Commercial Provider Manual

Texas

For questions regarding information found within this document, please email the Prominence Health Plan Provider Relations team at PHP-ProviderRelations@uhsinc.com.

LAST REVISED: JULY 2017

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1. WELCOME

Welcome to Prominence Health Plan. Thank you for choosing to join our network of participating physicians, hospitals and ancillary providers. To enhance the health and well-being of our members, Prominence Health Plan is committed to building strong, positive relationships with our participating providers.

Prominence Health Plan is committed to assisting its provider partners by supporting their efforts to deliver coordinated and appropriate health care to our members. Prominence is also committed to providing comprehensive and timely information to providers through this Provider Manual that details Prominence Health Plan's policies and procedures. This Provider Manual was developed as a guide to assist our contracted providers when providing services to Prominence Health Plan Members. While our attempt is to cover a broad range of topics, this guide is not all-encompassing and is subject to change without notice. Updates to this Provider Manual will be posted on our website at www.prominencehealthplan.com.

Phone Directory

Department	Phone Number
Provider Services (Verify eligibility, benefits, claim status)	866-500-2741
Contracting & Credentialing	775-335-3233
Utilization Management	Prominence Health Plan 775-770-9350 or 844-894-8086 eviCore Healthcare 844-224-0495
Provider Relations	775-770-9270
Customer Service	844-2179068 TTY Operator Assistance 800-326-6868

2. ABOUT PROMINENCE HEALTH PLAN

Introduction

Prominence Health Plan ("Prominence") was established in Reno, Nevada in 1993 as a Health Maintenance Organization (HMO) and was originally known as Saint Mary's Health Plans. In 2014, a subsidiary of Universal Health Services, Inc. (UHS) acquired the company and renamed it Prominence Health Plan. Prominence expanded to Texas in 2015, with the objective of building a foundation of excellent customer service and to provide a range of health insurance products to residents throughout the state.

UHS, Inc. through its subsidiaries owns Northwest Texas Healthcare System in Amarillo, South Texas Health System in McAllen and Texoma Medical Center in Denison. UHS, Inc. is one of the largest and most respected healthcare management companies in the nation. Through close collaboration with local providers, Prominence is able to deliver better care management, while continuing our strong tradition of excellent customer service.

What makes Prominence Health Plan Different?

- A commitment to paying clean claims promptly and accurately, while meeting all regulatory guidelines.
- A commitment to operating state-of-the-art information technology for claims processing, customer service, enrollment management, physician profiling and data analysis.
- A commitment to exceptionally trained Provider Relations representatives available to answer all provider inquiries.

Service Areas

In 2017, we service the following counties:

North Texas: Cooke, Fannin and Grayson counties
South Texas: Brooks, Hidalgo and Starr counties
Texas Panhandle: Deaf Smith, Gray, Moore, Potter and Randall counties

3. PROVIDER RESPONSIBILITIES

Introduction

This section of the Provider Manual addresses the respective responsibilities of participating providers. Our expanding network of primary care physicians, as well as the growing list of specialty providers, makes it more convenient to find Prominence Health Plan in your neighborhood.

Prominence does not prohibit or restrict participating providers from advising or advocating on behalf of a member about:

(1) The member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the member to provide an opportunity to decide among all relevant treatment options;

(2) The risks, benefits and consequences of treatment or non-treatment; and

(3) The member's right to refuse treatment and express preferences about future treatment decisions. An ancillary provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. A provider must ensure that individuals with disabilities are presented with effective communication on making decisions regarding treatment options.

Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations. As applicable, Prominence shall not prohibit the participating provider from providing inpatient services to a member in a contracted hospital if such services are determined by the participating provider to be medically necessary covered services under Prominence.

A provider's responsibility is to provide or arrange for Medically Necessary Covered Services for members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. A provider is further responsible to render Medically Necessary Covered Services to members in the same manner, availability and in accordance with the same standards of the profession as offered to the provider's other patients.

Primary Care Provider (PCP) Responsibilities

The following is a summary of responsibilities specific to a primary care provider who render services to members:

- Coordinate, monitor and supervise the delivery of health care services to each member who has selected the PCP for primary care services.
- Assure the availability of physician services to members in accordance with Section 2, Appointment Scheduling.
- Arrange for on-call and after-hours coverage.
- Submit a report of an encounter for each visit where the provider services the member or the member receives a Health Plan Employer Data and Information Set (HEDIS) service. Encounters should be submitted on a CMS 1500 form.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Medical Management for assistance.
- Ensure members are seen for an initial office visit and assessment within the first 30 days.
- A Physician/provider will consider member input into proposed treatment plans.

Specialist Responsibilities

Specialists are responsible for communicating with the PCP in supporting the medical care of a member. Specialists are also responsible for treating members referred to them by the PCP.

Responsibilities of All Participating Providers

The following is an overview of responsibilities for which all participating providers are accountable. Please refer to your contract, or contact your Provider Relations Representative for clarification about any of the following:

- All providers must comply with the appointment scheduling requirements as stated in the Appointment Scheduling Section.
- Provide or coordinate health care services that meet generally recognized professional standards and Prominence guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.
- Use Physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Registered Nurse (APRN) may provide direct member care within the scope or practice established by the rules and regulations of the State of Nevada and plan guidelines.
- The sponsoring provider will assume full responsibility to the extent of the law when supervising PA's and APRN's whose scope of practice should not extend beyond statutory limitations.
- PA's and APRN's should clearly identify their titles to members, as well as to other health care professionals.
- A request by a member to be seen by a Physician, rather than a Physician extender, must be honored at all times.
- Refer members with problems outside of his/her normal scope of service for consultation and/or care to appropriate Specialists contracted with Prominence (PCP's only).
- Refer members to participating physicians or providers, except when they are not available, or in an emergency. Providers should contact the Utilization Management department in the event it is medically necessary to refer a member to a non-participating provider for continuity of care purposes.
- Admit members only to participating Hospitals, Skilled Nursing Facilities (SNF's) and other inpatient care facilities, except in an emergency.
- Respond promptly to Prominence's requests for medical records in order to comply with regulatory requirements, and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any member, subscriber or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are benefits not included by Prominence in a member's healthcare policy, are excluded by Prominence, are provided by an ineligible provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with State and Federal law.
- Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Maintain quality medical records and adhere to all plan policies governing the content of medical records as outlined in the Prominence's quality improvement guidelines. All entries in the member record must identify the date and the provider.
- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state and federal regulations concerning safety and public hygiene.

- Communicate clinical information with treating providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Prominence, the member or the requesting party, at no charge, unless otherwise agreed to.
- Preserve member dignity, and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not to discriminate in any manner between members and non-members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.
- A Physician/provider will consider member input into proposed treatment plans.

Provider Licensure, Credentials and Demographic Information Changes

- Inform Prominence, in writing, within 24 hours of any revocation or suspension of his/her DEA number, and/or suspension, limitation or revocation of his/her license, certification, or other legal credential authorizing him/her to practice in the State of Nevada.
- Inform Prominence ***immediately*** of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his/her status with Prominence.

Provider Availability & Accessibility

Providers agree to make necessary and appropriate arrangements to ensure the availability of services to members on a 24-hour per day, 7-day per week basis, including arrangements for coverage of members after hours or when the provider is otherwise unavailable.

In the event participating providers are temporarily unavailable to provide care or referral services to members, they should make arrangements with another Plan contracted and credentialed provider to provide these services on their behalf.

If a covering provider is not contracted and credentialed with Prominence, he/she must first obtain approval to treat members. The provider should be credentialed by Prominence, he/she must sign an agreement accepting the Participating provider‘s negotiated rate and agree not to balance bill members. For additional information, please contact your local Provider Relations Department.

Additionally, providers are to establish an appropriate appointment system to accommodate the needs of members, and shall provide timely access to appointments to comply with the following schedule:

- Urgent Care within one (1) day of an illness;
- Sick care within one (1) week of an illness; and
- Well visit within one (1) month of an appointment request.

The provider will ensure that members with an appointment receive a professional evaluation within one (1) hour of the scheduled appointment time. If a delay is unavoidable, the patient shall be informed and provided with an alternative.

Vacations

Primary care providers should notify Prominence, in writing, of any extended vacation/ time-off of (2) two weeks or more, and disclose the provisions made for provider coverage in the PCP‘s absence. The provider covering for the PCP must be a participating provider with our Plan.

Appointment Scheduling
The following criteria comply with access standards:

1. **Primary care providers** should:
   - Provide medical coverage 24-hours a day, seven days a week;
   - Scheduled appointments should be seen within 30 minutes;
   - Schedule emergent referral appointments immediately;
   - Schedule routine sick care within one (1) week; and
   - Schedule well visit within one (1) month.

2. **Specialty care providers** should:
   - Schedule well visit within one (1) month;
   - Schedule routine sick care within one (1) week;
   - Schedule urgent referral within 24 hours; and
   - Schedule emergent referral appointments immediately.

Prominence collects and performs an annual analysis of access and availability data, and measures compliance to required thresholds. The analysis can include access to:
- well visit;
- sick care;
- urgent care; and/or
- after-hours care.

After-Hours Services
The primary care provider or covering physician should be available after regular office hours to offer advice and to assess any conditions, which may require immediate care. This includes referrals to the nearest Urgent Care Center or Hospital Emergency Room in the event of a serious illness.

To assure accessibility and availability, the Primary care provider should provide one of the following:
- 24-Hour answering service;
- Answering system with an option to page the Physician; or
- An advice nurse with access to the PCP or on-call Physician.

Closing Provider Panel
When closing membership panel to new members, providers must:
- Submit a request in writing, **60 days** prior to closing the membership panel.
- Maintain the panel open to all members who were provided services prior to closing the panel.
- Submit a written notice of the re-opening of the panel, to include a specific effective date.

Prominence will assist providers in providing communication to members with disabilities or language services. Please contact Prominence Health Customer Services to arrange services for the deaf, blind, or those who need a language interpreter.

PCP Initiated Member Transfer
A participating primary care provider (PCP) may not seek or request to terminate their relationship with a member, or transfer a member to another provider of care based upon the member's medical condition,

amount or variety of care required, or the cost of covered services required by the member.

