, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually in June for the prior year and represent a mandated activity for health plans contracting with the Centers for Medicare and Medicaid Services (CMS). A portion of measures are designated as “hybrid” measures and plans are allowed to collect medical record data for the prior measure year during the annual Medical Record Review (MRR) project. This project typically runs from the end of January until the first week in May. Each spring, Cox HealthPlans Representatives collect records from practitioner offices to impact this MRR project and establish final HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Cox HealthPlans’s privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Cox HealthPlans’ HEDIS results are available upon request. Contact the Health Plan’s Quality Improvement Department by email at khammond@coxhealthplans.com to request information regarding those results.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Beneficiary Rights and Responsibilities

Cox HealthPlans beneficiaries have certain rights of which Participating Providers must be aware:

Beneficiaries have the right to:

- Receive information about the organization and its services, practitioners and Providers, and Member rights and responsibilities.
- Be treated with respect, consideration, recognition of your dignity, and right to privacy consistent with professionally recognized standards of care.
- Participate with practitioners in making decisions about your health care.
- Discuss appropriate or medically necessary treatment options for your conditions, regardless of cost of benefit coverage.
- Be informed about, and refuse to participate in any experimental treatment.
- Be informed about applicable fees and payment policies.
- Change your Primary Care Provider (PCP).
- Get information about Cox HealthPlans, our services, network providers, and the credentials of health care professionals.
- Receive complete information concerning a medical evaluation, diagnosis, treatment, and prognosis from your provider.
- Voice complaints or appeals about the organization or the care it provides. Cox HealthPlans adheres to CMS procedures for handling appeals and grievances.
- Make recommendations regarding the Plan’s member rights and responsibilities policy.
- Receive the Benefits to which you are entitled under your Health Plan and Schedule of Benefits.

• Access wellness information to help you maintain a healthy lifestyle.
• Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.
• Interpretive Services as necessary. Non-English-speaking Members can contact the same Customer Services telephone number printed on the back of the ID Card to connect to a language services interpreter.
• Privacy and confidential handling of your disclosures and records. You may approve or refuse their release, except when the release is required by law.
• Cox HealthPlans is committed to protecting the confidentiality and security of health information. A complete privacy statement is provided on an annual basis. It is also accessible at any time on our website.

Beneficiaries have the responsibility to:

• Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
• Provide an accurate health history, including information about medications and over-the-counter products, dietary supplements, and allergies or sensitivities.
• Follow plans and instructions for care that you have agreed to with your practitioners.
• Take part in understanding your health problems and participate in mutually agreed-upon treatment goals, to the degree possible.
• Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship.
• Present your current ID Card each time you receive a medical/pharmaceutical service.
• Inform providers about living wills, medical power of attorney, or other directives affecting care.
• Treat healthcare providers, staff, and others, with respect.
• Know your Provider Network and verify the Provider's status at your time of service.
• Follow up with your Provider to verify Preauthorization is obtained as required by your Health Plan.
• Read and understand your EOC and Schedule of Benefits and other materials from us concerning your health Benefits.
• Understand how to access care in routine, Emergency, and Urgent situations; and to know your health care Benefits as they relate to out-of-area coverage, Deductible/ Co-insurance/ Co-payments, etc.
• Know the limitations and exclusions of your Health Plan.
• Provide timely, accurate, and complete information to us about other health care coverage and/or insurance Benefits you may carry as it pertains to your plan.
• Accept personal fiscal responsibility for costs not covered by insurance if applicable.
• Inform us of changes affecting your coverage including but not limited to your name, address, telephone number, and family status.

Other Beneficiary Rights

- Patients have the right to go to a women's health Specialist (such as a gynecologist) for routine and preventive services without a referral.
- Patients have the right to direct access to mammography.
- Patients shall have direct access to influenza vaccinations. No copay shall be required for

influenza and pneumococcal vaccines.

