MSO
OF PUERTO RICO

PROVIDER MANUAL 2022

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1. OVERVIEW

1.1 Introduction

At MSO of Puerto Rico, LLC (MSO), we are known for helping clients achieve optimum results through innovation. We are facilitators of organizational solutions focused on improving quality metrics across the entire spectrum of a company's operations. A dedicated team of highly skilled professionals conform the MSO Team to always ensure that quality is the guiding light in our operations and every service we offer.

Founded in 2009, MSO has worked for the largest Medicare Advantage (MA) cin Puerto Rico. We have helped them to consolidate their position as leaders in the MA sector while always striving to continue improving quality standards.

Our mission is to enable our partners, customers, and providers to achieve better results, by creating lasting, productive, professional partnerships. Our vision is to be the leading system in integrated health services. In addition, our values are the innovation, the constant pursuit of excellence, trustworthiness and the key to our success lies in always ensuring customer satisfaction through a mentality of committed service, which allows us to develop and implement key solutions for the benefit of the client and the patients they serve.

1.2 About This Manual

This manual provides a summary of the necessary information to bring services to our clients' membership. It's aimed at participants within the MSO Provider Network who manage benefits and services while remaining in compliance under our contract with our clients. Each section provides the necessary information; procedures and workflows to streamline medical practice and office administration. This manual is intended to be a "summary of information" and by no means replaces the Provider Services Agreement, the complete set of company policies and procedures, program descriptions, or manuals developed by MSO or any of our clients. It applies to provider relations with MSO along with the Provider Services Agreement. If you would like more detailed information on any subject contained in this manual, please contact our Provider Services Department, Monday through Friday from 7:00 AM to 7:00 PM: at the following telephone numbers:

- 787-993-2317 (Metro Area)
- 1-866-676-6060 (toll-free)

1.3 MMM Healthcare, LLC (MMM) & its relationship with CMS

In 1977, the Secretary of Health, Education and Welfare created the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS). This federal organization manages both the Medicare and Medicaid programs, by setting standards and monitoring organizations and providers that render medical services for Medicare/Medicaid beneficiaries. Medicare is a national health insurance program for people 65 or older, certain younger disabled people and people with permanent kidney failure (End Stage Renal Disease). This insurance is available through the following four parts:

- Part A: Hospital insurance
- Part B: Medical insurance
- Part C: Medicare Advantage Plan
- Part D: Medicare Prescription Drug Coverage

In 1982, CMS began contracting with certain Health Maintenance Organizations (HMO) to help control the skyrocketing medical costs for both the government and its medical beneficiaries. In order for an HMO to be considered for a contract, it must display the ability to provide quality healthcare at a reasonable cost and have a strong emphasis on preventive healthcare.

1.3.1 Option to Original Medicare

When the Balanced Budget Act (BBA) of 1997 was passed, many changes came about in Medicare and how CMS administered the Medicare benefits. As a result of these changes, Medicare Managed Care Plans were called Medicare Advantage Plans. This program was designed to offer Medicare members more choices in how they may receive their Medicare benefits. Additional major changes took place in the Medicare program with the enactment of the Medicare Modernization Act.

The following is a description of one of the ways Medicare members may now choose to receive their benefits:

1. Managed Care Plans (Coordinated Care Plans) – MMM contracts are considered Coordinated Care Plans (Health Maintenance Organization (HMO)) with a Medicare Advantage contract. Such plans use a network of contracted providers and have agreed to provide care for plan members in exchange for a fixed amount of money from Medicare each month. The health plan may or may not charge a premium depending on their level of funding from the government and may offer benefits in addition to those offered by Medicare. Provider selection is more restrictive with Coordinated Care Plan than Original Medicare. Members are required to use a specific panel of contracted providers. There is, however, significant financial incentive over traditional fee-for-service Medicare for Members to comply with this requirement. Other types of plan under MMM are the HMO POS (Health Maintenance Organization with Point-of-Service (POS) option) and the PPO (Preferred Provider Organization). The HMO POS works similarly to traditional HMO

plans, as they have a network of providers the member must use to receive medical care but may also allow the member to visit out-of-network providers, if it is authorized by the plan. The PPOs have a provider network at lower costs for the member; but unlike HMOs, the member has the option to use non-network doctors who might charge higher cost sharing, plus they do not need to select a primary care physician, or referrals for specialist care. MMM also offers HMO SNP plans. These plans are exclusive for people with specific characteristics or conditions. MMM has HMO C-SNPs for people with chronic conditions such as diabetes, chronic heart failure and cardiovascular diseases. Also, MMM has HMO DSNPs, our organization has a contract with the Puerto Rico Health Insurance Administration (ASES, by its Spanish acronym) to offer a Dual Eligibility plan, under the Medicare Platino Program. People eligible for both Medicare and Medicaid can join these plans.

In addition, to the Medicare Advantage option, or Medicare Part C, the BBA regulations introduced changes to eligibility and enrollment, benefits, quality assurance, participating providers, payments to Medicare Advantage organizations, premiums, appeals and grievances, and contracting rules.

2. In 2006, Medicare implemented a new part called Medicare Part D, which offers prescription drug benefits.

3. Compensation for MMM - CMS pays MMM a fixed amount per member per month (PMPM). In return, MMM must provide members with all necessary medical services as included and accepted in the BID.

4. CMS Responsibilities - CMS is responsible for coordinating and monitoring contracting Medicare Advantage organizations. Their responsibilities include but are not limited to the following:

    a. Approve contracts and all marketing materials.
    b. Provide on-site and off-site evaluations of Medicare Advantage Plans.
    c. Process enrollments and disenrollment's retroactively from the plan.
    d. Review complaints from Medicare members and providers.
    e. Ensure compliance with regulations through monitoring and oversight.
    f. Create any applicable regulations.

Starting with MMM application for a Medicare Advantage contract, CMS reviewed and monitored all health plan activities. They review the plans' overall ability to sell coverage to individuals, operational capabilities, and financial performance to assure that the organization can meet all its contractual obligations. All legal requirements and regulations must be met in order to maintain a contract with CMS.

1.3.2 Marketing Guidelines

CMS monitors all MMM marketing efforts to assure that Medicare members are provided with complete and accurate information to make an informed decision.

Medicare is concerned that all prospective members understand the plan benefits and rules. MMM must disclose the plan lock-in restrictions, and the need for authorizations for certain services. It is extremely important that you have a clear understanding of these regulations in order to understand the marketing activities that may take place with some of your patients.

1.3.2.1 Summary of marketing guidelines**:**

1. The Medicare Advantage Organization offers its benefit plan to all Medicare members. It also provides them with adequate written descriptions of its rules, procedures, benefits, fees and other charges, services and necessary information for the member to make an informed decision about enrollment.

2. Communicates the annual enrollment season and all enrollment periods, whether of limited or continuous duration, through the appropriate channels.

3. Provides a written copy of the current member rights and responsibilities to the member at the time of enrollment and annually thereafter.

4. Requests that enrollment application forms are submitted to CMS for approval prior to use and must comply with CMS instructions and regulations regarding format and content.

5. Requests that a clear and full explanation of the lock-in membership rules must be given to the potential members.

6. Submits all marketing materials to CMS for approval or under the File & Use certification before distributing them to Medicare members.
7. May not claim recommendation or endorsement from CMS, or that CMS recommend that a person enrolls in the organization.
8. May not communicate incorrect written or oral declarations including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands the information contained in CMS approved materials.
9. Cannot offer gifts or payments as an incentive to enroll in the organization.
10. MIPPA (Medicare Improvement Patient and Providers Act) created new restrictions to the way in which health plans can approach potential members. This new law and regulation require that the health plan obtain prior authorization from the potential member before making any contact. This law also establishes prohibitions as to where marketing activities can be conducted. The following items are considered either advertising or explanatory marketing materials:
    a. Advertisements: newspaper, television, radio, yellow pages and billboards.
    b. Written promotional material: flyers, direct mail pieces and brochures.
    c. Enrollment and disenrollment application forms.
    d. Sales materials: flip charts, slides, over-heads and poster boards.

e. Any third-party marketing material: providers, agents, etc.

1.3.3 Marketing Do's and Don'ts

It's important that providers are knowledgeable of appropriate and inappropriate behaviors in the marketing of Medicare Advantage and Prescription Drug Plans.

1.3.3.1 CMS Marketing Guidelines

General Rules

1. MA organizations may not do any of the following:
    a. Provide information that is inaccurate or misleading.
    b. Make unsubstantiated statements, except when used in logos or taglines.
    c. Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MA organization.
    d. Engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas, or vice versa.
    e. Target potential enrollees based on income levels, unless it is a dual eligible special needs plan or comparable plan as determined by the Secretary.

f. Target potential enrollees based on health status, unless it is a special needs plan or comparable plan as determined by the Secretary.

g. State or imply plans are only available to seniors rather than to all Medicare beneficiaries.

h. Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries, unless it is a special needs plan or comparable plan as determined by the HHS Secretary. This prohibition does not apply to MA plan names in effect prior to July 31, 2000.

i. Display the names or logos or both of co-branded network providers on the organization's member identification card, unless the provider names or logos or both are related to the member selection of specific provider organizations (for example, physicians or hospitals).

j. Use a plan name that does not include the plan type.

k. Claim they are recommended or endorsed by CMS, Medicare, the Secretary, or HHS.

l. Convey that a failure to pay premium will not result in disenrollment, except for factually accurate descriptions of the MA organization's policies adopted .

m. Use the term "free" to describe a $0 premium, any type of reduction in premium, reduction in deductibles or cost sharing, low-income subsidy, or cost sharing pertaining to dual eligible individuals.

n. Imply that the plan operates as a supplement to Medicare.

o. State or imply a plan is available only to or is designed for beneficiaries who are dually eligible for Medicare and Medicaid, unless it is a dual-eligible special needs plan or comparable plan as determined by the Secretary.

p. Market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan.

q. Target marketing efforts primarily to dual eligible individuals, unless the plan is a dual eligible special needs plan or comparable plan as determined by the HHS Secretary.

r. Claim a relationship with the state Medicaid agency, unless a contract to coordinate Medicaid services for enrollees in that plan is in place.

2. MA organizations may do the following:

a. State that the MA organization is approved to participate in Medicare programs or is contracted to administer Medicare benefits or both.

b. Use the term "Medicare-approved" to describe benefits or services in materials or both.

c. Use the term "free" in conjunction with mandatory, supplemental, and preventative benefits provided at a zero cost share for all enrollees.

General Marketing Requirements

1. MA organizations may not do any of the following:
    a. Provide cash or other monetary rebates as an inducement for enrollment or otherwise.
    b. Offer gifts to beneficiaries, unless the gifts are of nominal value (as governed by guidance published by the HHS OIG), are offered to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates.
    c. Provide meals to potential enrollees regardless of value.
    d. Market non-health care related products to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited.
    e. Compare their plan to other plans, unless the information is accurate, not misleading, and can be supported by the MA organization making the comparison.
    f. Display the names or logos or both of provider co-branding partners on marketing materials, unless the materials clearly indicate via a

disclaimer or in the body that "Other providers are available in the network."

g. Knowingly target or send unsolicited marketing materials to any MA enrollee during the Open Enrollment Period (OEP).

Beneficiary Contact

1. MA organizations may
    a. Make unsolicited direct contact by conventional mail and other print media (for example, advertisements and direct mail) or email (provided every email contains an opt-out option).
2. MA organizations may not do any of the following if unsolicited:
    a. Use door to door solicitation, including leaving information of any kind, except that information may be left when an appointment is pre-scheduled but the beneficiary is not home.
    b. Approach enrollees in common areas such as parking lots, hallways, and lobbies.
    c. Send direct messages from social media platforms.
    d. Use telephone solicitation (that is, cold calling), robocalls, text messages, or voicemail messages, including, but not limited to, the following:

i. Calls based on referrals.

ii. Calls to former enrollees who have disenrolled or those in the process of disenrolling, except to conduct disenrollment surveys for quality improvement purposes.

iii. Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission to be contacted.

iv. Calls to prospective enrollees to confirm receipt of mailed information.

e. Calls are not considered unsolicited if the beneficiary provides consent or initiates contact with the plan. For example, returning phone calls or calling an individual who has completed a business reply card requesting contact is not considered unsolicited.

Contact for Plan Business

1. MA organizations may conduct the following activities as plan business:

   a. Call current enrollees, including those in non-Medicare products, to discuss Medicare products. Examples of such calls include, but are not limited to the following:

      i. Enrollees aging into Medicare from commercial products.

      ii. Existing enrollees, including Medicaid enrollees, to discuss other Medicare products or plan benefits.

iii. Members in a Part D plan to discuss other Medicare products.

b. Call beneficiaries who submit enrollment applications to conduct business related to enrollment.

c. With prior CMS approval, call LIS enrollees that a plan is prospectively losing due to reassignment. CMS decisions to approve calls are for limited circumstances based on the following:

   i. The proximity of cost of the losing plan as compared to the national benchmark; and

   ii. The selection of plans in the service area that are below the benchmark.

d. Agents/brokers calling clients who are enrolled in other products they may sell, such as automotive or home insurance.

e. MA organizations may not make unsolicited calls about other lines of business as a means of generating leads for Medicare plans.

2. When reaching out to a beneficiary regarding plan business, MA organizations must offer the beneficiary the ability to opt out of future calls regarding plan business.

Events with Beneficiaries

1. MA organizations and their agents or brokers may hold educational events, marketing or sales events, and personal marketing appointments to meet

with Medicare beneficiaries, either face-to-face or virtually. The requirements for each type of event are as follows:

a. Educational events must be advertised as such and be designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug programs, or any other Medicare program.

    i. At educational events, MA organizations and agents/brokers may not market specific MA plans or benefits.

    ii. MA organizations holding or participating in educational events may do any of the following:

        1. Distribute communications materials.
        2. Answer beneficiary-initiated questions pertaining to MA plans.
        3. Set up future personal marketing appointments.
        4. Distribute business cards.
        5. Obtain beneficiary contact information, including Scope of Appointment forms.

    iii. MA organizations holding or participating in educational events may not conduct sales or marketing presentations or distribute or accept plan applications.

    iv. MA organizations may schedule appointments with residents of long-term care facilities (for example, nursing homes,

assisted living facilities, board and care homes) upon a resident's request. If a resident did not request an appointment, any visit by an agent or broker is prohibited as unsolicited door-to-door marketing.

2. Marketing or sales events are group events that fall within the CMS's definition of marketing.
    a. If a marketing event directly follows an educational event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning.
    b. MA organizations holding or participating in marketing events may do any of the following:
        i. Provide marketing materials.
        ii. Distribute and accept plan applications.
        iii. Collect Scope of Appointment forms for future personal marketing appointments.
        iv. Conduct marketing presentations.
    c. MA organizations holding or participating in marketing events may not do any of the following:
        i. Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event.
        ii. Conduct activities, including health screenings, health surveys, or other activities that are used for or could be

viewed as being used to target a subset of members (that is, "cherry-picking").

iii. Use information collected for raffles or drawings for any purpose other than raffles or drawings.

3. Personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple). Personal marketing appointments are not defined by the location.

   a. Prior to the personal marketing appointment beginning, the MA plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with the beneficiary(ies).

   b. MA organizations holding a personal marketing appointment may do any of the following:

      i. Provide marketing materials

      ii. Distribute and accept plan applications.

      iii. Conduct marketing presentations.

      iiii. Review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns.

   c. MA organizations holding a personal marketing appointment may not do any of the following:

      i. Market any health care related product during a marketing appointment beyond the scope agreed upon by the

beneficiary, and documented by the plan, prior to the appointment.

ii. Market additional health related lines of plan business not identified prior to an individual appointment without a separate Scope of Appointment identifying the additional lines of business to be discussed.

iii. Market non-health related products, such as annuities.

1.3.3.2 Puerto Rico Health Insurance Administration (ASES) Marketing Guidelines

1. ASES does not permit the performance of any sales activities, presentations, distribution and/or acceptance of enrollment applications in any Puerto Rico Government Agencies, Public Corporations or other government facilities. Similarly, ASES does not allow any MAO to perform marketing activities within fifty (50) meters of the entrance of a Puerto Rico Medicaid Office.
2. MAOs may conduct sales activities, including sales presentations, the distribution of marketing materials and the distribution and collection of enrollment forms in common areas of a healthcare setting. Common areas in a healthcare setting include, but are not limited to common

entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms.

3. MAOs may not market in restricted areas. These restricted areas generally include, but are not limited to: exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical staff, and where they receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with their pharmacy providers and obtain medications).
4. Communication materials, as opposed to marketing materials, may be distributed and displayed in all areas of the healthcare setting.
5. Appointments with beneficiaries residing in long-term care facilities (including nursing homes and assisted living facilities, board and care homes) are ONLY permitted upon request by the beneficiary.
6. Contracted providers or facilities may be used to distribute marketing materials if the provider or facility distributes or makes available marketing materials for all plans in which the provider or facility participates.
7. Marketing materials may only be distributed to individuals who meet criteria for enrollment.

ASES will sanction or establish monetary penalties to any MAO that fails to comply with these guidelines, as applicable.

2. PROVIDER RESPONSIBILITIES

2.1 Network / Provider Participation

MSO of Puerto Rico, LLC (MSO) has an established comprehensive network of community providers, to serve Medicare Health Plan members, and any other Health Plan membership. The size and development of the network is directly impacted by the size of the health plans' membership. As their membership grows, so does our network. MSO has established mechanisms to monitor the network and identify gaps or areas that may need improvement. The provisions and guidance included in this Provider Manual apply, jointly, to the Provider Services Agreement.

Our network consists of primary care physicians (PCP), specialists, dental providers, mental health, hospitals, and ancillary providers all working together to maintain and improve the health status of members who receive services from our providers. Through innovative care management, provider participation and technological advancements, MSO facilitates the delivery of high-quality healthcare services. As a member of the network, your cooperation, comments, insights, and satisfaction are of the significant importance to us. We strive to make your managed care experience with MSO a positive one. We encourage you to participate in the various committees we have established,

such as the Credentialing Committee or the Quality Improvement Committee. We also appreciate your feedback and concerns regarding network development, policies and procedures and special MSO quality programs. If there is any issue or concern, you can always contact your Provider Relations Representative or any staff member.

With a local presence in the communities that we serve, MSO seeks to maintain a respected place in the healthcare community. Your participation in our network will help us achieve that goal; the Health Services, Provider Relations and Sales & Marketing staff works in your communities on a daily basis. These personnel are available for trainings and orientations, care management/discharge planning and response to any questions or concerns.

The provisions and guidance included in this Provider Manual apply, by extension, to the Provider Services Agreement.

2.2 Conditions of Participation of Provider for Medicare Advantage Program and Commercial Plans.

Conditions of participation are those requirements that a provider is contractually obligated to meet in order to be considered for inclusion in MSO's Provider Network. These conditions are mandated by the federal government (the Centers for Medicare and Medicaid Services [CMS]) and are included in Article 2 Provider Responsibilities and other Articles of your MSO Provider Services Agreement. Please refer to your Provider Services Agreement for a full description of your responsibilities.

The following is a summary of the Conditions of Participation/Provider Responsibilities:

1. **Medicare Participant**. Provider shall maintain full participation status in the federal Medicare Program. This includes all facility employees, owned and contracted healthcare practitioners, healthcare providers, and healthcare facilities, and those other employees, contracted individuals and entities who will provide services to members under this agreement. Provider certifies he/she/it does not have any agents, management staff, or persons with ownership or control interests whom have been convicted of criminal offenses related to their involvement in Medicare, Medicaid or social service programs under Title XX of the Social Security Act; has not been excluded from participation in any federal healthcare program, including without limitation the Medicare Program, and shall notify MSO immediately in the event he/she/it is excluded from participation in the Medicare Program.

2. **Covered Services**. Provider will provide, or arrange to provide, covered services, including emergency services, to members in accordance with the applicable Member Agreement. Provider shall provide and assure the continuity of care in a timely and appropriate manner. Continuity of care includes, among others, coordination between primary and specialty care, appropriate combination of prescribed medications, coordinated use of ancillary services, appropriate discharge planning and timely placement at different levels of care including hospital, skilled nursing, and home healthcare. Provider acknowledges and agrees that referrals of members to non-Network Providers for covered services require the approval of MSO or

MSO's Medical Director and that all referrals shall be to Network Providers except if such referral is not practical in an emergency when in the best medical judgment of the provider the service or care required cannot reasonably be obtained from a Network Provider.

The following services are covered by the Medicare Advantage plans.

- Medicare Preventive Services
  - Abdominal Aortic Aneurysm Screening
  - Annual Wellness Visit
  - Bone Mass Measurement
  - Breast Cancer Screening
  - Cardiovascular Disease Risk Reduction Visit
  - Cardiovascular Disease Testing
  - Cervical and Vaginal Cancer Screening
  - Colorectal Cancer Screening
  - Health and Wellness Education Programs
  - HIV Screening
  - Immunizations
  - Medical Nutrition Therapy
  - Medical Diabetes Prevention Program (MDPP)
  - Obesity and Therapy to Promote Sustained Weigh Loss
  - Prostate Cancer Screening Exams

- o Screening and Counseling to Reduce Alcohol Misuse
- o Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
- o Screening for Sexuality Transmitted Infections (STIs) and Counseling to Prevent STIs
- o Smoking and Tobacco Use Cessation (Counseling to Stop Smoking or Tobacco Use)
- o Glaucoma Screening
- o Diabetes Self-Management Training
- o Barium Enemas
- o Digital Rectal Exams
- o EKG following Welcome Visit
- o Welcome to Medicare Preventive visit

- Ambulance Services
- Cardiac Rehabilitation Services
- Chiropractic Services - manipulation of the spine to correct subluxation
- Diabetes Screening
- Diabetes self-Management Training, Diabetes Services and Supplies
- Durable Medical Equipment (DME) and related supplies
- Emergency Care
- Hearing Services – Diagnostic Hearing Balance and Evaluations to Determine Medical Treatment
- Home Health Agency Care

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Medicare Part B Prescription Drugs
- Opioid Treatment Program Services
- Outpatient Diagnostic Tests and Therapeutic Services and Supplies
- Outpatient Hospital Observation
- Outpatient Hospital Services
- Outpatient Rehabilitation Services
- Outpatient Substance Abuse Services
- Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers
- Outpatient Blood Services
- Partial Hospitalization Services
- Physicians/ Practitioner Services, Including Doctor's Office Visits
- Podiatry Services
- Prosthetic Devices and Related Supplies
- Pulmonary Rehabilitation Services
- Services to Treat Kidney Disease
- Skill Nursing Facility (SNF) Care
- Supervised Exercised Therapy (SET)
- Urgently Needed Services

- Vision Care – services for the Diagnosis and Treatment of Diseases and Injuries of the Eyes, Eyeglasses or Contacts Lenses After Cataract Surgery
- Prescription Drugs

Other supplemental benefits that may be covered by Medicare Advantage Plans are:

- Acupuncture
- Chiropractic Services - Routine Care
- Preventive and Comprehensive Dental Services
- Eye Exams – Routine Care
- Eyewear – Eyeglasses and Contact Lenses
- Hearing Services –Routine Hearing Exams, Fitting Evaluation for Hearing Aids
- Hearing Aids
- Help with Certain Chronic Conditions
- Podiatry Services – Routine Foot Care
- Additional Sessions of Smoking and Tobacco Cessation Counseling
- Special Supplemental Benefits for the Chronically Ill
- Meals
- Transportation Services
- OTC items

This benefit may vary by plan.

3. **Patient Rights**. Provider shall not discriminate in the treatment of members or delivery of services to members, either in the quality, quantity, or type of services rendered or in any other manner, on the basis of race, color, sex, disability, handicap, sexual orientation, age, religion, nationality, ancestry, veteran's status, place of residence, health status, need for health services or source of payment for services rendered. Provider will observe, protect, and promote the rights of members as patients.
4. **Notification of Institutionalized and ESRD Members**. Provider shall notify MSO when it learns that an enrolled individual becomes institutionalized and is expected to be a resident for thirty (30) days or more (a member who has been a resident for thirty (30) days or longer of a nursing home, sanitarium, rest home, convalescent home, or long-term care hospital), or has been medically determined to have End Stage Renal Disease (ESRD). MSO shall notify CMS to ensure accurate reimbursement for this member.
5. **Notification of Member Who Becomes Eligible for Hospice.** Provider shall notify MSO or Health Plan when it learns of a member who selects Medicare hospice coverage (a member who has a terminal illness and whose life expectancy is six (6) months or less, and services are received through a Medicare-certified hospice). This is so that the Health Plan can notify CMS and ensure accurate reimbursement for this member.
6. **Advance Directives**. Provider shall document in member patient records of the existence of an Advance Directive in compliance with the Patient Self-

Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990).

7. **Covering Providers**. A Physician or other licensed healthcare provider, as may be appropriate, who has entered into an agreement, either oral or written, with a provider to arrange covered services for their members when the participating provider is not available. Covering Physician may or may not be under an agreement with MSO or Health Plan, however covering physicians shall meet MMM contracting criteria (or MSO's, if such function is delegated by Health Plan to MSO).
8. **Insurance and Liability Coverage**. Physician's providers, ancillary and organizational providers shall maintain malpractice insurance coverage at a minimum level of $100,000 per incident, $300,000 per policy period. Health Professionals requires a $75,000 minimum coverage. Each one, as otherwise required by applicable laws or regulations.
9. **Claims and/or Encounter Information**. Provider shall submit claims/encounter information, in an acceptable format, for covered services for members within 30 days by the end of the month in which service was provided. In the event of a claim submitted to MSO more than ninety-(90) days after the date of provider's provision of the covered services, claim will be denied and the Provider may not bill the member.
10. **Records:** Provider agrees to maintain medical, financial, administrative, and other records in accordance with any applicable laws and MSO's standards.

Provider agrees to allow MSO access for quality and utilization services audits.

11. **Medical Management Protocols**: Provider will comply with medical and administrative protocols established by MSO.
12. **Grievance System**: Provider agrees to cooperate with the resolution of Member complaints.
13. **Appeals System**: Provider agrees to cooperate with the resolution of Member appeals.
14. **Change in Benefits**: Provider agrees that MSO may change Covered Services to maintain compliance with federal or Commonwealth of Puerto Rico regulations.
15. **Compliance with Law**: Provider shall comply with all applicable ordinances, statutes, regulations or other requirements of the municipality, Commonwealth of Puerto Rico and federal authorities.
16. **Re-credentialing:** Provider must successfully complete the credentialing process a minimum of every three (3) years.
17. **Five Star Quality Program**: Provider shall support and comply with the Health Plan Five Stars Quality Program as established and modified by the Health Plan from time to time.
18. **Connectivity:** Provider shall comply, in a timely and accurate manner, with the requirements for electronic submission of claims, referrals, pre-authorizations as well as any other electronic submission initiative

(InnovaMD) established by MMM or MSO. Provider shall participate in the MSO Health Information Exchange (HIE) program.

19. **Risk Adjustment Data Validation (RADV)**: Provider shall provide access of all records to MSO, Health Plan or their designated representatives, to perform internal risk adjustment data validation audits.

20. **Submission of Claims for Commercial Health Plan members:** Provider shall submit all claims for payment of covered services pursuant to the terms and provisions of Act No. 104 of July 19, 2000, as amended, and the regulations promulgated thereon by the Puerto Rico Insurance Commissioner. Under Act 104, commonly known in Spanish as, *"Ley de Pronto Pago"* any provider must submit a claim for payment of services rendered within ninety-(90) days from the date the services were rendered and the claim, if clear and complete, shall be paid within thirty-(30) days from the date of receipt of said claim. MSO is not obligated to pay any claim received after the ninety-(90) day time period specified in this section.

21. **Continued Access to Care After Termination**: Provider shall notify members when they leave the network (voluntarily or involuntarily) and must provide access for continued care through the current period of active treatment, or up to 90 calendar days after the end of contract for members who have been under the ongoing care of the provider. Requests by members or providers to continued access should be submitted to the

Preauthorization Unit. For members in their second or third trimester of pregnancy, continued care will be provided through the post-partum period.

22. **Qualified Medicare Beneficiary Program (QMB):** The QMB Program is a Medicaid benefit that pays Medicare premiums and cost sharing (subject to state payments limits) for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. For Medicare-Medicaid Plans in the capitated model of the Financial Alignment Initiative and for Program of All Inclusive Care for the Elderly (PACE Organizations), coinsurance, copays, and deductibles are zero for all Medicare A/B services. For more information please access www.innovamd.com

2.2- 2.3 - Accesibility Standards:

Medicare Advantage Platino provider needs to comply with the following accessibility standards based on their specialty:

Provider Type	Regular/Routine	Urgent Care
PCP's	14 days	24 hours
Specialist	30 days	N/A

Provider Type	Non-Urgent Conditions	Urgent Care	Behavioral Health Crisis Services	Detoxification Services
Mental Health	14 days	24 hours	2 hours or less	Immediately according to medical necessity

After Hours Accessibility and Continuity of Care

Provider shall make all Covered Services available and accessible to Members twenty-four (24) hours per day, seven (7) days per week, and three hundred sixty-five (365) days per year and in a manner that assures continuity of care. This may be through the help of a support center or by referring to facilities that offer services after hours.