Reasonable efforts should always be made to establish a satisfactory provider/member relationship. The PCP should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider/member relationship.

If a satisfactory relationship cannot be established or maintained, the PCP must continue to provide medical care for the member until such time that the member can be transitioned to another PCP.

The PCP may request that a member be assigned to another practice if his/her behavior is disruptive to the extent that his/her continued assignment to the PCP substantially impairs the PCP's ability to arrange for or provide services to either that particular member or other patients being treated by the PCP. The PCP may request transfer of the member only after it has met the requirements of this section and only with Prominence's approval. The PCP may not request transfer of a member because he/she exercises the option to make treatment decisions with which the PCP disagrees, including the option of no treatment and/or diagnostic testing. The PCP may not request transfer of a member because he/she chooses not to comply with any treatment regimen developed by the PCP or any health care professionals associated with the PCP.

Before requesting transfer of a member, the PCP must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations for individuals with mental or cognitive conditions, including mental illnesses and developmental disabilities. The PCP must also inform the member of his/her right to use Prominence's grievance procedures.

The PCP must submit documentation of the specific case to Plan for review. This includes documentation:

- Of the disruptive behavior;
- Of the PCP's serious efforts to provide reasonable accommodations
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;

The PCP must submit to Prominence:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MA organization's ability to arrange for or provide services to the individual or other patients in the PCP's practice;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.

The request for transfer must be complete, as described above. Prominence will review this documentation and render a determination regarding the request for transfer. Prominence will make the determination within thirty (30) days of receipt of the request for transfer and will notify PCP within three (3) days of the determination.

Except in extreme circumstances, the transfer to a new PCP will not occur until the first of the month following Plan's determination of approval of transfer.

Prominence will notify member once Prominence has approved the transfer. The PCP need not take further action.

Provider Participating with Telemedicine

If Prominence has approved a provider to provide telemedicine services to Prominence Health members, the provider is required to have protocols in place to prevent fraud, waste and abuse. The provider must implement telemedicine fraud, waste and abuse protocols that address the following:

(1) Authentication and authorization of users;
(2) Authentication of the origin of the information;
(3) The prevention of unauthorized access to the system or information;
(4) System security, including the integrity of information that is collected, program integrity and system integrity; and
(5) Maintenance of documentation about system and information usage.

Provider Information Changes

Thirty (30)-day prior notice to your Provider Relations Representative is **required** for any of the following changes:

- Tax identification number
- Group name or affiliation
- Physical or billing address
- Telephone or facsimile number

Participation & Credentialing

Providers are accepted for participation after being approved by Prominence's credentialing process. Prominence does not discriminate or make credentialing decision based on applicant's race, creed ethnic/national identity, gender, age or sexual orientation, or on type of procedure or patient in which the provider specializes.

Participating providers are required to notify Prominence immediately when a new provider joins their practice. Notify the local Provider Relations Representative and the representative will send an application for completion. Please see the Credentialing Overview Section to learn more about our credentialing requirements.

Provider Termination

In addition to the provider termination information included in your contractual agreement with Prominence, the provider must adhere to the following terms:

- Any contracted provider must provide at least **90-days** prior written notice before a without cause termination;
- Terminations occur on the last day of the month. For example, if a termination letter is dated January 15, the termination will be effective April 30; and
- Providers who receive a termination notice from Prominence may submit an appeal. Please refer to the Credentialing Section of the manual for specific guidelines.

Please Note: Prominence must provide written notification to all appropriate agencies and/or members upon a provider suspension or termination, as required by regulations and statutes.

Continuity of Care – Terminated Provider

Prominence will provide continued services to members undergoing a course of treatment by a provider that no longer participates with Prominence, if the following conditions exist at the time of contract termination:

a. Such care is medically necessary. Continued care is allowed through the completion of treatment,

until the member selects another treating provider, or until the next Open Enrollment period – not to exceed six (6) months after the termination of the provider's contract.

b. Continuation of care through the postpartum period for members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated with a terminated treating provider.

For continued care under this subsection, Prominence and terminated provider continue to abide by the same terms and conditions as existed in the terminated contract. However, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.
This subsection does not apply to providers terminated from Prominence for cause.

Utilization Management & Quality Improvement Programs (UM/QI)

Prominence has UM/QI programs that include consultation with requesting providers when appropriate. Under the terms of the contract for participation with Prominence's network, providers agree, in addition to complying with state and federal mandated procedures, to cooperate and participate in Prominence's UM/QI programs, including quality of care evaluation, peer review process, evaluation of medical records, provider or member grievance procedures, external audit systems and administrative review.

Further, to comply with all final determinations rendered pursuant to the proceedings of the UM/QI programs, all participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section.

Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Preferred Drug List

Please refer to the Pharmacy Section of this manual for a description of Prominence's Preferred Drug List and prescribing criteria. Please contact your Provider Relations Representative for a copy of the Preferred Drug List or visit www.ProminenceHealthPlan.com.

Confidential Member Information & Release of Medical Records

All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with the HIPAA Privacy and Security Rules established on April 14, 2003. All provider practice personnel must be trained on privacy and security rules.

The Practice should ensure that there is a Privacy Officer on staff, that a policy and procedure is in place for confidentiality of member's protected health information and that the Practice is following procedure or obtaining appropriate authorization from members to release protected health information.

All members have a right to confidentiality. Any health care professional or person who directly or indirectly handles the member or his/her medical record must honor this right. Every practice is required to post their Notice of Privacy Practice in the office or provide a copy to members.

Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Confidential Information includes:

a) Any communication between a member and a provider; and
b) Any communication with other clinical persons involved in the member's health, medical and mental care.

Included in this category are:

1) All clinical data, i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number, etc.;
2) Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
3) Any communicable disease (such as AIDS) or HIV testing protected under federal or state law.

When a member enrolls in Prominence, his/her signature on the Enrollment Form automatically gives the healthcare provider permission to release his/her medical record to Prominence, other providers in Prominence network who are directly involved with the member‘s treatment plan and agencies conducting regulatory or accreditation reviews.

Before any individual not working for Prominence can gain access to the member‘s medical record, written authorization must be obtained from the member, member‘s guardian or his/her legally authorized representative (except when there is a statute governing access to the record, a subpoena or a court order involved). Disclosures without authorization or consent may include, but are not limited to Armed Services Personnel, Attorneys, Law Enforcement Officers, Relatives, Third Party Payers, and Public Health Officials. All disclosures must be made within accordance of the HIPAA guidelines and Privacy Rule.

Member Rights & Responsibilities

Prominence strongly endorses the rights of members as supported by State and Federal laws. Prominence also expects members to be responsible for certain aspects of the care and treatment they are offered and receive.

All member rights and responsibilities are to be acknowledged and honored by Prominence staff and all contracted providers. Contracted providers are provided with a declaration of Prominence Health member rights and responsibilities in this manual. In addition, providers are given a handout of these rights and responsibilities and are urged to post them in their respective offices.

Members are afforded a listing of their rights and responsibilities as a member in their Prominence Health member Handbook. See the Forms section for rights and responsibilities that Prominence endorses and expects providers and members to acknowledge and reinforce. Member Rights and Responsibilities are also posted on Prominence‘s website at www.prominencehealthplan.com.

Advance Medical Directives

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. The law provides that each member (age 18 years or older of sound mind) should receive information concerning this provision and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance. Members may also designate another person to make a decision should they become mentally or physically unable to do so. If a member has executed advance directives, this should be noted in a prominent location in the member‘s medical file. Providers should request a copy of the executed advance directive to maintain in the medical record.

Cultural Competency

Cultural competency is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals, to work effectively in cross-cultural situations.

Cultural competency occurs in both clinical and non-clinical areas. In the clinical area, it is based on the patient-provider relationship. In the non-clinical arena, it involves organizational policies and interactions that impact health care services.

Fraud, Waste and Abuse

Prominence has implemented a FWA program to prevent, detect and report health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Prominence will use a number of processes and procedures to identify and prevent fraud and abuse. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, civil and/or criminal prosecution, fines and other penalties.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. Some examples of fraud:

- Billing for services not furnished;
- Soliciting, offering or receiving a kickback, bribe or rebate; or
- Violations of the provider self-referral (Stark) prohibition.

Waste - Generally, means over-use of services or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Abuse - Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. Some examples of abuse:

- Charging in excess for services or supplies;
- Providing medically unnecessary services; or
- Providing services that do not meet professionally recognized standards.

Pertinent Statues, Laws and Regulations

False Claims Act

The Federal False Claims Act 1985 permits a person with knowledge of fraud against the United States Government, referred to as the "qui tam plaintiff," to file a lawsuit on behalf of the Government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the federal False Claims Act.

A claim is broadly defined to include any submissions that results, or could result, in payment.

Claims submitted to the government includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

Liability can also be created by the improper retention of an overpayment. Examples include:

- A provider who submits a bill for medical services not provided.
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
- An agent who submits a forged or falsified enrollment application to receive compensation from a Plan Sponsor.

Whistleblower and Whistleblower Protections

The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as whistleblowers. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Examples include:

- A frequent flier campaign in which a provider may be given a credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company's product.
- Free laboratory testing offered to health care providers, their families and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

HIPAA Privacy - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.

HIPAA Security - The Security Rule outlines specific protections and safeguards for electronic PHI.
If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Potential FWA committed by Pharmaceutical Manufacturer

- Illegal Off-label Promotion - Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns;
- Illegal Usage of Free Samples - Providing free samples to providers knowing and expecting those providers to bill the federal health care programs for the sample;
- Billing for items or services not rendered or not provided as claimed;

- Submitting claims for equipment or supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using all-inclusive code);
- Failure to properly code using coding modifiers;
- Altering medical records;
- Improper telemarketing practices;
- Compensation programs that offer incentives for items or services ordered and revenue generated;
- Inappropriate use of place of service codes;
- Routine waivers of deductibles/ coinsurance;
- Clustering; and
- Up coding the level of service provided.