- Cox HealthPlans shall cover renal dialysis for those temporarily out of a service area.
- To obtain information about their health care coverage and cost; the Evidence of Coverage tells beneficiaries what medical services are covered and what they have to pay. If they need more information, they should call Customer Service. Patients have the right to an explanation from Cox HealthPlans about any bills they receive for services not covered by Cox HealthPlans. Cox HealthPlans must tell beneficiaries in writing why Cox HealthPlans will not pay for or allow them to get a service, and how they can file an appeal to ask Cox HealthPlans to change this decision. Provider's staff should inform beneficiaries on how to file an appeal, if asked, and should direct beneficiaries to review their Evidence of Coverage for more information about filing an appeal.
- To obtain information about Cox HealthPlans, plan providers, drug coverage, and costs
- To receive more information about beneficiaries' rights
    - Patients have the right to receive information about their rights and responsibilities. If beneficiaries have questions or concerns about their rights and protections, they should be directed to call Customer Service. Patients can also get free help and information from their State Health Insurance Assistance Program (SHIP). Additionally, beneficiaries can obtain a free copy of the Beneficiary Medicare Rights and Protections booklet by calling 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.
    - Patients can call 24 hours a day, 7 days a week, or beneficiaries can visit Medicare.gov to order this booklet or print it directly from their computer.
- To take action if a beneficiary thinks they have been treated unfairly or their rights are not being respected
    - If beneficiaries think they have been treated unfairly or their rights have not been respected, there are options for what they can do. If beneficiaries think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, we must encourage them to inform us immediately. They can also call the Office for Civil Rights in their area. For any other kind of concern or problem related to their Medicare rights and protections described in this section, beneficiaries should call Customer Service. Patients can also get help from their State Health Insurance Assistance Program (SHIP).

Benefits and services

All Cox HealthPlans beneficiaries receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, Cox HealthPlans makes available to each participating Primary Care Physician a list of their active beneficiaries. Along with the beneficiary's demographic information, the list includes the name of the plan in which the beneficiary enrolled.

Please be aware that recently terminated beneficiaries may appear on the list. (See the Eligibility section of this manual).

Cox HealthPlans encourages its beneficiaries to call their Primary Care Physician to schedule appointments. However, if a Cox HealthPlans beneficiary calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the beneficiary and explain to them your office policy regarding appointments. If this problem persists, please contact Cox HealthPlans Provider Customer Service number listed in the Quick Reference Guide.

Excluded services

Refer to the plans' specific Explanation of Coverage (EOC) or contact the provider customer center for assistance.

Emergency Services and Care After Hours

An emergency is defined by Cox HealthPlans as the sudden onset of a medical condition with acute

symptoms (the full definition of Emergency Services is located in your Agreement). A beneficiary may reasonably believe that the lack of immediate medical attention could result in:

- Permanently placing the beneficiary's health in jeopardy;
- Causing serious impairments to body functions; or
- Causing serious or permanent dysfunction of any body organ or part

In the event of a perceived emergency, beneficiaries have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life-threatening, beneficiaries have been instructed to go immediately to the nearest emergency room facility. Patients who are unable to contact their PCP prior to treatment have been instructed to contact their PCP as soon as is medically possible or within 48 hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up care or provide training in selfcare as necessary.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a beneficiary's emergency care. The PCP or his/her designee must be available 24 hours a day, seven days a week to assist beneficiaries needing emergency services. The hospital may attempt to contact the PCP for direction.

Patients may have a copayment responsibility for outpatient emergency visits unless an admission results.

Cox HealthPlans will reimburse Non-Participating Providers in accord with CMS requirements for emergency services rendered to beneficiaries if they become injured or ill while temporarily outside the service area. Patients may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent Care Services

Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention due to a beneficiary's unforeseen illness, injury, or condition, it was not reasonable given the circumstances to obtain the services through Cox HealthPlans' provider network, and the beneficiary is either temporarily absent from Cox HealthPlans' service or the Cox HealthPlans provider network is temporarily unavailable or inaccessible. The beneficiary must first attempt to receive care from his/her PCP. Cox HealthPlans will cover treatment at a participating Urgent Care Center without a referral.

Continuing or follow-up treatment

Continuing or follow-up treatment, except by the PCP, whether in or out of the service area, is not covered by Cox HealthPlans for HMO products unless specifically authorized or approved by Cox HealthPlans. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the beneficiary can reasonably be transported to a participating hospital or returned to the care of the PCP.

Advance Medical Directives

The Federal Patient Self-Determination Act grants beneficiaries the right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare & Medicaid Services (CMS), and our own policies and procedures, Cox HealthPlans requires all Participating Providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

All providers contracted directly or indirectly with Cox HealthPlans may be informed by the beneficiary that the beneficiary has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the beneficiary to provide a copy of the advance directive to be included in his/her medical record.

Providers are required to document in a prominent place of a beneficiary's medical record whether the beneficiary has executed an advanced directive.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the beneficiary's written advance directive, he/she must inform the beneficiary and Cox HealthPlans. Cox HealthPlans and the PCP and/or treating provider will arrange for a transfer of care. Participating Providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

To ensure providers maintain the required processes to advance directives, Cox HealthPlans conducts periodic beneficiary medical record reviews to confirm that required documentation exists.

