Pruitt Health
PREMIER

Provider Manual

You have a choice in your healthcare

PruittHealthPremier.com

Table of Contents

Plan Overview

Introduction

PruittHealth Premier ("health plan" or "Plan") is a Medicare Advantage Institutional Special Needs Plan designed to improve the care for the residents of Nursing Facilities in North Carolina, South Carolina. PruittHealth Premier's target population is an institutionalized Medicare beneficiary who resides or is expected to reside in a contracted long-term care (LTC) facility for 90 days or longer.

Model of Care

The Plan's Model of Care provides nursing home residents with a patient-centered, primary care driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the Model of Care is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits offer additional services and support for the Plan's specialized population.

Goals of the PruittHealth Premier's Institutional Special Needs Plan (I-SNP) Model of Care:

- Improve access to medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve transitions of care across health care settings and providers;
- Improve access to preventive health services;
- Assure appropriate utilization of services; and
- Improve member health outcomes.

Participating providers should know:

1) All members are required to choose or designate a Primary Care Physician (PCP) at enrollment. The Plan refers to PCPs providing regular services for residents at long-term care facilities as "SNFists" or NFists." A SNFist or NFist is a physician who is (1) contracted with PruittHealth Premier, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for PruittHealth Premier members in the Nursing Facility (NF), "in the Assisted Living (AL), or Skilled Nursing Facility (SNF) setting, including coordination and management of the delivery of all covered services. PruittHealth Premier members can choose their PCP/NFist from the list of contracted NFists maintained and published by PruittHealth Premier. Members can change their PCP/NFist at any time. Changes are typically effective the 1st day of the following month.

2) All members are assigned a Nurse Practitioner or a PA (an "Advanced Practitioner"). Contracted Plan Advanced Practitioners provide both direct primary care services in

collaboration with Plan PCPs and coordinate services and care for members. Advanced Practitioners develop member care plans, participate in Interdisciplinary Care Team meetings, and provide routine preventive services and complete comprehensive health risk assessments for members.

3) The Plan has received permission from CMS to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from the member's Advanced Practitioner and PCP, to treat members in the nursing home when appropriate and reserves acute hospital stays for members requiring more intensive services.

4) PruittHealth Premier uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Advanced Practitioner. This approach aids in care coordination as well as the pre-authorization of services.

5) The Plan is "provider friendly" and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, pre-authorization, and referral processes outlined in this manual.

Working with the Plan

Key Contacts

Member Services Department at 1-844-224-3659 (TTY 711)

Plan's Provider Services Department: 1-844-224-3659 (TTY 711)

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility during each visit, or before the appointment.

PruittHealth Premier has the most current eligibility information. You can verify member eligibility through the following ways:

- Member ID Card: Note that changes do occur, and the card alone does not guarantee member eligibility.
- Provider Web Portal: PruittHealth Premier web portal allows providers to verify eligibility online 24/7 at https://planprovportal.align-360.com/EZ-NET60PHP/Login.aspx or
- Please call the Member Services Department at 1-844-224-3659 (TTY 711)

Please note membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) may retroactively terminate members for various reasons and recoup payments

it made to the plan. When this occurs, PruittHealth Premier claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question. Typically, the beneficiary is disenrolled to Medicare fee-for-service. If the Medicare timely filing period has passed, Federal law gives providers an extra six months after the plan's recoupment to file a claim.

Benefits and Services

All PruittHealth Premier members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers may contact the Provider Services line for information on covered services and verification of applicable member copayments and/or cost-sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost-sharing as permitted under PruittHealth Premier or by law. Participating providers of PruittHealth Premier are however, prohibited from balance-billing members copayments and/or cost-sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, click here http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.

Emergent and Urgent Services

PruittHealth Premier follows the Medicare definitions of "emergency medical condition", "emergency services", and "urgently-needed services" as defined in the Medicare Managed Care Manual Chapter 4 Section 20.2:

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

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

Emergency services: "Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

Urgently-needed services: "Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan network."