Potential FWA committed by Skilled Nursing Facility ("SNF")

- SNFs improperly up coding resident RUGs assignments to gain higher reimbursement;
- SNF improperly utilizing therapy services to inflate the severity of the RUG classification to obtain additional reimbursement; and

Hospital

- Failure to follow the same day rule;
- Abuse of partial hospitalization payments;
- Same day discharges and readmissions;
- Improper billing for observation services;
- Improper reporting of pass through costs;
- Billing on an outpatient basis for inpatient only procedures;
- Submitting claims for medically unnecessary services by failing to follow local policies; and
- Improper claims for cardiac rehabilitation services.

Potential FWA committed by Provider and Others

- Chiropractor intentionally billing for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining payments;
- A psychiatrist billing Prominence, and private insurers for psychiatric services that were provided by his nurses rather than himself;
- Provider certifies on a claim form that he performed laser surgery on a beneficiary when he knew that the surgery was not actually performed on the patient;
- Provider instructs his employees to tell the OIG investigators that the provider personally performs all treatments when, in fact, medical technicians do the majority of the treatment and the provider is rarely present in the office;
- Provider, who is under investigation by the FBI and Prominence, alters records in an attempt to cover up improprieties;
- Neurologist knowingly submits electronic claims to the carrier for tests that were not reasonable and necessary and intentionally up coded office visits and electromyograms;
- Podiatrist knowingly submits claims to the plan for non-routine surgical procedures when he actually performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses; and
- Performing tests on a beneficiary to establish medical necessity.

Potential FWA committed by Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary;
- Continued billing for rental items after they are no longer medically necessary;
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed;
- Providing and/or billing for substantially excessive amounts of DME items or supplies;
- Up coding a DME item by selecting a code that is not the most appropriate;
- Providing a wheelchair and billing for the individual parts (unbundling);
- Delivering or billing for certain items or supplies prior to receiving a provider's order and/or appropriate certificate of necessity;
- Completing portions of the certificate of necessity that is reserved for completion by the treating provider only;
- Cover letters to encourage providers to order medically unnecessary items or services;
- Improper use of ZX modifier;
- Providing false information on the DMEPOS supplier enrollment form;
- Knowing misuse of a supplier number, which results in improper billing;
- Furnishing more visits than as medically necessary;
- Duplicate billing for the same service;
- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service;
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's State licensure;
- Providing services at no charge to an assisted living center

Plan's Processes for Identification of Fraud, Waste and Abuse

Prominence has software and monitoring programs designed to identify indicators for fraud, waste and abuse, including, but not limited to:

- Multiple billing: Several payers billed for the same services (e.g. billing medications under Part A or Part B and then billing again under Part D;
- Billing for non-covered services;
- Duplicate Billing;
- Unbundling of charges;
- Up-coding;
- Fictitious providers;
- Billing of unauthorized services;
- Billing with the wrong place of service in order to receive a higher level of reimbursement;
- Claims data mining to identify outliers in billing;
- Billing for services or supplies not provided;
- Improper use of ZX modifier;
- Failure to follow the same day rule (hospital);
- Abuse of partial hospitalization payments; or
- Billing on an outpatient basis for inpatient only procedures.

Reporting Obligation and Mechanisms

If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it.

Providers, Vendors and Delegates can call Prominence's Compliance Hotline at 775-770-9444, or the Texas Attorney General's Office at 800-252-8011.

Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

Prominence will notify the CMS Regional office of any issues that involve Medicare members.

Resources

Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504)
http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf

Office of the Inspector General
http://www.oig.hhs.gov/fraud.asp

3. CREDENTIALING

Introduction

Review and approval through Prominence's credentialing process is required for network provider participation. During this process, the credentialing application is reviewed against Prominence's policies and procedures and the provider's credentials are verified. Any issues identified such as malpractice claims history, licensure sanction or Medicare sanction is reviewed by the Credentialing Committee, which is the Peer Review Committee of Prominence. It is the provider's responsibility to fully complete the entire credentialing application and supply a written explanation to any item of negative information. Prominence accepts the Nevada Standardized Credentialing Application. An application cannot be processed until all areas are completed and all documents are provided. Further, a site inspection evaluation is required for all Primary care providers and OB/GYN specialists.

Please note that providers have the following rights in connection with the credentialing process: The right to review information submitted to support their credentialing application:

- Upon request to Credentialing a provider has the right to review information that is obtained by Prominence from outside sources and which it uses to evaluate the credentialing application. The exception to the information that may be reviewed is peer references and information that is peer review protected.

The right to correct erroneous information:

- When information is obtained by Prominence from other sources, and the information substantially varies from that supplied by the provider, in accordance with Credentialing Policy CR 1 Prominence will notify the provider of the right to correct the erroneous information; provide the timeframe for making the changes; the format for submitting the changes; and the name of the person to whom, and the location where the corrected information must be sent.

The right to receive the status of their credentialing or re-credentialing application upon request:

- Prominence will respond to a provider's request for status on their credentialing application within fifteen (15) business days. The information provided will advise of any items still needed, or any difficulty or non-response in obtaining a verification response.

The application is then taken through the initial credentialing process and brought to the Credentialing Committee (composed of practicing providers credentialed by Prominence). Any request by the Credentialing Committee for additional information will be immediately requested from the provider.

Providers are initially credentialed for a thirty-six month credentialing period, after which re- credentialing is required. Periodically, Prominence may request updates for expired documentation such as malpractice insurance. If there are changes to any of the information/documentation submitted in support of the application such as board certification status, please let Prominence know.

Credentialed Providers

The following licensed provider types are required to be credentialed in order to provide medical services to Prominence Health members. The provider types include, but are not limited to:

- Medical Doctors (MD's);
- Osteopathic Doctors (DO's);
- Podiatric Doctors (DPM's);
- Chiropractic Doctors (DC's);

- Optometric Doctors (OD's);
- Oral Surgeons (DMD's or DDS's)
- Psychologists (PhD's);
- Advanced Practice Registered Nurse (APRN);
- Physician Assistants (PA);
- Certified Nurse Midwife (CNM);
- Licensed Midwives
- Audiologists (AuD)
- Physical Therapists (PT) - if contracting directly with us. If through an accredited facility, then only the facility needs to be credentialed;
- Occupational Therapists (OT) - Same as PT;
- Speech Pathologist (SP) - Same as PT;
- Licensed Clinical Social Workers (LCSW);
- Masters in Social Work (MSW);
- Licensed Marriage & Family Therapists (LMFT's).

Prominence also credentials Facilities and Ancillary Providers. An Application/Data Collection Form and the following supporting documents are required but are not limited to: AHCA Certificate; CMS Certificate Accreditation Certificate; and General insurances. Examples of Facilities and Ancillary Providers are, but are not limited to:

- Hospitals;
- Ambulatory Surgery Centers (ASC);
- Skilled Nursing Facilities (SNF);
- Diagnostic Facilities;
- Inpatient Hospice Facilities;
- Dialysis Centers;
- Home Health Agencies;
- Nursing Homes
- Durable Medical Equipment (DME) providers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Outpatient Physical, Occupational & Speech Therapy (PT, OT, ST) Facilities

NOTE: (a) Hospital based providers are not required to be credentialed/re-credentialed by Prominence; (b) Health Plan requires a signed collaboration statement from supervising M.D. for APRN's & PA's, regardless of the state statute.

Initial Credentialing Process

The Initial Credentialing Process is as follows:

Step 1. The provider fully completes all necessary sections of the credentialing application/form and submits the required documents to Prominence. PCP and OB/GYN Specialists will need to participate in a Site Inspection Evaluation.

Step 2. Primary source verification is performed concerning education, training, board certification, licenses and other submitted documents and information.

Step 3. The Medical Director reviews files prior to the next scheduled meeting and may ask for additional explanations if deemed necessary prior to the application being presented to the Credentialing Committee.

Step 4. The provider's file is then presented to the Credentialing Committee.

Step 5. If approved, the file is noted accordingly and proceeds to step 6. If additional information is requested by the Committee, the request is conveyed to the provider and the file is placed in a pending status, awaiting the requested information. Once received, the Committee will re-evaluate the application.

Step 6. Upon approval, the provider information is loaded into the Prominence database for purposes of claims payment and directory listing.

Step 7. The provider is notified in writing of their credentialed status and the effective date of their contract within 60 calendar days following the Committee's decision.

Step 8. The assigned provider relations representative will conduct an in-service visit with the provider and selected staff.

The credentialing process takes approximately 90-days from receipt of complete application through presentation to the Credentialing Committee.

Re-Credentialing

Credentialed providers must be re-credentialed every 36 months. The Credentialing Department establishes this date as 36-months following the provider's approval. The provider will be notified approximately 120-days prior to the expiration of credentialing. The re-credentialing review process is similar to the initial credentialing process and includes the following:

- Completion of a re-credentialing application or CAQH application
- Verification is performed concerning licenses, board certifications and other submitted documents and information;
- Internal Plan information from provider services, customer service, complaints/grievances and Quality Improvement, as applicable.

If a provider fails to return the re-credentialing application in a timely fashion and their credentialing period lapses, the provider may not render services to a member until the initial credentialing process is completed.

Liability Insurance

Prominence credentialing policies concerning liability coverage conform to Texas Statutes. In the absence of evidence of professional Liability Insurance, providers will be asked for their State financial responsibility form as part of their credentialing packet. This will allow Prominence to confirm compliance with these guidelines.

Upon request, a provider must provide Prominence with evidence of liability coverage and any renewals, replacements or changes.

Updated Documents

Prominence is required to maintain documentation/verification of certain documents that expire throughout the provider's participation with Prominence. These documents include but are not limited to medical license and board certification.

Ongoing Monitoring

After a provider is approved for participation in Prominence, ongoing monitoring of the providers credentials is performed in accordance with Federal, State and NCQA Accreditation requirements.

Ongoing monitoring involves monthly/quarterly review of the following:

- Licensure Sanctions
- OIG Sanctions
- The Excluded Parties Listing System EPLS Sanctions
- Report of providers exceeding the Complaint Volume thresholds

Providers identified with a State licensure sanction that does not remove licensure are requested to provide full information to Prominence, and the information is then reviewed by the Medical Director/Credentialing Committee for acceptance.