Back-up provisions: On-Call and Covering Providers. In the event that provider uses the services of other physicians for coverage purposes, covering arrangements shall be made with other physicians except in unusual and unanticipated circumstances such as emergent and urgent care. In all cases, the provider shall arrange with the covering physician that they will accept payment form the Health Plan according to the Health Plan's Medicare Fee Schedule as payment in full, except for any applicable Member Cost Sharing amounts. Provider shall ensure that the covering physician shall execute a Covering Physician will not, under any circumstances, bill Members for Covered Services, except for any applicable Member Cost Sharing, and except as otherwise provided in the applicable Member Agreement. Provider shall indemnify the Health Plan and any affected member for any medical expense incurred by the Health

Plan or the member if the covering physician bills, charges or attempts to collect any amount in excess of the amounts payable under this agreement.

2.3 Provider Communication for Coordination of Care/ Release of Member Information

The purpose of MMM's Clinical Programs is to coordinate, direct and monitor the quality and cost effectiveness of health care resources, and ensure services are rendered on a timely manner, in the appropriate care settings. Care Coordination is an effective collaborative process that aims to identify high-risk patients, identify high-cost chronically ill cases, assess treatment options and opportunities to coordinate care, design treatment programs to improve quality and efficacy of care, control costs, and manage patient care to ensure the optimum outcome.

Our clinical staff serves as a liaison between patient and provider in order to promote the patient's adherence to recommended treatment plan and to ensure proper communication between the parties. As part of their essential duties clinical programs staff also coordinates for the member appointments with specialist and sub-specialist providing the member all necessary coordination to ensure adherence to treatment plan and continuity of care before, during and after transitions. As part of the Case Managers interventions, communication is established via phone with the members Primary Care Physician-Specialist to promote communication between the care team. The members

Individualized Care Plan is also discussed with the member, member's PCP and or caregiver to address members needs assuring the continuity of care and the coordination of benefits across the continuum of care.

Through InnovaMD Providers Portal and Smart Paper the provider can access the member's health and clinical information. The Individualized Care Plan is available in the portal as well as members CAMP Discharge Summary, HRA Results and important clinical information and history. The Care Management Programs updated ICP is also mailed to the member and sent by fax to the primary care physician to maintain the provider aware of member's changes in health status.

2.4 Enrollment Department

The Enrollment Operations Division (EOD) works in conjunction with MMM operations. Daily, the EOD receives enrollment requests from the Sales Department and once the enrollment clerk validates the completeness of the request, continues to process and submit all new member enrollment application forms, package change requests, perform cancelations, and disenrollment. It also sends and receives member related correspondence. In addition, the EOD processes any updates to member information and any of the requests mentioned above to maintain the member's data constantly updated within the enrollment processing system (Market Prominence).

The EOD processes all member requests related to Enrollment and Disenrollment.

When Enrollment or Disenrollment requests are received, EOD will process requests complying with all CMS (Centers for Medicaid and Medicare Services) & others Agencies regulations, and established timeframes.

Effective January 2016 MA plans must deny enrollment requests for unlawfully present or incarcerated beneficiaries.

2.4.1 Election Periods

The Organization will receive an Enrollment or Disenrollment request during certain times of the year as required by CMS and described as follows:

1. October 15 to December 7, each year – anyone can make any type of change.
2. January 1 to March 31 – MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP (Open Enrollment Period).

Generally, Medicare members cannot make changes at other times of the year, unless they meet certain special exceptions, such as, but not limited to:

1. Moving out of the plan service area.
2. Desire to join a plan in the service area that has 5 stars rating.
3. Having a Chronic Condition (contact MA Organization to verify applicable conditions).
4. Exceptions for Employer Groups may apply.

2.4.2 Disenrollment

There are two (2) types of Disenrollment that can be received in the Organization: Voluntary Disenrollment and Involuntary Disenrollment.

2.4.2.1 Voluntary Disenrollment:

A disenrollment request by the member or their authorized representative is received only during one of the election periods described above. The member may disenroll by:

1. Enrolling in another plan (during a valid election period).
2. Giving or faxing a signed written notice to the MA organization, or through employer or union, where applicable:
    a. Submitting a request via Internet to the MA organization (if the organization offers said option).
    b. Calling 1-800-Medicare.

2.4.2.2 Involuntary Disenrollment:

A disenrollment that is requested by CMS due to the organization's determination that the individual is no longer eligible to remain enrolled in a plan, or when an organization initiates disenrollment (i.e.: failure to pay premiums and plan termination).

The MA organization must disenroll a member from an MA plan in the following cases as established by CMS:

1. A change in residence address makes the individual ineligible to remain enrolled (this includes incarceration).

2. The member loses rights to either Medicare Part A or B.
3. The SNP enrollee loses special needs status and does not renew their SNP eligibility prior to the expiration of the deemed period of continued eligibility, which is six (6) months after they lose eligibility of the Special Need Status (i.e.: dual eligible member who loses Medicaid benefit).
4. The MA organization contract is terminated, or the MA organization reduces its service area, thus excluding the area where the member resides. (Some exceptions may apply).
5. Member fails to pay their Part D Income Related Monthly Adjustment Amount (IRMAA) to the government and CMS notifies the plan to carry out the disenrollment.
6. The member is not lawfully present in the United States

2.5 Provider Promotional Activities

Providers under contract with MSO performing functions on behalf of a plan sponsor, related to the administration of plan benefits (including all activities related to assisting in enrollment and education) cannot steer, or attempt to steer an undecided potential enrollee toward a plan, or limited number of plans, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent.

2.5.1 Contracted providers must comply with these requirements:

2.5.1.1 When marketing is prohibited.

1. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:
    a. Exam rooms.
    b. Hospital patient rooms.
    c. Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).
    d. Pharmacy counter areas.

2.5.1.2 Where marketing is permitted.

1. Marketing activities and materials are permitted in common areas within the health care setting, including the following:
    a. Common entryways.
    b. Vestibules.
    c. Waiting rooms.
    d. Hospital or nursing home cafeterias.
    e. Community, recreational, or conference rooms.

2.5.1.3 Provider-Initiated Activities

1. Provider-initiated activities are those conducted by a healthcare professional, including pharmacists, at the request of the patient or as a

matter of a course of treatment, when meeting with the patient as part of the professional relationship between healthcare provider and patient.

2. Provider-initiated activities do not include those conducted at the request of the Plan/Part D sponsor or pursuant to the network participation agreement between the Plan/Part D sponsor and the provider.
3. Provider-initiated activities fall outside of the definition of marketing as outlined in §§422.2260 and 423.2260.
4. Permissible contracted provider-initiated activities include:
    a. Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from https://www.medicare.gov) including in areas where care is delivered;
    b. Providing the names of Plans/Part D sponsors with which they contract and/or participate;
    c. Answering questions or discussing the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered);
    d. Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social

Security Office, CMS' website at https://www.medicare.gov, or 1-800-MEDICARE;

e. Referring patients to Plan marketing materials available in common areas; and

f. Providing information and assistance in applying for the LIS.

g. Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

2.5.1.4 Plan-Initiated Providers Activities

1. CMS defines plan-initiated activities as those activities where either a Plan/Part D sponsor requests contracted provider to perform a task or the provider is acting on behalf of the Plan/Part D sponsor. For plan-initiated activities, the Plan/Part D sponsor must ensure compliance with requirements applicable to communication and marketing.
2. Providers are allowed to:
    a. Make available or distribute and display communication materials, including areas where care is being delivered.
    b. Make available plan marketing materials and enrollment forms outside of the areas where care is delivered.
3. However, providers are not allowed to:
    a. Accept/collect scope of appointments forms,

b. Accept Medicare enrollment applications

c. Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider

d. Mail marketing materials on behalf of the Plans/Part D sponsors

e. Offer inducements to persuade their patients to enroll in a particular plan or organization

f. Conduct health screening as a marketing activity

g. Distribute marketing materials/applications where care is being delivered

h. Offer anything of value to induce plan enrollees to select them as their provider.

i. Accept compensation from the plan for any marketing or enrollment activities

2.5.1.5 Plan Activities and Materials in a Healthcare Setting

1. Plan activities in the health care setting are those activities, including marketing activities that are conducted by Plan /Part D Sponsor staff or on behalf of the organization, or by any downstream entity, but not by a provider.

2. All marketing activities must comply with the requirements included in sections 1.5.1.1 and 1.5.1.2. Plans/Part D Sponsors are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting beneficiaries in areas where individuals primarily receive healthcare services or are awaiting to receive those services. However, during MA organization activities, the following is permitted:

    a. Accepting and collect Scope of Appointment forms.

    b. Accepting enrollment forms.

    c. Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

2.5.1.6 Prohibition on the Provision of Meals.

1. Medicare Advantage and Medicare Prescription Drug Plans may not allow prospective enrollees to be provided meals, or have meals subsidized at any event or meeting at which plan benefits are being discussed or plan materials are being distributed. CMS only allows snacks to be provided during activities like the ones mentioned below:

- Fruit
- Raw vegetables
- Pastries
- Cookies or other small dessert items
- Muffins
- Cheese
- Chips
- Yogurt

- Crackers
- Nuts

2.5.1.5 Comparative and Descriptive Plan Information

1. Providers may distribute to their patients printed information provided by a plan sponsor, comparing the benefits of different plans with which they contract.
2. Providers may not perform health screening (cherry picking) when distributing information to their patients, as this is a prohibited marketing activity.

2.5.1.6 Providers/Provider Group Websites

1. Providers may indicate links to plan enrollment applications or provide downloadable enrollment applications. The site must provide links or downloadable formats for enrollment applications of all plans in which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

2.5.1.7 Health Fairs or Educational Events.

1. These events may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. CMS has made clear that the purpose of educational events is to provide objective information about the Medicare program or health improvement

and wellness. As such, educational events should not be used to steer or attempt to steer a member towards a specific or limited number of plans.

2.5.1.8 Leads from Providers

1. Plans and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes. This obligation includes compliance with the provisions of the HIPAA privacy rule and its specific regulations regarding use and disclosure of beneficiary information.

2.5.1.9 Scope of Appointment

1. Prior to a sales orientation, sales representatives/brokers must have a completed authorization coupon (Sales Appointment Confirmation) or a recorded phone call with the authorization.

2. Plans must secure Scope of Appointment documentation prior to the appointment. Any Scope of Appointment form must be completed by the member and returned prior to the appointment. The documentation must be in writing, in the form of an agreement signed by the member, or a recorded oral agreement. A member may sign a Scope of Appointment form at a marketing presentation to schedule a follow-up appointment

2.6 Credentialing and Privacy

2.6.1 Introduction

There are policies and procedures designed to assist MSO of Puerto Rico, LLC (MSO) with processes including credentialing, termination and re-credentialing of practitioners, hospitals and other providers. The credentialing committee will decide which healthcare professional providers will be credentialed. In general, professionals who exercise independent judgment should be subject to the procedures discussed in the credentialing and re-credentialing program. At a minimum, the MSO will credential medicine doctors, behavioral healthcare physicians, while osteopathy, podiatry, dentistry and chiropractic professionals can be listed as independent practitioners in the Provider Directory. The procedures and criteria for each professional provider are modeled after those used for practitioners, with appropriate adjustments made for the professional in question. In addition, organizational providers such as hospitals, home care agencies, skilled nursing facilities, laboratories and other non-physician providers are subject to the credentialing process.

2.6.2 Purpose

The credentialing program ensures that the plan's practitioners and providers meet the standards of professional licensure and certification. This process enables MSO to contract and retain a quality network of practitioners and providers to serve its client's membership and ensure ongoing access to care. It consistently and periodically evaluates and emphasizes a practitioner or provider's ability to deliver

quality care, and to successfully manage the healthcare of plan members between credentialing and re-credentialing cycles.

The credentialing program enables the plans to ensure that all practitioners and providers are continuously in compliance with CMS requirements, MSO policies and procedures, and any other applicable regulatory entity's requirements or standards. The appeal process is established when considering contracting with a practitioner or provider who does not meet established credentialing standards such as negative findings in the NPDB report, before a final determination is made.

2.6.3 Credentialing Committee Structure & Activities

The credentialing committee is chaired by a medical director who is responsible for the oversight of activities of MSO's credentialing program. The credentialing committee is responsible for reviewing practitioner, hospital and non-practitioner provider selection and qualifications per federal mandates and identifying deficiencies that may require corrective actions. There are contemporaneous, dated, and signed memorandums that reflect all committee decisions and actions.

Responsibilities of the committee include reviewing all practitioner applicants to ensure compliance with credentialing requirements and ultimately making recommendations for approval or denial.

1. Updated credentials
2. Medical record standards compliance
3. Office site standards compliance

4. Member grievance trends
5. Results of quality review studies
6. National Provider Data Base (NPDB) / HIPD reports
7. Office of Inspector General (OIG), General Service Administration (GSA) and Medicare Exclusions verification
8. Negative Certificate of Penalty Record
9. Sex Offenders verification

2.6.3.1 Credentialing and Re-credentialing

MSO conducts credentialing and re-credentialing activities for providers that include medicine doctors, behavioral healthcare physicians, as well as dentistry, chiropractic, podiatry, physical therapy and other licensed providers whom they contract to provide services to members. Other providers who are credentialed are hospitals and all ancillary services, such as laboratories and urgent care centers. The credentialing committee makes the final approval or denial decision on every practitioner application. For denials**,** a letter is sent out within 2 labor days of the decision. Credentialing and re-credentialing includes primary source verification in accordance with clients, MSO policies and procedures set forth by CMS, ASES or any other regulatory agency. Site visits are conducted on all high volume (10 members or more) primary care practitioners and other specialist. At the time of re-credentialing, individual practitioner performance profiling is evaluated through consideration of information from: member grievances, site visits, medical records reviews, special quality improvement projects, and updated

credentials, including but not limited to DEA, ASSMCA malpractice, and provider application, among others.

2.6.3.2 Practitioner Rights

The practitioner is informed that they have the right to review all information obtained during evaluation of their credentialing application. The practitioner is informed if credentialing information obtained by the credentialing department is substantially different from that provided by the practitioner and given the opportunity to correct any erroneous information.

The practitioner has the right to request the status of their credentialing/re-credentialing application to be able to:

1. Review information submitted to support their credentialing application.
2. Correct erroneous information.
3. Receive status of their credentialing or re-credentialing application.
4. Receive notification of these rights.

Practitioner Rights during the credentialing application process are outlined on the credentialing application, and on the www.innovamd.com website.

2.6.3.3 Confidentiality

Information obtained in the credentialing process is confidential. All credentialing documents, committee memorandums, and peer review files are kept in a secure location. Only appropriate staff has access to confidential credentialing documents.

2.6.3.4 Nondiscriminatory Credentialing and Re-credentialing

A periodic audit of credentialing files that are in process, denied, or approved, ensures that practitioners are not victims of discrimination. Scheduled audits of practitioner complaints are reviewed for alleged discrimination. The Credentialing Committee is comprised of a heterogeneous membership, and a signed statement from those making the credentialing recommendations affirms that they do not discriminate. MSO is committed to an anti-discrimination policy in all its programs and services. MSO is consciously and proactively inclusive of all areas of diversity including, but not limited to race, ethnicity, color, nationality, ancestry, gender, sexual orientation, religion, age, financial status, marital status, language, and disability or immigration status.

2.6.4 Provider Review Initial Process

The Network Management and Contracting staff processes all received applications. All applications will be accepted if the information collected represents and matches the plans' standard application form. Each provider that seeks acceptance as a participating provider must submit a completed (in all parts) standard application (provided). The application form is designed for use with providers who are seeking participation status.

The provider submits the application before presenting an application to the credentialing committee, the Network Management and Contracting staff determines whether the application is complete, and the applicant meets the administrative requirements set forth in the credentialing plan. A request including all credentials

must be submitted to the Network Management and Contracting staff in order to be presented in the Evaluation process. If the Evaluation Committee approves the application, the same goes to credentialing process and to Credentialing Committee for determination.

2.6.4.1 Credentialing Review Committee

The credentialing committee reviews each application received to determine whether the applicant meets the professional criteria set forth in the credentialing program. The committee in its sole discretion recommends acceptance or denial of an application. It may request further information from the applicant; or it may hold an application, pending the outcome of any investigation of the provider by a licensing board or any other organization or institution; or it may recommend any other action it deems appropriate. The committee may base its decision or recommendation on any factors it deems appropriate.

If the application is denied and the applicant requests an appeal, a meeting will be held with the Appeals Committee for reconsideration and final determination. An applicant is offered the opportunity to request the Appeals Committee to reconsider its application denial, or a hearing panel. After the reconsideration determination date, and in a seven-day timeframe, the provider receives final determination of Peer Review Committee. If the final action is denial and it is based on unprofessional conduct or competence, the action is reportable to the Data Bank and to the corresponding professional board.

2.6.5 Verification Process

As part of the primary source verification process, the original source of a specific credential is verified to assure the accuracy of a qualification reported by an individual healthcare practitioner/provider. Examples include medical school, graduate medical education program, and medical board.

2.6.5.1 Querying the Data Bank

The National Practitioner Data Bank is intended to assist healthcare entities in identifying unacceptable performance and unprofessional conduct by practitioners and other healthcare practitioners. The contents of the Data Bank include information about adverse actions taken against practitioners by state licensing authorities and other healthcare institutions.

Before granting a practitioner participation status, and at the time of re-credentialing, the credentialing coordinators should determine whether the Data Bank has any Adverse Action Reports about the provider.

2.6.5.2 Professional Licensure

The MSO Credentialing Department verifies the current status of the provider's license directly with the CD submitted by the Puerto Rico Professional Board with the Puerto Rico Professional Board and obtains a copy of the provider's license.

The Board verifies practitioner credentials as a condition of licensure and generates a good standing certificate. The Physician Board requires practitioners to submit attestation of the Puerto Rico Medical College, thus the plan will not

verify said credential.

2.6.5.3 Sanction History

The MSO Credentialing Department queries the Medicare and Medicaid sanction history for the most recent period available from the data source. A query or verification is a written report. Periodic reports or bulletins that give sanction activity information and are released by the primary source may accompany written verification. The reviewer should include in the credentialing file a dated, signed note stating what information was verified and by whom.

The following sources have sanction information:

1. Updated credentials
2. Medical record standards compliance
3. Office site standards compliance
4. Member grievance trends
5. Results of quality review studies
6. NPDB/HIPD reports
7. OIG, GSA and Medicare Exclusions verification
8. Negative Certificate of Penalty Record
9. Sex Offenders verification

Opt In/Opt Out: If a practitioner or provider opts out of Medicare, that practitioner or provider may not accept federal reimbursement for a period of two (2) years. The only exception to that rule is for emergency and urgently needed services where a private contract has not been entered with a member who receives such

services. The Plan must pay for emergency or urgently needed services offered by a practitioner or provider to a member in their MA plan that has not signed a private contract with a member but may not otherwise pay opt-out practitioners or providers. Information on providers who opt-out of Medicare may be obtained from the website; the MSO checks this list on a monthly basis. If a provider named in a report is identified as being a participating provider, the MSO immediately investigates the provider's credentialing file and reports information to the credentialing committee chairperson. The Credentialing Department staff uses the report to determine if any provider named on the report has an active contract.

2.6.5.4 Preclusion List

The Centers for Medicare & Medicaid Services (CMS) published CMS-4182-F on April 16, 2018, rescinding the Medicare enrollment requirement for contracted providers that receive payment from Medicare Advantage (MA).

The Preclusion List will consist of providers (individuals and entities) that fall within either of the following categories

1. Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
2. Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

3. MSO will remove from their network any contracted provider who is included on the Preclusion List, as soon as possible.

2.6.5.5 DEA

A federally issued DEA Certificate/Registration is required for the prescription of certain classes of pharmaceutical agents. Practitioners must obtain a DEA certificate to prescribe controlled substances. The DEA must be verified through DEA diversion Website.

2.6.5.6 Hospital Privileges Verification

The provider's application is used as a testimony for verification of hospital privileges.

2.6.5.7 Malpractice Coverage

Evidence of malpractice coverage and coverage amounts consistent with the Office of the Commissioner of Insurance of Puerto Rico, or the provider application is used as a certification for malpractice coverage. Coverage that excludes services essential to the practice of the provider's specialty is unacceptable. Malpractice coverage is not verified.

2.6.5.8 Education and Training

Board certification, or the highest level of training achieved by the provider, must be verified. Verification of the highest level constitutes verification of residency or graduation from a professional school. For practitioners who are not board certified, verification of completion of a residency program is done, unless no

residency program has been completed, in which case the credentialing specialist needs to verify graduation from an acceptable school of medicine. When accepting a non-board-certified practitioner, the MSO Credentialing Department should consider whether the following factors exist:

1. Board Certification and Residency Training:

   Any of the following sources may be used to verify that a Doctor of Medicine or osteopathy is board certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in the specialty in which the provider practices.

   - Board Docs
   - AMA Practitioner Master File
   - Hospital verification for residency by telephone or mail

2. Medical School and Other Professional Schooling Graduation from medical school can be verified with the following:

   - Medical school
   - AMA Practitioner Master File

Verification of professional schooling for other healthcare professionals can be done directly with the appropriate school or oversight agencies.

2.6.5.9 Work History

Complete work history, with a compliance of five (5) years or more from internship to the present, and with no more than six (6) months of work history gaps, needs

to be included in the application or can be stated in a curriculum vitae. Primary verification is unnecessary.

2.6.5.10 Office Practices

Office practices are evaluated during the re-credentialing process, site visits occur to PCPs (10 members or more) and psychiatrics. The visit must be annually prior to the credentialing committee's consideration and from the contract's effective date. Results of the structured site visit are documented on a standard form. Aggregation and analysis of all data collected from the practitioner's office site visit should be presented to the credentialing committee. A licensed professional staff with clinical background performs the onsite visit. A review of documentation practices is also performed as part of the onsite visit. The site visit requirement for initial credentialing use, only applies to providers defined as high volume according to the annual adequacy analysis performed by Provider Network Operations.

2.6.5.11 Ownership and Control Interests

Federal Regulations in 42 USCA § 1396a (p) and 42 C.F.R. § 438 require that MSO monitors payments of Medicaid funds to providers. In accordance with regulations, MSO developed a form and established a requirement for all participating providers with contract: at the time of their initial enrollment or during re-credentialing, all applicable providers must complete and submit a report that identifies any Ownership and Control Interests that may exist.

2.6.6 Re-credentialing

2.6.6.1 Re-credentialing includes the following steps:

1. Receipt from the provider and review of a completed reappointment application
2. Validation of renewal of credentials with expiration dates. Credentials which expire include:
    - State license. Direct documentation from the Board is needed.
    - DEA, ASSMCA and CDS Certificate, as applicable
    - Negative Certificate of Penalty Record
    - Evidence of current malpractice coverage
3. Board certification. If the provider's board requires recertification, the credentialing specialist must verify that the provider has been successfully recertified when applicable. If the provider was preparing for board certification, but not certified during the last review, board certification status must be verified and updated. Renewal of expired credentials should be confirmed at the time of expiration and during the comprehensive re-credentialing cycle.
4. Query and review of reports from the Data Bank, State Board of Medical Examiners or Department of Professional Regulations, Medicare and Medicaid sanction monitoring sources and internal sources.

Note: Evidence required by MSO can be sent by email to credentialinghelpdesk@mso-pr.com or through your Credentialing Field Specialist.

2.6.7 Procedures for Suspension and Termination

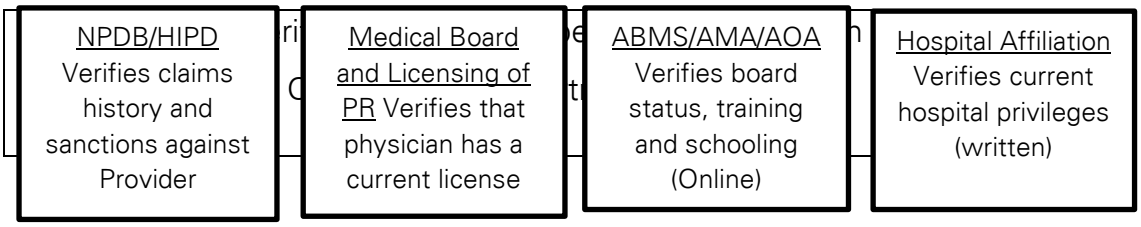
2.6.7.1 Credentialing Committee Review

Whenever the Credentialing Department receives information suggesting that suspension or termination of a provider's participation may be warranted for professional reasons, in the staff's sole discretion, it should compile all pertinent information and refer the matter to the Credentialing Manager, who after review of related documents will refer to the credentialing committee. If the credentialing committee decides that further information is needed, the committee should obtain it from the provider or from any other relevant source available.

Following its deliberations, if the credentialing committee decides that no corrective action needs to occur, meeting memorandums should reflect the reasons for this decision. Alternatively, if the committee in its sole discretion decides to recommend specific corrective actions or the termination of a provider's participation, meeting memorandums should reflect this recommendation and the reasons for it. The provider will be notified of the committee's decision.

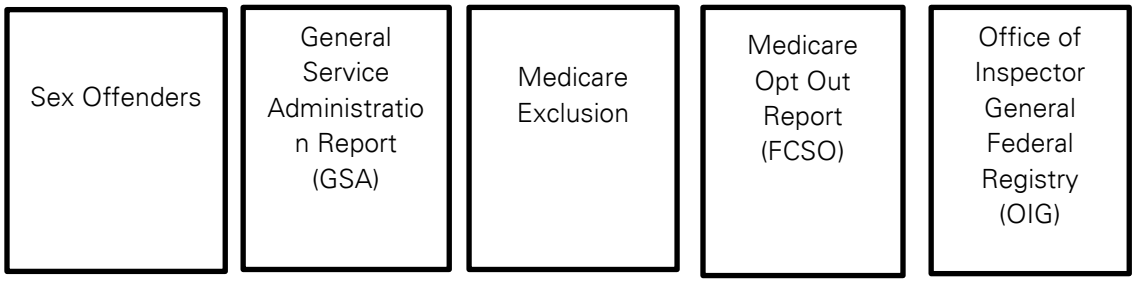
MSO Credentialing Flowchart

Initial Application submitted by Provider through the electronic application on the MSO of PR, LLC. Web site, if any other information is required must be submitted through InitialCredEvaluation@mso-pr.com (email) and Evaluated by the Evaluation Committee.



A current copy of the following is also required (depending on specialty)

The following reports are checked



Once all data has been collected and processed, the file will then be prepared for Credentialing

Credentialing Committee makes determination and for denials a letter will be sent by email. (Generally, in a time frame of 16 working hours or less)

The Credentialing Auditor reviews the file to ensure conformity with guidelines, prior to Credentialing Committee.

2.6.7.2 MAO / Provider Notification:

(Rev. 121, Issued and effective: 04-22-2016). In accordance with 42 CFR 422.202(d)(4), a MAO and a contracting provider must provide at least a 60-day written notice to each other before terminating the contract without cause

2.7 Delegation

Delegation is a formal process by which MSO gives a provider group or an entity (delegate) the authority to perform certain functions on its behalf, in a manner consistent with CMS, ASES, OIC and regulations. Some of these actions may include credentialing, utilization management, and claims payment, among others. It should also be noted that a function might be fully or partially delegated. The decision of what function may be considered for delegation is determined by the type of contract a provider group has with MSO, as well as the ability of the provider group or entity to perform the function.

Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated. The type of contract determines the decision of

what functions are considered for delegation to a provider group with MMM Healthcare, LLC (MMM), as well as the ability of the provider group to perform the function. Contact MSO for detailed information on delegation.

Although MMM can delegate the authority to perform a function, it cannot delegate the responsibility.

If a provider wants to delegate any services, such delegation must be pre-approved by the MMM Delegation Oversight Committee and set forth in a separate addendum that shall include the following requirements:

1. Written arrangements must specify delegated activities and reporting responsibilities.
2. The organization evaluates the entity's ability to perform the delegated activities prior to delegation. The organization must document that it has approved the entity's policies and procedures with respect to the delegated function.
3. Written arrangements must provide for revocation of the delegation activities and reporting requirements in instances where either CMS or both companies determine that such parties have not performed satisfactorily.
4. Written arrangements must specify that the performance of the parties be monitored by MMM on an ongoing basis.
5. Written arrangements must specify that either: (as applicable)

a. The credentials of medical professionals affiliated with the party or parties will be reviewed by MMM.

b. The credentialing process will be reviewed and approved by MMM and that the company must audit the credentialing process on an ongoing basis.

c. Contracting providers agree to safeguard member privacy and confidentiality and assure accuracy of member health records;

d. Contracts must specify a prompt payment requirement, the terms and conditions of which are developed and agreed-to by the MA organization and its contracted providers and suppliers;

e. Contracts must hold Medicare members harmless for payment of fees that are the legal obligation of the MA organization to fulfill. Such provision will apply but will not be limited to insolvency of the MA organization, contract breach, and provider billing.