The PruittHealth Premier network includes multiple hospitals, emergency rooms, and providers able to treat the emergent conditions of 1-844-224-3659 (TTY 711) members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues occuring onsite in the member's nursing home or in the service area, the PCP/NFist is generally responsible for providing, directing, or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCP/NFist or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCP/NFist, working with the Plan Advanced Practitioner, is generally responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members may have a copayment responsibility for outpatient emergency visits unless it results in an admission.

While most members remain in the service area, 1-844-224-3659 (TTY 711) members may receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved for only continuity of care.

PruittHealth Premier's network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost-sharing.

Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by PruittHealth Premier:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, and eyeglasses (which are only covered after cataract surgery) unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost-sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost-sharing amount.

Continuity of Care

PruittHealth Premier's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves PruittHealth Premier's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, PruittHealth Premier will work to transition a member into care with a Participating Physician or other provider within PruittHealth Premier's network. PruittHealth Premier is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

PruittHealth Premier also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in PruittHealth Premier's network. Under these circumstances, PruittHealth Premier will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

PruittHealth Premier will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at 1-844-224-3659 (TTY 711).

Referrals

PruittHealth Premier uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Plan Advanced Practitioner to help in care coordination.

A member's PCP or Plan Advanced Practitioner may make referrals for in-network specialists. Whenever possible, in-network specialists are encouraged to provide member visits in the member's nursing facility for safety and comfort. All specialist physician services must be approved by the member's PCP or HP Nurse Practitioner

Whether the referral originates with the PCP, Plan Advanced Practitioner, or specialists, referrals should be made to PruittHealth Premier participating physicians/facilities. **The PCP or Plan Advanced Practitioner must approve the referral.**

Referrals to "out of network" physicians or facilities require prior authorization from the Plan's Utilization Management team. Out of network referrals may be allowed in certain circumstances where in-network providers or services are not reasonably available to the member, or there is a continuity of care concern (see section on Continuity of Care).

Notification of Inpatient and Observation Admissions

PruittHealth Premier requires providers to notify the plan of inpatient and observation admission as follows:

- Admissions following outpatient procedures or observation status—notification
- Observation Status—notification

For notification of admission, providers should call: 1-844-224-3659 (TTY 711)

Emergent admission notification must be received within one business day of admission. For observation stays, PruittHealth Premier expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though PruittHealth Premier waives the three-day stay requirement.

Prior Authorization

Requests for prior authorizations of services should be made before or at the time of scheduling the service. Plan PCPs, Practitioners, and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures, and outpatient services ordered by the PCP or Advanced Practitioner.

PruittHealth Premier recommends calling at least fourteen (14) days in advance of an elective admission, procedure, or service. Requests for prior authorization will be prioritized according to the level of medical necessity. For prior authorizations, providers should call: 1-844-224-3659 (TTY 711) option 3, fax 1-800-489-9518, or email UMInquiryRequest@PruittHealthPremier.com.

Services Requiring Prior Authorization

Providers should refer to Appendix 1, or the provider section of the plan's website at PruittHealthPremier.com for the table(s) listing services typically requiring referral or authorization. As this table is updated on a yearly basis, the presence or absence of a service or procedure on the list does not determine coverage or benefit.

Documentation for Prior Authorizations

The Utilization Management Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider of the determination. Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- Primary Care Physician name/ Health Plan Advanced Practitioner
- Servicing/Attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service

Decisions and Time Frames

Expedited: When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited requests will be determined within 72 hours or as soon as the member's health requires.

Routine: If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days.

Once the Utilization Management Department receives the request for authorization, PruittHealth Premier will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, PruittHealth Premier will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. **Claims for services requiring prior authorization must be submitted with the assigned authorization numbers.** This authorization number can be used to reference the admission, service or procedure.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, SNF, or other inpatient admission to ensure:

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility contract

Utilizing CMS guidelines and Milliman Care Guidelines (MCG) to review criteria, PruittHealth Premier's Utilization Management department and the Plan's Medical Directors will conduct a medical necessity review. PruittHealth Premier is responsible for final authorization.

PruittHealth Premier's preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility UM staff within 1 Business Day of notification or on the last covered day. If clinical information is not received within 24 hours of admission or on the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria. If it is not feasible for the facility to contact PruittHealth Premier via phone, facilities may fax the member's clinical information within one business day of notification to 1-800-489-9518.