When the provider is identified as meeting or exceeding the member compliant volume threshold set by Prominence for receiving member complaints, the provider is notified via letter, and a follow-up from provider relations is made. In the event member complaints exceed Prominence's threshold specific to office site quality, a satisfactory site inspection evaluation is required, and the evaluation is performed by Provider Relations. Information is then submitted to the Medical Director/Credentialing Committee for review and acceptance.

Provider Appeal Rights – Non-Approval of Credentialing

In the event the Committee denies a provider's credentialing, the provider has the right to appeal the decision within 30 days of receiving the denial notice. The appeal rights are provided by the Medical Director, as Chairman of the Credentialing Committee and the notification letter will specify the reason for the non-approval. All credentialing appeals are held in accordance with Prominence's internal policies and procedures.

Provider Appeal Rights

In the event Prominence makes an adverse participation decision against a participating provider for reasons of quality of care or conduct, the affected provider will be notified in writing within 30-days of the adverse decision, and will be provided notice of rights to appeal. The letter will specify the reason for the adverse determination and will include if relevant the data used to evaluate the provider. The letter will include the timeframe of 30-days from the provider's receipt of Prominence's letter for an appeal request to be submitted to Prominence; the name of the person to whom the appeal should be submitted; the provider's right to submit any additional information in support of the appeal; and the right to representation by an attorney. If an appeal is requested, the date, time and place where the appeal will be heard will also be provided.

Providers that receive a final termination decision for a validated quality of care issue will be reported to the State Licensure Board and to the National provider Data Bank in accordance with State and Federal requirements.

Information concerning providers denied credentialing is notified to the appropriate State agency as required by Texas Statute.

4. MEMBER ELIGIBILITY & SERVICES

Customer service

The primary purpose of the Prominence Health Customer Service Department is to answer questions and attempt to resolve issues, problems and concerns raised by members.

The Customer Service Department can be contacted at 844-217-9068. We also encourage the use of our website at www.prominencehealthplan.com.

Members and providers may call customer service to:

- Change a primary care provider;
- Receive educational materials;
- Learn about authorizations;
- Disenroll from Prominence;
- Obtain a new identification card;
- Find participating pharmacies;
- Verify member eligibility;
- Ask copayment, coinsurance and deductible questions;
- Inquire about claims payment;
- File a member complaint/grievance;
- Notify Prominence of a change in information – new address, phone number or other personal information; and
- Receive member assistance with the Appeals & Grievance process.

Staff Selection and Training

The Customer Service Department is committed to hiring highly qualified individuals, providing top- notch training and monitoring activities to support attainment of Prominence's service commitments. Telephone calls are monitored to maintain standards regarding information accuracy, timely follow-up and member service attitudes.

Service Standards

The Prominence Health Plan Customer Service Department is designed to address issues, solve problems, answer questions and listen to concerns from members and physicians or providers. Our service commitments are to:

1. Answer calls within 30 seconds;
2. Respond to voice mail messages within 24 business hours; and
3. Respond to urgent calls within one (1) hour.

Prominence will track the types of issues that you and your staff bring to our attention so that we may correct any underlying problems.

Member Identification Card

Each member will receive an identification card that allows them access to receive services from the Prominence network of participating physicians/providers. A sample of the Prominence identification card for each product is available in the Sample Forms section of this manual. Physicians/providers should ask to see the member identification card at each scheduled appointment.

Some important points to remember:

- The practice should make a copy of both sides of the identification card for their member medical record;
- For purposes of privacy, the identification card has a *unique* member number used for most transactions;
- The identification card lists the most common copayments, coinsurance and deductible amounts;
- The identification card lists the toll-free Customer Service telephone number;
- The identification card has the address to mail claims;
- The identification card does not reflect the effective date of the provider; it is the effective date the member became effective with Prominence; and
- The Physician/provider can always verify eligibility by requesting to see the member identification card each time the member has an appointment. The member should also be asked if there have been any changes since their previous appointment.

Member Transfers

The following guidelines apply to the transfer of a member, upon his/her request, from one Primary Care office to another:

- The member's decision to transfer should be strictly voluntary;
- The member must not have been directly recruited by phone or in person by anyone involved with the Primary Care office;
- The member must not have been influenced to transfer to or out of the office due to improper/incorrect information or for medical reasons; and
- Upon the member's request and completion of a Medical Record Release Form, the office is required to send his/her medical records to the newly selected Primary Care office.

Methods of Eligibility Verification

Providers have two methods to verify member eligibility:

1. *Provider Portal* – Prominence has a Web portal to verify member eligibility, benefits and claims status quickly and efficiently.
2. *Customer Service* – Customer Service Department staff are available to verify member eligibility at 844-217-9068.

For questions regarding the Web Portal, please contact Provider Relations at 775-770-9270.

5. UTILIZATION MANAGEMENT DEPARTMENT

Introduction

The Utilization Management (UM) Department is involved in the coordination of care for our members. The roles of the department include utilization review of Prior Authorization requests, concurrent review of members in hospitals and skilled nursing facilities, Disease Management (especially for members with high-risk diseases such as diabetes and congestive heart failure) and Case Management (for members with high-risk issues, non-compliance or multiple acute disease processes).

The UM Department works closely with provider offices and members to help coordinate care and enhance member adherence to the treatment plan. This includes gathering clinical information from provider offices. All hospitalized members receive a call following discharge to ensure they have all post-discharge medication, equipment and nursing assistance, if required. Prominence Health encourages members to see their primary care physician within seven days of discharge from an inpatient stay. The UM Department is also available to assist your office regarding any questions related to the prior authorization request process and Case/Disease Management.

Department Philosophy

The Utilization Management Department's goal is to create partnerships with health care physicians, providers and members that result in the following:

1. Avoidance of acute illnesses and diseases through prevention and/or early detection of medical problems;
2. Enhancement and improvement of general levels of health and fitness;
3. Enabling of members through education, to develop awareness of the importance of prevention and health maintenance as key to general health and fitness; and
4. Assistance for members in understanding their partnership role with health providers.

The Department will strive to achieve these objectives through three methods:

1. Development of an efficient utilization management program as outlined below;
2. Developing strong disease management and lifestyle change programs; and
3. Establishing effective case management programs focused on interventions for potential or existing catastrophic medical situations.

eviCore Healthcare

In our continuing effort to improve the quality of care for our health plan members, Prominence Health Plan partners with eviCore Healthcare. Effective November 1, 2016, providers will be required to obtain prior authorization from eviCore. Some additional services will now need prior authorization by eviCore, including Physical, Occupational, and Speech Therapy; Chiropractic Services; and Sleep Studies/PAP equipment and supplies. eviCore Healthcare's advanced clinical guidelines are available at www.evicore.com.

Authorizations are required for:

- Cardiac Imaging Services
- Chiropractic
- Genetic Counseling and Testing
- Imagining Studies, including Ultrasound (excludes routine x-rays and OB Ultrasounds >2)
- Joint Procedures – hip, knee, shoulder: Arthoplasty, arthoscopy, and open procedures
- Medical Oncology
- Pain Management Procedures and Implants

- Physical, Occupational and Speech Therapy Services
- Radiation Therapy Services
- Sleep Studies/Sleep Apnea/PAP Equipment/Supplies
- Spinal Procedures/Surgeries

To request an authorization:

- Online portal at www.evicore.com
- Call 1-844-224-0495
- Fax 1-855-774-1319 (MSK) or 1-800-540-2406 (Imaging)

*** Please note, authorization requests cannot be initiated by fax for Medical Oncology, Radiation Therapy, Genetic Counseling & Testing, or Sleep Studies.*

For urgent requests: If services are required in less than 72-hours due to medically urgent conditions, please call our toll-free number for expedited authorization reviews. Be sure to tell our representative the authorization is for medically urgent care.

Staff Availability

The Utilization Management (UM) department will be available for all prior authorization requests Monday through Friday 8:00 a.m. to 5:00 p.m. at 844-894-8086. Also available is 24-hour, seven (7) days a week confidential voicemail and incoming fax.

eviCore is available for all prior authorization requests Monday through Friday 8:00 a.m. to 5:00 p.m. at (844) 224-0495. Also available is 24-hour, seven (7) days a week confidential voicemail and incoming fax.

Contact Information

The Utilization Management (UM) department may be contacted at:

Prominence Health Plan

- Phone (775) 770-9350 or (844) 894-8086
- Fax Inpatient (888) 391-3720
- Fax Outpatient (888) 393-2335
- Fax Behavioral Health (888) 393-2348
- Medical Necessity Appeals (888) 393-2393

eviCore Healthcare

- Phone (844) 224-0495
- Fax Imagining Studies (800) 540-2406
- Fax MSK (855) 774-1319
- Fax Medical Necessity Appeals (866) 699-8128

Prior Authorization General Information

The PCP, specialists or ancillary provider is responsible for submitting all prior authorization requests (see prior authorizations) to Prominence Health Plan.

The time frames for response for requests are as follows:

- *Standard Requests:* The department processes authorization requests as quickly as possible. The time frame for Non-Urgent requests is 15 calendar days.

- *Expedited/STAT Requests*: Expedited requests are defined as one where applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee‘s ability to regain maximum function. These requests must be completed and the member notified within 24 - 72 hours from the time we receive the request at Prominence. In order for our Prior Authorization request staff to continue to process all requests for service quickly, we ask that you please review all requests your office submits before you write STAT, URGENT, ASAP or EXPEDITED.

Status of a Prior Authorization Request

A provider may determine the status of an authorization in several ways:

- Access the Prominence's Provider Portal. Here you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations Representative for assistance.
- Access the eviCore Healthcare portal.
- Call the Utilization Management (UM) Department during normal business hours, 8:00 a.m. to 5:00 p.m. on weekdays, to check the status of a request or;
- A member should contact customer service to receive information regarding a requested service.

Member Request to Plan for Decision on Services

Members have the right to contact Prominence directly to request a decision on a service they believe Prominence should provide or pay for. This request is considered a request for an organization determination and Prominence must review and respond to this request as it would from any provider.