All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

For more detailed information on delegation, you may contact MSO

3. MEMBER RIGHTS AND RESPONSIBILITIES

3.1 MMM & PMC Member Rights and Responsibilities

The following information regarding Member Rights and Responsibilities is an excerpt from the Evidence of Coverage (EOC) documents of the plans MSO serve. This information is distributed upon enrollment of a new member and at least annually thereafter. Member satisfaction as well as the care and treatment of the plan members we serve are essential components of our organization. Therefore, it is important to understand Member Rights and Responsibilities.

3.1.1 Member's right to be treated with fairness and respect

Members have the right to be treated with dignity, respect, and fairness at all times. The health plan must obey laws that protect them from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health status, ethnicity, creed, age, or nationality, claims experience, medical history, genetic information, evidence of insurability or geographic location within the service area. If members need help with communication, such as help from a language interpreter, please call the Member Services Departments for MMM or PMC. Member Services can also help to file a complaint about access (such as wheelchair access). Members may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or their local Office for Civil Rights. In addition, members may call Medicare at 1-800-MEDICARE (1-800-633-4227), twenty-four (24) hours a day, seven (7) days a week, to file a complaint if they have problems related to language or a disability.

3.1.2 Member's right to the privacy of their medical records and personal health information

There are federal and state laws that protect the privacy of a member's medical records and personal health information. We protect all personal health information under these laws. Any personal information that members submit upon their enrollment in this plan is fully secured. We make sure that only authorized personnel come in contact with, or has access to, member records. In most cases, we must obtain written permission from members, or from an appointed representative, before we can disclose any health information to anyone that is not directly providing

or paying for their care. There are exceptions allowed or required by law, such as the release of health information to government agencies that are verifying quality of care.

The plan will release this information, including prescription drug event data, to Medicare, which may in turn release it for research and other purposes that follow all applicable federal statutes and regulations.

The laws that protect a member's privacy also grant them rights to receive information and control the way in which their health information is used. By law, the company is required to provide them with a notice that explains these rights and offers details of how the company protects the privacy of their health information. Members have the right to look at medical records kept by the plan and are entitled to receive a copy of their records (a fee may be charged for making copies). Members also have the right to request that additions or corrections be made to their medical records; if this is the case, the request will be reviewed, and a determination will be given to deem whether the changes requested are appropriate. Members have the right to know how their health information has been given out and used for non-routine purposes. If they have questions or concerns about the privacy of their personal information and medical records, they can call the Member Services Department of their health plan.

3.1.3. Member's right to see our network providers, receive covered services and have their prescriptions filled within a reasonable period of time

As explained in the EOC, members will receive most or all of their care from network providers, that is, from physicians and other health providers who are affiliated to that plan. Members have the right to choose a network provider (we will inform them which physicians are accepting new patients). Members have the right to go to a women's health specialist in their plan (such as a gynecologist) without a referral.

Members also have the right to timely access to providers and to see specialists when care from a specialist is needed. "Timely access" means that members can make appointments and receive services within a reasonable amount of time. Members have the right to timely access their prescriptions at any network pharmacy.

3.1.4 Member's right to know their treatment options and participate in decisions about their healthcare

Members have the right to obtain full information from providers when they receive medical care, and the right to fully participate in decisions regarding their healthcare. Providers are also required to explain matters of any kind in a way that members can understand. Member rights include knowing about all treatment options that are recommended for their condition, no matter their cost or whether they are covered

by the MA plan. This includes the right to know about the different Medication Therapy.

We offer management programs in which they may participate. Members have the right to be told about any risks involved in their care and must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from us if they believe that a provider has unfairly denied care that they believe they were entitled to receive or care they believe they should continue to receive. In such cases, members must request an initial decision titled an Organization Determination or a Coverage Determination. Organization Determinations and Coverage Determinations are discussed in the Evidence of Coverage. Members have the right to refuse treatment.

This includes the right to leave a hospital or other medical facility, even if their physician advises them not to leave. This includes the right to stop taking a medication. If a member refuses treatment, they accept full responsibility for what happens as a result of their refusal of treatment.

3.1.5 Member's right to use Advance Directives (such as a living will or a power of attorney)

Members have the right to ask someone such as a family member or friend to help them with decisions about their healthcare. In some instances, people may become

unable to make healthcare decisions for themselves due to accidents or a serious illness. If members so wish, they can use a special form to give someone the legal authority (designate an official proxy) to make decisions for them if they ever lose the capacity to effectively make decisions. Members also have the right to give their physicians written instructions about how they want to handle their medical care if they are suddenly unable to make decisions for themselves. The legal documents that members can use to give their directions in advance are called Advance Directives. There are different types of Advance Directives. Some examples of these include: "living will" and "power of attorney for healthcare".

If members wish to issue an Advance Directive, they may obtain a form from a company representative, lawyer, or social worker. In some cases, members may also obtain Advance Directive forms from organizations that offer information about Medicare. It is important to understand that Advance Directives are legal documents.

Members should consider having a lawyer assist them in the preparation of these documents. It is important to sign this form and keep a copy at home. Members should give a copy of the form to a Provider Representative and to the person designated as the official proxy. It is advisable to give copies to close friends or family members as well.

If members know in advance that they will be hospitalized, and have to sign an Advance Directive, they should have a copy with them at the hospital. If a member is admitted to the hospital, the hospital staff shall ask whether they have signed an

Advance Directive form and whether they have it with them. If they have not signed an Advance Directive form, the hospital has forms available and shall ask if members want to sign one.

It is a member's choice whether they want to fill out an Advance Directive form (even when they are in the hospital. According to law, no one can deny a member care or discriminate against members based on whether they have signed an Advance Directive or not. If a member signed an Advance Directive, and they believe that a physician or hospital did not follow the instructions provided in the document, the member may file a complaint with the Department of Health, Medical Assistance Program (SHIP).

3.1.6 Member's right to obtain information about their plan

Members have the right to obtain information about the company plan. This includes information about their financial condition, and how their MA plan compares to other health plans. To obtain any of this information, members may contact the Member Services Department.

3.1.7 Member's right to receive information in other formats

Members have the right to have their questions answered. Their plan must have individuals and translation services available to answer questions from non-English speaking members and must provide information about their benefits that are accessible to, and appropriate for, persons eligible for Medicare due to disability.

The information is available for free in other languages. Also, upon request, the information may be available in different formats, like Braille, Spanish language, large print and other formats. Members may contact the Member Services Department if they need plan information in another format or language.

3.1.8 Member's right to obtain information about network pharmacies and/or providers

Members have the right to get information about network pharmacies, providers, their qualifications, and how we pay our physicians. To obtain this information, members can call the Member Services Department of their health plan.

3.1.9 Member's right to obtain information about prescription drugs, Part C medical care or services, and costs

Members have the right to an explanation about any prescription drugs or Part C medical care or services not covered by their plan. We must inform them in writing why the plan will not pay for, or approve, a particular prescription drug or Part C medical care or service, and how they can file an appeal to request reconsideration

for this decision. See the Evidence of Coverage for more information about filing an appeal. Members also have the right to an explanation even if they obtain the prescription drug, Part C medical care or services from a pharmacy or provider not affiliated with our organization. Members also have the right to receive an explanation about any utilization-management requirements, such as step therapy or prior authorization, which may apply to their plan. Members can review a list of the covered drugs and services in their plan's formulary on the company website or call the Member Services Department for more information.

3.1.10 Member's right to make complaints

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. See in the Member's EOC for more information about complaints. When filing a complaint, every member must be treated fairly (i.e. no retaliation). Members have the right to receive a summary of information about the appeals and grievances that other members have filed against their plan in the past. To obtain this information, they can contact the Member Services Department.

3.1.11 How to get more information about member rights If members have questions or concerns about their rights and protections, they can:

1. Contact the Member Services Department of their plan at the numbers on the back of their Plan ID.

2. Get free help and information from their State Health Insurance Assistance Program (SHIP) [Contact information for their SHIP is in the Member's Evidence of Coverage].
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections".
4. Call 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 TTY (hearing impaired).
5. Make suggestions regarding the Plan's member rights and responsibilities policy.

3.1.12 What can members do if they believe they have been treated unfairly or their rights are not being respected?

If members believe that they have been treated unfairly or their rights have not been respected, they may contact the Member Services Department or:

1. If they think they have been treated unfairly due to their race, color, nationality, disability, age, or religion, they can call the Civil Rights Office at 1-800-368-1019 or 1-800-537-7697 TTY (hearing impaired) or call their local Civil Rights Office.
2. If they have any other kind of concern or problem related to their Medicare rights and protections described in this section, they can also get help from their SHIP.

3.1.13 Responsibilities of a member in a plan include:

Members should become familiar with their coverage and the rules they must follow to receive care. They can use their EOC booklet to learn about their coverage, what they must pay, and the rules they need to follow. If questions arise, they may contact the Member Services Department of their health plan.

1. Use all their insurance coverage. If members have additional health insurance coverage or prescription drug coverage besides their plan, it is important that they use their other coverage in combination with the coverage of their MA plan to pay for their healthcare or prescription drug expenses. This is called "coordination of benefits" since it involves coordinating all health or drug benefits that are available to them.
2. Members are required to inform their plan if they have additional health insurance or drug coverage.
3. Notify providers when seeking care (unless it is an emergency) that they are enrolled in a plan. Members must present their plan membership card to providers.
4. Members must give their physician and other providers the information they need to care for them, as well as following the treatment plans and instructions that members and their physicians agree upon. If members have any questions, they must be sure to consult with their physicians and other providers and have them explain treatment in a way they can understand.

5. Members must act in a way that supports the care given to other patients and helps the smooth running of a physician's office, hospitals, and other offices. They must pay their coinsurance or copayment for covered services. Members must pay for services that are not covered by their health plan.
6. Notify the plan if they move and change mailing address. If members move within the Service Area, the plan needs to keep their membership record up to date. If members move outside of the Service Area, they cannot continue their membership with the plan.
7. Platino Member, it's their responsibility to keep their certification to the Government Health Insurance Program (Medicaid) up to date. They have to attend to the annual recertification appointment and inform the plan about any changes to their eligibility for Medicaid.

   Call Member Services for help if you have questions or concerns.

3.2 Privacy and Confidentiality

Confidentiality and privacy of a member's medical information is extremely important to MSO and their client MMM. All companies have implemented a confidentiality policy that requires all employees, committee members and Board of Directors to sign a Confidentiality Statement.

Based on MMM commitment to comply with federal and state laws and regulations, MSO and the Provider Services Agreement also includes provisions which stipulate that each provider shall comply with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and its implementing regulations at 45 C.F.R. Parts

160,162, and 164, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (collectively, "HIPAA") and any privacy and security federal and state laws and regulation. Providers shall protect the confidentiality, integrity and availability of the information contained in medical records and business documentation, in accordance with all applicable federal and state regulatory requirements.

MSO requires that each provider adopt a confidentiality policy for their office and require as well that all provider staff members comply with all applicable privacy and security regulations. MSO and MMM as well as the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Resources, Office of Civil Rights (OCR), monitor providers with respect to the handling of protected health information and confidential information. Contracted provider offices are reviewed for confidentiality, privacy and security policies, procedures, and practices during credentialing site visits.

3.2.1 A broad summary of applicable rules and provisions related to confidentiality is outlined below.

3.2.1.1 Health Insurance Portability and Accountability Act (HIPAA)

A major purpose of the HIPAA Privacy Rule is to define and limit circumstances in which an individual's protected health information (PHI) may be used or disclosed by covered entities. The privacy provisions of HIPAA apply to health information created or maintained by healthcare providers who engage in certain electronic transactions, health plans, and healthcare clearinghouses. The statute protects individually identifiable health information, that is related to the past, present, or

future physical or mental health or condition of an individual, to the provision of health care to an individual or the past, present, or future payment for the provision of health care to an individual and identifies or could identify the individual (45 CFR §160.103). Examples of health information protected by HIPAA are the medical records whether it is on paper or electronically.

A covered entity is a healthcare provider that conducts certain transactions in electronic form regulated by HIPAA (called here a "covered healthcare provider"), a healthcare clearinghouse, or a health plan.

A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or healthcare operations or otherwise permitted or required under HIPAA Law and must make reasonable efforts to use, disclose or request only the minimum of (PHI) needed to accomplish the intended purpose of the use, disclosure or request. A covered entity may not condition treatment, payment, enrollment, or benefit eligibility on an individual granting an authorization, except in limited circumstances. The authorization must be written in plain language and specific terms as required by HIPAA. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party.

Covered entities must ensure that an authorization of uses and disclosures is a valid authorization that complies with the content requirements as required by the Privacy Rule before any use or disclosure of information is made.

In addition, the HIPAA Privacy Rule provides individual's rights respect their health information such as:

- Right to inspect or request a copy of his/her protected health information,
- Right to correct or amend his/her protected health information,
- Right to request confidential communications,
- Right to request restrictions of uses and disclosures of his/her protected health information,
- Right to obtain a list or report of those his/her protected health information has been share,
- Right to receive a copy of the Notice of Privacy Practice that describes how their health information may be use or disclose, in paper or electronic format.

The US Congress established civil and criminal penalties for covered entities that misuse personal health information. In other hand, the Office for Civil Rights (OCR) at the Department of Health and Human Resources (HHS) can impose civil penalties on covered entities that fails to comply with a requirement of the HIPAA Act.

3.2.1.2 Code of Federal Regulations

Federal regulations require that a Medicare Advantage Organization, such as MMM, must establish procedures to abide by all Federal and State laws regarding

confidentiality, enrollment and disclosure of medical records, or other health information. Medicare Advantage Organizations must safeguard the privacy of any information that identifies an enrollee.

3.2.1.3 State Law

In Puerto Rico, the Patient's Bill of Rights (Article 11) establishes that a patient has the right to have full confidence that their medical records and health information will be kept strictly confidential and that all providers and health insurers will take necessary measures to protect the privacy of their patients when managing all related documents and information.

Also, the Mental Health Law of Puerto Rico (Law Num. 408 of October 2, 2000) requires providers to maintain in strict confidentiality, the mental health information of the patients contained on the medical record and forbid the disclosure of such information to third parties without the patient authorization.

3.2.1.4 Contractual Arrangements

MMM agreements with CMS require compliance with federal regulations regarding privacy, confidentiality, and HIPAA administrative simplification rules. These rules address the transmission and disclosure of patient information between covered entities. According to the rules, MMM must safeguard protected health information to limit incidental uses or disclosures of PHI made pursuant to an otherwise permitted or required use or disclosure.

In addition, MMM offers Platino benefits for eligible beneficiaries. Under the contract provisions with ASES (Puerto Rico Health Insurance Administration) for the Medicare Platino Program, confidentiality provisions are also addressed. The provisions on the contract indicate that all medical records of Medicare Platino enrollees shall be treated as confidential and shall only be disclosed to provide necessary medical care, to conduct quality assurance functions and peer review functions, or as necessary to respond to a complaint or appeal. The transmission of information with providers shall only be conducted according to HIPAA Law. Similar to a provider's obligation to comply with applicable federal and Commonwealth laws and regulations, a Provider must abide by the contract provisions that apply to them in the agreements and must maintain all relevant safeguards to protect the confidentiality of his/her patient's health information.

4. MEMBER APPEALS AND GRIEVANCES

4.1 Appeals and Grievances

MMM Healthcare, LLC (MMM) appeals and grievances policies and procedures are consistent with standards from CMS. The policies clearly define the processes to be followed when a member's appeal or grievance is received and evaluated, and a determination is rendered, including expedites requests. This information is communicated to MMM members through an Evidence of Coverage (EOC) document upon enrollment and yearly afterwards. EOC is also available through MMM Website.

MMM follows specific written procedures for the receipt and handling of all issues raised by members, contract providers and non-contract providers. These procedures describe the way members or designated representatives (authorized through an Appointment of Representative form) should submit appeals or grievances to MMM. Members or designated representatives may seek assistance with the process from a Member Services Representative at any time.

4.1.1 Appeals

Any party to an organization determination i.e., a member, a member's representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered. In payment cases contract providers do not have appeal rights. However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of liability" saying it will not ask member to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

MMM maintains and administers an appeals system for members, to address the review of adverse organization or coverage determinations on the healthcare services a member is eligible to receive. Providers must cooperate with MMM in the resolution of member appeals by providing medical records or any other related information that supports the investigation into a member's medical needs, within the required timeframe.

If a member wishes to appeal an adverse decision regarding the provision of a service, covered medication or payment for services (reconsideration of an initial

determination), they are instructed to present the request in writing. However, if the member believes the request meets expedite criteria, the request may be submitted orally.

A member may submit a written request for reconsideration, personally or through their authorized representative, up to sixty-(60) days after the initial determination notice date.

As part of the first contact with a member, the MMM Appeals and Grievances Analyst acknowledges receipt of standard part C appeals and explains the process to be followed, as well as the expected timeframe for a resolution.

An initial Organization Determination or Coverage Determination Notice is mailed to a member at the time of a service or medication denial, with the reason for the determination and the member's appeal rights. This provides information regarding how to file an appeal. If an initial determination is made not to provide or pay for a service, the member has the right to request a reconsideration of that initial decision.

An acknowledgment letter is then sent to the member, or authorized representative, upon receipt of a standard part C appeal. Medical records are requested, as necessary. A standard appeal for denial of service shall be resolved as expeditiously as the enrollee's health condition requires, but no later than thirty (30) days from the date the request was received by MMM, plus a 14-days extension, if necessary. For Medicare part B prescription drugs, the request will be evaluated within 7 calendar days. Part B drug timeframes cannot be extended. An appeal for a denial of

medication must be resolved as expeditiously as the enrollee's health condition requires, but no later than seven (7) days from the receipt date. All expedite appeals are resolved within 72 hours from the date of receipt. Member and non-contract provider payment appeals must be solved within sixty-(60) days from the date of receipt. All timeframes are consistent with CMS guidelines.

Medical directors make all decisions regarding medical necessity. If MMM upholds the initial decision not to provide or pay for a service (Part C), the appeal is forwarded to the Independent Review Entity contracted by CMS (Maximus Federal Services) for further review, and final determination. The case may be subject to further levels of administrative or judicial review.

4.1.2 Expedited Appeals

The member, their authorized representative, or their treating physician may submit expedited appeals orally or in writing.

Someone other than the member, including any treating physician, may file a written, signed and dated appeal or a verbal expedited appeal on behalf of the member if the member appoints the individual to act on their behalf. If a representative submits the appeal, the Appointment of Representative (AOR) or a written equivalent notice must be submitted before the expedited appeal is considered.

The expedited appeal must be resolved within 72 hours if it meets expedited criteria due to a member's medical condition. A medical director shall evaluate the appeal within 24 hours of its filing and determine if it meets expedite criteria. If the appeal does not meet the requirements due to the service in question and the member's health condition, the appeal will be processed as a standard appeal within 30 calendar days for Part C or 7 calendar days for Part D and Part B prescription drugs. A member or representative may present an expedited grievance if do not agree that their request for reconsideration should be evaluated as a standard appeal.

4.1.3 Grievances

MMM has written policies and procedures for handling the resolution of a grievance. All member issues not related to the provision or payment of a service or covered medication are processed as grievances.

A grievance is considered any communication from a member or authorized member representative, oral or written, expressing dissatisfaction with any aspect of MMM or the provider's operations, regardless of whether any action is requested. Grievances may include, but are not limited to, complaints about:

1. Quality of service provided.
2. Timeliness of services.
3. Provider billing.
4. Interpersonal aspects of care.
5. Failure to respect a member's rights.
6. Enrollment / Disenrollment Issues.

All grievances received by the plan are resolved in accordance with applicable procedures. A provider must cooperate with MMM in the resolution of member grievances.

MMM grievance procedures clearly identify the steps of the process, time limits for each step, and member rights and responsibilities at each step. Each grievance must be resolved within 30 days, plus an extension of 14 days, if necessary. The Member Services Representative who receives the grievance will try to resolve the situation immediately. If it's not possible to provide immediate resolution to the member, the case will be referred for investigation to the appropriate department.

4.1.4 How does MMM use this information?

MMM monitors issue resolution processes by maintaining individual and aggregated appeal and grievance data. This data is analyzed as part of the Quality Assurance and Information obtained through the issue resolution process is maintained for a minimum of ten (10) years after final resolution. Aggregate information is available to MMM members upon their request in accordance with CMS guidelines.

4.1.5 For Your Reference and Use

We have developed documents to be used in the event you need to file an appeal or grievance on behalf of a member. The following forms are included in this section.

- Appointment of Representative (AOR)*
- Member Appeal Form*

Please be advised that this manual includes different forms for MMM members. If you would like more information regarding appeals and grievances, please contact your Provider Relations Representative.

4.2 Cooperation with the Quality Improvement Organization

In accordance with the Omnibus Budget Reconciliation Act of 1986, Medicare Advantage Organizations must maintain an agreement with the Medicare Quality Improvement Organization (QIO) regarding the federally mandated QIO responsibility for performing certain required reviews of healthcare services to the Medicare population. In Puerto Rico, LIVANTA is responsible, under a contract with the federal government, for independent review of medical necessity, appropriateness, and quality of care offered to Medicare beneficiaries.

Specifically, the PR-Medicare QIO's Review Plan Scope of Work contract is aimed to achieve goals that:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of healthcare
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary, and that are provided in the most cost-effective setting
- Protect beneficiaries by expeditiously addressing individual complaints such as beneficiary complaint, provider-based notice appeals, and other related statutory QIO responsibilities

Providers are required to cooperate fully with the local LIVANTA in performing their review, appeal, or complaint resolution functions.

4.2.1. Below is the information communicated to health plan members regarding their rights to an independent review.

- LIVANTA Immediate Review of Hospital Discharges- MMM and PMC members have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of their illness or injury.
- According to Federal Law, their discharge date must be determined solely by their medical needs.
- When a member is being discharged from the hospital, they will receive a written notice of explanation called a "Notice of Non-Coverage" or "Notice of Discharge and Medicare Appeal Rights" if they disagree with the discharge determination. This document outlines their appeal rights. Either MMM, PMC, or the hospital, is required to issue this notice.
- The member has the right to request a review by the LIVANTA of any written Notice of Non-Coverage / Notice of Discharge and Medicare Appeal Rights that they receive from MMM and PMC or from the hospital on our behalf stating that we will no longer pay their hospital care. Such a request must be made by noon of the first workday after they receive the Notice.

- The member cannot be made to pay for hospital care or services received before LIVANTA made its decision and notified them.

LIVANTA has contracted physicians who are paid by the Federal Government to review Medical Necessity, appropriateness, and quality of hospital treatment offered to Medicare patients, including those enrolled in a managed care plan (like MMM).

Contact information for LIVANTA:

Address: Livanta LLC

BFCC-QIO

10820 Guilford Road, Suite 202

Annapolis Junction, MD 20701-1105

Phone: 1 (787) - 520 – 5743

Toll Free: 1 (866) 815-5440

TTY: 1 (855) 843-4776

Fax: 1 (855) 236- 2423

4.3 Corrective Action, Hearing and Appellate Review

4.3.1 Purpose and Use

4.3.1.1 Purpose

The Corrective Action, Hearing and Appellate Review Policy is intended to establish guidelines for the investigation, corrective action, hearing, and appellate review processes relating to providers with whom MSO contracts ("Provider"). Nothing in this policy is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services by MSO Providers.

4.3.1.2 Use

This policy and all other bylaws, policies, procedures, rules, regulations, guidelines and requirements by MMM Healthcare, MMM Multi Health, PMC Medicare Choice and MSO of Puerto Rico (hereinafter and only for the purposes of this policy, collectively referred to as "MSO"), which may apply to MSO Providers, are unilateral expressions of the current requirements of policies and procedures established by MSO relating to its Providers. This policy does not constitute a contract of any kind whatsoever. This policy shall be interpreted, applied and enforced within MSO's sole discretion in connection with the terms and conditions as agreed in the Provider Services Agreement (hereinafter the "Agreement"). It is the responsibility of each Provider to obtain, read, understand and abide by all bylaws, policies, procedures, rules, regulations, guidelines and requirements.

ARTICLE 2

INVESTIGATION AND CORRECTIVE ACTION POLICY

2.1 Investigation

2.1.1 Initiation of Routine Investigation.

A routine investigation may be initiated through the Peer Review Committee or the Quality Improvement Committee, whenever a Provider engages in or makes acts or statements, or exhibits demeanor or professional conduct, with regard to health

services provided to any member(s), and the same is, or is reasonably likely to be detrimental to the quality of patient care or safety, disruptive to MSO's operations, or an impairment of the community's confidence in MSO, MMM or their reputation.

2.1.2 Requests and Notices.

Any person or entity, including any member, may make a request for investigation as outlined herein. All requests for investigation must be made in writing to the Compliance Officer. All such requests for investigation must be supported by references to specific activities or conduct that constitute grounds for the request.

2.1.3 Investigation.

The Compliance Officer for review shall refer all requests for investigation to the appropriate committee. The committee may determine that either the request does not warrant an investigation or direct that an investigation be undertaken. Independent third parties or entities may be utilized in the investigation process. The investigative process is not a "hearing" as that term is used in Article 3 of this Policy. It may involve an interview with an MMM Provider(s) involved and with the individual or group making the request, as well as with other individuals who may have knowledge of the events involved.

2.1.4 Interviews Prior to Investigation and Corrective Action.

When considering the initiation of an investigation or corrective action, the committees or any committee or individual appointed to investigate the matter, may, in their sole and absolute discretion, arrange for an interview with the affected

provider. At the interview, circumstances prompting the consideration of investigation or corrective action may be discussed and the Provider may be asked to present relevant information on their own behalf. A written record shall be maintained reflecting the substance of the interview that is part of the professional review information in the matter. If the Provider fails or declines to participate in the interview, the appropriate investigation or corrective action shall be initiated. This interview is not a procedural right of the Provider and need not be conducted according to the procedural rights outlined in Article 3 of this Policy.

2.2. Corrective Action Recommendation.

2.2.1 The Action. As soon as practicable after conclusion of the investigative process, if any, but in any event within thirty-(30) days, unless deferred, the Peer Review Committee, or its designee, shall act upon the result of such investigation. The action may include, without limitation, recommending:

1. Dismissal of the case.
2. A warning or a formal letter of reprimand.
3. A probationary period with retrospective review of cases, but without special requirements for concurrent consultation or direct supervision.
4. Individual requirement for consultation or monitoring.
5. Suspension or revocation of contract.

2.2.2 Deferral.

If additional time is needed to complete deliberations, or additional information is needed, the committee may defer action or investigation, as applicable. A subsequent

recommendation should be made as practicable after the deferral and completion of the deliberations or considerations of the additional information.

2.2.3 Procedural Rights.

A recommendation for suspension or revocation of a contract is deemed adverse and entitles the Provider to the procedural rights outlined in Article 3 of this Policy.

2.2.4 Other Action.

A recommendation for rejection, warning/reprimand, probation with retrospective review or concurrent monitoring, intensified review or consultation, or diminished prerogatives, are not deemed adverse and shall be transmitted to the Chief Medical Officer together with all supporting documentation. Thereafter, the Chief Medical Officer will process the recommendation and take appropriate action.

2.3 Automatic Suspension

Automatic suspension or agreement termination shall be initiated whenever certain circumstances exist as outlined in the agreement, this Policy or other bylaws, policies, procedures, rules, regulations, guidelines and requirements of MSO.

2.3.1 Commonwealth of Puerto Rico License.

By accepting an Agreement, each Provider agrees to immediately notify, through MSO Officials, of any investigation, admonishment, letter of concern, stipulation, or

action taken by the Commonwealth of Puerto Rico Department of Financial and Professional Regulation about their license to practice medicine in Puerto Rico.

1. **Revocation.** Whenever a Provider's license to practice medicine in the Commonwealth of Puerto Rico is revoked, MSO will immediately and automatically suspend their contract.
2. **Restricted or Stipulation.** Whenever a Provider's license is partially limited, restricted or under stipulation in any way, the Provider's provision of health services to any member is similarly limited, restricted or subject to stipulation, immediately and automatically.
3. **Suspension.** If a license is suspended, the agreement is immediately and automatically suspended effective upon and for at least the term of the suspension.
4. **Other Action.** If a Provider is admonished, given a letter of concern or placed on probation, stipulated or subjected to any other action not addressed in A, B, or C above by their licensing authority, the matter shall be reviewed by the Contracting Committee to determine whether an investigation shall be initiated.

2.3.2 Drug Enforcement Agency (DEA).

If a Provider's right to prescribe controlled substances is revoked, restricted, suspended, put under a stipulation or placed on probation by a proper licensing authority, they shall be prohibited from prescribing such substances by the DEA to

any members automatically and to the same degree. This will be effective upon and for at least the term of the imposed restriction. Every Provider, by accepting the terms of the contract, agrees to immediately notify, through the Contracting Committee, of any investigation, admonishment, letter of concern, stipulation or action taken by a proper licensing regulating authority with regard to the Provider's right to prescribe medication.