Specific to the ISNP: Review is not required for readmission to the referring NF (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be faxed to 1-800-489-9518.

A PruittHealth Premier Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the PruittHealth Premier Medical Director deems the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), e.g. facility, attending/ordering provider verbally and in writing and will notify the member as required by law. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact 1-844-224-3659 (TTY 711).

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, PruittHealth Premier will approve the request or issue a denial if the request is not medically necessary. PruittHealth Premier will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

PruittHealth Premier also issues written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is expected to fax a copy of the signed NOMNC back to Utilization Management Department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal. **Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. The Plan will not generate these NOMNCs.**

Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility. Late authorization, or not providing clinical information as requested, will result in an administrative adverse determination, and does not allow the provider to appeal.

Only a PruittHealth Premier Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating

provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, PruittHealth Premier notifies the facility or provider's office of the denial of service. Notices are issued to the provider, the member, or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal.

PruittHealth Premier employees are not compensated for denial of services. The PCP/NFist or Attending Physician may contact the Medical Director by telephone to discuss decisions only before an adverse determination is rendered.

After the adverse determination is rendered the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and/or member as applicable. Written notifications are sent to the members and requesting provider as follows:

- For non-urgent pre-service decisions-within 14 calendar days of the request.
- For urgent pre-service decisions–*within 72 hours of the request.
- For urgent concurrent decisions–*within 24 hours of the request.

**Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than three calendar days after the oral notification.*

PruittHealth Premier complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

Billing and Claims

Claims Submission

While PruittHealth Premier prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact your local PruittHealth Premier Provider Services Department at: 1-844-224-3659 (TTY 711).

PruittHealth Premier also offers the ability to submit claims through the EZNet Provider Portal, instructions on how to gain access to the portal can be found on the plan website: PruittHealthPremier.com.

Forward all completed paper claims forms to the address noted below:

PruittHealth Premier, Box 908, Addison, TX 75001

Timely Filing

As a PruittHealth Premier participating provider, you have agreed to submit all claims within the timeframe outlined in your provider agreement with PruittHealth Premier.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: cms.gov/manuals/downloads/clm104c12.pdf.

PruittHealth Premier can only pay claims which are submitted accurately. The provider is, at all times, responsible for accurate claims submission. While PruittHealth Premier will make its best effort to inform the provider of claims errors, ultimately claim accuracy rests solely with the provider.

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

Physicians in the same group practice, but who are in different specialties may bill and receive payment without regard to their membership in the same group.

Claim Payment

PruittHealth Premier pays clean claims according to contractual requirements. A clean claim is a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by PruittHealth Premier, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim.

Pricing

Original Medicare typically has market adjusted prices by code (i.e., CPT or HCPCS) for the services traditional Medicare covers. However, there are occasions where PruittHealth Premier offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, PruittHealth Premier will work to arrive at a fair market price by

researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. PruittHealth Premier requests you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement is incorrect.

PruittHealth Premier will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. PruittHealth Premier will also follow guidelines put forth by the AMA CPT, and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by PruittHealth Premier is subject to the appeals/payment dispute and clinical review policies and procedures outlined in this manual.

New or Non-Listed Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when new codes are developed/added for new and newly approved services or procedures, or if existing codes are changed.

PruittHealth Premier follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, PruittHealth Premier will make every effort to load the new code as quickly as possible.

In the event a provider submits a code and PruittHealth Premier claims system does not recognize it as a payable code or does not have a contracted allowance, the following process will occur:

- PruittHealth Premier maintains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. Examples include but are not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS;

- The provider may then appeal the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and

- PruittHealth Premier will pay for any services that include proof of payment by Original Medicare within the past six (6) months at the provider's contract rate or, if not addressed, 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing for which the provider furnishes proof.

- Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re-adjudication process.

- All codes/services submitted for payment but not recognized by the claims system will be subject to verification of medical necessity. **Providers should always call for**

preauthorization of any procedure/service/or code for which they have concerns about coverage.