Policies

Compliance Program

The purpose of Cox HealthPlans' Compliance Program is to articulate Cox HealthPlans' commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Cox HealthPlans' operations. Furthermore, Cox HealthPlans' Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

Cox HealthPlans and its delegates are committed to full compliance with Federal and State regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Cox HealthPlans' business reputation and credibility

with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its beneficiaries. Cox HealthPlans and its employees are also committed to meeting all contractual obligations set forth in Cox HealthPlans's contracts with the Centers for Medicare & Medicaid Services (CMS). These contracts allow Cox HealthPlans to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Compliance Program is designed to prevent violations of Federal and State laws governing Cox HealthPlans' lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities. Cox HealthPlans has in place policies and procedures for coordinating and cooperating with CMS, State regulatory agencies, and other regulatory offices. Cox HealthPlans also has policies that delineate that Cox HealthPlans will cooperate with any audits conducted by CMS or law enforcement or their designees.

To report suspected or detected Medicare program non-compliance, please contact Cox HealthPlans' Compliance Department at:

Mail:

Cox HealthPlans
Attn: Compliance Department
PO Box 5750
Springfield, MO 65801-5750

Email: compliancesiu@coxhealthplans.com

All such communications will be kept as confidential as possible but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

You may request a copy of the Cox HealthPlans Compliance program document by contacting your Cox HealthPlans Provider Relationship Representative.

Fraud, Waste, and Abuse (FWA)

Cox HealthPlans goes to great lengths to ensure that our providers—doctors and other health care providers—are reputable and are able to provide quality care. However, there is always a possibility that a provider, or a consumer, will engage in unethical, potentially fraudulent practices. Even a single fraudulent claim can raise the cost of health care benefits for everyone. See how you can help avoid and prevent health care fraud.

What is health care fraud?

Health care fraud is a crime. Health care fraud means to deceive another, like a private insurer, by intentionally misrepresenting or concealing a material fact(s) in order to obtain money or property, such as health care coverage or benefits. Fraud takes many forms and can include direct misrepresentations as well as half-truths and the knowing concealment of facts.

Some examples of provider health care fraud are:

• Billing for services not actually performed; billing for drugs not actually dispensed
• Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures that aren't medically necessary; billing for a higher quantity of drugs than was actually dispensed
• Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery
• Upcoding—billing for a more costly service than the one actually performed
• Unbundling—billing each stage of a procedure as if it were a separate procedure
• Accepting kickbacks for patient referrals

The Compliance Department is responsible for minimizing Cox HealthPlans' risk of health care fraud. The Compliance Department partners with others to help identify suspicious claims, stop payments to fraudulent providers, and punish wrongdoers.

The Compliance Department also works with state and federal law enforcement, regulatory agencies, and other insurance companies to detect and prevent health care fraud and assist in the pursuit of restitution and/or prosecution of health care fraud offenders.

To report potential FWA, please contact Cox HealthPlans's Compliance Department at:

• Mail:

Cox HealthPlans
Attn: Compliance Department
PO Box 5750
Springfield, MO 65801-5750

• Phone: 417.269.2814

• Email: compliancesiu@coxhealthplans.com

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our beneficiaries, Cox HealthPlans conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-10 and HCPCS, codes billed by our providers. The analysis allows Cox HealthPlans to comply with its regulatory requirements for the prevention of FWA and to supply our providers with useful information to meet their own compliance needs in this area. Cox HealthPlans will review your coding and may review medical records of providers who continue to show significant variance from their peers. Cox HealthPlans strives to ensure compliance and enhance the quality of claims data, a benefit to both Cox HealthPlans' medical management efforts and our provider community. As a result, you may be contacted by Cox HealthPlans' contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

Steps to meet your FWA obligations

Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

Complete the mandatory online training at:

- Provider Compliance | CMS
- Web-based training(WBT) course: Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training.

Medicare Advantage Program Requirements

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to modification in accordance with federal statutory and regulatory changes to the Medicare Advantage program. Such modification shall not require the consent of provider or Cox HealthPlans and will be effective immediately on the effective date thereof.