2.3.3 Professional Liability Insurance.

MSO or state or federal law automatically suspends a Provider's Agreement if they fail to maintain professional liability insurance in such amounts as required, whichever is highest.

2.3.4 Other Grounds for Automatic Suspension or Immediate Termination.

2.3.4.1 Additional grounds for automatic suspension may include failure to comply with special appearance requirements or requests by MSO and other grounds as may be outlined elsewhere in this Policy or in other bylaws, policies, procedures, rules, regulations, guidelines and requirements of MSO.

2.3.4.2 Pursuant to the terms and conditions set forth in the Agreement, MSO may terminate the Provider immediately upon written notice.

2.3.5 Procedural Rights.

A Provider whose Agreement is automatically suspended or terminated pursuant to Section 2.3 above shall not be entitled to the procedural rights set forth in Article 3 of this Policy. A Provider whose Agreement is automatically suspended due to a

violation of any provision of subparagraph 2.3.1 must submit a written request for reinstatement to the Credentialing Committee with documented proof that the deficiencies leading to the suspension have been corrected. If documented proof that the deficiency has been corrected is provided to the satisfaction of the Credentialing Committee and the request for reinstatement is denied, the Provider is entitled to the procedural rights outlined in Article 3 of this Policy, and, no later than the end of the tenth (10th) business day after the date reinstatement was denied, shall give the affected Provider Special Notice of the denial of their request for reinstatement. Failure to be reinstated within ninety (90) days of the automatic suspension shall be deemed as voluntary resignation of contract and the affected Provider will not be entitled to exercise procedural rights as outlined in Article 3 of the Policy.

2.3.6 Notice.

A Provider who is automatically suspended or terminated by operation of this Section 2.3 shall be given notice of such automatic suspension or immediate termination from MSO, by first class mail, certified postage, email or hand delivery, after imposition of such automatic suspension or immediate termination and their procedural rights, if applicable in accordance with the Agreement.

2.4 Summary Suspension.

A summary suspension shall be initiated by MSO with the input of the Peer Review Committee whenever MSO identifies the existence of a Provider's conduct that, in its sole discretion, requires that immediate action be taken to prevent danger to life, or substantial likelihood of injury to any member. A summary suspension is effective immediately and the Contracting Vice President shall provide prompt special notice of the suspension to the Provider. A suspended Provider's patient who is a member and an inpatient in a hospital must be assigned to another Provider as required by MSO. This assignment shall be made by MSO and shall consider the wishes of the patient in choosing a substitute Provider when feasible. This assignment will be made by MSO, and the company, when feasible will consider the member's wishes when choosing a substitute Provider.

2.4.1 Procedural Rights.

Unless MSO, upon further review, immediately terminates or modifies the suspension to one of the lesser sanctions as outlined herein, the Provider shall be entitled to the procedural rights outlined in Article 3 of this Policy.

2.4.2 Other Action.

A Peer Review Committee recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights shall be transmitted immediately, together with all supporting documentation, to MSO for its determination. In the instance of a favorable decision by MSO, the recommendation will have the effect of revoking the summary suspension completely or reinstating the Provider with

whatever corrective action was assessed by the preceding Peer Review Committee the final decision.

ARTICLE 3

HEARING AND APPELLATE REVIEW

3.1 Initiation of Hearing.

A Provider shall be entitled to a hearing whenever an adverse determination is made by MSO based on the competence or professional conduct of the Provider that could adversely affect the health or welfare of a patient(s). The aforementioned adverse determination is made during a professional review activity as set forth in Section 3.2.2. of this Policy by MSO, based upon a recommendation from the Contracting, Credentialing Committee, Peer Review Committee, or their designees subject to terms and conditions set forth in the Agreement including but not limited to the Resolution of Issues Section of the Agreement. In the event MSO should decide to take adverse action without a similar recommendation from the corresponding committee regarding those matters set forth in Section 3.2.2. of this Policy, herein below, the affected individual shall also be entitled to a hearing before MSO emits a final decision. The hearing shall be conducted in a formal manner with the participation of a medical director.

3.2 The Hearing.

3.2.1 Notice of Recommendation.

A. When a recommendation is made or action taken which, according to this Policy, entitles an individual to a hearing, the affected individual shall promptly be given written notice by the Compliance Officer. This notice shall contain:

1. A statement of the recommendation made and the general reasons for said Recommendation.
2. Notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of their receipt of the notice, and that any request for a hearing must be in writing and submitted to the Compliance Officer.
3. Notice that failure to submit a written request for a hearing to the Compliance Officer within the specified time period shall constitute a waiver of the right to a hearing and appeal in the matter, and any other rights to which a Provider may otherwise have been entitled to under this Policy, as well as under the bylaws, policies, procedures, rules, regulations, guidelines and requirements of MMM and MSO.
4. A summary of the individual's rights in the hearing, as provided for in this Policy.
5. A statement that after receipt of a timely request for hearing, the individual will be notified of the date, time and place of the hearing after the hearing is set.
6. A statement that if the adverse action is a summary suspension, the individual is not entitled to exercise hearing and appeal rights until after the

matter has been investigated, and unless the Peer Review Committee, with the input of the Chief Medical Directors, makes a recommendation or determination to take adverse action, as set forth in Section 3.3 (including all subsections) of this Article.

B. Said individual shall have thirty-(30) days following the date of the receipt of such notice within which to request a hearing by the Peer Review Committee hereinafter referred to. Said request shall be made through a written notice delivered to the Compliance Officer. In the event the affected individual does not request a hearing within the time and in the manner herein above set forth, the Provider shall be deemed to have waived their rights to said hearing, appellate review, and any other rights to which they may otherwise have been entitled under this Policy and the bylaws, policies, provisions, rules, regulations, guidelines and requirements, and to have accepted the action involved; such action shall become effective immediately upon final action by MMM and MSO.

3.2.2 Grounds for Hearing.

No recommendation or action of the Contracting and Credentialing Committee, Peer Review Committee or MSO, other than those hereinafter indicated, shall be deemed adverse and constitute grounds for a hearing:

1. Denial of initial credentialing process to participate in the health plan network for grounds relating to competency of professional conduct or infringement of quality of care standards.
2. Denial of renewal of re-credentialing process for grounds relating to competency of professional conduct or infringement of quality of care standards.
3. Suspension or termination of credentialing process and membership in the Provider Network for grounds relating to competency of professional conduct or infringement of quality of care standards.

3.2.3 Unappeasable Actions.

Neither voluntary resignation of contract, nor the imposition of any general consultation requirement, nor requirements for special or intensified review, no matter when imposed by MSO, shall be deemed adverse and shall not constitute grounds for a hearing, but shall take effect without hearing or appeal.

3.2.4 Notice of Hearing and Statement of Reason.

The Compliance Officer shall schedule the hearing and shall give Special Notice of its time; place and d ate, in writing, to the affected Provider(s). The notice shall also include a proposed list of witnesses who will give testimony or evidence in support of the Contracting Committee and/or Peer Review Committee's recommendation at the hearing. The hearing shall begin as soon as possible, but no later than thirty-(30) days after the notice of the hearing, unless the parties have specifically agreed to an earlier hearing date in writing. This notice shall contain a statement of the reasons for

the recommendation as well as the list of patient records supporting the recommendation. This statement, and the list of supporting patient records, and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant as determined by the Chair of the Peer Review Committee, or its designee, to the continued appointment or privileges of the individual requesting the hearing. The notice of the hearing should also contain a list of the individuals appointed to the Peer Review Committee and provide the affected Provider an opportunity to object to the appointment of any individual upon written notice to the Compliance Officer with the reasons for the objection stated thereon. All objections will be resolved as deemed appropriate by the Chief Medical Officer.

3.2.5 Peer Review Committee and Officers.

The Peer Review Committee shall consist of at least the following:

1. Physician members of MSO
2. External physician member of the Peer Review Committee
3. One senior staff member of MMM

MSO shall ensure that the majority of the hearing panel members are peers of the affected physician. Panel members do not need to have identical specialty training neither similar practice. Should any member of the panel have participated in the course of the investigation at any previous level or be in direct economic competition with the affected Provider(s), that member is disqualified from participation on the Peer Review Committee in the specific instance. Knowledge of the matter involved

shall not preclude any individual from serving on the Peer Review Committee. The Chair of the Peer Review Committee will be the lead Officer of the hearing.

The Chair shall:

a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence.
b. Maintain decorum throughout the hearing.
c. Determine the order of procedure throughout the hearing.
d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and the admissibility of evidence.
e. Act in such a way that the Peer Review Committee in formulating its recommendations considers all information relevant to the credentials of the Provider requesting the hearing.
f. Act at all times to see that all relevant information is made available to the Peer Review Committee.

The Peer Review Committee has the authority to establish the rules and requirements of the Hearing, in addition to the rules outlined in Article 3, and to decide prehearing objections and requests. However, no prehearing interviews of witnesses are permitted unless both parties agree to the interviews and are present during the interviews. The parties shall be required to attend a Prehearing Conference at the election of the Peer Review Committee. At the Prehearing Conference, the Peer Review Committee shall advise the parties of any rules or requirements of the

Hearing that are in addition to those rules outlined in this Article 3, and may decide any prehearing motions of the parties that are filed in advance of the Prehearing Conference. The Peer Review Committee may also advise the parties of additional rules or requirements of the Hearing in writing.

3.2.6 Failure to Appear.

Failure without good cause of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of the hearing, appellate review, and any other rights to which the Provider may otherwise have been entitled to, under this Policy and the bylaws, policies, procedures, rules, regulations, guidelines and requirements of MMM and voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

3.2.7 Postponements and Extensions.

Postponements and extensions of time beyond any time limits set forth in this Policy may be requested by anyone but shall be permitted only by the Peer Review Committee in its sole discretion on a showing of good cause, and only if the request is made as soon as reasonably.

3.2.8 Deliberations and Recommendation of the Peer Review Committee.

Within seven (7) business days after the final adjournment of the hearing, if practicable, the Peer Review Committee shall conduct its deliberations outside the presence of any other person, except its legal counsel, and shall render a

recommendation, accompanied by a report, which shall contain a concise statement of the reasons supporting the recommendation made, and shall deliver said report to the Chief Medical Officer. The Peer Review Committee's report may confirm, reject or modify the recommendation or action that was the subject of the hearing.

3.2.10 The Notice and Disposition of Peer Review Committee Report.

The Compliance Officer shall, no later than the end of the fifth (5th) business day, after the Board of Directors' receipt of the Peer Review Committee's report and recommendations, notify the affected Provider of the findings and recommendations of the Peer Review Committee by written notification.

The Chief Medical Officer shall take action thereon by adopting or rejecting the Peer Review Committee's recommendations in whole or in part, or by referring the matter back to the Peer Review Committee for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation should be made to the Chief Medical Officer and may include a directive that any additional hearing be conducted to clarify issues that are in doubt. As soon as practicable after receipt of such subsequent recommendation and any new evidence in the matter, the Chief Medical Officer shall take final action.

The Compliance Officer shall promptly send the affected Provider written notice informing them of the action taken.

3.2.11. Effect of Peer Review Committee Report and Recommendations.

The Peer Review Committee reports unfavorable findings and recommendation. If the recommendations of the Peer Review Committee are unfavorable to the individual who requested the hearing, the notice sent by the Compliance Officer to the individual pursuant to Article 3, Section 3.2.10. shall advise them of their right to an appeal and the time period and requirements for submitting a MSO of Puerto Rico, LLC request for an appeal; state that failure to request an appeal within the specified time period shall constitute a waiver of the right to appellate review, and all other rights to which the provider may have otherwise been entitled to under this Policy and the bylaws, policies, procedures, rules, regulations, guidelines and requirements of MMM; and state that as soon as practicable after receipt of a timely request for an appeal the individual will be notified of the date, time and place of the appeal.

3.2.12. Favorable Findings and Recommendations of the Peer Review Committee.

If the Peer Review Committee recommendations are favorable to the individual who requested the hearing, the Compliance Officer shall promptly forward the recommendations, together with all supporting documentation, to MSO for final action. MSO shall take action thereon by adopting or rejecting the Peer Review Committee recommendations in whole or in part, or by deferring the matter back to the Committee for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation should be made back to the Chief Medical Officer Board, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. As soon as practicable after receipt of such subsequent recommendation and any new evidence

in the matter, MSO shall take final action. The Compliance Officer shall promptly send the individual who requested the hearing Special Notice informing them of each action taken pursuant to Article 3, Section 3.2.10. Favorable action by MSO shall be effective as the final action, and the matter shall be considered finally closed. If MMM's action is unfavorable to the individual who requested the hearing, the notice shall inform them of their right to request an appeal, if it has not been previously exercised or waived, and the other matters listed in paragraph 3.2.11.A. above.

3.3 Hearing Procedure.

3.3.1 Representation.

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine documents and witnesses and present their case. They shall inform the Chair of the Peer Review Committee in writing of the name of the person at least ten (10) business days prior to the date of the hearing. The Chair of the Peer Review Committee may also appoint a person, who may be an attorney, to present support for the recommendation and other actions that gave rise to the hearing, and to examine and cross-examine witnesses at the hearing. The Peer Review Committee shall also have the right to legal representation.

3.3.2 Right of Both Sides.

At the hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine and

impeach any witness on any matter relevant to the issues, and to rebut any evidence. If the person requesting the hearing does not testify on his or her own behalf, they may be called and examined as if under cross-examination. Both sides may submit written statements after the close of the hearing within the timeframe set by the Peer Review Committee.

3.3.3 Admissibility of Evidence.

The hearing shall be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. The Chair of the Peer Review Committee shall admit any relevant evidence if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Peer Review Committee may request such a memorandum to be filed, at the close of the hearing. The Peer Review Committee may interrogate the witnesses, call additional witnesses or request documentary evidence, as it deems appropriate.

The Peer Review Committee may accept testimonial evidence by way of affidavit. In the event either party proposes testimony by affidavit, it shall notify the other party at least seven (7) business days prior to the date of the hearing.

The notice shall attach a copy of the proposed affidavit. The Peer Review Committee shall give the testimony by affidavit whatever weight it deems appropriate, considering the content of the testimony, the issue under consideration and the

absence of an opportunity for cross examination. The Peer Review Committee may accept testimonial evidence by way of printed or video deposition if agreed upon by the parties or ordered by the Chair, upon a showing of good cause.

3.3.4 Official Notice.

The Chair of the Peer Review Committee shall have the discretion to take official notice of any matter, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the Commonwealth of Puerto Rico. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

3.3.5 Basis of Recommendation.

The recommendation of the Peer Review Committee shall be based on the evidence presented and admitted at the hearing. This evidence may consist of the following:

1. Oral testimony of witnesses
2. Memorandum of points and authorities presented in connection with the hearing.
3. Any information regarding the person who requested the hearing so long as that information has been admitted into evidence at the hearing and the person

who requested the hearing had the opportunity to comment on and, by other evidence, refute it.

4. Any and all applications, references, and accompanying documents.
5. All officially noted matters.
6. Any other evidence that has been admitted or stipulated to by the parties and provided to the Peer Review Committee.

3.3.6 Burden of Proof.

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

A. the MSO Committee, whose recommendation or action prompted the hearing initially, shall first come forward with evidence in support of its recommendation or action. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in support of their challenge to the recommendation or action.

B. After all the evidence has been submitted by both sides, the Peer Review Committee shall affirm the recommendation or action of the Contracting or Credentialing Committee and/or Peer Review Committee in making said recommendation, unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was not supported by the evidence then available, or otherwise is not supported by the evidence presented at the Hearing. Notwithstanding the foregoing, the Peer Review

Committee may modify the recommendation or action of the committee, in its discretion, but may not expand any proposed unfavorable recommendation or decision.

3.3.8 Attendance by Committee Members.

Recognizing that it may not be possible for all members of the Peer Review Committee to be present continually at all sessions of the Peer Review Committee, since it is necessary to conduct a hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Peer

Review Committee is always not present. The fact that certain Peer Review Committee members were always not physically present during the hearings will not disqualify them or invalidate the hearing. A Peer Review Committee member who is forced to be absent from portions of the hearing must certify that they have read that portion of the transcript of the hearing from which they were absent before being permitted to vote. The vote shall be by majority of those appointed to the Peer Review Committee who is entitled to vote.

3.3.8 Adjournment and Conclusion.

The Chair of the Peer Review Committee may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Peer Review Committee shall, at a time convenient to itself, conduct its deliberations

outside the presence of the parties. Once the hearing recommendation as affirmed or modified is forwarded to the Board of Directors, the hearing shall be adjourned.

3.3.9 Confidentiality of Hearing Proceedings

The parties agree that the Hearing Procedure and all information resulted from such process shall be kept confidential by the parties and by any third persons or entities subject to the Hearing Procedure. Should any party choose to enforce or appeal the Peer Review Determination shall comply with the Resolutions of Issues and Dispute Resolution conditions as agreed in the Agreement.

Disclosure of all or part of the Confidential Information may be made by the parties only to their respective management, officers, board of directors, attorneys, accountants, financial advisors, tax professionals, and then on a need to know basis only. Any person identified in the preceding sentence to whom Confidential Information is disclosed will be deemed bound by the confidentiality provisions of this section and the Agreement and the disclosing party shall require the person(s) receiving the disclosure not to divulge the Confidential Information.

Disclosure of all or part of the Confidential Information may also be made by the parties as required by law or by order or subpoena of a court with jurisdiction over the parties. Provided, however, that if any subpoena, order or discovery request (the "Document Request") is received by any of the parties hereto calling for the production of Confidential Information, such party shall promptly notify the other party hereto prior to any disclosure of same. In such case, the subpoenaed party shall: (a) make available as soon as practicable (and in any event prior to disclosure), for

inspection and copying, a copy of the specific portion of the Confidential Information it intends to produce pursuant to the Document Request; and (b) to the extent possible, shall not produce anything in response to the Document Request for at least fifteen (15) business days following notice of the Document Request. The subpoenaed party shall take appropriate actions to resist production, as permitted by law, so as to allow the parties to try to reach agreement among them, with third parties, or to procure court, agency or arbitrator rulings on what shall be produced, or for the other party to intervene in the proceedings in question to oppose disclosure or subject the same to confidentiality conditions.

3.4 Appeal.

3.4.1 Time for Appeal.

Within ten (10) business days after the affected Individual is notified of an adverse recommendation from the Peer Review Committee, or an adverse recommendation from the Board of Directors, modifying a recommendation of a Peer Review Committee which was favorable to the affected individual, the Provider may request an appellate review. The request shall be in writing, and shall be delivered to the Chief Medical Officer, either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the issues they wish to be considered at the appellate review. If such appellate review is not requested within ten (10) business days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

3.4.2 Grounds for Appeal.

The grounds for appeal from an adverse recommendation of the Peer Review Committee shall be that:

A. There was substantial failure on the part of the Peer Review Committee, to substantially comply with the process outlined in this Policy or other bylaws, policies, procedures, rules, regulations, guidelines and requirements of MSO in the matter that was the subject of the hearing so as to deny due process or a fair hearing

B. The findings and recommendations were made arbitrarily, capriciously or with prejudice

C. The findings and recommendations of the Peer Review Committee are not supported by substantial evidence

3.4.3 Time, Place and Notice.

Whenever an appeal is requested as set forth in the preceding sections, the Compliance Officer or their designee shall, within ten (10) business days after receipt of such request, if practicable, schedule and arrange for an appellate review. The Compliance Officer or their designee shall cause the affected Individual to be given notice of the time, place and date of the appellate review. The date of the Appellate Review shall not be less than fifteen (15) business days, or more than thirty (30) days from the date of receipt of request for Appellate Review. When a request for Appellate Review is from a Provider who is under a suspension, then in effect the

Appellate Review shall be held as soon as the arrangements may reasonably be made, and not more than thirty-(30) days from the date of receipt of the request for Appellate Review. The Chief Medical Officer for good cause may extend the time for the Appellate Review.

3.4.4 Nature of Appellate Review.

A. The appellate review is conducted by an Appellate Review Committee consisting of at least three (3) external Physicians (MSO will ensure that the majority of the Peer Review Committee are Peers of the affected physician). The Compliance Officer shall serve on the Appellate Review Committee. The Compliance Officer from the other Peer Review Committee members shall select one member of the Appellate Review Committee and the affected Provider from the other Council members shall select one member of the Appellate Review Committee. The affected Provider shall advise the Compliance Officer in writing of their selection of the Peer Review Committee member in their request for appellate review as provided in this Policy. If the Compliance Officer and the Affected Provider choose the same Council member to service on the committee, the Compliance Officer shall select an additional Council member so that the Appellate Review Committee is composed of at least three (3) Council members. The Compliance Officer shall act as the Presiding Officer.

B. The proceedings shall be in the nature of an appellate review of the procedures employed and shall be based upon the record of the hearing before the Peer Review Committee, the Peer Review Committee's report, and all subsequent

results and actions thereon. The appellate review shall also consider the written statements submitted as described below.

C. The Provider seeking appellate review must submit a written statement detailing the findings of facts, conclusions and procedural matters with which they disagree, and their reasons for such disagreements, by Special Notice to the Compliance Officer. The Compliance Officer shall forward a copy of the Provider's written statement to the body whose adverse action or recommendation occasioned the appellate review and the body may file a written statement in response. The written statement may cover any matters raised at any step in the hearing process and legal counsel may assist in this preparation. The Provider's statement and the written statement of the body whose adverse action or recommendation occasioned the appellate review shall be submitted to the Appellate Review Committee through the Compliance Officer at least ten (10) business days prior to the scheduled date of the appellate review. Copies of the written statements shall be sent by Special Notice to each party as soon as practicable prior to the scheduled date of any appellate review, but in any event the Compliance Officer shall ensure that access occurs not later than five (5) business days prior to the scheduled date and time of the appellate review.

D. The Appellate Review Committee shall allow the parties or their representatives to personally appear and make oral statements in favor of their positions.

E. New or additional matters or evidence that the Appellate Review Committee deems significant to the Peer Review Committee's consideration of the matters which were not raised or presented during the original hearing may be referred by the Committee back to the Peer Review Committee for reconsideration of its recommendations. New or additional matters or evidence not raised or presented at the original hearing may be introduced upon good cause shown, as determined by the Appellate Review Committee as to why such matters or evidence were not introduced at the original hearing. The other party shall be given an opportunity to respond to such new or additional matters of evidence.

F. The Appellate Review Committee shall have all powers granted to the Peer Review Committee and such additional powers as it determines are reasonably appropriate to the discharge of its responsibilities.

G. A majority of the members of the Appellate Review Committee must be present throughout the review and deliberations. If a member is absent from any part of the proceedings, they shall not be permitted to participate in the deliberations of the decision.

H. The Appellate Review Committee may recess the proceedings or reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed.

I. The Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

3.4.5 Final Decision of the Chief Medical Officer.

A. The Appellate Review Committee may affirm, modify, or reverse the findings and/or recommendations of the Peer Review Committee, or in its discretion, may refer the matter back to the Peer Review Committee for further review, as soon as practicable and in accordance with its instructions. As soon as practicable after receipt of the Peer Review Committee's findings or recommendations, the Appellate Review Committee shall make its final decision in the matter.

B. the Appellate Review Committee shall render its recommendation in writing and forward it to the Chief Medical Officer through the Compliance Officer. The Chief Medical Officer shall, as soon as practicable after receipt of the Appellate Review Committee's decision, act on the decision by affirming, rejecting or modifying said decision to the affected Provider no later than the end of the fifth (5th) business day after the date of the Board of Directors' action in the matter. The Chief Medical Officer's action shall be final and not subject to further hearing or appellate review.

3.4.6 Right to One Hearing and Appeal Only.

No affected Provider shall be entitled as a matter of right to more than one (1) hearing and one (1) appellate review on any single matter.

ARTICLE 4

CONFIDENTIALITY, IMMUNITY AND RELEASES

4.1 Authorizations and Conditions.

By submitting a request for or retaining contract, a Provider**:**

4.1.1 Authorizes representatives of MSO to solicit, provide and act upon information bearing upon the Provider's professional ability and qualifications; including, but not limited to, information from any Hospital at which the Provider is a member of the Medical Staff

4.1.2 Agrees that information regarding the provider may be provided to the Hospital and that the provisions of such information to the Hospital has no impact on the protections, privileges and confidentiality associated with such information

4.1.3 Agrees that information not otherwise protected from disclosure or used under Commonwealth of Puerto Rico or federal law may be provided to third parties such as, but not limited to the National Practitioner Data Bank (NPDB)

4.1.4 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of MSO who acts in accordance with the provisions of Article 4.

4.2 Confidentiality of Information.

Information with respect to any Provider submitted, collected or prepared by any representatives of this or any healthcare facility, organization, or medical staff, for the purposes of evaluating and improving patient safety, the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research and determining that healthcare services are professionally indicated and performed in compliance with applicable standards of care shall, to the fullest extent permitted by law, be confidential and shall not be used in any way except as provided herein or other bylaws, policies, procedures, rules, regulations, guidelines and requirements of MMM, or except as otherwise provided by state or federal law. Such confidentiality shall also extend to information of the kind that may be provided by third parties. This information shall not become a part of any particular patient's record.

4.3 Immunity from Liability.

4.3.1 For Action Taken.

By applying for or accepting a contract, each Provider agrees that no representative of MSO shall be liable to them for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of their duties as representative, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

4.3.2 For Providing Information.

By applying for or accepting a contract, each Provider agrees that no representative of MSO and no third party shall be liable to the Provider for damages or other relief by reason of providing information, including otherwise protected, privileged or confidential information, to a representative of MMM to an appropriate state regulatory agency, or to a third party concerning a Provider who is or has requested or accepted credentials and provided further that such information is related to the performance of duties and reported in a factual manner.

4.4 Activities and Information Covered.

4.4.1 Activities.

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning but not limited to:

4.4.1.1 Request for credentials

a. Periodic reassessment of credentials

b. Corrective or disciplinary action

c. Hearings and appellate reviews

d. Quality improvement program activities

e. Utilization and claims reviews

f. Profiles and profile analysis

g. Malpractice loss prevention

h. Other MSO activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

4.4.2 Information.

The information referred to in this Article may relate to a Provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

4.4.3 Releases.

Each Provider shall, upon request of MMM, execute general and specific releases in accordance with the tenor and import of this Article 4. Execution of such releases is not a prerequisite to the effectiveness of Article 5.

ARTICLE 5

ANNUAL REVIEW, ADOPTION AND AMENDMENT

5.1 Annual Review.

The Contracting, Credentialing Committee and the Peer Review Committee, or their designees, shall recommend any revisions it deems appropriate to the Chief Medical Officer for action.

5.2 Amendment. This Policy may be adopted, amended or repealed, in whole or in part by the Executive Committee and/or Board of Directors.

5. HEALTH SERVICE

5.1 Primary Care Physician Audits

Our Medicare Advantage client (MMM Healthcare, LLC) conducts an annual evaluation of Primary Care Physicians (PCP) with ten (10) or more assigned members to ensure that medical records are maintained in a confidential manner, healthcare is accessible, available, and provided in a safe and clean environment, and meets HIPAA Privacy requirements. A score ranging from 80%-100% means that standards are met, while 79% or below indicates that the provider does not meet standards and requires re-evaluation within six (6) months. Providers scoring below 80% compliance score after 3 audits will be referred by the QIC to the Credentialing Committee (CC), recommending termination of contract. Then, the Credential Committee will submit its recommendation to the Contracting Department for final determination. In turn, providers with scores of 85% or more for three consecutive annual Quality Audits will be excluded from annual audits and will be audited two years after last audit date.

The PCP will receive written notification of the results. An on-site visit may also be conducted at a physician's office if a complaint or grievance has been filed regarding some aspect of care or service. Below are the standards of medical record review.

5.1.1 Primary Care Physician Medical Record Review Standards

General Health Information

Each of the standards listed below corresponds to the standard on the Medical Review Worksheet: **MEDICAL RECORD DOCUMENTATION 2021**

1. Each page within the record contains both the patient's name and last names, date of Birth (DOB) or Member ID number.

The patient's name or identification number is noted on all pages of the record. Individual medical records are maintained for each patient. Both requirements must be met to receive a score of *yes*. Family charts are not acceptable.

2. The record includes personal, DOB and biographical data, included:

Gender Date of birth Marital Status Address Home phone number Work phone number Copy of insurance card or information Spouse/Wife/ Family/significant relatives' information and telephone number

3. All entries dated and authenticated by either the initials or signature of a physician followed by credential (M.D.)

<u>All</u> entries in the medical record are dated, signed and initialed followed by credential (M.D.) provider name, license number, provider signature, day, month, and year.

4. The record must be legible to all reviewing parties.

   An illegible record will result in an incomplete review.

<u>All</u> entries in the record are legible. Capable of being read or deciphered or capable of being discovered or understood. An illegible record will result in an incomplete review.