Claims Encounter Data

Providers who are paid under capitation must submit claims within the same timely filing limit required in their provider agreement with PruittHealth Premier or non-capitated claims to capture encounter data as required per your PruittHealth Premier Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after PruittHealth Premier has determined coverage and payment. The statement provides a detailed description of how the claim was processed.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by PruittHealth Premier are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your contract, the member may not be billed for services denied by PruittHealth Premier unless the member received the denial **before** the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed PruittHealth Premier's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this.

Obtaining pre-services review will reduce denials.

Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow this process. Payment dispute procedures are separate and distinct from appeal procedures.

A formal payment dispute request is required from the Provider to contest a paid amount on a claim which does not include a medical necessity or administrative denial. All Payment Disputes must be:

- Submitted in writing within 60 days from the original payment
- Include a cover letter with:
    - Claim Identifiable information

    - The specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
    - Copy of the original remittance advice (RA)
    - All applicable medical records or other attachments supporting additional payment

Providing the above information enables the Payment Dispute Unit to properly and promptly review the request. Requests that do not follow all of the above may delay resolution. PruittHealth Premier will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Mail provider claims payment disputes to:
PruittHealth Premier Medicare Payment Dispute, PO Box 2190, Glen Allen, VA 23058-2190

Participating Provider Administrative Plea/Appeals Responsibility

A provider may submit a formal request to review a previous decision where a determination was made stating the Participating Provider failed to follow administrative rules, assigning liability to the Provider (see original decision letter) where the services were rendered.

All requests must be:

- Submitted in writing
- Submitted within 60 days from the decision letter date
- Include a cover letter with:
    - Member Identifiable information
    - Date(s) of service in question
    - The specific rationale as to why the administrative rules were not followed, requiring an exception to be made or extenuating circumstance warranting a re-review of the request for provision of payment.
- Include necessary attachments:
    - Copy of the original decision
    - All applicable medical records

Mail requests for review to:
PruittHealth Premier Appeals & Grievances, PO Box 2190, Glen Allen, VA 23058-2190 or fax requests to: 1-800-862-2730.

In the event PruittHealth Premier waives the administrative requirement, and the request requires a medical review, PruittHealth Premier will not request additional records to support the provider's argument. The provider is expected to submit the necessary information to substantiate the request for payment.

Providing the above information enables the appeals team to properly and promptly review requests within 60 business days. In the event PruittHealth Premier waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable timeframes. Requests that do not follow the above requirements may be delayed.

Non-Participating Provider Appeals Rights

If a claim is partially or fully denied for payment, the non-participating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification.

When submitting the reconsideration of the denial of payment on a claim, a signed Waiver of Liability form must be included. A waiver of liability form can be obtained on the Providers page of the Plan website. The Waiver of Liability form holds the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the non- participating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement.

The appeal must be in writing and mailed to:

PruittHealth Premier Appeals Department, PO Box 2190, Glen Allen, VA 23058-2190

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice, the financial responsibility for that member shifts from **PruittHealth Premier** to Original Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services **PruittHealth Premier** is financially responsible for during this time include any supplemental benefits **PruittHealth Premier** offers in addition to Original Medicare benefits.

Members can revoke hospice elections at any time. If so revoked and once notified by CMS, the Plan will resume coverage for the member the first of the following month. These rules apply for both professional and facility charges.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e., property and casualty insurer, an automobile insurer, or worker’s compensation carrier), not two health insurers.

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by PruittHealth Premier Claims Department.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to PruittHealth Premier with any information regarding the third-party carrier. All claims are processed per the usual claims' procedures.

For claims related questions, please contact your local PruittHealth Premier Provider Services Department at: 1-844-224-3659 (TTY 711). A Network Services Representative will gladly assist.

Member Grievances and Appeals

Appeals

Members of PruittHealth Premier have the right to appeal any decision about PruittHealth Premier's failure to provide or pay for what they believe are covered services.

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by PruittHealth Premier;
- Services they have not received, but believe are the responsibility of PruittHealth Premier to pay; and/or
- A reduction in or termination of service a member feels is medically necessary.

Also, a member may appeal any decision to discharge from the hospital. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to PruittHealth Premier Evidence of Coverage (EOC) for additional information.

For pre-service determinations, the enrollee's treating physician acting on behalf of the enrollee or staff of the physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead); or any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding may file an appeal.