Member Requesting Specialist visits, diagnostic procedures, or therapeutic treatments:

- Member has not spoken to PCP: If a member informs Prominence they want to have a service and they have not spoken with their PCP about this request, customer service will direct the member to make an appointment with your office to discuss this service.
- Member has spoken with PCP: If the member informs Prominence they have already spoken with you or your office about this service, our Customer Service Department will send this information to the UM Department in order to begin the decision process:
  - UM will call and fax your office twice about this request and let your office know what service(s) the member is requesting. Your office must respond within two calendar days for a standard request and same day if the request is expedited.
  - A final decision will be made on standard requests within five calendar days or for expedite requests within two calendar days. The decision will be based on information provided and Prominence Medical Director will make a determination of whether to approve or deny the service.

The final determination will be communicated to the member and your office either orally or in writing depending on the decision.

Specialist or Provider Requests to Plan for Decision on Services

When Utilization Management (UM) receives a request for organization determination directly from a Specialist or provider:

- UM will call your office, inform your staff of the request and fax to you all the information received from the Specialist or provider.
- Your office will be advised you will have five calendar days for standard requests and same day for expedited requests to respond back to the department with your recommendation on the request.

- UM will call and fax your office again on Calendar Day Three for standard to make certain you are processing the request, if no response has been received.
- If no information is received by the required timeframe, the request and information will
- be forwarded to Prominence's Medical Director for a final decision.

Criteria

Prominence Coverage Guidelines - For a copy of the specific Utilization Management Review Criteria, please contact the Utilization Management department, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Prominence's Utilization Director also has access to an external independent review agency consisting of board-certified specialists for consultation on issues that fall outside of his/her expertise.

Medically Necessary Services or Medical Necessity – Services and/or supplies provided by a hospital, skilled nursing provider, physician, or other healthcare provider required to identify or treat a Beneficiary's illness or injury and which, as determined by Prominence's Medical Director or Utilization Management committee, are:

A. Meet the following conditions:
   1. consistent with the symptoms or diagnosis and treatment of a Beneficiary's medical condition, disease, ailment, or injury;
   2. appropriate with regard to standards of good medical practice;
   3. not provided for cosmetic purposes;
   4. not solely for the convenience of a Beneficiary, his/her Physician, hospital, or other health care provider; and
   5. the most appropriate supply or level of service which can be safely provided to a Beneficiary. When specifically applied to an inpatient Beneficiary, it further means that a Beneficiary's medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to a Beneficiary as an outpatient.

B. "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

C. The fact that a provider has prescribed, recommended, or approved medical or allied goods or services, does not make such care, goods or services medically necessary, a medical necessity or a covered service.

Approved Requests

When a Prior Authorization Request is approved, an Authorization Notification will be faxed to the PCP and the requesting provider(s). This notice will contain the valid time frame of the authorization, the date of the decision, who requested the authorization, who is authorized to provide the services and which services were authorized. The PCP or provider is delegated the responsibility of notifying the member of the approval and arrange the needed services.

Pended Requests

When the Prior Authorization Request is Pended, the UM department may contact the provider to gather additional information. The requests will be either verbal or faxed to the provider's office, labeled:

- 1st Request for Information
- 2nd Request for Information

- Each request has a specific time frame for response and will also inform the provider of what is required. If the provider does not respond to both requests and the Medical Director is unable to make a decision, the appropriate Denial Letter will be mailed to the member and faxed to the providers.

Denied Requests
If a service is denied, the member, PCP and provider will receive a letter informing everyone in detail the reason for the denial, the criteria on which the decision was based, how to access a copy of the criteria and Appeal rights. This letter will also provide contact information for Prominence Medical Director if the provider would like to discuss the case further. If two business days have elapsed since the initiation of the denial letter, any further action on the request will be handled through the Appeals Process explained in this manual.

Prominence will comply with all Federal and State requirements concerning denial of services. Prominence's Medical Director and UM staff are available during normal business hours to assist providers with inquiries regarding a service denial or to provide a copy of the criteria used to make the determination providers should contact the UM department by calling the number listed at the beginning of this section.

Emergency and Urgent Care Services

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:

- place the individual's health in serious jeopardy;
- result in serious impairment to bodily functions;
- result in serious dysfunction of a bodily organ or part;
- result in serious disfigurement; or
- for a pregnant woman, result in serious jeopardy to the health of the fetus.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to perform emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Urgently needed services are covered services that:

- Are not emergency services as defined in this section;
- Are provided when a member is temporarily absent from Prominence's service area (or, if applicable, continuation). (Note that urgent care received within the service area is an extension of primary care services); and
- Are medically necessary and immediately required, meaning that:
  - The urgently needed services are a result of an <u>unforeseen</u> illness, injury or condition; and
  - Given the circumstances, it was not reasonable to obtain the services through Prominence's participating provider network.

Note that under unusual and extraordinary circumstances, services may be considered urgently needed when the member is in the service or continuation area, but Prominence's provider network is temporarily unavailable or inaccessible.

Second Opinions

In accordance with state requirements, a member may request and is entitled to a second medical/surgical opinion when:

- The member feels he/she is not responding to the current treatment plan in a satisfactory manner, after a reasonable lapse of time for the condition being treated;
- The member disagrees with the opinion of a provider regarding the reasonableness or necessity of a medical/surgical procedure; or
- The treatment is for a serious injury or illness related to the medical need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g. diagnostic techniques such as cardiac catheterization and gastroscopy).

The member will select the provider from whom he/she is seeking a second opinion. The member may choose:

- A participating provider listed in a directory provided by Prominence; or
- A non-participating provider located in the same geographical service area of Prominence.

Any tests or procedures deemed necessary by a non-participating provider should be performed within Prominence‘s network.

Prominence Physician‘s professional judgment concerning the treatment of a member after review of a second opinion shall be controlling as to the treatment obligations of Prominence.

Treatment not authorized by Prominence shall be at the member‘s expense.

Provider Request

All providers requesting a second opinion must utilize Prominence‘s existing network unless the required specialist is not available. All second opinion requests for non-participating providers must be submitted through the Prior Authorization Request process.

Case Management Program

The purpose of the Case Management Program is to achieve and maintain member wellness through a program of advocacy, communication, education, identification and facilitation of services. The Plan has a developed Case Management Program that assists members who may have the following disease processes or other similarly complex health issues:

- Complex Case Management
    - Wounds
    - Transplants
    - Multiple hospital admissions for same or related diagnosis
    - Major system failure
    - Multiple trauma
    - Head or spine injuries with severe deficits
    - High ED utilization
    - Cancer with extensive treatment
    - Multiple Comorbidities or complex medical conditions

Members are identified for Case Management Programs through several sources, including, but not limited to:

- Information from Health Assessment Tool responses;
- Discharge Planning from acute or skilled services;
- Claim or Encounter Data
- Pharmacy Data
- Information through UM services;

Member participation in the Case Management Program is on a voluntary basis and a member may choose to opt out of participation.

The Case Manager works closely with the member, member's family and professional staff in the development of a mutually agreed Care Plan. The Case Manager will monitor and assist the member in reaching the goals and outcomes developed in this plan of care and will be in constant communication with the member's physician regarding the member's progress.

To request enrollment or an evaluation for possible enrollment into Case Management, call the Utilization Management Department at 844-894-8086

Disease Management Programs

Disease Management Programs provide assessment, education and health coaching for health plan members who share a common diagnosis. Prominence has determined the following diseases to be indicative of the needs of Prominence's population:

- Diabetes;
- Cardiovascular Disease; and

Members are identified for Disease Management Programs through several sources, including, but not limited to:

- Claim or Encounter Data
- Laboratory Results
- Pharmacy Data
- Information from UM services;
- Discharge planning from acute or skilled services
- Member self-referral
- Physician or provider referral, and/or;
- Information gathered from member Health Assessment Tool responses.

This program is voluntary to members, who may or may not choose to participate in the program.

To request enrollment or an evaluation for possible enrollment for a patient into a Disease Management Program, call the UM Department at 844-894-8086, and ask for the Case/Disease Management Department.

Preventive Health Guidelines

Prominence has adopted the U.S. Preventive Services Taskforce Guidelines. Prominence annually reviews preventive health guidelines to reflect any changes in recommendations regarding screening, counseling, and preventive services. These guidelines can be referenced on the website for the Agency of Health Care, Research and Quality at http://www.ahrq.gov/clinic/pocketgd.htm.

Financial Incentives

Prominence makes Utilization Management decisions based only on appropriateness of care and service, in conjunction with member benefits and coverage. Prominence does not reward providers or other individuals for issuing denials of coverage or care. Prominence does not encourage or provide incentives regarding Utilization Management decisions that result in underutilization of health care services.

Affirmative Statement

Prominence distributes a statement to all members and to all practitioners, providers and employees who make Utilization Management decisions, affirming the following:

1. Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

6. MEDICATION MANAGEMENT

Introduction

Prominence has developed a Preferred Drug List (PDL) to promote clinically appropriate utilization of medication in a cost-effective manner.

The drugs on Prominence's PDL are set up in a tier system that offers providers and members a choice of medications. Generic medications listed will have the widest choice and the least copayment. Brand medication options could be limited in certain classes or may not be available within the Prominence formulary.

Prominence's Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for PDL consideration. The Pharmacy and Therapeutics Committee, is comprised of Prominence's Medical Director, Pharmacy Director, a clinical pharmacist representing Prominence's Pharmacy Benefits Manager and physicians from Prominence's provider network. Providers can request the addition of a drug to the PDL by writing to Prominence's Medical or Pharmacy Director. Physicians interested in participating in our Pharmacy and Therapeutics Committee should contact our Medical Director.

Preferred Drug List

Prominence maintains its own Preferred Drug List (PDL), a listing of medications intended to assist Prominence's physicians and pharmacy providers in delivering comprehensive, high quality, and cost effective pharmaceutical care.

The Pharmacy and Therapeutics Committee reviews all therapeutic classes and selects medications based on effectiveness, safety, and cost. The PDL is posted on Prominence's website at www.prominencehealthplan.com when updated. Printed copies are also available by calling Prominence at 866-500-2741.