5. The record includes medication list, and any medication allergies or adverse reactions (patient-stated intolerances to medications) must be noted in the record. This notation may be made on the chart cover, on a cover page inside the record or on each page of the record.

Previous and current medication should be evidenced on the medical record for patients seen three or more times. Allergies/adverse reactions (patient-stated intolerances to medications) are prominently noted in the chart. This notation, allergy sticker, may be made on the chart cover, on a cover page inside the record or on each page of the record. "NKA" for no allergies is prominently displayed. "NKDA" for no drug allergies is prominently displayed.

6. For patients seen at least three times, the record must document the following, if applicable: Use of Tobacco, Alcohol, and substance Abuse

Patient history documents whether the patient uses tobacco. Patient history documents current and past alcohol use or no use. Patient history documents current and past substance abuse or no abuse. All three must have documentation to score yes.

7. All labs, X-rays, and other ancillary care provider reports signed/initiated or noted.

There must be a physician's signature or initial on all ancillary reports. Ancillary reports include, but are not limited to consultant summaries, laboratory and radiology or imaging study results. Appropriate lab and radiology studies are ordered, documented and consistent with physical findings. All ancillary reports are signed or initialed by the physicians or noted in the progress notes.

8. A complete immunization history with notation that immunizations are "up to date" must be included.

The patient history documents the immunization history, administration, and exclusion. Influenza vaccine administration reported annually. Pneumococcal vaccine administration reported every 5 years

9. An initial and annual thereafter history and family history profile complete and documented for patients with two or more visits

An initial history and family history profile is completed and documented or recommended for patients with two or more visits. • The initial history includes description of chief complaint, illness history, past and present systems review and social history. • A patient family profile is the patient's family history of illness. It should document immediate family history, i.e.: parents and siblings, and indicate pertinent illness or causes of death.

10. A comprehensive physical examination completed and documented annually for patients with two or more visits

A comprehensive physical examination is completed and documented or recommended for patients with two or more visits. • A comprehensive physical examination includes a description of eight or more organs, systems, or corporal areas, requires description and detailed information. The corporal areas are head, face, neck, thorax, breast, axils, abdomen, genitals, inguinal region, buttock, back, vertebral column and extremities. The organ systems are eyes, throat, nose, ear, cardiovascular, respiratory, gastrointestinal, genitourinary, muscular, skeletal, integument, neurological, psychological, hematopoietic, and immunological.

11. History of present illness is documented on each visit; the physician has obtained information from the patient/caregiver of patient's complaint or reason for the visit, and it is recorded in the chart. The physician has conducted an assessment and entered a diagnosis.

Appropriate assessment and diagnosis are recorded at every encounter. Include: • Description of the chief complaints, signs and symptoms, localization, quality, severity, chronology, duration, context, and adverse factors • Diagnosis • Follow-up visits

12. Diagnostic work-up and plan of treatment is recorded.

Diagnostic work-up (laboratory, X ray, other diagnostic procedures) and plan of treatment is documented for health problems identified during each visit.

13. If prescriptions were given to the patient, documentation of instructions, e.g., dosage and frequency documented. If medication was administered to the patient, was the drug dosage, and site recorded.

Documentation of reviews of all medications that the member is taking (including prescriptions, OTCs and herbal or supplemental therapies). A review of side effects for a single medication at the time of prescription alone is not enough. If the member

is not taking any medications, notation of this fact and the date on which it was noted is also considered compliant. Dosage and frequency or administration site of prescribed medication is documented in the chart.

14. Document TRC – 18 years and older (Not. of Adm and Not. of discharge (3 days),

    Engage and MRP (within 30 days), MRP (both list current and discharge medications).

Transitions of Care - Four sub-metrics reported:

Notification of Inpatient Admission - Documentation of receipt of notification of inpatient admission on the day of admission or the following 2 days (3 days)

Receipt of Discharge Information - Documentation of receipt of discharge information on the day of discharge or the 2 following days (3 days). Includes practitioner responsible for the member's care during the inpatient stay, procedures or treatment provided, diagnoses at discharge, current medication list, testing results, or documentation of pending tests or no tests pending and instructions for patient care post - discharge.

Patient Engagement After Inpatient Discharge - Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

Medication Reconciliation Post-Discharge - Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

*Exclude the member's episode when there exits evidence of readmission or transfers, hospice, and death (MY).

15. Unresolved problems from previous office visits noted and addressed in subsequent visits:

Unresolved problems from previous visits are addressed and documented during subsequent visits. Example: previous visits: abdominal pain scale 5, Tx: Pepcid 20mg PO, 9am and 5pm, next visits: not abdominal pain present.

16. When consultation is required the reason for the referral noted in the patient

    record

The reason for a referral to a consultant is noted in the patient record. Communication with consultants is documented in patient record and specific follow-up noted.

17. Abnormal consultations, lab, X ray reports filed in the chart have explicit notation on

    record of follow-up plans

Abnormal consultation, lab, X ray reports filed in the chart have explicit notation in record of follow-up plans. All the results need provider sign.

18. There is evidence of patient education/counseling regarding self-care, specific illness acute and/or chronic, and preventive medical care (fall prevention, urinary incontinence, emotional management, and physical activities) located in the patient record.

The medical record has references to patient receiving education or teaching regarding self-care, specific patient illness acute and/or chronic, diet, exercise, and preventive medical care (fall prevention, urinary incontinence, emotional management, and physical activities) and follow up visits.

19. Document the prevention and management of patients with multiple visits in emergency room and admissions.

Document the follow-up services of prevention and management of patients with multiple high-risk conditions, multiple visits in emergency room/admissions within 7 days of the ED/admissions visits. Chronic Dx: COPD, Asthma, Bronchitis, Alzheimer's, Dementia, CKD, Depression mayor, CHF, MI, Atrial fibrillation, and Transient Ischemic attack.

20. There is evidence of a current "Advance Directive" noted in a prominent place in the patient's record

Advance directives. Directives pertaining to treatment preferences and the designation of a surrogate decision-maker if a person should become unable to make medical decisions on their own behalf. Advance directives generally may be a living will, power of attorney or healthcare proxy Actionable medical orders. Written instructions regarding initiation, continuation, withholding or withdrawal of forms of life-sustaining treatment. Living wills. Legal documents denoting preferences for life-sustaining treatment and end of life care Surrogate decision maker. A written document designating someone else to make future medical treatment choices.

Oral statements. Conversations with relatives or friends about life-sustaining treatment and end of life care documented in the medical record. Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be notated in the medical record during the measurement.

Notation in the medical record of a discussion with a provider or the initiation of a discussion by a provider was documented in a prominent place in the record.

21. Evidence in the record of functional status assessment for patients 65 y/o >

Documentation in the medical record must include evidence of functional status assessment and the date on which it was performed.

Notations for functional status assessment may include the following. Functional independence.

Loss of independent performance, Activities of Daily Living (ADL), social activities, or Instrumental Activities of Daily Living (IADL) and standards tools.

The level of assistance needed to accomplish daily activities.

22. Evidence in the record of Pain Screening for patients 65 y/o >

Documentation in the medical record must include evidence of pain screening or a pain management plan and the date on which it was performed. Evidence of pain screening may include the following:

1. Notation of the presence or absence of pain
2. Results of a screening using a standardized pain screening tool for example but not limited to:
    a. Multidimensional Pain Inventory
    b. Faces Pain Scale
    c. 0–10 Numeric Rating Scales verbal or visual
    d. Verbal Descriptor Scale
    e. Brief Pain Inventory (Short Form)
3. Evidence of a pain management plan may include the following.
    a. Notation of no pain intervention and the rationale.
    b. Notation of plan for treatment of pain, which may include use of pain medications, psychological support, and patient/family education.
    c. Notation of plan for reassessment of pain including reassessment time interval.

23. Evidence in the record of height, weight, Body Mass Index (BMI) and B/P at least once a year. B/P for each visit – goal – equal or less than 129/79mmhg.

The chart has notation of the weight of the person scaled according to height in each visit. The chart has evidence of Blood Pressure Measure in each visit.

24. Evidence in the record of the signed HIPAA document

The chart has evidence of the signed HIPAA document.

25. Screening Preventive test results

Evidence in the record of the following preventive measures, diagnostic results of:

4. LDL - goal less than 100mg/dl. 5. Mammography- every two years if normal results. If $\geq$ 74y/o – every 30 months is acceptable. Age Range 40-74. 6. Colonoscopy- every 10 years, Sigmoidoscopy- every 5 years or Occult blood (annually) $\geq$ 40 y/o. 7. Osteoporosis screening in older woman - OSW (BMD) – 67 – 85 years 8. Woman without fracture - Bone mineral density test – 2 years in woman or treatment. 9. Woman with fracture - BMD and treatment (12 months with Alendronate, Alendronate – Cholecalciferol, Risedronate, Zoledronic acid, Ibandronate, other agents: Abaloparatide, Denosumab, Raloxifene, Romosozumab and Teriparatide). 10. Glaucoma screening for patients without prior diagnosis of the condition every two years if normal results. $\geq$ 65 y/o 11. PSA - 50 A 69 y/o Digital Exam and/or Blood Sample * Non-recommended PSA – Based screening in older men (70 years). Exclusions: Prostate cancer diagnosis, Dysplasia of the prostate and elevated results PSA >4.0 ng/ml The chart has diagnostic results of all the above at least annually except as specified. Preventive screening at least once a year and maintain in control values:

26. Diabetic Member: For Diabetic Member; the medical record has documentation of the following preventive test results:

- Eye Exam – For Diabetic Retinopathy - negative/two years, positive – annually, both eyes
- Foot Care - at least twice a year.
- Lipid profile - goal less than 100mg/dl.
- Glycosylated hemoglobin - goal less than 7.99%.
- Micro albumin or macro albumin results
- Kidney health evaluation- Uacr (Urine:alb + create) and eGFR (CMP) both results in the MY

The chart has diagnostic results of all the above at least annually.

27. For Congestive Heart Failure (CHF) Member

For diagnosis purposes, the medical chart has documentation of Echocardiogram results; annually in exacerbations and/or cardiologist recommendation, 2 years for follow-up, according to the CHF stage.

28. For members with Myocardial Infarct (MI), the medical chart has documentation of evidence of Beta-blocker prescription and Cardiac rehabilitation notes

Evidence of Beta-blocker prescription and primary care provider progress note indicates that the member receives Cardiac rehabilitation by Cardiologist or by Cardiac Rehabilitation Center services. Exclusions: Asthma, COPD, Obstructive chronic bronchitis, Chronic respiratory conditions due to fumes and vapors, Hypotension, heart block >1 degree or sinus bradycardia, a medication dispensing event indicative of a history of Asthma and intolerance or allergy to beta-blocker therapy.

29. For Members with Chronic Obstructive Pulmonary Disease (COPD).

The medical chart has documentation of *Simple Spirometry results* annually for members 40 years of age and older with a new diagnosis of COPD or Newly active COPD and Chest X ray results - every two years. *Management:* - Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. - Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event. Chest X-Ray results - every two years.

30. For members with Asthma.

Evidence of Inhaled Steroids use

31. Medical record retention policy

The office staff is aware of the Medical Record Retention policy as established by CMS. " *CMS requires that providers submitting cost reports retain all patient records for at least five years after the closure of the cost report. And if you're a Medicare managed care program provider, CMS requires that medical records are* ***retained for 10 years****."* How should medical records be retained? The Medicare program does not require a specific media format—records can be in the original form or in a legally reproduced form—which may be electronic or digital. Whichever format is used, it's important to use a system that protects and ensures the security and integrity of all records. Records should be accurately written, promptly completed, properly filed and readily accessible.

Revised: mpm – 8/2022

5.1.2 Behavioral Health Medical Record Review Standards 2021

General Health Information- Each of the standards listed below corresponds to the standard on the Medical Review Worksheet for medical charts of patients with three or more visits.

1. Each page within the record contains both the patient's name and last names, date of Birth (DOB) or Member ID number.

The patient's name or identification number is noted on all pages of the record. Individual medical records are maintained for each patient. Both requirements must be met to receive a score of *yes*. Family charts are not acceptable.

2. The record includes personal and biographical data. The following information may be included:

Gender Date of birth Marital Status Name of spouse or significant other, next of kin or closest living relative Address Home phone number Work phone number Copy of insurance card or information Family/significant other telephone number

3. All entries dated and authenticated by either the initials or signature of a physician followed by his/her credentials (M.D.).

All entries in the medical record are dated, signed, and initialed followed by credential (M.D.). All entries must include day, month, and year.

4. The record must be legible to all reviewing parties.

All entries in the record are legible. Capable of being read or deciphered or capable of being discovered or understood. An illegible record will result in an incomplete review.

5. The record includes medication list, and any medication allergies or adverse reactions (patient-stated intolerances to medications) must be noted in the record. This notation may be made on the chart cover, on a cover page inside the record or on each page of the record. If there are no known allergies or no known drug allergies, "NKA" or "NKDA" must be prominently displayed.

Previous and current medication should be evidenced on the medical record. Allergies/adverse reactions (patient-stated intolerances to medications) are prominently noted in the chart. An allergy alert sticker is present on the front of the chart or on the inside cover. "NKA" for no allergies or "NKDA" for no drug allergies is prominently displayed.

6. All records must contain an informed consent for treatment.

This document must be signed by both patient and physician to establish that the patient understands why the medication is being administered, for how long, and its possible side effects.

7. The record must document the following, if applicable:

    1. Use of Tobacco
    2. Use of Alcohol
    3. Substance Abuse

Patient history documents whether the patient uses tobacco, past alcohol use or no use, and current and past substance abuse or no abuse. This documentation can be found on the initial evaluation and can be updated annually, if needed. Documentation of all three toxic habits is required to score *yes.*

8. There must be a physician's signature or initials in all ancillary reports. Ancillary reports include

    but are not limited to consultant summaries and laboratory tests. Appropriate lab and radiology studies are ordered, documented and consistent with physical findings.

All ancillary reports are signed or initialed by the physician or results are noted in the progress notes.

9. An initial and annual thereafter social history and family history profile completed and documented.

• The initial social history includes description of chief complaint, past and present systems review and history of physical abuse, emotional abuse, sexual abuse (if it applies). Includes legal data such as: incarceration, legal complaints, probation, driving under the influence, domestic violence, and aggression history (if it applies). • A patient family profile is the patient's family history of illness. It should document immediate family history, i.e.: parents and siblings, and indicate

pertinent mental health illness and/or psychiatric related causes of death. I t should explore psychiatric conditions such as:

- Depression
- Bipolar Disorder
- Anxiety
- OCD
- Schizophrenia
- ADD
- Mental Retardation
- Suicides
- Aggressive behavior
- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Other

10. An initial and annual, thereafter, medical history profile completed and documented.

The medical history includes diabetes, cancer, thyroid disease, hypertension, cardiac conditions, epilepsy, rheumatic conditions, lung conditions, neurological conditions, or others. Must also include allergies and surgeries.

11. An initial psychological history completed and documented.

The initial history includes history of previous treatment, date of last visit, or name of previous treating clinician.

12. An initial psychiatric history completed and documented, if applies.

The initial history includes history of previous psychiatric treatment, date of last visit, or name of previous treating clinician.

13. History of present mental health condition is documented on each visit; the physician has obtained information from the patient/caregiver of patient's complaint or reason for the visit, and it is recorded in the chart. The physician has conducted an assessment and entered a diagnosis.

Appropriate assessment and diagnosis are recorded at every encounter. Include:

- Description of the chief complaints, signs and symptoms, chronology, duration, context, and adverse factors
- Diagnosis
- Scheduling of follow-up visits

14. Diagnostic work-up is documented for health problems identified during each visit.

Diagnostic work-up and plan of treatment is recorded.

15. A mental status evaluation must be performed during each visit.

A mental status evaluation that must include:

- Enrollee's affect: dull, widespread, congruent, incongruent, restricted, and labile.
- Enrollee's speech: spontaneous, adequate, high, low, verbose, poor.
- Enrollee's mood: depressed, euphoric, irritable, anxious, euthymic.
- Enrollee's thought content: logic, coherent, relevant, illogical, and irrelevant.
- Enrollee's judgment: adequate, regular, poor
- Enrollee's insight: adequate, regular, poor
- Enrollee's attention: adequate, decreased, poor
- Enrollee's memory: Immediate (adequate, decreased, poor), Recent (adequate, decreased, poor), Remote (adequate, decreased, poor).

16. Treatment plans are consistent with diagnosis.

In mental health, the treatment plan refers to a written document that outlines the progression of therapy. The treatment plan generally is documented at the initial evaluation and consists of four parts:

- Presenting Problem - A brief description of the main issue or issues.
- Goals of Therapy - An annotated list of both the overall goal(s) and the interim goal(s) of therapy. Must be documented in the initial evaluation.
- Methods - A short, noted list of the techniques that will be used to achieve the goals.
- Time Estimate - A brief estimate of the length of time and/or number of sessions needed.

To measure consistency with diagnosis, treatment plans should have:

- Objective measurable goals.
- Estimated timeframes for each goal completion.
- Estimated timeframe for discharge from treatment.
- Goals problem resolution.

17. If prescriptions were given to the patient, documentation of instructions, e.g., dosage and frequency, are documented in the chart? If a medication was administered to the patient, the drug dosage and site are recorded.

Documentation of reviews of all medications that the member is taking (including prescriptions, OTCs and herbal or supplemental therapies). Dosage, frequency or administration site of prescribed medication are documented in the chart, or a copy of the prescription given if included in the chart, is also acceptable. A review of side effects for a single medication at the time of prescription alone is not enough. If the member is not taking any medications, notation of this fact and the date on which it was noted is also considered compliant.

18. When medications are prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medications prescribed.

There must be a valid justification for the use of psychiatric medications. Each medication prescribed must be designed for the symptom to be treated, and/or the diagnosis to be treated.

19. Comprehensive progress notes documentation.

Progress notes should include documentation of presenting problem, along with relevant psychological and social conditions, affecting the enrollee's medical and psychiatric status.

20. Follow-up visits on inpatient discharge

On inpatient discharge; there must be evidence of follow-up ambulatory visit on 7 and or 30 days.

21. On inpatient discharge; there must be evidence of follow-up ambulatory visit on 7 and or 30 days. Additional

includes information of transition of care was performed.

Transitions of Care - Four sub-metrics reported:
Notification of Inpatient Admission - Documentation of receipt of notification of inpatient admission on the day of admission or the following 2 days (3 days)
Receipt of Discharge Information - Documentation of receipt of discharge information on the day of discharge or the 2 following days (3 days). Includes practitioner responsible for the member's care during the inpatient stay, procedures or treatment provided, diagnoses at discharge, current medication list, testing results, or documentation of pending tests or no tests pending and instructions for patient care post - discharge.
Patient Engagement After Inpatient Discharge - Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
Medication Reconciliation Post-Discharge - Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). *Exclude the member's episode when there exits evidence of readmission or transfers, hospice, and death (MY).

4. Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

22. Unresolved problems from previous office visits noted and addressed in subsequent visits:

Unresolved problems from previous visits are addressed and documented during subsequent visits.

23. When consultation is required the reason for the referral noted in the record.

The reason for a referral to a consultant is noted in the patient record. Communication with consultants is documented in patient record and specific follow-up noted.

24. Abnormal consultations, lab, X ray reports filed in the chart have explicit notation on record of follow-up plans

1. There must be a physician's signature or initial all ancillary reports. Ancillary reports include, but are not limited to:
    a. Consultant summaries and laboratory tests.
    b. Appropriate lab and radiology studies are ordered, documented and consistent with physical findings.
2. Abnormal consultations, lab, X ray reports filed in the chart have explicit notation on record of follow-up plans.

Documentation of the following laboratories results for specific conditions and/or medication management, if applies:

- Lithium levels: BUN and Creatinine at least once a year
- Depakote liver enzymes: ALT and AST at least once a year
- Clozapine: CBC weekly during the first 6 months then biweekly.

25. There is evidence of a current "Advance Directive" noted in a prominent place in the patient's record.

Advance directives. Directives pertaining to treatment preferences and the designation of a surrogate decision-maker if a person should become unable to make medical decisions on their own behalf. Advance directives generally may be a living will, power of attorney or healthcare proxy

Actionable medical orders. Written instructions regarding initiation, continuation, withholding or withdrawal of forms of life-sustaining treatment.

Living wills. Legal documents denoting preferences for life-sustaining treatment and end of life care

Surrogate decision maker. A written document designating someone else to make future medical treatment choices.

Oral statements. Conversations with relatives or friends about life-sustaining treatment and end of life care documented in the medical record. Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be notated in the medical record during the measurement.

Notation in the medical record of a discussion with a provider or the initiation of a discussion by a provider was documented in a prominent place in the record.

26. Evidence in the record of the signed HIPAA document

The chart has evidence of the signed HIPAA document.

The office staff is aware of the Medical Record Retention policy as established by CMS.

" CMS requires that providers submitting cost reports retain all patient records for at least five years after the closure of the cost report. And if you're a Medicare managed care program provider, CMS requires that medical records are retained for 10 years."

How should medical records be retained?

The Medicare program does not require a specific media format—records can be in the original form or in a legally reproduced form—which may be electronic or digital. Whichever format is used, it's important to use a system that protects and ensures the security and integrity of all records. Records should be accurately written, promptly completed, properly filed and readily accessible.

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5.1.3 PCP OFFICE SURVEY STANDARDS 2021

General Health Information- Each of the standards listed below corresponds to the standard on the PCP Office Survey to perform the same day of the medical record review documentation standards audits.

PCP OFFICE SURVEY STANDARDS

1. The physician's office must be adequately marked (providers name, phone, and hours available) from the street.

Score Yes:	The physician's office is identified with a prominently displayed sign. The entrance is easily identified. If the office is in a building, the physician's name is on the building directory. Two of these three requirements must be met to receive a score of yes.
Score No:	The physician's office is not identified with a prominently displayed sign; the entrance is not easily identified; the physician's office is in a building and the physician's name is not on the building directory. Meets none or only one of the three requirements.

2. Parking and buildings must have appropriate access and accommodations for the general practices and handicapped.

Score Yes:	Parking and buildings must have appropriate access and accommodations for the general practices and handicapped. A single practitioner may have three or more spaces, while a larger practice will require more spaces. Handicap spaces must be designated.
Score No:	The parking was not adequate as indicated above for general practices and handicapped.
Score N/A:	Office is in a metro-downtown area (e.g., Old San Juan, downtown Humacao or Fajardo) or cultural building.

3. The physician's office provide for onsite visits and Telehealth for patients visits and follow-ups.

Score Yes:	The physician's office provides for walk-in/onsite visits and Telehealth for patients visits and follows must be met to receive a score of yes.
Score No:	The physician's office does not provide for walk-in/onsite visits and Telehealth for patients visits and follows must be no met to receive a score of No.

4. The physician's office has appropriate protocol for COVID 19 Pandemic.

Score Yes:	The physician's office has appropriate protocol for COVID 19 Pandemic. The instructions and materials are visible and available for the patients and employee. Include: hands sanitizer, mask, distance parameter according to Local Health Department and CDC guidelines.

Score No:	The physician's office has not appropriated protocol for COVID 19 Pandemic. The instructions and materials are not visible and available for the patients and employee. No met with Local Health Department and CDC guidelines.
Score N/A:	Local Health Department and CDC guidelines eliminated the COVID19 Pandemic protocols

5. Seating must be adequate and proportional to the size and type of practice.

Score Yes:	Observe the seating arrangements while in the waiting room. Note if patients are required to stand. Family members, not patients, may be required to stand.
Score No:	Seating is inadequate, and not proportional to the size and type of practice.

6. The lobby / office / restrooms must be clean, orderly and secure.

Avoid any furniture /object that could become a fall or impact hazard.

Score Yes:	The area is neat and clean. This area is cleaned regularly and is free of excess clutter. Avoid any furniture /object that could become a fall or impact hazard.
Score No:	The areas are not clean, orderly, and well maintained. This area does not appear to have been cleaned regularly and is not free from excess clutter. furniture /object that could become a fall or impact hazard was observe.

7. The exits must be adequately marked and in keeping with local requirements and fire codes.

Score Yes:	The exits are adequately marked and in keeping with the local requirements and fire codes. The building or office complex management is generally responsible for meeting this standard.
Score No:	The exits are not marked. The fire inspection was expired.

8. The examination rooms and equipment must be clean, orderly and adequate.

Score Yes:	The examination rooms and equipment are neat and clean. These areas are cleaned regularly and are free of excess clutter. Medical supplies from prior patients have been removed.
Score No:	The examination rooms and equipment are not clean, orderly and well maintained. These areas do not appear to have been cleaned regularly and are not free from excess clutter. Medical supplies from the previous patient have been left in the room.

9. There must be operating procedures that can ensure patient's evaluation within 15 minutes of the scheduled appointment time.

Score Yes:	There must be operating procedures that can ensure patient's evaluation within 15 minutes of the scheduled appointment time.

Score No:	There not operating procedures that can ensure patient's evaluation within 15 minutes of the scheduled appointment time. Patients waiting more than 30 minutes or hours for to be evaluated by MD. No Met - Patients waiting more than 16 minutes or hours for to be evaluated by MD. Determine the average time waiting _16 to 30min, __31 to 1hour, __1hr to 2hr, __2:01hr or more.

10. There must be a procedure for follow-up of missed appointments and tracking received and requested referrals.

Score Yes:	The provider has a procedure for follow-up of missed appointments. Procedure is known by office staff. The provider's office has a method for the recording of received and requested referrals. These must be recorded in the patient's chart or on a log.
Score No:	The provider does <u>not</u> have a procedure for follow-up of missed appointments. The provider's office does <u>not</u> record referrals.

11. The providers have initiatives for members experience survey

Score Yes:	The provider has initiatives for members experience survey. Establish a frequency, use standards or customizing tool, maintains results and evidence the action plan in the identified opportunity to improve.
Score No:	The provider has not initiatives for members experience survey.

12. There must be a procedure for the delivery of patient education material, including preventive health information.

Score Yes:	There is educational material visible in the office. Provider has a procedure for the delivery of patient education

	material including preventive health information. The staff must be aware of the procedures.
Score No:	There is no education material available in the office. Provider does not have a procedure for ensuring the delivery of patient education material including preventive health information.

13. There must be policies and procedures in place that address the protection and release of medical records to maintain patient confidentiality.

Score Yes:	The patient files are maintained in an area which is monitored by the office staff and are not freely accessible to patients. (Medical records are generally kept behind the receptionist's desk or counter) The provider has a policy for the written release of medical records. The staff must be aware of this policy. Both requirements must be met to receive a score of yes.
Score No:	The patient files are freely accessible, confidentiality is not maintained. The provider does not have a policy, or if has a policy, the staff is unaware of that policy.

14. Preventive maintenance of all equipment

Score Yes:	Review equipment such as EKG machine to observe a sticker that evidence having been inspected by a technician to assure calibration for proper functioning. Or request from the staff a log of inspection. The staff must be aware of this policy.
Score No:	The equipment does not have inspection sticker is not there a log of the eservices having been provided.

15. Standards for storage of drugs, needles and prescription pads should be documented, or clearly practiced when viewing storage and

patient care areas.

Score Yes:	Inspection of the provider's office demonstrates proper storage of drugs, medication and other patient care items which prevent misuse, contamination, or accidents. All patient care supplies should be kept above floor level. All controlled substances are maintained in a secure area. All these standards must be met to receive a score of yes.
Score No:	The provider does not meet the above standards.
Score N/A:	If the provider does not maintain a supply of medications or prescription pads, score "not applicable."

16. Limited Secure Access.

Score Yes:	All drugs and medicines on the premises, including samples, must be keep in secure place. Only the provider and authorized staff can dispense.
Score No:	The drugs, including samples, not in secure place. Patient is in the same place that the drugs are.
Score NA:	No drugs and sample in the provider's office.

17. Dated Supplies. Medications are dispensed prior to the expiration date.

Score Yes:	All drugs and medicines on the premises, including samples, do not have an expired expiration date. The reviewer should spot check stock medication and samples.
Score No:	Out of date medication was found.
Score N/A:	If the physician does not maintain medications in the office for dispensing, score "not applicable."

18. Controlled substance logs are maintained for a five-year period or as regulated by state law.

Score Yes:	The physician's office has a five-year controlled substance log.
Score No:	The physician's office does not maintain a controlled substance log or has not maintained the log for an adequate time.
Score N/A:	If the physician does not maintain controlled substances, score "not applicable."

19. Open Vials Dated. Date monitoring of drugs, medications and open multiple dose vials must be maintained, and responsibility assigned for this function.

Score Yes:	Inspection of the physician's office demonstrates date monitoring of drugs, medications, and open multiple dose vials. The reviewer must note the date the vial was opened. It is generally recommended that vials be discarded prior to the expiration date or when contamination is suspected or apparent. All the above standards must be met to receive a score of yes.
Score No:	The physician's office does not meet all the above standards.
Score N/A:	If the physician does not utilize vials, score "not applicable."

20. Medication must be properly stored. If refrigeration is required, there must be a refrigerator or freezer used strictly for medical purposes.