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals will receive an independent review (made by someone not involved in the initial

decision). Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may still be to uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 60 days from the original decision. Appeal requests should include a copy of the denial, and any medical records supporting why the service is needed.

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an appeal orally, please call 1-844-224-3659 (TTY 711). An enrollee or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers contracted with PruittHealth Premier may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the process outlined in the "Billing and Claims" section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances the Plan should consider.

Part C Appeals Phone and Fax Number

- Phone: 1-844-224-3659 (TTY 711)
- Fax: 1-800-489-9518

Grievances

Members of PruittHealth Premier have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns;
- Involuntary disenrollment situations; and/or
- Complaints concerning the quality of services a member receives.

Complaints may be received by Advanced Practitioners, Nursing Facilities, Plan Customer Service representatives, and through Member Services. All complaints are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with PruittHealth Premier in investigating grievances related to the provider or providers services.

Provider Information

Provider Credentialing

Providers must be contracted with and credentialed by PruittHealth Premier or the entity under contract to perform credentialing services. PruittHealth Premier may agree to delegate credentialing to a provider organization so long as a) a Delegation Agreement is signed by both parties, and b) a delegation audit is conducted and found to be satisfactory.

Application Process

Providers must submit a completed State Mandated Credentialing application, CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.

If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information, and explanations.

Providers must provide appropriate clinical detail for all malpractice cases that are pending or resulted in a settlement or other financial payment.

Send completed credentialing applications to:

GA: networksupport@pruitthealthpremier.com

NC/SC: networksupport@pruitthealthpremier-nc.com

Credentialing and Recredentialing Process

Once a Provider has applied for initial consideration, PruittHealth Premier's Credentialing Department or its designee will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank.

The credentialing process generally takes up to ninety (90) days to complete but can in some instances take longer. Once credentialing has been completed, and the applicant is approved, the Practitioner will be notified in writing of their participation effective date. All practitioners are required to recredential at least every three years to maintain participating status. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit re-credentialing information at least four

months in advance of their three-year anniversary date. Three separate attempts will be made to obtain the required information via mail, fax, email or telephonic request. Practitioners who fail to return recredentialing information before their re-credentialing due date will be notified in writing of their termination from the network.

If the network is not in need of specific coverage, the Plan reserves the right to not credential providers.

Office Site Evaluations

Office site surveys and medical recordkeeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue and/or as otherwise mandated by all applicable laws and regulations. Practitioner offices are evaluated in the following categories:

- Physical Appearance and Accessibility
- Patient Safety and Risk Management
- Medical Record Management and Security of Information
- Appointment Availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow-up site evaluation will be done within 60 days of the initial site visit (if necessary) to ensure the corrective action was implemented.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least thirty days in advance. The Plan will establish a time for the provider to view the information at the Plan's offices.

Providers have the right to correct erroneous information when information obtained during the credentialing process varies substantially from what was submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within 30 days of notification.

Providers have the right to be informed of the status of their application and may request the status of the application either telephonically or in writing. The Plan will respond within two

business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Facility/Organizational Provider Selection Criteria

When assessing organizational providers, PruittHealth Premier utilizes this criterion:

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other Plan criteria
- Maintains current professional and general liability insurance as applicable
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare, Medicaid, or any other government health-related program
- Need for coverage related to the organization's location and services
- For "providers of services" under section 1861(u) of the Social Security Act, must have a provider agreement with CMS permitting them to provide services under original Medicare; is not on the precluded provider list

Facility/Organizational Provider Application and Requirements

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
- If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
- Copies of all applicable state and federal licenses (i.e., facility license, DEA, Pharmacy license, etc.).
- Proof of current professional and general liability insurance as applicable.
- Proof of Medicare participation.
- Copy of DEA Registration.
- If accredited, proof of current accreditation.
    - Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high-tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
- If not accredited, a copy of any state or CMS site survey that has occurred within the last three years including evidence the organization successfully remediated any deficiencies identified during the survey.