The Preferred Drug List only applies to outpatient medications filled at network pharmacies and does not apply to inpatient medications or those obtained from or administered by a Physician. Typically, most injectable drugs, except those listed on the PDL, are not covered by the pharmacy benefit. These must be approved through the Utilization Management department.

Generic Substitution

Generic drugs, excluding those with a narrow therapeutic index, should be dispensed when available. The FDA has approved a selection of generic equivalents for branded medications. Generic substitution is mandatory when an A or AB rated generic drug is available. Drugs listed on the State Negative Formulary are exempt from generic substitution requirements.

Drugs Not on the Preferred Drug List

Medications not on the Prominence Preferred Drug List (PDL) are not a covered benefit. A drug override can be requested when a medication is not on the PDL by using the Prior Authorization form and providing the related clinical information. Approval is based on the member's medical and prescription benefit coverage, acceptable medical standards of practice and FDA-approved uses.

Prior Authorization (PA)/ Step Therapy (ST)

Some drugs on the Preferred Drug List may have a designation of PA. These are drugs that will require the provider to send in a request to cover this medication. Medical documentation, including any labs, tests, diagnosis and/or previous medications failed, are needed for the request to be considered. There are some drugs that would require the use of first line drugs before the drug being prescribed will be approved. This is called Step Therapy. Documentation that the first line drugs have been tried and failed or are not tolerated by the patient needs to be submitted with the Prior Authorization/Step Therapy Request before the request can be considered.

Copayments

The Preferred Drug List is categorized into 5 Tiers as described below. The co-payment varies with each category where the preferred generic has the lowest co-payment and the non-preferred brands have the highest. Brands not appearing on the Preferred Drug List are not covered.

- Tier 1: Preferred Generic
- Tier 2: Non Preferred Generic
- Tier 3: Preferred Brand
- Tier 4: Non Preferred Brand
- Tier 5: Specialty

Injectables

Most Injectables of all types require authorization through the Prior Authorization form process with the following exceptions:

- One time Antibiotics;
- Intra-articular injections of steroids; and
- Intravenous or intra-muscular injection of steroids.

Pharmacy Use

All members should use network pharmacies. A list of participating pharmacies is in the provider directory. If a member uses a non-network pharmacy, the medication may not be covered.
Members may use out-of-area pharmacies for emergencies only.

Medication / Treatment Compliance Surveillance is designed to:

- Monitor and enhance medication treatment compliance among members;
- Monitor and evaluate medication treatment patterns among providers; and
- Identify potential negative effects of medication treatment, to include drug-to-drug interactions, contraindications, and medication side effects.

Drug Utilization Review Program

To promote safe and cost effective utilization, selected high-risk, high cost, specialized use medications, or medications not included on the Prominence's Preferred Drug List (PDL) require a Prior Authorization. A designated form for this request is in Section 10 of this manual. Approval is granted for medically necessary requests and/or when PDL alternatives have demonstrated ineffectiveness.

When these exceptional needs arise, the Physician should fax a completed Prior Authorization form to Prominence. Approval for use is based on the member's medical and prescription benefit coverage, acceptable medical standards of practice and FDA-approved uses. Additional forms may be obtained by sending your request to the Prominence's Utilization Management Department at 844-894-8086.

7. QUALITY IMPROVEMENT PROGRAMS

Overview

Prominence has established a Quality Improvement (QI) Program designed to comply with state and federal regulations and to promote quality care and service for Prominence Health members. The QI Program also provides a system for improving organizational processes.

Provider contracts require participation in the Prominence QI Program.

The ongoing QI Program is based on the guiding quality principle of Continuous Quality improvement (CQI), where performance improvement results from ongoing and systematic measurement, intervention, and follow-up of key clinical and non-clinical aspects of care. The QI Program includes the use of performance data available through standardized measures, state and national benchmarks and root cause analyses that relate to measuring outcomes and identifying opportunities for improvement.

Analytical resources are available through Quality Improvement staffing, and through the employment of project-specific consultants. Our staff has access to end-user data-systems for data including quality, claims/encounters, enrollment utilization, appeals and grievances, credentialing and customer service to provide information for performance measures and quality improvement activities.

A printed copy of the QI Program is available, upon request, to Prominence providers and members.

Goals/Objectives

Program goals are to:

- Improve and maintain Prominence Health Plan members' physical and emotional status;
- Promote health, risk identification, and early interventions;
- Empower members to develop and maintain healthy lifestyles;
- Involve members in treatment and care management decision-making;
- Facilitate the use of evidence-based medical principles, standards and practices;
- Promote accountability and responsiveness to member concerns and grievances;
- Coordinate utilization of medical technology and other medical resources efficiently and effectively for member welfare;
- Facilitate accessibility and availability of members to care in a timely manner;
- Promote member safety in conjunction with effective medical care; and
- Provide culturally and linguistically competent health care delivery and promote health care equity.

Primary objectives of the Prominence Quality Improvement Program include:

- Proactively pursue methods to improve care and service for members;
- Develop interventions to improve the overall health of members;
- Develop systems to enhance coordination and continuity of care between medical and behavioral health services;
- Maintain systematic identification and follow-up of potential quality issues;
- Educate members, physicians, hospitals and ancillary providers Prominence Health Plan's quality management goals, objectives, structure and processes; and
- Promote open communication and interaction between and among providers, members and Prominence.

Prominence Quality Improvement Program components include:

- Member rights and responsibilities;
- Confidentiality of member information;
- Member satisfaction, including grievance and appeals;
- Access and availability of care and services;
- Medical record keeping practices;
- Preventive health and HEDIS measures;
- Clinical quality improvement initiatives;
- Quality of care evaluation;
- Peer review;
- Grievances and appeals;
- Utilization management, disease management and case management initiatives;
- Coordination and continuity of care, including medical and behavioral health;
- Credentialing re-credentialing activities;
- Monitoring of delegated services;
- Member safety;
- Risk management;
- Delegation oversight;
- Provider and enrollee communication; and
- Behavioral health.

The Prominence Quality Improvement Program is evaluated and updated at least annually, with input from Prominence staff, network providers, and members.

The Prominence Quality Improvement Program includes a committee structure that incorporates committees designed to review and monitor Utilization management, quality management, pharmacy and therapeutics, credentialing, peer review, and grievances/appeals activities.

Providers who wish to participate in any of these committees are encouraged to notify Prominence for consideration. A company-wide quality steering committee oversees all quality related activities and reports to the Board of Directors.

Provider Notification of Changes

Prominence will notify physicians and providers of material changes in writing, 30-days prior to putting the change into effect. These changes are communicated via the Prominence website (www.prominencehealthplan.com), the Provider Manual and/or the Provider Newsletter.

A material change is a change that may influence a Physician or provider‘s decision to remain in Prominence‘s network. Examples of material changes are those that affect the organization‘s payment structure, the size of member panels, or the scope of a Physician and/or provider‘s administrative responsibilities.

Please contact your local Prominence Provider Relations Representative should you have questions related to a change notification.

Medical Health Information

Participating providers are expected to provide information to members regarding their health status and treatment options, including self-treatment. Information provided includes the risk, benefits and consequences of treatment or non-treatment. Providers should also allow members to participate in treatment decisions and to refuse treatment.

Medical Record Standards

In accordance with the Prominence Participation Agreement, the provider shall ensure medical records are accurately maintained for each member. It shall include the quality, quantity, appropriateness and timeliness of services performed under this contract.

Medical records shall be maintained for a period of no less than ten years, including after termination of this Agreement and retained further if records are under inspection, evaluation or audit, until such is completed.

Upon request, Prominence or any Federal or State regulatory agency, as permitted by law, may obtain copies and have access to any medical, administrative or financial record of Physician-related and Medically Necessary Covered Services to any member. The Physician further agrees to release copies of medical records of members discharged from the Physician to Prominence for retrospective review and special studies.

A medical record documents a Prominence Health member's medical treatment, current and past health status, and current treatment plans. A member's medical record is an essential component in the delivery of quality health care. Prominence has established medical record standards available to all participating providers. Providers are required to comply with these standards.

Medical Record Standards

- Every page in the record contains the member's name, member ID number and birth date;
- Includes personal/biographical data including age, date of birth, sex, address, employer, home and work telephone numbers, marital status and legal guardianship;
- The record reflects the primary language spoken by the member and any translation needs of the member.
- All entries are signed and dated;
- All entries include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;
- All entries in the medical record contain legible author identification. Author identification is a handwritten signature, stamped signature, or a unique electronic identifier. Signature is accompanied by the author's title (MD, DO, APRN, PA, MA);
- The record is legible to someone other than the writer;
- The record is maintained in detail;
- Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is noted in the record (no known allergies = NKA);
- Past medical history is easily identified and includes serious accidents, significant surgical procedures, and illnesses. For children and adolescents (21 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses;
- Past medical history (for members seen three or more times) easily identified and includes serious accidents, significant surgical procedures, and illnesses. For children and adolescents (21 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

- The immunization record is up to date;
- Diagnostic information, consistent with findings, is present in the medical record;
- A treatment plan, including medication information, is reflected in the medical record;
- A problem list including significant illnesses, medical conditions, health maintenance concerns and behavioral health issues are indicated in the medical record;
- Medical record includes a medication list;
- For members 12-years and over, notation concerning the use of cigarettes and alcohol use and substance abuse is present (for members seen three or more times).
- If a consultation is requested, a note from the consultant is in the record;
- Emergency Room discharge notes and hospital discharge summaries (hospital admissions which occur while the member is enrolled in Prominence, and prior admissions, as necessary) are appropriate and medically indicated in the medical record;
- The record includes all services provided including, but not limited to, family planning services, preventive services and services for the sexually transmitted diseases;
- There is evidence that preventive screening and services are offered in accordance with the Prominence care preventive services policies, procedures, and guidelines;
- The record contains evidence of risk screenings;
- The record contains documentation that the member was provided with written information concerning member's rights regarding advance directives, and whether or not the individual has executed an advance directive;
- The record contains documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record.
- The record documents members seeking assistance with special communications needs for health care services;
- Documentation of individual encounters provides adequate evidence of:
  - The history and physical expression of subjective and objective presenting complaints, including the chief complaint or purpose of the visit.
  - Medical findings or impressions of the provider, as well as provider's evaluation of the member.
  - Diagnoses;
  - Treatment plan;
  - Laboratory and other diagnostic studies used or ancillary services ordered;
  - Therapies, home health and prescribed regimens;
  - Encounter forms or notes regarding follow-up care, calls, or visits;
  - Unresolved problems from previous visits;
  - Lab, imaging and other diagnostic reports filed in the chart and initialed by the PCP to signify review.
  - Reports from specialists and other consultative services referred by PCP
  - Discharge reports from hospitalizations
  - Disposition, recommendations, instructions to the enrollee, evidence of whether there was follow - up and outcome of services;
- Medical records are secured in a safe place to promote confidentiality of member information;
  - Records are maintained in a location with access limited to authorized staff
  - Records are readily available for provision of care
- Medical records and all member information are maintained in a confidential manner;
  - Minor members' consultations, examinations, and treatment for sexually transmissible diseases are maintained confidentially;
- Additional medical record recommendations include:

- All entries are neat, legible, complete, clear, and concise, written in black ink;
- Entries are dated and recorded in a timely manner;
- Records are not altered, falsified or destroyed;
- Incorrect entries are corrected by drawing a single line through the error;
- Avoiding correction fluid or markers that will obscure writing;
- Dating and initialing each correction;
- Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation; and
- All telephone messages and consent discussions are documented.