Score Yes:	The physician's office maintains medications that require refrigeration in a separate refrigerator. Medications may not be stored with soft drinks and lunches or biological specimens. The reviewer should inspect refrigerator for contents.
Score No:	Refrigerated medications are kept with lunches and soft drinks or biological specimens.
Score N/A:	If the physician's office does not have medications that require refrigeration, score "not applicable."

21. There must be appropriate identification and proper disposal of used needles and non-reusable items.

Score Yes:	The physician's office has proper identification and disposal containers for needles and non-reusable items. Used needles and syringes should be stored in a puncture-proof container.
Score No:	The physician's office does not have proper containers for needles and non-reusable items.

22. There must be appropriate identification and proper disposal of all hazardous materials.

Score Yes:	The provider's office has a procedure in place that ensures proper management and disposal of hazardous materials. The staff must be aware of these procedures. (The reviewer should note if office has a red box for needles disposal, a box of gloves and waste receptacles utilized for hazardous waste are clearly identified.)
Score No:	The provider's office does not have a procedure or office staff is not aware of the procedure.

23. There must be a hand washing sink and soaps available.

Score Yes:	The provider's office has a hand washing sink and soap available for staff use. Ideally, soap dispensers or pump bottles of liquid soap should be provided at each sink to prevent cross-contamination. If bar soap is used, it must never be left to lie in water. Disposable paper towels should be used at all sinks.
Score No:	The above standards are not met.

24. Physician's office has a procedure for handling patients with potentially contagious illnesses.

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Score Yes:	Physician's office has a procedure for handling patients with potentially contagious illnesses, e.g., separate waiting room, separate entrance, and control infection protocols.
Score No:	Physician's office does not have a procedure for handling patients with potentially contagious illnesses, e.g., separate waiting room, separate entrance, and control infection protocols.

25. There must be a procedure for the handling and sterilization of reusable equipment and supplies.

Score Yes:	The physician's staff must demonstrate maintenance and knowledge of these standards. Personal protective equipment, such as gloves, should be made available. The reviewer should: • Determine methods used. • Note whether disinfectant containers are labeled with the type of solution and if the solution is clean or dirty. • Identify whether the date for the next change of solution is clearly marked on the containers. (Are they following their standards or those recommended by the manufacture of the solution?). • Note whether all sterilized items are labeled with an expiration date. (It is generally recommended that plastic wrapped items be re-sterilized in 6 months, and towel wrapped every 30 days.) All the above standards must be met to receive a score of yes.
Score No:	The physician's staff are <u>not</u> aware of, <u>nor</u> do they practice these standards.
Score N/A:	Note, if only disposable equipment is utilized.

26. All patient care areas must be clean and disinfected.

Score Yes:	The physician has a procedure to ensure the cleanliness of the patient care areas. The staff should be aware of these procedures. These include universal precaution procedures to minimize transmission of infection, sterilization maintenance logs, knowing how to disinfect a room used by a patient with an infectious disease and routine cleaning procedures.
Score No:	The physician does <u>not</u> have a procedure in place, or the office staff are <u>not</u> aware of the procedure.

27. There must be a procedure for the handling the disposal of non-reusable items.

Score Yes:	The physician's office should have containers clearly marked "Not Reusable." Regulated or contaminated waste, such as contaminated sharps containers or laundry, should be labeled with a fluorescent orange or orange red "Biohazard" label or disposed of in a red container or bag. All the above standards must be met to receive a score of yes.
Score No:	Containers are <u>not</u> clearly marked.

28. The office has procedures for evacuation in the event of external emergency such as fire, tornado, bomb threat

Score Yes:	There must be a patient evacuation plan as designed by the office staff or from the building management available. Staff is familiar with the plan.
Score No:	There is <u>no</u> plan and/or staff <u>not</u> familiar with procedure.

29. The office has procedures and equipment for patient in office emergency events.

Score Yes:	The physician has appropriate emergency equipment and procedures available. Procedures should address emergencies such as respiratory arrest, trauma and patient reaction to medications or procedures. If a practitioner performs minor office procedures, (s)he should have emergency equipment available. If there are <u>no</u> emergency supplies available, document reasons in the comments section and submit for Medical Director review. A common list of required medications, supplies and equipment are oxygen, ambu-bag, airway and emergency drugs (e.g., Epinephrine, Lidocaine, Dextrose.)
Score No:	The physician does <u>not</u> have appropriate emergency equipment or procedures to address medical emergencies.

30. One staff member other than the physician must be trained in emergency measures such as CPR.

Score Yes:	At least one staff member is CPR certified.
Score No:	No staff member is CPR certified. Evidence of CPR was expired.

31. There must be evidence that the office maintains a log indicating that regular inspection and maintenance has occurred on all equipment such as oxygen, radiology, and lab equipment; fire extinguisher and/or other equipment.

Score Yes:	The physician's office has a written quality control policy on equipment maintenance. The office follows the written plan. This would include routine maintenance of fire extinguishers, defibrillator, crash cart and any other equipment in the office. Review the maintenance schedule.
Score No:	The office does not have a written quality control policy on equipment maintenance, or if the office has a written plan, it does not utilize the plan.

32. All calls must be routed to the appropriate staff member.

Score Yes:	The physician has a call triage procedure to ensure calls are routed to the appropriate staff member.
Score No:	There is no procedure.

33. Regular office hours must be scheduled to provide optimal availability of the physician. Considering that the practice in Puerto Rico is usually that patients are evaluated by the physician according to the time of arrival, a

specific appointment time is not provided. Most PCP appointment are by date not time; the procedures are known and understood by appropriate staff members. For example, the person responsible for scheduling appointments knows the definition and procedure for office visits.

Score Yes:	Appointment procedures are known and understood by appropriate staff members and scheduling falls within specified time frames.
Score No:	Appointment scheduling does not fall within specified time frames. Routine appointments within 14 days.
Score N/A	Provider does not schedule that type of appointment.

34. There should be provisions for 24-hour, 7-day-a-week care. Provisions and instructions for seeking 24-hour care.

Score Yes	The physician has provisions for 24-hour, 7- day-a week care. After office hours, the physician has either a well-informed answering service or a detailed answering machine message that provides instructions for access to after-hours coverage and emergency care.
Score No	The physician does <u>not</u> have 24-hour coverage or adequate arrangements and instructions for after-hours care.

35. Medical chart record retention policy.

Score Yes	The physician has medical chart record retention policy. For inactive member's medical record retention for 5 years (PR), evidence to deliver the medical record to the member or evidence disposition with authorize companies.
Score No	The physician does not have Medical chart record retention policy

5.2 Ambulatory Preauthorizations

5.2.1 Preauthorization Philosophy

The Preauthorization Unit is accountable to determine medical necessity and appropriateness of services, procedures, and equipment. It also affords the opportunity to determine whether the services, procedures or equipment are a covered benefit for the member and whether the member can be directed towards in-network services when applicable and appropriate.

5.2.2 Objectives

The objectives of the preauthorization process include:

1. Promote appropriate use of medical services, based on the member's plan of benefits, without compromising quality of care, by monitoring the timeliness of care rendered, quality of care indicators and appropriateness of acuity levels and care settings.
2. Identify effects of under-utilization as well as over-utilization.
3. Provide a mechanism to access the continuity of care, minimizing complications as result of not accessing services.

5.2.3 Organizational Determinations Benchmarks

The program includes benchmarks and standards for the timely, fair and consistent review of preauthorization requests. MSO facilitates the service requisitions process providing physicians an electronic program for fast submission of the requests through our electronic portal InnovaMD, which is easy to use and guarantees the

security of the electronic transmission process. In addition, it improves the preauthorization determination turnaround time benefitting providers and members.

Internal audits are made to measure the quality of the performance. All requests are well thought out based on Regulatory Agencies like Medicare standards and regulations as follows. Final determinations are notified to members for expedite requests by telephone calls and for expedite and standard request by mail, as well for requesting and servicing providers are sent by fax.

5.2.3.1 Standard timeframes and notice

MSO will issue a response as fast as the member's health condition requires, and no later than 14 calendar days after the day the organization receives a request for a standard review. Notification of the determination is communicated to the member in writing within the 14 days of receipt of the request. Requesting and Servicing Provider receive the notification by fax within the time frame establish.

5.2.3.2 Expedite Determinations and notice

A member, or any physician may submit an expedite request for an organizational determination when they believe that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue could involve a claim for payment for services that the member has already received. However, if a case includes both

a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

Expedited determinations must be completed within 72 hours of receipt of the request.

Notification must be provided within the 72 hour time frame. Plan may notify the enroll verbally or in writing. If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification. If the Health Plan grants a request for expedited reconsideration, a notice will be given in accordance with the timelines for reconsideration. It is very important to receive the authorization request with all the necessary clinical evidence to facilitate the promptness of the final determination. The notifications of final determinations are sent to providers everyday by fax and to members by mail.

5.2.4 Organizational Determination Guidelines

The preauthorization requests are reviewed against established Clinical Criteria and other support systems as follows:

1. Medicare National Coverage Guidelines and criteria.
2. Local Medical Review Policy
3. Nationally Recognized Clinical Criteria.
4. Reasonable medical evidence or a consensus of healthcare professionals in a particular field.

5. Face-to-Face evaluation is used for Mobility Assistance Equipment.
6. Certification of Medical Necessity (CMN) applied to shoes for diabetic patients.
7. MCG evidence-based clinical guidelines, which are annually updated.
8. Sanford Guidelines.
9. Apollo Guidelines

When cases do not meet these criteria, these should be sent to a medical reviewer for final determination. Medical reviewer performs a final management of call to the requesting supplier in search of more information, prior to the final determination. On the other hand, through the provider's Call Center, a provider can contact a medical reviewer to discuss a case or a decision. If you are interested in a copy of these guidelines, you can call the service providers at the telephone numbers listed in this Manual.

5.3 Essential Information to Submit Preauthorization

Documents and/or information needed at the time to request some of the services that require Preauthorization

All requests should include clinical justification

Remember: At the time of requesting services it is very important to describe the symptoms and conditions of the member to justify the requested service. If all the information is provided properly, a request can be determined quicker.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
PET Scan/PET CT Scan	• Diagnostic test results (must include results of positive biopsies). • Procedures and results of previous X-ray studies. • Pre-treatment • Indicate if patient has not started treatment (chemo, radiation) • Signs and symptoms	• Detect cancer, validate effectiveness of treatment of chemotherapy or radiotherapy, and validate recurrence of cancer, cardiac, gastrointestinal, or endocrine diseases. Neurological disorders, differentiation of dementia vs. epilepsy, frontotemporal dementia, among others.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
CT Scan	• Procedures and previous studies results (X-rays, MRI, sonograms). • Previous treatments • Suspected diagnosis • Anatomic area (if applicable) • Signs and symptoms	• Utilized to evaluate tissue thickness. • Use radiation showing details of any part of the body, including the bones, muscles, fat, organs and blood vessels. • Used to diagnose: Cancer, tumors, calcifications, trauma, internal bleeding, among others. • Used for fracture that a simple x ray could not diagnose. • Used for very small fracture that cannot be displayed with details.
MRI	• Procedures and previous x-rays studies results, CT, x-rays, sonograms, EMG and NCV • Previous treatments • Suspected diagnosis • Signs and symptoms	• Diagnosis of cerebral disease, epilepsy, infections, inflammation, tumors, problems with the auditory canal, problems with the pituitary, nerves paralysis, some metabolic problems, heart damage, spinal cord

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		lesions, articulation damage, vascular problems, among others.
MRA	• Procedures and previous studies results (sonograms, noninvasive vascular studies) • Previous treatments • Suspected diagnosis • Signs and symptoms	• Aneurism, aorta conditions, stroke, hemorrhage, myelopathy, renal artery stenosis, vascular conditions, among others.
MUGA-78472	• Previous studies results like EKG, echocardiogram, MRI or Cardiac CT. • Indicate if patient will be operated • Diagnosis or suspicion	• Congenital heart disease, coronary artery disease, ventricular dysfunction, heart failure, diseases of the heart valves, among others.
MIBI-78452	• Previous studies results like EKG, echocardiogram, proof of non-diagnostic exercise (pulley). • Diagnosis related to chest pain of and/or suspects. • Symptoms • Indicate in the documentation if patient is suitable for pulley test. • Results of cardiac biomarkers (if applicable).	•Chest pain related to; coronary disease, ventricular dysfunction, cardiac arrest, heart valves disease, Diabetes, among others.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	• Indicate whether medication will be administered.	
Bone Imaging Whole body-78306	• Previous studies result like x-rays, serological laboratories, chemical biomarkers related to the diagnosis. • Diagnosis or suspicion • Symptomatology	• Breast, prostate, esophageal, or lung Cancer with suspicion of metastasis to the bone, osteomyelitis, sarcoma and bone deformities.
Automatic External Defibrilator-K0606	• Studies of electrophysiology (arrhythmia previous history) • Date of infarction (if applicable) • Family history of high risk (if applicable) • Percent of ejection (EF) recent	• Patients with diagnosis of dilated cardiomyopathy • Arrhythmias •Payment family or hereditary terms with high risk of life-threatening ventricular tachyarrhythmia, such as hypertrophic cardiomyopathy and long QT syndrome. • Patients with implanted defibrillator that requires to be removed for clinical reasons, which should be justified.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Oxígeno (gas, líquido, tanque H) Concentrador Gas- E1390 Portable Gas- E0431 Concentrador portable- E1392 O2 líquido-E0439 O2 líquido portable- E0434 Tanque H- E0424	• Recent results of oximetry or arterial gases, (30 days or less) resting, during effort, night or which apply • Respiratory equipment currently in use • Specify if it is gas or liquid, frequency, route and capacity. •Justification for tank H to be able to be evaluated, this is a service not covered by Medicare, and is considered not medically necessary since it is used as a "back-up" equipment by Medicare) "	• Respiratory conditions with results of less than or equal to 88% blood oxygen saturation. • Respiratory conditions with equal or less than 55 mg/hg blood gas results.
CPAP -E0601 O BPAP-E0471	• Results of two studies of sleep (diagnostic and qualification) • Progressive neuromuscular condition that justifies the use of the equipment (if applicable) e.g. sclerosis amyotrophic lateral, muscular dystrophy, spinal amyotrophy, among others. • Indicate if you require hot humidifier	• Diagnosis of Obstructive Sleep Apnea • Neuromuscular conditions • Severe COPD

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Oral Appliance	• Sleep study results. • Evaluation of the pulmonologist. • History of related conditions. • Documented contraindications to the use of Cpap or Bpap. • Neck circumference measurements. • Epworth scale score • BMI	• Diagnosis of obstructive sleep apnea. • Patients who cannot use the CPAP or BPAP machine for any justified reason.
Standard Bed- E0260	• Member diagnosis • Weight and height of the member (recent) • Capacity of patient (or caregiver) to operate the equipment safely.	• Patients requiring being positioned 30 degrees of elevation due to respiratory or cardiovascular conditions, risk of aspiration, among others.
Bariatric Bed- E0303, E0304	• Member diagnosis • Weight and height of the member (recent) • Patient's ability to operate the equipment safely.	• Patients requiring being positioned 30 degrees of elevation due to respiratory or cardiovascular conditions, risk of aspiration, among others. • More than 350 to 600 lbs. weight for Heavy Duty. •Weight of 601 lbs. forward for Extra Heavy Duty.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Mattress (foam-E0272, gel-E0185, innerspring-E0271, dry pressure-E0184)	• Member diagnosis • Weight •Specify which mattress is ordered. • Justification if you have less than the time required by Medicare.	• Potential development of pressure ulcers or already have them. • Urinary/fecal incontinence, nutritional deterioration, circulatory problems, sensitivity.
Alternate Pressure Mattress -E0277	• Member diagnosis • Weight •Specify which mattress is ordered. • Justification if you have less than the time required by Medicare. •Grade and localization of ulcers.	• Bed ridden patient has used other alternatives of mattress. •Patient is in a program for ulcer healing.
Rollator /Cleverlite-E0143+E0156	• Specify which equipment is requested since both uses the same coding. • Diagnosis • Patient's capacity to operate the equipment safely.	• Neurological conditions, rehabilitation (active process)
Regular Walker or hemiwalker -E0135	• Member diagnosis • Justification for equipment and attachments associated, if applicable. • Patient's capacity to operate the equipment safely.	• Limitation to walk that limit the ADL's, rehabilitation

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Commode (portable toilet)-E0163	• Member diagnosis • Member's weight • Patient's physical limitations to move. • Patient's housing conditions and home access to bathroom (establish need for equipment without or with removable armrests).	• Inability to use the toilet because of being confined to bed, does not have toilets at home, cannot leave your room, and is limited to one level of the home that has no health service.
Bariatric Commode (portable toilet)-E0168	• Member diagnosis • Member's weight • Patient's physical limitations to move. • Patient's housing conditions and home access to bathroom. •Specify if should have removable armrests (obese patients, wide hip who cannot use the regular commode).	• Inability to use the toilet because of being confined to bed, does not have toilets at home, you cannot leave your room, is limited to one level of the house and has no elevator. • Weight greater than 300 lbs.
Standard Wheelchair-K0001	• Member's diagnostic • Justification • Patient's capacity to operate the equipment safely. • Service duration • Patient's physical and cognitive limitations.to use the equipment.	• Limitation for ambulating or coordinate movements that limit the ADL 's • Rehabilitation • The patient's need cannot be resolved with a cane or Walker.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	• Adequate space at home for use of equipment.	•Patient can self-propel themselves, has a caregiver can assist him with the equipment.
Light Wheelchair-K0003	• Member's diagnostic • Justification • Patient's capacity to operate the equipment safely. • Service duration • Patient's physical and cognitive limitations to use the equipment.	• It meets the criteria for the standard wheelchair. • The patient's need cannot be resolved with a cane or Walker. •Patient cannot self-propel them self in a standard wheelchair, but can in one light, you have a caregiver can assist you with the equipment.
Ultra-light Wheel Chair -K0005	• Member's diagnostic • Justification • Patient's capacity to operate the equipment safely. • Service duration • Patient's physical and cognitive limitations to use the equipment.	• It meets the criteria for the standard wheelchair. • The patient's need cannot be resolved with a cane or Walker. • Patient not can self-propel themselves in a standard

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		wheelchair, a lightweight wheelchair is still very heavy, can be self-propelled in ultra-light Chair.
Heavy Duty Wheelchair -K0006	•Weight • Justification • Patient's capacity to operate the equipment safely. • Service duration • Patient's physical and cognitive limitations to use the equipment.	• It meets the criteria for the standard wheelchair • Weight of 350 lbs. or more.
Extra Heavy Duty Wheelchair -K0007	• Justification • Patient's capacity to operate the equipment safely. • Service duration • Patient's physical and cognitive limitations to use the equipment.	• It meets the criteria for the standard wheelchair. • The patient's need cannot be resolved with a cane or Walker. • Weight should be less than 350 lbs. but be the body constitution should be broad.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Transportation Chair-E1038/E1039	• Weight • Justification • Patient has a caregiver to operate the equipment safely. • Service duration	• Patient cannot move by itself. • Complies with the criteria of the standard wheelchair.
Reclining backrest - E1228	• Related diagnostics • Justification • Service duration	• Reclining backrest potential for development of pressure ulcers. • Patient is incapable of making changes in position or move. • Patient who were catheterized. • Helps increase the muscle tone.
Leg lifters-K0195	•Related diagnostics • Justification • Service duration	• You must have a wheelchair at home. • Has a musculoskeletal condition or has an immobilizer that prevents 90 degrees of flexion in knee. • Has a swelling in the lower limbs that require elevation of the legs.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		• Meets criteria for a reclining backrest.
Removable arms - E0973	• Related diagnostics • Justification • Service duration	• You must have wheelchair at home. • Patient requires a height in the arms different to which the wheelchair gives, passes at least 2 hours a day in the wheelchair (eg. Quadriplegic patients, hemiplegic or involuntary movements of the arms.
Safety belt -E0978	• Related diagnostics • Justification • Service duration	• You must have a wheelchair at home. • Patient has weakness in the upper muscles, instability in the body upper part or muscle spasticity (motor disorder).

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Motorized Chair-K0815 and others or Customized E1399, Scooter-E1230	• Complete Face-to-Face assessment in all its parts. • If it's required additional accessories. • Patient's ability to operate the equipment safely.	• Neuromuscular conditions that limit the ADL "s for example; inflammatory muscle disease, hereditary Neuropathies, distal myopathies, Myasthenia Gravis, among others." • The patient's need cannot be resolved with a cane, walker or standard wheelchair.
Cushion Chair E2601/E2602 and Back Cushion-E2611/E2612	• Member's diagnosis • Weight • Justification	• Must have a wheelchair. • Potential to develop ulcers or loss of sensation on contact due to prolonged daily use of wheelchair.
Standard Bath Chair/Bariatric - E0240	• Member's diagnosis • Weight	• Not covered by Medicare, send justification of need. • Preventing falls, amputation, vertigo, loss of vision, among others.
Trapeze-E0940-E0912	• Respiratory diagnosis • Weight • Justification (history of orthopedic surgery, etc.)	• More than 250 lbs. weight for Bariatric equipment.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		• Patient needs change of position or to lie down in bed.
Hydraulic crane - E0630	• Diagnosis • Weight • Justification (history of a bedridden patient in rehabilitation) • Service duration	• Patient needs to make transfers from the bed to a wheelchair or portable toilet and vice versa. • Must have two skilled caregivers to operate the equipment safely.
Cervical Traction - E0840, E0855, E0860	• Member diagnoses. • Number of pounds of traction.	• Patients with temporomandibular disorders, musculoskeletal or neurological impairment. • Distortion of the lower jaw or neck.
Suction Machine- E0600	• Justification and related diagnostics • Patient's ability to operate the equipment safely. • Service duration • Physical and cognitive limitations of the patient to use the equipment.	• Cancer or throat or mouth surgery, problems to swallow, loss of consciousness, or consciousness obtunding problems.
Strips excess - A4253 and lancets- A4259	• Diabetes Diagnosis (I, II) • Daily frequency of use	• Diabetics with glucose disorder requiring one frequency higher than that

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	•Justification to the surplus (history of usage of insulin pump).	provided for by Medicare; 1 day for not insulin dependent and 3 daily for the insulin dependent.
Continuous Glucose Monitor-K0553 / K0554 (CGM)	•Diagnosis of diabetes (I, II). • Justification for use	• Diabetic members with poor glucose control, who additionally also use regular glucometers and supplies. • For patients who are monitored 4 times a day or more • For patients using an insulin pump who require frequent dose adjustments
Insulin Pump-E0784	• Diagnosis of diabetes (I, II). • Document treatment failure and complications •Symptoms • A1C lab results	• Indicated for diabetic patients with uncontrolled diabetes that does not improve with the prescribed treatment, it must include justification.
Blood pressure monitor-A4670	• Member coverage • Does not require preauthorization	• Diagnosis of HBP in pharmacological treatment (it is an added benefit of coverage, not all patients

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		have it). Preauthorization not required.
Enteral nutrition	Justification and related diagnoses. • Specify the name of the feed. • Number of cans or kcal per day. • Specify that it is via PEG or gastrostomy • Specify if it is by gravity or by machine. • Does not require preauthorization	• For patients with dysphagia who have gastrostomy or PEG. • Patients with poor absorption or disease of the intestines.
Nutrimas	• Member coverage.	• Added benefit of post-hospital discharge meals that has an annual limit.
Benefit of meals at home	• Member coverage.	• No medical order is required. • Member can request it
Oral feeding supplements	• Specify the name of the feed. • Number of cans or kcal per day. • Specify that it is for oral use.	• Patients with low weight or cachexia. • Patients with micronutrient deficiencies (vitamins and minerals). • It is an OTC benefit
Equipment Repair - K0739	• Specify which one is the damaged equipment.	• The damaged equipment is evaluated depending on the time that the member owns

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	• Specify what happened to the equipment • Specify how long the patient has had the equipment or if is of their property.	it (warranty vs. 5 years according to Medicare). • If it can't be fixed, a new medical order will be requested to evaluate the need for new equipment.
Oxygen Repair- K0740	• Specify which equipment is damaged. • Specify what happened to the equipment. • Specify if oxygen was approved by the plan.	• The damaged equipment is evaluated depending on the time that the member owns it (warranty vs. 5 years according to Medicare). • If it can't be fixed, a new medical order will be requested to evaluate the need for new equipment.
Prosthesis	• Evaluation of the Physiatrist (if it is the first time that the member will use it) • Evaluation of the cardiologist (for members with a history of coronary artery disease)	• Primary or secondary arthritis • Rheumatoid arthritis, Avascular Necrosis, osteoarthritis • Amputation, Cancer
Mastectomy bra, lumbar belts and knee orthosis	• Medical order that includes the diagnoses related to the equipment. • Bra size	• Patients operated on for mastectomy. • Patients requiring stability.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	• Lumbar belts; specify if it is rigid or semi-rigid	• Patients with weakness or deformity. • To rehabilitate an injury and relieve pain.
Compression stockings	• Medical order that includes the diagnoses related to the equipment. • Measurements and parameters in mm Hg	• For the improvement of venous disease, prevention of varicose veins, post-thrombolytic syndrome and venous thromboembolism in bedridden patients.
Pneumatic compression device	• Medical order that includes the diagnoses related to the equipment • Documentation of previous failed treatment	• For patients with chronic venous insufficiency, lymphedema, dermatitis or stasis ulcers, which a conservative treatment has not benefited.
CPM (Continuous Passive Motion)	• Medical necessity or clinical justification and diagnoses related to the equipment	• Indicated for patients with a diagnosis of osteoarthrosis of the legs, tear of the

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		cartilage or meniscus of the knee, patients in a post-arthroscopic knee procedure within the first 10 days.
Therapeutic shoes, orthopedic shoes and inserts for diabetic members	• Diagnosis of diabetes (I, II). • CMN (Medical Necessity Certificate) • Specify whether they are regular or made to- measure and justification.	• For diabetic patients wearing hooks or braces. • For diabetics with blood circulation problems, foot deformity, history of ulcers, loss of sensation in the foot, corns, ulcers and / or if the limb has had an amputation
Nebulized Therapy	• Medical necessity or clinical justification and diagnosis for changes in continuity of the present treatment or treatments. • Amount and frequency of use (number of vials).	• Asthma, COPD, other respiratory conditions that deserves the use of nebulized therapy, for example; cystic fibrosis, pneumonia, influenza, bronchitis, among others.
Intravenous Medication Therapy	• Name of the medication, dosage, via, frequency and continuity of service. • Diagnosis justifying the service.	• Clinical justification supporting the requested service.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
	• Related laboratories (if applicable), as sensitivity cultures, CBC, chemistry, etc.	
Wound Care	•Wound description (measures and grade), anatomical area, photos and clinical documentation. • Name of the medication for the treatment.	• Diagnosis related to wounds
EECP (Vasotherapy)- G0166	• Result of catheterization in percentages or study of image. • Cardiovascular studies invasive and non-invasive. • Certification of cardiologist (rational for that member is high risk to undergo bypass grafting (CABG). • Classification of angina (III or IV) and evidence of no PAD or PVD venous disease. • Drugs related to diagnosis.	• Angina in patients with SIHD (Stable Ischemic Heart Disease) • Failed surgical or percutaneous revascularization procedures. • Patient is not a candidate for bypass surgical or percutaneous further due to comorbidity or coronary Anatomy not susceptible of revascularization.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Cyberknife (SRS)	• Order with related diagnoses. • Clinical justification that supports the requested service. • Karnofsky Performance Scale	• Indicated for patients with brain lesions, benign brain tumors, trigeminal neuralgia, brain cancer, metastasis to the brain and / or other organs
Hyperbaric Chamber (HBO)-99183	• Service/modality, frequency, and duration of treatment, results of PTCO2	• Ulcers (photos required) • Radiation necrosis • Osteoradionecrosis
CORF (Comprehensive Rehabilitation Outpatient Facility)	• Medical history of your condition, current diagnosis, clinical findings, expected goals of rehabilitation and which are directly related to an injury or disability.	• Disability, malformation or amputation of a limb, outpatient.
Home assistance services (In Home)	• Member coverage • Medical order specifying the services the member needs.	• Member must not be active in a care program such as: Municipal Housekeeper Program,