Facility/Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential

or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted after the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within 30 days and may be re-audited, at a minimum within 60 days, to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards, even after re-auditing, will not be eligible for participation.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process before approval or reapproval as a participating provider. The Plan Medical Director may approve providers who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and re-credentialing process must be obtained and verified within one hundred eighty (180) days before presentation to the Medical Director or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discrimination in the Decision-Making Process

PruittHealth Premier's Credentialing Program is compliant with all CMS and State regulations as applicable. Through the universal application of specific assessment criteria, PruittHealth Premier ensures fair and impartial decision-making in the credentialing process. No provider is participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their plan effective date. Providers are advised not to see PruittHealth Premier members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

In the event a provider's participation is limited, suspended or terminated, the provider is notified in writing within 60 days of the decision. Notification will include a) the reason(s) for the action, b) outlines the appeals process or options available to the provider, and c) provides the time limits for submitting an appeal. A panel of peers review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential, handled and stored confidentially and securely as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information are not disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

PruittHealth Premier conducts routine, ongoing monitoring of the preclusion list, license sanctions, Medicare/Medicaid sanctions and the CMS Opt-Out list between credentialing cycles. Participating providers who are identified as having been sanctioned are subject to review by the Plan Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider whose license has been revoked or has been precluded, excluded, suspended and disqualified from participating in any Medicare, Medicaid or any other government health-related program or who has opted out of Medicare will be automatically terminated from the Plan.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by Credentialing and Recredentialing Process of the Plan.

Plan Notification Requirements for Providers

The following list of changes must be reported to PruittHealth Premier by contacting your Provider Services Representative within the timeframe outlined in the Provider Agreement:

- Practice address
- Billing address

- Fax or telephone number
- Hospital affiliations
- Practice name
- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory.

Closing Patient Panels

When a participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against PruittHealth Premier members by closing their patient panels for PruittHealth Premier members only. Providers who decide they will no longer accept any new patients must notify PruittHealth Premier's Network Operations Department, in writing, at least 60 days before the date on which the patient panel will be closed.

Access and Availability Standards for Providers

PruittHealth Premier has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. PruittHealth Premier also requires all providers to offer standard hours of operation that (1) do not discriminate against Medicare enrollees, and (2) are convenient for PruittHealth Premier members, the facilities where members reside, and facility staff who aid in member care. PCPs are NOT to provide routine visits at times that coincide with regular facility meal times, or interfere with expected member sleep patterns by occurring before 8 am or after 8 pm, or occur during nursing staff shift changes.

Provider Responsibility

- PruittHealth Premier members have access to care 24 hours a day, 7 days a week as medically necessary. PruittHealth Premier has the additional policies in place to make sure members have timely access to routine, preventive, and urgent care services. PCPs—referred to by PruittHealth Premier as NFists—are required to provide routine, preventive care and monitoring visits for their assigned members on-site at the

member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as a moderate or high risk.

- Routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner.
- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.
- Specialists are required to be available for a consult or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, PruittHealth Premier Advanced Practitioners, PruittHealth Premier Medical Director and Utilization Management staff, and nursing home facility staff):
    - Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately. Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
    - Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.
- A provider may not balance bill a member for providing services that are covered by PruittHealth Premier. This excludes the collection of standard co-pays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.

Network Access Monitoring and Compliance

Using valid methodology, PruittHealth Premier will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- NFist visit frequency report: Utilizes claims data to monitor the frequency of NFist routine visits for members.
- Medical specialty appointment access: Utilizes the third next available appointment methodology to survey selected high-volume specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology, and urology for availability of consult or new patient appointment within 21 calendar days.
- After-hours care telephone survey: Annual survey of nursing facility staff and Nurse Practitioners about the after-hours availability and responsiveness of NFists to routine and urgent calls.

- Member satisfaction survey: Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, PruittHealth Premier will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access to care (provider or after hours) are collected through PruittHealth Premier Member Services Department line or submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Provider Marketing Guidelines

The below is a general guideline to assist PruittHealth Premier providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to a number of plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions.

Providers Can:

- Mail or provide a letter to patients notifying them of their affiliation with PruittHealth Premier.
- Provide objective information to patients on specific plan attributes and formularies, based on a patient's medications and healthcare needs in the course of treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), PruittHealth Premier marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Provide beneficiaries with communication materials furnished by PruittHealth Premier in a treatment setting.
- Refer patients to the plan marketing materials available in common areas.