Assessing the Quality of Medical Record Keeping

Prominence will assess provider compliance with these standards, and monitor the processes used in provider's offices. Prominence establishes performance goals for compliance with our medical record documentation standards.

Improving Medical Record Keeping

If a provider does not meet medical record standards, both Provider Relations and Quality Improvement staff will work with the provider to improve medical record keeping. Providers with identified deficiencies may be sent suggestions of how to improve their medical record-keeping practices, record-keeping aids, or examples of best practices that meet Prominence's record-keeping standards.

Medical Record Review

Prominence adheres to the Privacy Rule established by the Health Insurance and Portability Act of 1996 (HIPAA), which outlines national standards to protect individuals' medical records and other personal health information. The rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. It also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

To ensure HIPAA compliance, Prominence performs on-site medical record audits at the time of re-credentialing and during routine medical record evaluations. Medical records are reviewed for compliance with documentation requirements as outlined by regulatory and accreditation agencies. They are also evaluated for compliance with preventive, chronic and acute health care standards. Providers who do not meet Prominence standards for medical record documentation will be referred to the Medical Director for follow-up, or to the Quality Improvement Committee for further action.

Note that in accordance with the HIPAA guidelines, explicit member authorization is not required for release of records to Prominence in the course of Health Care Operations.

Medical Record Privacy & Confidentiality Standards

Medical Record Privacy and Confidentiality Standard 1

All Prominence Health members' individually identifiable information whether contained in the member's medical record or otherwise is confidential. Such confidential information, whether verbal or recorded, in any format or medium, includes but is not limited to, a member's medical history, mental or physical condition, diagnosis, encounters, authorization, medication or treatment, which either identifies the member, or contains information that can be used to identify the member.

Medical Record Privacy and Confidentiality Standard 2

In general, medical information regarding a Prominence Health member must not be disclosed without

obtaining written authorization. The member, the member's guardian, or conservator must grant the authorization. If the member signs the authorization, the member's medical record must not reflect mental incompetence. If authorization is obtained from a guardian or conservator, evidence such as a Power of Attorney, Court Order, etc., must be submitted to establish the authority to release such medical information.

Medical Record Privacy and Confidentiality Standard 3
To release member medical information, the requesting entity must use a valid and completed Medical Information Disclosure Authorization Form, prepared in plain language.

The form must include the following:

- Name of the person or institution providing the member information;
- Name of the person or institution authorized to receive and use the information;
- The member's full name, address, and date of birth;
- Purpose or need for information and the proposed use thereof;
- Description, extent or nature of information to be released identified in a specific and meaningful fashion, including inclusive dates of treatment;
- Specific date or condition upon which the member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation;
- Date that the consent is signed, which must be later than the date of the information to be released;
- Signature of the member or legal representative and his or her authority to act for the member;
- The member's written acknowledgment that member may see and copy the information described in the release and a copy of the release itself, at reasonable cost to the member;
- The member's written acknowledgment that information used or disclosed to any recipient other than a health plan or provider may no longer be protected by law;
- Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization; and
- A statement that the member can refuse to sign the authorization.

Medical Record Privacy and Confidentiality Standard 4
Pursuant to laws that allow disclosure of confidential medical information in certain specific instances, Prominence may release such information without prior authorization from the member, the member's guardian, or conservator for the following reasons:

- Diagnosis or treatment, including emergency situations;
- Payment or for determination of member eligibility for payment;
- Concurrent and retrospective review of services;
- Claims management, claims audits, billing and collection activities;
- Adjudication or subrogation of claims;
- Review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges;
- Coordination of benefits;
- Determination of coverage, including pre-existing conditions investigations (as applicable);
- Peer review activities;
- Risk management;
- Quality assessment, measurement and improvement, including conducting members

satisfaction surveys;
- Case management and discharge planning;
- Managing preventive care programs;
- Coordinating specialty care, such as maternity management;
- Detection of health care fraud and abuse;
- Developing clinical guidelines or protocols;
- Reviewing the competency of health care providers and evaluating provider performance;
- Preparing regulatory audits and regulatory reports;
- Conducting training programs;
- Auditing and compliance functions;
- Resolution of grievances;
- Provider contracting, certification, licensing and credentialing;
- Due diligence;
- Business management and general administration;
- Health oversight agencies for audits, administrative or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions;
- In response to court order, subpoena, warrant, summons, administrative request, or similar legal processes;
- To comply with Nevada law relating to workers' compensation;
- To County coroner, for death investigation;
- To public agencies, clinical investigators, health care researchers, and accredited non-profit educational or health care institutions for research, but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed;
- To organ procurement organizations or tissue banks, to aid member medical transplantation;
- To state and federal disaster relief organizations, but only basic disclosure information, such as member's name, city of residence, age, sex and general condition;
- To agencies authorized by law, such as the FDA; and
- To any chronic disease management programs provided member's treating Physician authorizes the services and care.

Medical Record Privacy and Confidentiality Standard 5
All individual Prominence Health member records containing information pertaining to alcohol or drug abuse are subject to special protection under Federal Regulations (Confidentiality of Alcohol and Drug Abuse member Records, Code 42 of Federal Regulation, chapter 1, Subchapter A. Part 2). An additional and specific consent form must be used prior to releasing any medical records that contain alcohol or drug abuse diagnosis.

Medical Record Privacy and Confidentiality Standard 6
Special consent for release of information is needed for all members with HIV/AIDS and mental health disorders. In general, medical information for members who exhibit HIV/AIDS and/or mental health disorders will always be reported in compliance with Nevada state law. Additional information will be released regarding a member infected with the HIV virus only with an authorized consent.

Information released to authorized individuals/agencies shall be strictly limited to the information required to fulfill the purpose stated in the authorization. Any authorization specifying "any and all medical information" or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

8. CLAIMS

Clean Claim Definition

A clean claim is a claim that contains the required elements necessary in order to process the claim.

The Texas Department of Insurance (TDI) has adopted regulations detailing the specific data elements for a claim to be considered clean. These regulations may be found at www.tdi.texas.gov.

Claim accuracy, completeness, and clarity are very important.

- Do not write on or cover the claim bar code
- Do not fold, staple or crease claims
- Use black ink
- If handwriting, print legibly
- Keep names, numbers, codes, etc., within the designated boxes and lines
- Rubber stamp signatures are acceptable
- Include a return address on all claim envelopes
- Send any necessary attachments with your claim (claim form on top, attachment on the bottom).

Timely Submission of Claims

Prominence abides by Texas Prompt Payment provisions of the State of Texas, including TIC Chapter 843.337 (Payment of Claims to physicians and providers and 28 TAC § 11.901(a)(8), as applicable.

Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute, unless your contract stipulates something different.

Members cannot be billed for services denied due to a lack of timely filing. Claims appealed for timely filing should be submitted with proof along with a copy of the EOP and the claim.

Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of Prominence, or a similar receipt from other commercial delivery services.

General Payment Guidelines

Claims should be submitted in one of three formats:

- Electronic claims submission,
- CMS 1500 Form, or
- UB04 Form.

Physicians/providers are required to use the standard CMS codes for ICD10, CPT, and HCPCS services, regardless of the type of submission.

Member Responsibility

The Physician/provider should collect the following payments from the member based upon the terms of your contract and the benefit plan design:

- Copayments
- Deductibles
- Coinsurance

Charges that can be billed and collected from the member will be indicated on the Explanation of Benefits (EOB) notice from Prominence. **The provider gets an explanation of payment (EOP).**

Prohibition of Billing Members

As a participating physician/provider you have entered into a contractual agreement to accept payment directly from Prominence. Payment from Prominence constitutes payment in full, with the exception of applicable co-payments, deductibles, and/or co-insurance as listed on the EOB/EOP.

You may not balance bill members for the difference between actual billed charges and your contracted reimbursement rate. A member cannot be *"balance billed"* for covered services denied for lack of information. Failure to notify Prominence of a service that requires prior authorization will result in payment denial. In this scenario, members may not be balance billed and are responsible only for their applicable co-payments, deductibles, and/or coinsurance.

A member cannot be billed for a covered service that is not medically necessary. Unless the member's informed written consent is obtained prior to rendering a non-covered service. This consent must include information regarding their financial responsibility for the specific services received.

Maximum Out-of-Pocket Expenses (MOOP)

The term Maximum Out-of-Pocket (MOOP) refers to the limit on how much a Plan enrollee has to pay out-of-pocket each year for medical services that are covered.

All of our plans have a MOOP. If a member reaches a point where they have paid the MOOP during a calendar year (coverage period), the member will not have to pay any out-of- pocket costs for the remainder of the year for covered services. If a member reaches this level, Prominence will no longer deduct any applicable member expenses from the provider's reimbursement.