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		Veteran's Hospital Housekeeper Program or others. • Member must not be hospitalized or residing in a long-term care facility, Nursing Home, Community Care Centers and / or admitted to a Rehabilitation Center. • For patients with at least one of the following conditions: CHF stage 3 or 4, COPD stage 3 or 4, heart attack and / or stroke with residual neurological deficit, temporary disability, bedridden or other condition that affects the member to perform the tasks of daily living.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Genetics Laboratories	• Diagnosis or suspicion • Laboratories from (if applicable), such as CBC, chemistry, biomarkers (if applicable). • Identify if patient is in active treatment or completed chemotherapy, few lines of treatment been used, if applicable.	• Cancer diagnosis, for constitutional or acquired abnormalities. These tests also may be ordered to establish specific treatment before a diagnosis of malignancy or verify the combination of different regions of the chain of DNA and RNA markers.
Sleep Studies- 95805,95807,95808, 95810 and 95811	• Diagnosis of OSA • History of obesity or respiratory conditions. • Symptoms	• To diagnose OSA, parasomnia, narcolepsy, RLS, among others.
Procedures of nails/divisions or skin biopsies	• Identify which procedure will be (cutting, debridement, removal etc.) • Nails: Identify anatomical area (which finger, which hand). • Skin: Identify anatomical area, size of the lesion.	• Biopsies / divisions: conditions requiring taking tissue to diagnose or treat a specific lesion of the skin (tumors, mass, etc.) among others. Need to remove dead tissue, callus. •Nail: thickening, fungus, ingrown, infection and abscesses.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Lithotripsy -50590	• Results of previous as KUB, sonogram, or abdominal/pelvic CT studies. • Location and size of the stone	• Kidney stones. Patient should not have coagulopathy, blockage or arterial aneurysm.
Cochlear implant	• Audiometry results. • Must specify if the member has no contraindications for surgery	• Diagnosis of bilateral moderate to profound sensorineural hearing
Penile Implant	• Diagnosis and classification of impotence (organic or inorganic) • Therapeutic failure of medications for erectile dysfunction. • Written consent of the patient. • Medical history • Related laboratories	• Patients diagnosed with erectile dysfunction with therapeutic failure who have intact libido.
Green Laser Therapy for BPH-52648	• Since when does diagnosis of BPH • Results of urodynamic studies, residual volume. • Score of AUA (American Urology Association) • Indicate if patient is high-risk surgery, TURP.	• Benign prostatic hyperplasia

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Diagnostic endoscopy -43235 / ligation of varicose veins -43244	• Identify which procedure • Diagnosis or suspicion • Symptoms • Personal or family history of cancer	• Bleeding, esophageal varices, Crohn's disease, dysphagia, among others.
Cystoscopy -52000	• Diagnosis or suspicion • Laboratories from (if applicable), as sensitivity cultures or urinalysis • Symptoms	• Hematuria, urinary problems, obstruction
Corneal transplants	• Specific medical order and requested code. • Type of transplant (epithelial, lamellar, etc.) • Last eye examination in 12 months or less. • The eye diagrams. • Specific court (PKP, Deska, LKP)	• Patients with loss of vision, severe, thinning, opacity, inflammation or ulcers of the cornea, between other.
Transplantation of amniotic membrane	• Specific medical order and requested code. • Type t size of the membrane • Last eye examination in 12 months or less. • Diagram of the eye.	• Patients who have had extensive conjunctival resection (usually by tumors or scars), as well as ulcers and corneal and conjunctival epithelial defects.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
Surgeries: eyes,	• Clinical history and previous treatments related to diagnosis	• Eyes; cataracts, glaucoma, the eye capsule opacification, macular edema, retinopathy, high eye pressure etc.
Cataracts surgery - 66982,66983, 66984	• Snellen Chart results, findings of tonometry, evidence of limitation to perform activities of daily living (ADL's), symptoms.	• Cataracts, glaucoma
Gastric "Bypass" obesity (Bariatric surgery)- 43645,43770, 43775,43845	• BMI • Diagnosis related to obesity • Time carrying on continuous tx for obesity without success. • Results Helicobacter Pylori • Evaluation and recommendation of a psychiatrist. • Letter of each of the specialists who recommended surgery. • (PSG) sleep study results	• BMI greater than 40 • Conditions related to obesity, such as: Musculoskeletal disorders, cardiovascular and metabolic.
Rhinoplasty, Abdominoplasty, Septoplasty, Blepharoplasty, Breast Reduction, MOHS surgery and	• Rhinoplasty, Abdominoplasty, Septoplasty - medical treatments, medical history. • Blepharoplasty - requires Visual fields, photos.	• Clinical evidence that demonstrates that the surgery is not for cosmetic purposes.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
other potentially cosmetic procedures	• Breast reduction-size bust, symptoms and pre-treatment (e.g. Physical therapy, medications).	
Speech Generating Device	• Speech pathologist evaluation. • Evidence of the member's cognitive and physical abilities • Diagnosis related to speech impairment	• For people with visual and motor disabilities or learning disabilities, who need help to improve their independence and communication skills.
Watchman	• Evaluation of an electrophysiologist and an interventional cardiologist. • CHADS2 and / or CHA2D2-VASC results. • Documented anticoagulant treatment failure.	• Indicated for patients with valvular atrial fibrillation with justified therapeutic failure.
PAVR/TAVR/TAVI-33361,33362,33363, 33364,33365,333666 ,33367,33368 and 33369	• Evaluation of cardiovascular surgeon who recommended surgery. • Results of studies such as EKG, Echocardiogram, MIBI	• Aortic stenosis, aortic of porcelain, absence of endocarditis and sepsis. Co-morbid conditions that affect the aortic valve.

Services and Codes	Documents to include	Some clinical indications and necessary criteria by which would apply upon request
		• Must have contraindications to anticoagulation.

5.4 Care Management Program

5.4.1 Overview

MSO has developed a comprehensive Care Management Program (CMP) that is member-centered, and the PCPs serve as the member's primary point of contact for care coordination. CMP is a bio-psychosocial model acting as an effective collaborative process that facilitates effective teamwork between members and their healthcare team to focus on high quality services, expertise and targeted interventions aligned to member's needs. Our CMP utilizes evidence-based guidelines (MCG - Milliman Care Guidelines) among other clinical guidelines to educate members about self-care to improve health outcomes. This model incorporates biopsychosocial factors that play a significant role in human functioning in the context of disease or illness.

MSO assesses the health plan population to define the stratification of the population in the Care Management Programs (CMP) and reviews the established criteria for each one in order to provide services to cover population needs according to stratification. The CMP incorporates the following programs to promote self-management, adequate transition of care, continuity of care, active decision-making, and participation in healthcare interventions and outcomes:

a) Complex Case Management

b) Disease Management

c) Health Education

d) Discharge Planning (Care Transition)

All programs are available to the member which present high-risk clinical and psychosocial factors based on risk assessment stratification and other referral sources such as; high-utilization, chronic illness, frailty flag, polypharmacy, transitions among others. The CM Programs perform member's assessments to review health outcomes, treatment options, self-care skills, availability of supporting system and/or caregiver involvement, treatment compliance as established by healthcare providers and opportunities and/or barriers to improve health care. The multidisciplinary care team members maintain direct communication with Primary Care Physician (PCP), Specialist and Caregivers to establish and update the individual care plans, coordinate services, assess treatment options, determine adequate levels of care, among others to promote cost effective actions quality of care, and member's empowerment in their health management.

The purpose of the CMP is to ensure that member's needs or problems are being adequately managed or addressed assuring quality of care, appropriate service coordination, continuity of care and consistent health improvement.

Care Management includes interventions such as:

1. Advocate obtaining services for members with complex needs
2. Establish communication with member's practitioner and other health related professionals.
3. Establish a point of contact for members, servicing providers and practitioners.
4. Provide education to member regarding conditions and self-management
5. Facilitate provider network management
6. Address quality of care issues when feasible
7. Identifies opportunities to establish action plans to obtain better healthcare outcomes.

The CMP team is composed of Case Managers, Social Workers, Nutritionist, Health Educators, Discharge Planners, Disease Managers, Wound Care Specialists, Care Management Assistants, Medical Directors and other qualified healthcare professionals, who assist the physician in achieving member's wellness and autonomy in their health condition management. Also, they act as a support to members, beneficiaries and practitioners throughout the care coordination and care transition processes to assure continuity of care providing seamless transitions. The physician may call to request CMP services for any member. PCPs and members are

notified in writing if they are identified as meeting the criteria and accept to participate in a CMP. The Pharmacy Department also collaborates and participates of the Complex Case Management Program Weekly Case Rounds and is available for consultation ad hoc.

MMM Care Management Program (CMP) is organized and focuses on the coordination and integration of services needed by members and their families during a defined episode of care, usually from admission to special care facilities through the transition to home or any needed service at home. The CMP also emphasizes on provider performance assessment, reduction in unwarranted practice variation, and information reporting elements that produce the best outcomes and most effective use of resources.

5.4.1.1 Objectives of the Care Management Program

1. Assure quality of care
2. Promote optimal clinical outcomes
3. Facilitate cost-effective resource utilization
4. Advocate in benefit of members and their families
5. Promote an appropriate plan of care (Individualized Care Plan-ICP) for each member.
6. Establish collaborative relationships with physicians and nurses at participating hospitals.
7. Ensure that all members receive the appropriate services, at the proper time and in the most appropriate setting.

8. Provide education to family members about the dynamics of the member's condition and the future care that will be required.
9. Coordinate and integrate member care services with providers.
10. Facilitate member and family access to health services and providers.
11. Coordinate member and family needs with appropriate benefits and community services.

1.4.1.2 The Care Management process includes but is not limited to the following:

1. Monitor and measure along the continuum of care
2. Collect and analyze data
3. Validate quality outcomes
4. Document patient management in relation to clinical indicators
5. Promote the treating physician's authority over clinical decisions
6. Relate care management to the patient care continuum
7. Encourage scientific scrutiny of results and processes

5.4.1.3 Scope of Care Management Program

The extent of the CMP encompasses members in need of care planning, coordination with medical needs after hospitalization, those who cannot easily leave their home to receive necessary medical attention and members with disabilities, chronic conditions, or complex medical needs which need preventive health or dynamic interventions due to high risk levels.

5.4.2 Complex Case Management:

The Complex Case Management (CCM) is a bio-psychosocial and holistic approach to manage members with complex needs or high-risk members. MSO and the member's health plan assess the health plan population to define the stratification criteria established in the health risk assessment (HRA) and the predictive modeling tool approved by John Hopkins (ACG) and used to identify potential members to the CCM Program. In addition, the CCM establishes individual referrals performed by practitioners, caregivers, vendor and the member themselves to access CCM Services. The program criteria include:

REFERRAL CRITERIA **Has to meet 3 or more criteria**	
COMPLEX CASE MANAGEMENT	**DISEASE MANAGEMENT**
€ ***Utilization Criteria*** € **Multiple Admissions: More than 3 admissions within 3 months** € **Readmission within 30 days with same/similar diagnosis** € **Multiple ER Visits: More than 3 per month** € ***Major Surgery*** € **Mejor Trauma (MVA, TBI, etc.)** € **Bariatric Surgery** € **Major organ transplant** € ***Chronic conditions (4 or more)***	€ ***Has Chronic Condition*** € ***Congestive Heart Failure*** € Symptomatic w/o Echocardiogram € Hx. AMI and / or Pericardial Effusion and/or Endocarditis € Lack of adequate medications (ACE Inhibitors; Beta-blockers, Diuretic) € LDL >150 € ***Asthma***

€ ***Catastrophic Conditions*** € **HIV** € **End Stage Renal Disease** € **Active Cancer Under treatment** € **Multiple Sclerosis** € **Amyotrophic Lateral Sclerosis** € ***Polypharmacy*** **(30 or more prescriptions per quarter)** € ***Psycho-social Risk*** € **Access to care** € **Non-domiciled** € **Unable to travel** € **Cost of care** € **Inability to care for self** € **Recent falls** € ***Significant Change on Health Status*** € **New catastrophic Diagnosis** € **Diabetic with serious complications (amputation, infected ulcers)** € **Metastasis Cancer – New Diagnosis**	€ Has no prescribed medications to manage condition € Use of rescue medications (e.g. Albuterol, Ipratropium) € Oxygen dependence € ***Diabetes Mellitus*** € Newly diagnosed € Insulin dependent or use of Insulin Pump € A1c>9% € No monitoring € ***Chronic Obstructive Pulmonary Disease*** € Multiple Admissions: More than 3 admissions within months due to the above chronic condition € Readmission within 30 days with same/similar due to the above chronic condition. € Multiple ER Visits: More than 3 per month due the above chronic condition.

The CMP aims to obtain access to care and continuity of care. It also integrates an Interdisciplinary Care Team (ICT) as part of the Individualized Care Plan (ICP) development that is updated according with the member's management needs.

The scope of this program is based on member's health outcomes, quality of care and adequacy of services. It works collaboratively to:

1. Improve or develop Self-management Skills
2. Facilitate Coordination of Care
3. Perform Medication Review to assure adequate treatment plan and compliance
4. Promote Continuity of Care
5. Support members through transitions
6. Facilitate Benefits Accessibility
7. Improve Quality of Care
8. Assure Access to Care
9. Guarantee adequate Utilization Management
10. Support Condition Management
11. Integrate relatives, health professionals and other resources and promotes communication among them

5.4.2.1 <u>The objectives of the program are:</u>

1. Address members' needs to keep members with complex needs in their community and with the necessary resources to maintain the highest functional status possible, identify issues that might interfere with the provision of care and manage them effectively.
2. Improve members' health outcomes empowering them to have better control of their diseases through education, service coordination and orientation, medication review, monitoring and integration of available resources.

3. Improve member's satisfaction promoting an adequate customer grade of service.
4. Ensure adequate transitions of care through collaborative interventions and communication integration.
5. Facilitate the coordination and continuity of care promoting adequate network utilization, interdisciplinary care team interaction and member/caregiver participation on ICP development and update.
6. Increase member's self-management skills providing education based on clinical guidelines.

5.4.3 Disease Management

The Disease Management Program (DM) Program is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies population with chronic conditions such as members with CHF, Asthma, COPD, Hypertension and Diabetes. It is a system of coordinated healthcare interventions and communications for populations with conditions in which patients' self – care efforts are significant. The DM Program supports the physician or practitioner / patient relationship and plan of care, emphasizes preventions of exacerbations and complications utilizing evidence – based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health. It involves a multidisciplinary care team that provides holistic care.

The Disease Management Program has adopted clinical guidelines from recognized sources. Clinical guidelines are systematically developed; evidence-based statements that help practitioners make decisions about appropriate healthcare for specific clinical circumstances. The clinical practice guidelines utilized for Diabetes, Heart Failure, Hypertension, Coronary Artery Disease, Treatment of Patients with Major Depressive Disorder and Preventive services for adults are identified from recognized sources as, Institute for Clinical Systems Improvement, American Diabetes Association among others. Clinical practice guidelines and preventive guidelines are reviewed and updated annually by the Medical Director and Chief Medical Officer and published at the InnovaMD Providers Portal. On a quarterly basis a check process is completed to verify the update of the current guidelines, if the new version is available, the guideline is presented in the QIC as an established process.

5.4.3.1 The scope of the Disease Management Program is to:

1. Ensure that members are properly identified and stratified for the program based on the established criteria.
2. Ensure that all members served in the program have a comprehensive needs assessment.
3. Ensure that all active members in the program have a personalized care plan with interventions to meet the identified needs.
4. Ensure that the member's care services coordination, as well as the appropriate treatment, are provided in an efficient and effective manner.
5. Ensure members accessibility to available community resources.

6. Manage medical benefit resources effectively and efficiently while ensuring quality care is provided.
7. Identify and manage the variance of care outside the established care plan resulting in utilization or quality issues.
8. Promote communication within all related departments to benefit member's care.

5.4.3.2 Objectives of the Disease Management Program:

1. Assure quality of care
2. Promote optimal clinical outcomes
3. Facilitate cost-effective resource utilization
4. Advocate in benefit of members and their families
5. Promote an appropriate care plan for each member
6. Promote self-management in members with chronic conditions
7. Establish collaborative relationships with member physicians
8. Ensure that all members receive the appropriate services, at the proper time and in the most appropriate setting.
9. Educate member and caregivers regarding condition management and services.
10. Coordinate and integrate member care services with providers
11. Facilitate member and family access to health services and providers
12. Provide member with appropriate benefits and community services as needed

5.4.4 Discharge Planning and Care transition Unit

The Discharge Planning and Care Transition Unit is a bio-psychosocial model that includes members, their families and support systems to promote a seamless transition among levels of care accessing appropriate resources and/or services in a timely manner. The unit works collaboratively with Utilization Management, Complex Case Management, Quality program, Health Education and Disease Management, to design, monitor and follow-up the appropriate care plan for the served population as part of the discharge process. The unit's role continues to evolve to meet the needs of members. Utilization Management tools and the emphasis on community partnerships were driving forces in this new expanded and integrated role.

5.4.4.1 The scope of the Discharge Planning and Care Transition is to:

1. Ensure appropriate discharge planning coordination from Inpatient Facilities and other care settings.
2. Perform Pre-Authorizations and coordination of member's required services to ensure continuity of care after member's discharge.
3. Collaborate with Inpatient Facilities in order to promote communication and integration of member's health care providers.
4. Ensure members' seamless transition to the appropriate level of care.
5. Manage an effective comprehensive assessment to assure member improvement after transition through member's health perspective assessment, medication review, care plan development and updates,

medical appointment and community resource coordination when feasible among other interventions.

6. Identify changes in needs to intervene quickly and appropriately to avoid unnecessary readmissions.
7. Maintain direct communication with member's health providers to inform member's health status when provider action is required according to the member's assessment and identified needs.

5.4.4.2 The objectives of the unit are to:

1. Support members through transitions from hospital to home or ambulatory care to Skilled Nursing Facility or Rehab Facility.
2. In liaison with hospital identify admitted members with special needs to address or solve transition of care issues in order to maintain members healthy and/or stable in their community.
3. Promote an adequate care transition during each member's discharge planning process through the proactive service coordination and follow up after discharge, to solve or address clinical and/or social issues.
4. Perform an acute case management by comprehensive assessment, appropriate after discharge follow up and solve problems or needs coverage through a multidisciplinary care team based on a bio psychosocial model.

5. Reduce unnecessary hospitalizations and readmissions by early identification and appropriate intervention, promoting continuity of care, and assuring quality of services for the population served.
6. Assure appropriate discharge planning coordination from Inpatient facilities, optimizing the member's transition to the appropriate level of care.
7. Promote continuity of care based on individual needs between a hospital and alternate levels of care.
8. Collaborate with the patient, family, and healthcare team to facilitate discharge planning.
9. Recommend options for the continuing care of the patient and refer to programs or services that meet the patient's assessed needs and preferences.
10. Liaise with community agencies and care facilities to promote patient access, address gaps in service Provider support and encouragement to patients and families during the stages of assessment and discharge from the hospital.
11. Reduce the cost impact of hospitalization and emergency room services from members managed by the Discharge Planning and Care Transition Unit.

5.4.5 Health Promotion and Education

The Health Promotion and Education Program (HE) is responsible for developing and implementing educational interventions aimed at helping members and their

families/significant others, to understand and cope with the management of diagnosed conditions. This is to be accomplished by providing participating members educational interventions that are conducive to health and by providing an opportunity to members and families to engage in behavior that will improve and promote good health.

5.4.5.1 The objectives of the HEP are to:

1. Provide insights for health decisions and encourage changes when making these decisions.
2. Understand how to design health education programs and persuasive messages.
3. Provide learning experiences and the voluntary actions people can take, individually or collectively, for their own health, the health of others, or the common good of the community.

5.4.5.2 The scope of the HEP is to:

1. Identify the population with educational needs according with the risk levels established.
2. Plan educational strategies focused on health maintenance, promotion of healthy lifestyles and prevention of complications.
3. Implement and carry out educational strategies to impact the identified population.

4. Evaluate the educational strategies implemented to measure the achievement of the goals established and create future goals.
5. Maintain open communication among the Health Services departments that also intervene with the population identified to optimize care results.
6. Report the achievements and results obtained as evidence of the strategies implemented.

5.4.6 Organizational Structure

MSO's Care Management professional staff is composed of physicians, registered nurses, social workers, nutritionists, health educators, and others. Members of the administrative staff support all functions.

5.4.7 Roles and Responsibilities:

1. ***Medical Director***

   To oversee clinical guideline development, resolution of clinical issues and implementation of physician education related to the program.

2. ***Social Worker***

   To assist in the implementation of member outreach services, community referrals and home assessments as needed.

3. ***Nutritionist***

Evaluates the nutritional requirements and creates individualized nutritional plans for members.

4. ***Health Educator***

To develop, implement and evaluate member education activities and identify community resources and organizations related to comorbidities such as Diabetes, CHF, Cardiovascular Disorders, etc.

5. ***Care Manager***

Assess, facilitate, plan and advocate for health needs on an individual basis, including identifying and providing alternative care management solutions, resource coordination and member/member referrals.

6. ***Data Analyst***

Identifies and tracks disease specific clinical indicators. Monitors and evaluates results of program activities and determines outcomes. Assists in the production of reports, evaluates claims data, tracks, and monitors cost-containment.

5.4.8 Outcome Measures

The Care Management Program uses indicators to determine the success of the interventions for members and practitioners. Through an annual review process, benchmarks are identified, and goals are established for the following year. The indicators are measured against goals on an annual basis. Indicators for the program include cost and quality.

5.4.9 Care Management Program Participation

To request CMP services, providers should complete a "Referral form" and send the form via fax to 787-999-1742 or e-mail caremanagementreferrals@mmmhc.com. Upon referral, care managers will screen for appropriateness and urgency of initiating services. If the referral is accepted, care managers will proceed intervening with members in collaboration with PCPs and any relevant members of the healthcare team. If the CM referral is not accepted, the referral source will be notified and provided with the reason for not accepting the referral.

5.4.10 Support Programs:

The following table represents the additional support programs for Care Management.

SUPPORT PROGRAM	GENERAL DESCRIPTION
Tobacco Cessation Program/Smoking Cessation **(Break the habit)**	Designed to help members who wish to stop using tobacco products, as well as those who have quit using tobacco products to prevent a relapse
Educational Campaigns	Geared to promote healthy lifestyles, preventive services and treatment adherences. Main interventions are focused on decreasing incidences and prevalence of chronic conditions among members.

Home Visits	Aimed at helping members and their caregivers or significant other, to understand and manage chronic conditions through individualized interventions.
Tele Health	Clinicians can remotely monitor patients' vital signs and send them short surveys about their health status. This combination of objective data and subjective responses enables a clinician to make more timely care decisions and helps prevent unnecessary hospitalizations.

5.5 Transportation Unit

5.5.1 A. Philosophy

The Transportation Unit (TU) is an added value initiative from the Health Services Department in order to eliminate healthcare access barriers due to transportation limitations. The services are provided in a different level of care of nonemergency transportation, including ambulance, compact cars, handicapped bus with ramp and others.

The ambulance service (Non Emergency Ambulance) requires medical order and preauthorization process, must be clinically justified by a certified physician.

The compact cars and handicapped bus with ramp (Non Emergent Non Ambulance) it's a benefit for certain plan coverage. This benefit does not require prior authorization, but plan coordination is a must. It is a benefit for certain plan coverage options.

The Unit provides services to members who need transportation as part of their healthcare services, such as: hospital discharge, medical appointment, and ancillary and dialysis treatment.

The goal of the Transportation Unit is to ensure the availability of efficient, cost-effective, and high-quality transport services for members who need these available services.

5.5.2 Purpose

To provide eligible members high-quality, non-emergency and medical transportation services to access medical care, when no other transportation is available. Delivery of service is safe, prompt, and cost-effective and considers the member's health care needs. Staff and contractors are courteous, professional, and knowledgeable of a Variety of services, such as:

1. Modes of Transportation
2. Arranging Transportation
3. Coverage Benefit
4. Contacting Providers
5. Community Transportation Services

If you have any question, you can call Providers Services at 787-993-2317 (Metro Area) o 1-866-676-6060 (Toll-Free).

5.6 Annual Health Assessment (AHA) Program

The AHA is a form created by the health plan to promote an annual clinical assessment visit to all members to evaluate current, acute, and chronic conditions

to improve the quality of their medical care. The form is completed online through www.innovamd.com by PCPs. Instructions and other tools are also available to help the provider to complete the form.

The form is subject to annual revisions by the Plan. All PCPs must comply with the following minimum criteria:

Complete the form in a face-to-face encounter with the member.

Review the member's medical history to evaluate and assess existing and new conditions during the AHA encounter.

5.7 Coding and Clinical Documentation Practice

The following information includes key guidelines of medical documentation and coding to assist our providers; however, coding and documentation requirements are not limited to the content of this document. Every provider is responsible for revising contractual agreements, applying official guidelines and resources to his or her daily medical practice and are up to date on current changes.

5.7.1 General concepts in clinical documentation

"If it isn't documented, it hasn't been done" is a principal in the healthcare setting (CMS, 2015). Medical documentation is a crucial instrument used in planning, evaluating, and coordinating patient care in inpatient and outpatient settings. The content of the medical record is essential for patient care, accreditation, and reimbursement purposes. Each encounter should detail information pertinent to the

care of the patient, documentation of the performance of billable services, and serve as a legal document that describes a course of treatment. Periodic audits, whether internal and external, ensure that the record adequately serves these purposes and meets federal and state regulations (Grider, 2011).

Regardless of the format, electronic (EHR) or handwritten, all entries in the patient record must be legible to another reader, reliable, precise, complete, consistent, clear, and timely (Hess, 2015).

5.7.1.1. Please take into consideration the following key points (First Coast, 2006)

1. The Plan expects documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame are acceptable for clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service. Late entries must comply with addendum guidelines:
    a. The date the record is being amended
    b. The details of the amended information
    c. A statement that the entry is an addendum to the medical record (An addendum should not be added to the medical record without identifying it as such).
    d. The date of the service being amended

e. Legible name and signature of the provider writing the addendum

2. The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
3. Notes must include member's name and date of service on each page. Provider's name, credentials, license number and signature must also be present.
4. Every encounter (clinical note) must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered (see addendum guidelines above). They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to substantiate medical necessity retrospectively. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
5. Do not use codes in clinical documents; write instead the diagnosis and service in medical terminology (words) and standard abbreviations. Verify and call your EHR carrier if the program is not describing the diagnosis or procedure in a complete and acceptable format.
6. Common in EHR; do not copy and paste medical information from encounter to encounter. Patient's care must be verified individually to ensure accuracy avoiding medical errors and overpayment.

7. Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10.

5.7.1.2 Follow these additional guidelines for notes written by scribers (office staff) or dictation:

1. Scriber's name, signature, dictation and scribing date/time must be present in the note
2. The provider must review what is documented by the scriber and make a statement indicating if he or she agrees with documentation.

5.7.1.3 Follow these additional guidelines for medical student/residents:

1. CMS required that teaching physician was physically present during the critical or key portions of the service. Herein are some key guidelines but please refer to Medicare Claims Processing Manual, chapter 12 for more information:

    a. Ensure that the care provided was reasonable and necessary.
    b. Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) and statement indicating if he or she agrees with the resident's documentation.
    c. Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

d. Entry must be cosigned and dated by the teaching physician.

5.7.2 Additional documentation guidelines for evaluation and management services (E/M)

According to CMS, medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT/HCPCS code. It would not be medically necessary or appropriate to bill a higher level of E/M when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

5.7.2.1 The documentation of each E/M patient encounter should include:

1. Reason for the encounter (Chief complaint).
2. Relevant present, past, social and family medical history.
3. Pertinent physical examination; any abnormal finding must be described.
4. Any objective data reviewed or interpretation of findings in labs or imaging studies.
5. Assessment, clinical impression, or diagnosis.
6. Medical plan of care for each diagnosis.
7. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

8. Time must be documented; especially, time expended in counseling or coordination of care.
9. Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10.

5.7.2.2 Provider must select and use one of the following E/M documentation guidelines:

1. 1995 Documentation Guidelines for Evaluation and Management Services. Available at: https://www.cms.gov/Outreach-an-Education/ Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/ 95 Docguidelines. pdf.
2. 1997 Documentation Guidelines for Evaluation and Management Services. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEd WebGuide/ Downloads/97Docguidelines .pdf
3. Additional guidelines provided by CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ Downloads/eval-mgmt-serv-guide-ICN006764.pdf

5.7.3 Additional documentation guidelines for surgeons or any provider performing surgical procedures (Grider, 2011)

Surgery reports (note) must include at least the following:

1. If applicable, name of co-surgeon or assistant physician.
2. Indications to perform the procedure, pre and postoperative diagnoses.
3. Positioning and draping of the patient.
4. Anesthesia administration.
5. Detailed description of the actual procedure performed; surgical approach, identification of incisions, instruments used, any abnormality, hemostasis, closure of surgical site and any other pertinent information.
6. Condition of patient when he or she left operating room.
7. Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10.

5.7.4 Additional documentation guidelines for radiologists or any provider performing imaging diagnostic/screening studies (ACR, 2014)

The following components must be present in the report, please refer to a detail version of it in the corresponding professional association or official regulation:

1. Demographics
2. Relevant clinical information
3. Body of the report
4. Procedure and materials
5. Findings
6. Potential limitations
7. Clinical issues
8. Comparison studies and reports

9. Impression (conclusion or diagnosis)
10. Standardized computer-generated template reports
11. Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10.

    a. Refer to section 5.7.3 if the performed service includes procedures such as catheterization, joint injections, and biopsy. These services may require both imaging interpretation report and surgical note to comply with documentation standards.

    b. For medical orders please see section 5.7.4

5.7.5 Additional documentation guidelines for clinical laboratories or any provider performing these types of services

Documentation of the laboratory report must clearly describe any information required by CMS, CPT, HCPCS or ICD-10**.**

5.7.5.1 Documentation of orders:

According to CMS, an order may be delivered via the following forms of communication:

1. A written document signed by the treating physician/eligible professional, which is hand-delivered, mailed, or faxed to the testing facility. Documentation in the medical record must show intent to order and medical necessity for the testing.