- Display and distribute in common areas PruittHealth Premier marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Display promotional items with PruittHealth Premier logo.
- Allow PruittHealth Premier to have a room/space in provider offices completely separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a PruittHealth Premier sales representative.

Providers Cannot:

- Offer anything of monetary value to induce enrollees to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest.
- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Call patients to invite patients to the sales and marketing activities of a health plan.
- Advertise using PruittHealth Premier's name without PruittHealth Premier's prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment to New PCP/NFist

PruittHealth Premier PCP/NFists have a limited right to request a member be assigned to a new PCP/NFist. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.

- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts, and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to PruittHealth Premier. PruittHealth Premier will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment. If so, PruittHealth Premier will document all actions taken by the provider and PruittHealth Premier to cure the situation, including member education and counseling. A PruittHealth Premier PCP/NFist cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member also may request a change in PCP/NFist for any reason. The PCP/NFist change requested by the member will be effective the first (1st) of the month following the receipt of the request unless circumstances require an immediate change.

Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues identified by the Utilization Management staff and referred to the Quality Improvement Department staff. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families, or providers indicating a potential problem in the provision of quality care and services.

The purpose of identifying these issues is for tracking concerns related to the provision of clinical care and service, evaluating member satisfaction, and trending specific provider involvement with potential quality of care issues. Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-op complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome)

Quality complaints are categorized as:

- Access to care
- Availability of services

- Clinical quality concerns
- Provider/staff concerns

All Quality of Care issues are reviewed and investigated. PruittHealth Premier often requests records from providers and facilities as part of the investigation. The Quality Improvement Committee reviews trends related to Quality of Care issues. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re-credentialing.

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at PruittHealth Premier is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so the Plan may fully realize its vision, mission, and commitment to member care. In the implementation of the QI Program, PruittHealth Premier will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver healthcare services to meet the health needs of its target population. The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness, and outcome of care/services delivered to PruittHealth Premier's members. Also, to provide mechanisms for continuous improvement and problem resolution.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities
- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes utilizing the Align360 care management platform
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
- Collection and reporting of Structure and Process measures
- Participation and analysis of the Health Outcomes Survey (HOS)
- Participation and analysis of the Consumer Assessment of Health Plan (CAHPS) Survey
- Credentialing and re-credentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of under and over-utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements

- Collection and reporting of Part D Medication Management data (Pharmacy Department)

Utilization Reporting and Monitoring

Risk-based compensation methods may create an incentive for PruittHealth Premier providers and practitioners to limit approval of needed care. Over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, and the system as a whole, PruittHealth Premier monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. PruittHealth Premier then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions. PruittHealth Premier also carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. PruittHealth Premier unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Through guidelines established by the CMS, HEDIS requirements, and the Plan's policies and procedures, PruittHealth Premier requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted directly or indirectly with PruittHealth Premier may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and PruittHealth Premier. PruittHealth Premier and the PCP/NFist and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, PruittHealth Premier conducts periodic patient medical record reviews to confirm the required documentation exists.

Additional Rights

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect, and fairness at all times. PruittHealth Premier and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say PruittHealth Premier and its contracted providers cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The right to see participating providers, get covered services and get prescriptions filled promptly

Members will get most or all of their healthcare from participating providers—the doctors and other health providers who are part of PruittHealth Premier. Members have the right to choose a participating provider. PruittHealth Premier will work with members to ensure they find physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know about treatment choices and to participate in decisions about their healthcare

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their healthcare. PruittHealth Premier's providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether PruittHealth Premier covers them. This includes the right to know about the different Medication Management Treatment Programs PruittHealth Premier offers and those in which members may participate. Members have the right to be told about any risks involved in their care.

Members have the right to receive a detailed explanation from PruittHealth Premier if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave, and the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to make complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, PruittHealth Premier must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances or concerns and/or coverage determinations.

Corporate Compliance Program

Overview

The purpose of PruittHealth Premier's Corporate Compliance Program is to articulate PruittHealth Premier's commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern PruittHealth Premier's operations. Further, PruittHealth Premier's Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations.