Books and Records; Governmental Audits and Inspections

Provider shall permit the Exchange Authority, Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

Privacy and Confidentiality Safeguards

Provider shall safeguard the privacy and confidentiality of beneficiaries and shall ensure the accuracy of the health records of beneficiaries. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, timeliness, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of beneficiaries, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

Patient Hold Harmless

Participating Providers are prohibited from balance billing Cox HealthPlans beneficiaries including, but not limited to, situations involving non-payment by Cox HealthPlans, insolvency of Cox HealthPlans, or Cox HealthPlans' breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against beneficiaries or persons, other than Cox HealthPlans, acting on behalf of beneficiaries for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable beneficiary's Benefit Plan, or for collecting payment when rendering non-covered services if

the provider complies with the requirements of the non-covered services section of the Provider Manual.

Non-Covered Services

Providers may only collect fees from beneficiaries for non-covered services when the beneficiary has been provided with a standardized written Organization Determination (OD) denial notice from Cox HealthPlans prior to the item or service being rendered to the beneficiary, or if the beneficiary's EOC clearly states the item or service is a non-covered service.

In circumstances where there is a question whether or not the plan will cover an item or service, beneficiaries have the right to request an OD prior to obtaining the service from the provider? If coverage is denied, Cox HealthPlans provides the beneficiary with a standardized written OD denial notice which states the specific reasons for the denial and informs the beneficiary of his or her appeal rights. In absence of the appropriate Cox HealthPlans OD denial notice or a clear exclusion in the EOC, the beneficiary must be held harmless (i.e., cannot be held financially liable for the charges).

When a provider knows or believes that a service or item is not covered under the beneficiary's benefit, and the EOC does not explicitly state the item or service as non- covered, the provider must advise the beneficiary to request a pre-service OD from Cox HealthPlans or the provider can request the OD on the beneficiary's behalf before the provider moves forward with rendering the services, providing the item, or referring the beneficiary to another provider for the non-covered item or service.

Providers may not issue any form or notice that advises the beneficiary they will be responsible for the costs associated with non-covered services unless the beneficiary has already received the appropriate pre-service OD denial notice from Cox HealthPlans or the service or item is explicitly stated as a non-covered service in the EOC. Providers cannot hold a beneficiary financially liable for services or supplies that are not explicitly stated as non-covered in the beneficiaries EOC.

Reference the Prior Authorization Department section for more information on the organization determination process.

Delegation of Activities or Responsibilities

To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement ("Delegated Activities"), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Cox HealthPlans; and (ii) in the event that the Cox HealthPlans or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable state and/or federal laws and regulations and CMS instructions, then Cox HealthPlans shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Cox HealthPlans. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Cox

HealthPlans, or (ii) provider's credentialing process will be reviewed and approved by Cox HealthPlans and Cox HealthPlans shall audit provider's credentialing process on an ongoing basis. Provider acknowledges that Cox HealthPlans retains the right to approve, suspend or terminate any medical professionals, who shall be notified in writing of the reason(s), as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Cox HealthPlans maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit Cox HealthPlans' authority or responsibility to comply with applicable regulatory requirements.

Compliance with Cox HealthPlans 's Obligations, Provider Manual, Policies and Procedures

Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Cox HealthPlans' contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the Cox HealthPlans Provider Manual and all policies and procedures relating to the benefit plans.

Subcontracting

Cox HealthPlans maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Cox HealthPlans. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, state and federal laws and regulations; (ii) be consistent with the terms and conditions of the Agreement; (iii) contain Cox HealthPlans and beneficiary hold harmless language as set forth in the Agreement; (iv) contain a provision allowing Cox HealthPlans and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to beneficiaries or benefit plans upon request of Cox HealthPlans.

Compliance with Laws

Provider shall comply with all state and federal laws, regulations and instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

Program Integrity

Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Cox HealthPlans immediately if, at any time during the term of the Agreement, provider (or any of

its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in Cox HealthPlans shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any federal program involving the provision of health care or prescription drug services.

Continuation of Benefits

Provider shall continue to provide services under the Agreement to beneficiaries in the event of (i) Cox HealthPlans' insolvency, (ii) Cox HealthPlans' discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Cox HealthPlans, and, to the extent applicable, for beneficiaries who are hospitalized, until such time as the beneficiary is appropriately discharged.

Incorporation of Other Legal Requirements

Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against Participating Providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in your agreement.

Conflicts

In the event of a conflict between any specific provision of your agreement and any specific provision of the manual, the specific provisions of your agreement shall control.

Dispute Resolution

Refer to your agreement.

Disclosures to CMS

Cox HealthPlans discloses the following information to CMS:

- All information necessary to administer and evaluate the program, and to establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services
- Quality and performance indicators for plan benefits, to include disenrollment rates for beneficiaries enrolled in the plan for the previous two years
- Quality and performance indicators for the benefits under the plan regarding enrollee satisfaction and health outcomes