The MOOP can vary by Plan and may change from year to year. Please refer to the Summary of Benefits available online at our website: www.prominencehealthplan.com. You may confirm that a member has reached their MOOP by contacting the Customer Service Department.

Physician and Provider Reimbursement

Reimbursement for covered services is based on the negotiated rate as established in the Physician or Provider Agreement. Services that require a prior authorization will be denied if services were rendered prior to approval. Please refer to your Physician or provider Agreement to determine the method that applies to your contract.

Completion of "Paper" Claims

Paper claims should be completed in their entirety including but not limited to the following elements:

- The member's name and their relationship to the subscriber;
- The subscriber's name, address, and insurance ID as indicated on the member's identification card;
- The subscriber's employer group name and number (if applicable);
- Information on other insurance or coverage;
- The name, signature, place of service, address, billing address, and telephone number of the Physician/Provider performing the service;
- The tax identification number, NPI number, for the Physician or provider performing the service;
- The appropriate ICD-10 codes at the highest level;

- The standard CMS procedure or service codes with the appropriate modifiers;
- The number of service units rendered;
- The billed charges;
- The name of the referring Physician;
- The dates-of-service;
- The place-of-service;
- The authorization number;
- The NDC for drug therapy; and
- Any job-related, auto-related, or other accident-related information, as applicable.

Mail paper claims to:
Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89502
Attn: Claims Dept.

Electronic Claims Submission

Electronic data filing requires billing software through which you can electronically send claims data to a clearinghouse. Since most clearinghouses can exchange data with one another, you can continue to use your existing clearinghouse even when it is not the clearinghouse selected by Prominence.

Prior to submitting claims through a clearinghouse exchange, you must check with your existing clearinghouse to make sure they can complete the transaction with the Prominence vendor. If you do not have a clearinghouse, or have been unsuccessful in submitting claims to your clearinghouse, please contact our Customer Service department for assistance.

Our trading partner, EMDEON, can help establish electronic claims submissions connectivity with our Plan. You will need our payer number (distinct for each plan), which is **88029** for Prominence Health Plan.

Tips on successfully submitting electronic claims:

- Ensure your clearinghouse can remit information to our trading partner, EMDEON. You may reach EMDEON at 800-845-6592.
- Use the billing name and address on the electronic billing format that matches our records.
- Please notify our office of any name and address changes in writing.
- Field NM1 relates to box 33 of a CMS1500 or the UB04 for all electronic claims transmissions and 837's.
- Contact EMDEON with any transmission questions at 800-845-6592.

**Currently not available for dual specialty providers, PCP's with IPA affiliations, anesthesiology or ambulance providers.*

Electronic Transactions and Code Sets

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes a series of administrative simplification provisions including the adoption of national standards for electronic health care transactions.

On October 16, 2003, the Electronic Transaction and Code Set provision of HIPAA went into effect. Law requires payers to have the capability to send and receive all applicable HIPAA-compliant transactions and code sets.

One requirement is that the payer must be able to accept a HIPAA-compliant 837 electronic claim transaction, in standard format, using standard code sets and standard transactions. Specifically, claims submitted electronically must comply with the following provider-focused transactions:

- 270/271 – Health Insurance Eligibility/Benefit Inquiry & Response;
- 276/277 – Health Care Claim Status Request & Response;
- 278 – Health Care Services Review – Request for Review and Response; and
- 835 – Health Care Claim Payment/Advice
  The X12N-837 claims submission transactions replaces the manual CMS 1500/UB92 forms. All files submitted must be in the ANSI ASC X12N format, version 4010A, as applicable.

Encounter Data

Encounter Data is a record of covered services provided to our members. An Encounter is an interaction between a patient and provider (health plan, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient. Prominence requires the submission of claims for all encounters in order for Prominence to achieve state and federal reporting requirements.

Providers reimbursed on a capitation basis must file claims for all services. Claims submitted under a capitation contract are referred to as encounter data. Encounter data can be submitted on a paper claim format or through Electronic Data Interface (EDI) following the same rules as submitting claims. Prominence recognizes these services as paid under the capitation contract and not paid to the Physician or provider directly. These services become an integral part of the Prominence claims history database and are used for analysis and reporting.

Capitated physicians and providers who do not submit encounter data could be terminated from Prominence.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the procedure used to process health care payments for a patient with one or more insurers providing health care benefit coverage. Prior to claims submission, it is important to identify if any other payer has primary responsibility for payment. If another payer is primary, that payer should be billed prior to billing Prominence.

When a balance is due after receipt of payment from the primary payer, a claim should be submitted to the Prominence for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of their explanation of payment statement. Upon receipt of the claim, Prominence will review its liability using the COB rules and/or the Medicare crossover rules—whichever is applicable.

Correct Coding

Prominence has adopted a policy of reviewing claims to ensure correct coding. Prominence utilizes a corrective coding re-bundling/unbundling software, which is integrated with our claims payment system. Services that should be bundled and paid under a single procedure code will be subject to review.

Claims Appeals

Claims appealed for the denial *no authorization" or other medical reasons"* should be submitted to the attention of the Appeals Department. Please include documentation explaining why an authorization was not obtained, any pertinent medical records, a copy of the claim(s), and a copy of the denial statement received.

Claim appeals for denial of timely filing, incorrect payment, or denied in error, should be submitted to the attention of the Claims Department at Prominence's claims address. The time frame for appealing a claim denial is 180-days from the date of the denial on the explanation of benefits/payment. Cases appealed after the 180-day time limit will be denied for untimely filing.

There is no second level consideration for appeals outside the timely filing requirement. Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of Prominence, or a similar receipt from other commercial delivery services.

Prominence has up to sixty (60) days to review it for medical necessity and conformity to Plan guidelines.

Prominence is not responsible for payment of medical records generated as a result of a claims appeal. Cases received for lack of necessary documentation will be denied. The physician or provider is responsible for providing the requested documentation within 60 days of the denial in order to re-open the case. Records and documents received after that time frame will not be reviewed and the case will be closed.

In the case of a review in which the physician or provider has complied with Plan guidelines and services are determined to be medically necessary, the denial will be overturned. The physician or provider will be notified in writing to re-file the claim for payment. If the claim was previously submitted and denied, Prominence will adjust it for payment after the decision is made to overturn the denial.

Reimbursement for Covering Physicians

Covering physicians for primary care providers must agree to abide by Utilization Management and Quality Improvement guidelines. The payment rate is according to the Physician Agreement between the contracted PCP and Prominence. The covering physician shall not seek payment from Prominence or the member with the exception of those services for which the assigned PCP would have been permitted to collect, i.e., copayments, deductibles, and/or co-insurance from the member.

9. COMPLAINT & APPEALS PROCESS

Provider Complaint Process

A complaint is a written expression by a provider which indicates dissatisfaction or dispute with Prominence's policies, procedures, or any aspect of the Prominence's functions. Prominence logs and tracks all complaint received in writing. After a complete investigation of the complaint, Prominence shall provide a written response to the provider within thirty (30) calendar days from the received date of the complaint.

Member Complaint and Appeal Process

To ensure that member's rights are protected, all Prominence members are entitled to a complaint and medical necessity appeal process. The procedures for filing a complaint and/or a medical necessity appeal are outlined in the members Evidence of Coverage book.

Participating Provider Claims Appeals

This section explains the appeal process for denied claims only. The appeals process for pre-service denials can be found in the Utilization Management Section of this manual.

The terms and conditions of payment to participating providers follow the mutual obligations of Prominence and providers per our Provider Agreement. Per our Agreement, physicians and providers may not bill our members, except for any co-payments or co-insurance. Any claims disputes for services provided to our members have to be resolved per the contract's terms and conditions.

Balance billing members is also prohibited by TDI regulations. Claims may be denied for reasons including, but not limited to:

- Lack of authorization;
- Services not billed as authorized;
- Billing with an incorrect code;
- Place of service billed wrong; or
- Provider not member's PCP on date of service.

The specific reason for denial of the claim will be provided in the Evidence of Payment document that is sent to providers along with all paid/denied claims.

Once a claim is denied, the provider may request a reconsideration regarding Prominence's decision. Providers must make this request in writing within 60 days of receipt of the initial claims denial and send the request to the Grievance and Appeals address provided. Additional information to support the request may be sent at this stage. Please also see the Claims Appeals Section in Chapter 8 of this manual.

Mail Appeals to:
Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89510-8503
Attn: Provider Appeals

Fax Appeals to:
Attn: Provider Appeals
775-770-9036 Fax
775-770-9363 Alt Fax

Non-participating Providers Appeal

Prominence encourages the use of participating providers but when a non-participating provider is used, the non-par provider must follow these steps:

Step 1. Contact Prominence for all Prior Authorization requests. All claims of non-par providers for services provided without a proper authorization will be denied.

Step 2. If a claim is denied, the non-par provider can file an appeal. However, all non-par providers must sign a Waiver of Liability Form in order for the claim to be reconsidered for payment. The Waiver of Liability form is attached to the Appeal Acknowledgement Letter. If the Waiver Form is not completed and returned, the case is prepared and sent to the Maximus CHDR (the Independent Review Entity) for dismissal.

Step 3. Upon receipt of the Waiver Form, the claim and reason for the denial are reviewed. The Grievance and Appeals staff either pays the claim or presents the case for administrative review.

Step 4. Providers and members are notified in writing of approved or denied claims. Claims approved for payment on appeal are processed and paid within established time frames to either the provider or member—whichever is appropriate.

Step 5. Claims denied for payment after the appeal review, are processed and forwarded to Maximus Federal Services, the Independent Review Agency (IRE) contracted by CMS.

Expedited Claims Appeals

Providers can request an expedited appeal for Prior Authorization Requests only. There is not an expedited appeal for post-service denials.

10. SAMPLE FORMS & DOCUMENTS

Click on the links below for access to important forms and resources.

Prior Authorization List & Forms

- Texas Prior Authorization List
- Texas Prior Authorization Request form
- Behavioral Health Services
- Psychological and Neuropsychological Testing
- MedImpact Prior Authorization Request form

Join our Network

- Texas Standardized Credentialing Application
- Letter of Intent
- Provider Profile Sheet
- W-9

Sample Member ID Cards

- Coming soon!