PruittHealth Premier and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines PruittHealth Premier's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. PruittHealth Premier and its employees are also committed to meeting all contractual obligations outlined in PruittHealth Premier's contracts with the CMS. These contracts allow PruittHealth Premier to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing PruittHealth Premier's lines of business, including but not limited to, healthcare fraud, waste and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

PruittHealth Premierhas in place, policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. PruittHealth Premier also has policies ensuring

the Plan will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designees.

If you have compliance concerns or questions, call PruittHealth Premier Compliance Hotline toll-free at 1-844-317-9059 (TTY 711).

Fraud, Waste, and Abuse

PruittHealth Premier has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and PruittHealth Premier has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by PruittHealth Premier encompasses all aspects of PruittHealth Premier business and its business relationship with third parties, including healthcare providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at 1-844-317-9059 (TTY 711). The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affecting PruittHealth Premier's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at compliance@pruitthealthpremier.com
- By mail at: Corporate Compliance Officer, PruittHealth Premier, PO Box 2190, Glen Allen, VA 23058-2190
- Directly by phone at 1-844-317-9059 (TTY 711)

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

Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, PruittHealth Premier conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows PruittHealth Premier to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet

their own compliance needs in this area. PruittHealth Premier will review your coding and may review medical records of providers who continue to show significant variance from their peers. PruittHealth Premier endeavors to ensure compliance and enhance the quality of claims data, a benefit to both PruittHealth Premier's medical management efforts and our provider community.

To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

You may request a copy of PruittHealth Premier Compliance Program document by contacting PruittHealth Premier Provider Services at 1-844-224-3659 (TTY 711), or via email at compliance@pruitthealthpremier.com.

Appendix 1: Services Requiring Prior Authorization

Providers should refer to this table, or the provider section of the plan's website at PruittHealthPremier.com, for a listing of services typically requiring referral or authorization. As this table is updated on a yearly basis, the presence or absence of a service or procedure on the list does not determine coverage or benefit.

PruittHealth Premier Authorization/Referral Chart

Service Type	Requirement	Notes
Hospitalization: Inpatient Emergent (Medical and Psychiatric)	Notification	Within 1 business day.
Hospitalization: Inpatient Elective (Medical and Psychiatric)	Prior Authorization	
Hospitalization: Partial Day	Prior Authorization	
Hospitalization: Observation	Prior Authorization	
Ambulatory Surgery Center	Prior Authorization	
Cardiac and Pulmonary Rehab Services	Prior Authorization	
Certain Prescription Drugs	Prior Authorization	Limited number of drugs require authorization.
Chiropractic Services	Prior Authorization	
Comprehensive Dental	Prior Authorization	
Diabetic Supplies/Services	No Authorization Required	
Dialysis	Prior Authorization	
Durable Medical Equipment	Prior Authorization	
Genetic Testing/Screening Labs	Prior Authorization	
Hearing Aids	Prior Authorization	
Home Health Services	Prior Authorization	
Laboratory Services	No Authorization Required	
Medicare Part B Drugs and Step Therapy	Prior Authorization	For chemotherapy: Only initial administration requires authorization.
Mental Health Specialty Services	Prior Authorization	
Opioid Treatment Services	Prior Authorization	
Other Healthcare Professionals (SW/NP/PA)	Prior Authorization	For services outside the nursing facility.

All Out of Network Services	Prior Approval Required	
Outpatient Hospital Services	Prior Authorization	Infusion therapy only.
Outpatient Diagnostic Procedures and Tests	Prior Authorization	Performed outside of a physician office or nursing facility.
Outpatient Diagnostic/ Therapeutic Radiology	Prior Authorization	MRI, MRA, CT, CTA, PET, nuclear medicine all require authorization in all places of services. X-rays do not require authorization.
Prosthetics/Medical Supplies	Prior Authorization	
Part A Skilled Nursing Facility Services - Skill in Place or Treat in Place services	Prior Authorization	
Part A Skilled Nursing Facility: Post-Acute	Prior Authorization	*Per policy
Part B Therapy - Occupational, Physical or Speech Therapy Services	No Authorization Required	
Substance Abuse Services	Referral	
Telehealth	Referral & Authorization	
DATE: January 2020		