2. A telephone call by the treating physician/eligible professional or his/her office to the testing facility for transcription of a verbal order.
3. An electronic mail by the treating physician/eligible professional or his /her office to the testing facility.

If the order is communicated via telephone, both the treating physician/eligible professional or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. While a physician/eligible professional order is not required to be signed, the physician/eligible professional must clearly document, in the medical record, his or her intent that the test be performed.

5.7.6 General concepts in coding and billing

5.7.6.1 International Classification of Diseases 10th Rev. (ICD-10)

ICD-10 is an approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA). The Clinical Modification of the coding set (ICD-10-CM) is used for reporting diseases, disorders, symptoms, and medical conditions. The Procedure Coding System (ICD-10-PCS) is used to report inpatient (hospital Part A) services -hospitals under DRG contracts. Both coding systems include Official Guidelines for Coding and Reporting that providers must apply in their coding and documentation practices.

In addition to the above General Concepts in Clinical Documentation, for ICD-10-CM coding the provider must document for each encounter:

1. Complete assessment, co-existing diagnoses including the underlying condition and its complications/manifestations.
2. The manner the diagnosis is being treated, addressed, monitored and/or evaluated.
3. Do not code and report diagnosis stated as "rule-out" or other similar terms indicating uncertainty. Instead, code signs, symptoms, abnormal test results, or other reason for the encounter. Please refer to Section II. H of the ICD-10-CM Official Guidelines for Coding and Reporting for special instructions for inpatient facilities.
4. Always code the final result of a diagnostic test or procedure. If the final result is "normal", code sign and/or symptoms.
5. Always code the postoperative diagnosis of a medical procedure. Do not code the preoperative diagnosis since it may be changed once the procedure is done.

5.7.6.2 Healthcare Common Procedure Coding System (HCPCS)

HCPCS has been selected as the approved coding set for entities covered under HIPAA or reporting outpatient procedures. The first HCPCS's level is Current Procedure Terminology, Fourth Edition (CPT-4). It is based upon the American Medical Association. It includes three levels of codes and modifiers. Level I contain most common used codes for medical services and procedures. Level II (commonly referred as just "HCPCS") contains alphanumeric codes primarily for items and non-physician services not included in CPT; e.g., ambulance, DME,

orthotics, and prosthetics. These are alphanumeric codes maintained jointly by CMS and other institutions.

According to CMS, providers must report services correctly. Procedures should be reported with the most comprehensive CPT/HCPCS code that describes the services performed. Providers must not unbundle the services described by a HCPCS/CPT code. Some examples follow, providers SHOULD NOT:

1. Report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services.
2. Fragment a procedure into component parts.
3. Unbundle a bilateral procedure code into two unilateral procedure codes.
4. Unbundle services that are integral to a more comprehensive procedure.

Providers must avoid down-coding and up-coding. If a HCPCS/CPT code exists that describes the services performed, the provider must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. A HCPCS/CPT code may be reported only if all services described by that code have been performed.

Providers must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A provider should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service.

5.7.7 Plan's policies, contractual agreements and industry's official reference

Must also be used and followed when coding and billing for medical procedures and services including non-physician services. Some of these references are listed below:

1. Medicare National Coverage Determinations (Pub. 100-03)
2. Medicare Local Coverage Determinations
3. Medicare Claims Processing Manual (Pub. 100-04)
4. CMS Evaluation and Management Service Guide
5. National Correct Coding Initiative Policy Manual for Medicare Services.

Important, every code transmitted on a billing format (e.g., 1500) to the Plan must be the exact word-to-code translation of what is documented in the clinical note, diagnostic or procedure report for the specific member and date of service. The code must comply with the above standards and official references. Continued education and industry updates are essential in the providers' practice to maintain a high level of compliance.

5.7.8 Record keeping

All services billed may be subjected for future audits by the Plan or regulate agencies. Therefore, providers must maintain patients' medical record according to HIPAA and CMS guidelines. This includes keeping copy for at least 6 years from the date the service was performed.

Each provider is responsible to supply copy of the patient's record even if the service is performed in other facility that is not his or her own. For example, the physician

billed an inpatient visit 99223, he or she must keep copy of this visit note at his or her office even though the service was performed at the hospital.

5.7.9 References

1. Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2016. 1995 and 1997 Guidelines for Evaluation and Management Services. Extracted from: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf
2. First Coast. 2006. *Medicare B Update! Newsletter 3rd Quarter 2006 Vol. 4 Num. 3*. Extracted from: https:// medicare. fcso.com/ Publications_B/2006 /141067.pdf
3. Grider, Deborah J. 2011. *Medical Record Auditor: Documentation rules and rationales, with exercises, 3rd edition*. Chicago, IL: AMA
4. Hess, Pamela Carroll. 2015. *Clinical Documentation Improvement: Principles and Practice*. Chicago, IL: AHIMA
5. ACR. 2014. *Practice Parameter for Communication of Diagnostic Imaging Findings*. Extracted from: https:// www. acr.org/ ~/ media/ ACR/ Documents/ PGTS/guidelines/Comm_Diag_Imagig.pdf

6. CMS. 2017. *National Correct Coding Initiatives*. Extracted from: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

1. Each diagnosis must be documented using medical terms in words instead of codes. Providers may describe the diagnosis in medical terminology and standard abbreviations.
2. Each diagnosis must include evaluation and treatment plan evidencing how the physician is managing the condition.
3. All fields must be completed.
4. Maintain a copy of the AHA in the medical record. The form can be uploaded in electronic medical records.
5. Submit AHA forms before the cutoff date established by the Plan.

5.7.10 General Guidelines:

Complete the AHA form within 90 days from the date of service. Otherwise, you will have to re-evaluate the patient and submit the form again.

5.8 Clinical Guidelines

MMM adopt nationally approved clinical practice guidelines as the basis for our Care Management Programs. Clinical guidelines are systematically developed; evidence-based statements that help practitioners make decisions about appropriate healthcare for specific clinical circumstances. The effectiveness of the guideline is determined by scientific evidence, or in the absence of scientific evidence, expert opinion and professional standards. The Care Management Programs have adopted clinical guidelines from recognized sources. Clinical practice guidelines are reviewed and revised annually. Physicians or specialists will perform a review of research and literature prior to the adoption of guidelines. Upon notification of new information, all protocol

information will undergo a review of the information source and an assessment of costs and benefits to members in terms of the ability to improve outcomes prior to the decision to implement the change. The following guidelines have been adopted as the infrastructural support:

5.8.1 Asthma:

1. Diagnosis and Management of Asthma. December 2016, eleventh edition https://www.icsi.org/guideline/asthma-diagnosis-and-management-of/ https://www.icsi.org/wp-content/uploads/2019/01/Asthma.pdf

5.8.2 Chronic Obstructive Pulmonary Disease:

1. Diagnosis and Management of Chronic Obstructive Pulmonary Disease. Guide to COPD Diagnosis, Management and Prevention, 2016, https://www.icsi.org/wp-content/uploads/2019/01/COPD.pdf

5.8.3 Diabetes:

1. Standards of Medical Care in Diabetes, 2022 American Diabetes Association, https://diabetesjournals.org/care/issue/45/Supplement_12. Clinical Guidelines CKD and Diabetes 2020. https://www.kidney-international.org/article/S0085-2538(20)30718-3/fulltext

2. Clinical Guidelines HBP and Diabetes 2020. https://kdigo.org/guidelines/blood-pressure-in-ckd/

5.8.4 Heart Failure:

1. 2017 ACCF/AHA Guideline for the Management of Heart Failure A Report of the American College of Cardiology Foundation/American Heart Association

Task Force on Practice.

https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000509

2. Primary Prevention Cardiovascular Disease 2019.

https://pubmed.ncbi.nlm.nih.gov/30879355/

5.8.5 Preventive Services:

1. Health Care Guidelines: Healthy Lifestyles 2016: https://www.icsi.org/wp-content/uploads/2019/01/HealthyLifestyles.pdf
2. Treating Tobacco Use and Dependence: 2020 Update: https://www.ahrq.gov/prevention/guidelines/tobacco/index.html
3. A practical guide to help your patients quit using tobacco 2021.

   https://www.cdc.gov/tobacco/basic_information/for-health-care-providers/clinical-tools/
4. Treating Tobacco Use and Dependence 2008.

   https://www.cdc.gov/tobacco/patient-care/clinical-tools/index.html
5. Prevention and Management of Obesity for Adults 2013.

   https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_037112.pdf

5.8.6 HTN Management Program

1. Healthcare Guideline: Hypertension diagnosis and treatment November, 2017 -https://www.acc.org/latest-in-cardiology/articles/2017/11/08/11/47/mon-5pm-bp-guideline-aha-2017 /

5.8.7 Behavioral Health

1. Depression, Major, in Adults in Primary Care 2016 https://www.icsi.org/wp-content/uploads/2019/01/Depr.pdf

2. Practice guideline for the treatment of patients with schizophrenia 3rd edition 2020: https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890424841

5.8.8 Palliative Care

1. Palliative Care for Adults 2020. https://www.icsi.org/guideline/palliative-care/

6. CLAIMS

6.1 Claim Requirements

Physician or professional service claims are required to be submitted in the CMS-1500 standard format. MSO requires that the claim be submitted using the ICD-10, CPT, and HCPCS coding systems, as appropriate. We prefer to receive claims electronically from our Participating Providers, but we do accept claims submitted on paper. Instructions for completing the CMS-1500 and UB-04 claim forms can be obtained from the following websites:

CMS

www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

National Uniform Billing Committee

www.nubc.org

National Uniform Claim Committee

www.nucc.org

6.2 Electronic Claims

Providers who wish to submit claims electronically must use a national standard format and will be able to submit directly to MSO's Claims Department using the following payer ID:

MMM 660588600

PMC 660592131

6.3 Timely Filling

As outlined in the Provider Services Agreement, claims are required to be submitted within ninety-(90) days from the date of service. In the event a claim is submitted to MSO more than ninety-(90) days after the date of provider's provision of Covered Services, the claim will be denied, and the provider shall not bill the member.

6.4 Claims Processing

MSO will process 95% of clean claims within thirty-(30) days of receipt. Note: A "clean" claim is a claim that has no defect or impropriety, including lack of required substantiating

documentation from providers and suppliers, or circumstances requiring special treatment that prevents timely payment from being made on the claim. A claim is clean even though it may be referred to a medical specialist for examination within MSO. If additional documentation involves a source outside MSO, the claim is considered "unclean". MSO makes an initial determination within thirty-(30) days from receipt on all claims considered "unclean" from both contracted and non-contracted providers.

6.5 Claims Addresses

For MMM Claims	For PMC Claims
MMM Healthcare, LLC	PMC Medicare Choice
Att. Claims Department	Att. Claims Department
PO Box 71305	PO Box 361550
San Juan PR. 00936-8405	San Juan, PR 00936-1550

6.6 Claims Follow Up

If you would like to follow up on the status of your claim, you may contact the Provider Contact Center Department at 787-993-2317 (Metro Area) or 1-866-676-6060 (toll-free), Monday through Friday, from 7:00 a.m. to 7:00 p.m.

6.7 Adjustment Submission

Adjustments are defined as claims that have been previously paid (partially or completely) in which a provider identifies a payment error. The time limit to submit an adjustment is ninety-(90) days from the last date of payment on the Explanation of Payment (EOP).

6.7.1 Steps to submit an adjustment:

1. Provider will submit copy of the claim/s or the EOP identifying claims with a payment error. If submitting multiple claims, include the claim number of each claim on a separate sheet and attach EOPs.

2. Copy of any additional documentation is accepted, such as, but not limited to:

    a. Clinical information

    b. Progress notes

    c. CMS policy

    d. Any other documentation the provider deems necessary

3. Provider needs to submit the claims identified with an adjustment with an Adjustment Form that requires the following information:

    a. Identify if the provider submitting adjustment is a physician or a facility

    b. Identify if provider is participant or non-participant of the network

    c. Provider name

    d. Provider NPI (Rendering and Billing)

    e. Contact name

    f. Provider or contact telephone number

g. Member name

h. Member ID #

i. Claim No.

j. Cross reference number

k. Date of service

l. Date of payment (remittance date)

m. Reason for adjustment. Please select from the following:

1) Copy does not apply

2) Insufficient payment

3) Difference in units

4) Incorrect diagnosis

5) Incorrect provider

6) Incorrect place of service

n. Other (please give details)

o. Details

p. Representative signature

q. Date (date document was prepared)

4. Claims submitted for adjustment are received and stamped with the receipt date in the Claims Department.
5. Adjustment is analyzed and processed according to payment policy and procedures within the established timeframe of thirty-(30) days from receipt date.

For more information please go to : http://www.mmm-pr.com/proveedores

6.8 National Provider Identifier

In 1998, The Department of Health and Human Services adopted standard unique identifiers for healthcare providers, as well as for health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmissions of health information. Although the NPI requirement applies by law to electronic transactions, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes.

The NPI is assigned by the National Plan and Providers Enumeration System (NPPES) administrated by the Centers for Medicare and Medicaid Services (CMS). The Fox System company was contracted to assume the role of Enumerator. It will include the National Supplier Clearinghouse (NSC), Provider Number (PIN), National Council of Prescription Drug Plans (NCPDP), and the Unique Physician Identification Number (UPIN).

6.8.1 NPI Characteristics:

1. It is a ten (10) numeric position with a check digit at the end to help detect errors in data entry.

6.8.2 Replaces the UPIN and the PIN number

1. Applies to all transactions regulated by HIPAA
2. It is a number assigned for life
3. Individual providers will have only one NPI

4. Provider organizations with sub-divisions like IPA (Medicaid) can have more than one NPI

6.8.3 This will be the only Provider Identification Number

1. This number will not substitute any license (physician, DEA, State license)
2. Will not guarantee claims payment
3. Will not give authorization to be a par provider

6.9 Payments Policies Applicable to Professionals Claims

This document provides a list of Payment Policies selected by MSO to be applied in professional claims. All policies have been reviewed and approved by the MSO's Medical Director along with the Payment Policy Committee. Most of these policies are based on rules established by CMS.

POLICIES AND RULES	
• **National Correct Coding Initiative**	• Procedure Code Definition
• **Multiple Procedure Reduction**	• Procedure Code Guidelines
• **Global Surgery**	• Evaluation and Management Services
• **Professional, Technical, Global Services**	
• **Maximum Allowable Units of Service**	• Bilateral Procedures
• **Modifiers**	• NCD/LCD

6.10 Explanation of Payments

Explanation of Payments (EOP) are available for download at our provider's portal www.InnovaMD.com. Please refer to chapter 9 titled Connectivity for information on how to access. For information regarding adjustment codes definitions see Addendums Annex 2.

6.11 Coordination of Benefits with Medicare Group Plans

Coordination of Benefits (COB) is administered according to the member's benefit plan and in accordance with law. Coordination of Benefits (COB) is the process used to process health care payments when a member has coverage with more than one insurer. When it is identified that a member has coverage with more than one insurer:

1. Providers should first submit a claim to identified payers who have primary responsibility for payment of a claim before submitting a claim.
2. When filing a claim, you must include a copy of the other insurance's EOB with the claim.
3. MSO will pay deductibles, copayments, coinsurances, and other member responsibility amounts not paid by the Primary Carrier so long as the total payment does not exceed the amount MMM would pay as the Primary Carrier.
4. MSO may request a refund for COB claims paid in error for up to thirty (30) months from the original payment date.

5. MSO will attempt to recover any overpayments paid as the primary payer when insurance is primary.

COB allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

7. DENTAL

7.1 Dental General Policies and Procedure

7.1.1 Disclaimer

"The five-digit alphanumeric code obtained from the Current Dental Terminology, Copyright 2022 (CDT) by the American Dental Association (ADA), All Rights Reserved, is a listing of descriptive terms and alphanumeric identifying codes for reporting services and procedures performed by dentists. This Provider Manual includes CDT- 2022 descriptive terms and alphanumeric identifying codes for reporting services and procedures and other materials that are copyrighted by the American Dental Association.

The manual includes only CDT 2022 descriptive terms, alphanumeric identifying codes for reporting services and procedures that were selected by MSO for inclusion in this Provider Manual. Any user of CDT- 2022 outside this manual should refer to the

Current Dental Terminology, Copyright 2022 (CDT 2022) by the American Dental Association and the updates thereto. These publications contain the complete and most current listings of descriptive terms and alphanumeric identifying codes for reporting services and procedures.

No fee schedules, basic unit values, relative values guides, conversion factors or scales are included in any part of the Current Dental Terminology, Copyright 2022 (CDT) by ADA and the updates thereto. MSO agrees that it will accurately reproduce CDT- 2022 descriptive terms and alphanumeric identifying codes for reporting services and procedures and other information and/or material, to the extent that such are used, in the manual. Dental Codes not included in this manual will not be covered.

7.2 Diagnostic

7.2.1 D0100 – D0999 I. DIAGNOSTIC

7.2.1.1 Clinical Oral Examinations

GP: Infection control measures, tray or tray preparation and/or any prescription are included in the fee for the dental services provided.

GP: Appliances, procedures or restorations to correct congenital or developmental malformations are not covered.

GP: The time limitation for examinations is established by the contract and the Provider Dental Manual. Any combination of D0120, D0140, D0145,

D0150, D0160, D0170 or D0180 count toward the contract limitations or the Provider Dental Manual.

GP: Comprehensive oral evaluation D0150 may be billed again by the same dentist after the last service billed to a patient during the last (36) Thirty-six months.

GP: Oral examinations D0120 and D0150 include examination of all hard and soft tissues of the oral cavity including periodontal charting and oral cancer examination.

GP: Limited Oral Evaluation- Problem Focus D0140 should be billed with the only combination of intraoral D0220 and/or D0230. Any other radiography will be denied.

GP: Limited Oral Evaluation- Problem Focus D0140 is only payable with periapical radiographies, sedative fillings, palliative treatment and/or extractions. Any other service will be denied.

GP: The fee for consultation, diagnosis and treatment planning is part of the fee for the examination and/or diagnostic procedure(s). Including study models and/or diagnostic casts (D0470).

D0120 Periodic oral examination

Periodic oral evaluations are paid as periodic oral examinations, once every (6) six months.

D0140 Limited oral evaluation-problem focused

Limited oral evaluation-problem focused is paid as an emergency examination and is paid once every (6) six months.

D0145 Oral Evaluation for patient under three (3) years of ages

Covered 1 per year and limited for patient under three (3) years of ages and counseling with primary caregiver.

D0150 Comprehensive oral evaluation

Comprehensive oral evaluations are paid as initial oral examination for the first encounter with the dentist/dental office and subsequent submissions are paid as periodic oral examination D0120, once every (6) six months.

Comprehensive oral evaluation covers two per year with different dentist/dental office.

GP: This code is appropriate when evaluating a previously existing condition related to trauma, or a follow-up evaluation for continuing issues, but should not be used to report a post-operative visit.

D0160 Detailed and extensive oral evaluation-problem focused.

For special consultation only and limited to one in a (12) twelve-month period per specialist. Paid only to specialist (Oral Surgeons Maxillofacial and Endodontics).

D0170 Re-evaluation, limited problem focused (established patient, not post-operative visit)

D0180 Comprehensive Periodontal Evaluation

For special consultation only and limited to one in a (12) twelve-month period. Paid only to specialist (Periodontics).

7.2.2 Radiographs

GP: Diagnostic services such as radiographs must be necessary and done in connection with covered services.

GP: Non-diagnostic radiographs are not payable. Determination by dentist consultant review.

GP: The time limitation for radiographs is established by the contract and/or the Provider Dental Manual, but usually allows 1 set of bitewing X rays in a (12) twelve months period or a full mouth series or panorex in a 36 (thirty-six) months period.

GP: Post-operative x-ray for crowns, implants or fixed cemented bridge will be paid even if the patient does not have it available.

D0210 Intraoral-complete series of Radiographic Images (Full mouth)

A radiographic survey of the whole mouth, usually consisting of 14-18 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

Limited to every 36 months

GP: Not covered for patient 0 – 13 years old. If need it, by report will be required to be evaluated.

GP: A panoramic X-ray (D0330) will limit Full mouth radiography (D0210) and vice versa.

GP: A combination of panoramic X-ray (D0330) and two bitewings (D0272) will be considered as a full mouth series.

D0220 Intraoral-periapical-first film

First film is limited to once in a twelve (12) month period per member. For subsequence films, dentist most billed intraoral periapical films (code D0230).

D0230 Intraoral-periapical-each additional film

Routine working radiographs are part of the complete treatment procedure and not a separate benefit, except for final treatment.

GP: Second Film (D0230) is limited to once in a twelve (12) month period per member but not exceed the maximum of (6) six radiographies and/or

combination with bitewings (D0272), exception D0140 (limited oral evaluation-problem) only (1) one periapical) and post radiography for crowns, implants, fixed bridges and endodontic treatment.

D0270 Bitewings-single film

Bitewings-single film is limited to once in a twelve-month (12) period.

D0272 Bitewings-two films

Bitewings are limited to once in a twelve-month (12) period.

D0330 Panoramic film

Limited every 36 months

GP: A panoramic film with or without supplemental films (such as periapicals or bitewings) is considered a complete series, as D210, for time limitations, every 36 months.

GP: A full mouth radiography (D0210) will limit a panoramic X-ray (D0330) and vice versa.

D0367 Cone Beam capture and interpretation with field of view of both jaws Upper/Lower; with or without cranium

GP: Covered 1 every 6 months

D0383 Cone Beam image capture with field of view of both jaws Upper/Lower; with or without cranium

GP: Covered 1 every 6 months
GP: D0367 and D0383 will not be limited by a panoramic x-ray for diagnostic and treatment plans for implant services.

D0460 Vitality tests

Limited to (1) one per teeth and (2) two adjacent teeth, per quadrant, every 6 months.

7.3 Preventive

7.3.1 D1000-D1999 II. PREVENTIVE

7.3.1.1 Dental prophylaxis

GP: A prophylaxis done on the same date as a periodontal prophylaxis, curettage, scaling or root planning is considered to be part of and included in those procedures.

GP: The time limitation for the prophylaxis is once every (6) six month. Additional prophylaxes are optional and may be charged to the patient.

D1110 Prophylaxis-adult

A person age 14 and older is provided an adult prophylaxis.

D1120 Prophylaxis-child

A person under age 14 is provided a child prophylaxis.

7.3.1.2 Topical fluoride treatment (office procedure)

GP: A prophylaxis paste containing fluoride, or a fluoride rinse is considered a prophylaxis only.

GP: Fluoride gels, rinses, tablets, or other preparations intended for home application are not benefits.

GP: The age limitation for topical fluoride treatment is limited by contract and/or the Provider Dental Manual, is a benefit to patients under 19 and is limited to once every (6) six month.

D1208 Topical application of fluoride (prophylaxis not included)-child under 19.

Fluoride can be provided in adults with by report.

D1351 Sealant-per tooth

Sealants are payable once per tooth on the occlusal surface of permanent molars and bicuspids to patients under 14. The teeth must be free from caries and restorations on the occlusal surface.

The fee for sealants completed on the same date of service and on the same tooth as a restoration is included in the fee for the restoration.

No other restoration will be covered within 24 months after sealant is placed.

Sealant-per tooth is limited to one benefit per tooth per lifetime.

7.4 Restorative

7.4.1 D2000-D2999 III. RESTORATIVE

GP: The fee for restoration includes services such as, but is not limited to: slots, preparations, adhesives, etching, liners, bases, local anesthesia, polishing, occlusal adjustment and caries removal.

GP: Payment is made for restoring a surface only once within 24 months regardless of the number or combination of restorations placed. Benefits

may be allowed if done by another dental office, but not by the same Dentist.

D2140 Amalgam-one surface, permanent primary

D2150 Amalgam-two surfaces, permanent primary

D2160 Amalgam-three surfaces, permanent primary

D2161 Amalgam-four or more surfaces, permanent primary

7.4.1.1 Filled or unfilled resin restorations

GP: In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.

GP: Preventive resin restorations are considered sealants for payment purposes.

GP: Payment is made for restoring a surface only once within 24 months regardless of the number or combination of restorations placed.

GP: D2335 involves four surfaces including incisal angle. (MLFI) and (DLFI) can be paid on same tooth if service is done in different dates.

GP: Posteriors Resins that involves interproximal surfaces would be reported as D2392, D2393 and D2394.

7.4.1.2 Resin restorations anterior

D2330 Resin-one surface, anterior

D2331 Resin- two surfaces, anterior

D2332 Resin-three surfaces, anterior

D2335 Resin-four or more surfaces including incisal angle (anterior)

D2391 Resin-based composite-one surface - posterior

D2392 Resin- based composite – two surfaces - posterior

D2393 Resin- based composite –three surfaces- posterior

D2394 Resin- based composite – four or more surfaces- posterior

7.4.1.3 Crowns – Single Restorations Only

Notes:

The crown completion date or procedure date must be billed to MSO with the date the procedure was completed and not earlier.

Once the crown is completed, it must be sent with a post-operative radiograph and dentist and patient signature for payment.

GP: Crowns are covered in permanent teeth only and when is necessary for the restoration of a damaged tooth

GP: Will not be covered for aesthetic use.

GP: Codes D2712 -D2799 - D2931- D2932 may be used as a temporary crown and not need preauthorization. Will be covered every five (5) years per tooth.

GP: Code D2710 (Crown– resin-based composite (indirect). Require preauthorization and laboratory evidence must be sent for payment

GP: Codes (D2710 - D2712 – D2799 - D2931- D2932) are authorized to be used as a temporary crown in cases where codes (D2740, D2750, D2751, D2752,

D6058, D6059, D6060, D6065, D6066, D6067, D6740, D6750, D6752) will be the final restoration.

GP: Crowns (D2740, D2750, D2751 and D2752) are covered to one (1) per tooth every five (5) years for replacement and prior payments under this plan or any other will be taken into consideration with respect to the limitation.

GP: Re-cementation of crowns (D2915 - D2920`) is limited for payment to 1 per tooth per life, after 6 months of the initial cementation.

**D2710 Crown – resin-based composite (indirect). This service required preauthorization and laboratory evidence must be sent for payment

D2712 Crown – ¾ resin base composite (indirect). This service does not need preauthorization

**D2740 Crown – porcelain/ ceramic substrate

**D2750 Crown – porcelain fused to high noble metal

**D2751 Crown – porcelain fused to predominantly base metal

**D2752 Crown – porcelain fused to noble metal

D2799 Provisional crown. This service does not need preauthorization

D2915 Re- cement or re-bond indirectly fabricated or prefabricated post and core. This service does not need preauthorization

D2920 Re-cement or re-bond crown. This service does not need preauthorization

D2931 Prefabricated stainless steel crown – permanent tooth. This service does not need preauthorization

D2932 Prefabricated resin crown. This service does not need preauthorization

***Means services requires preauthorization and X-rays. See Fee Schedule for more details*

7.4.1.4 Other restorative services

GP: A sedative filling includes the removal of caries and the placement of the temporary cement. Limited to once per tooth in a 24-month period. Direct or indirect pulp cap on the same tooth is considered a duplication of services.

GP: A sedative filling will be covered after 4 weeks of a restoration in the same tooth and same Dentist. Benefits may be allowed if done by another dental office, but not by the same Dentist.

D2940 Sedative filling

GP: Post and Core will be covered one (1) per tooth per life.

GP: Buildup including any pins when required. Covered every 24 months.

GP: Codes (D2712 -D2799 - D2931- D2932- D2950- D2951- D2952 - D2954) do not need preauthorization.

D2950 Core buildup, including any pin when required. This service does not need preauthorization

D2951 Pin retention – per tooth, in addition to restoration. This service does not need preauthorization

D2952 Post and Core in addition to Crown, indirectly fabricated. This service does not need preauthorization

D2954 Prefabricated post and core in addition to crown. This service does not need preauthorization

7.5 Endodontics

7.5.1 D3000-D3999 IV. ENDODONTICS

Note:
Once the Root Canal therapy in molar are completed, it must be sent with a post-operative radiograph and dentist and patient signature for payment.

7.5.1.1 Pulp Capping

GP: Allowance for indirect pulp cap includes the sedative restoration.

GP: Direct or indirect pulp caps provided on the same date as the final restoration are considered part of a single complete restorative procedure.

GP: Limited to once per tooth in a 24-month period.

D3110 Pulp cap-direct (excluding final restoration)

The fee for a pulp cap-direct is included in the fee for the restoration if done on the same date or if done less than four (4) weeks of the treatment.

Note: Payment for Final restoration is covered if done after four (4) weeks of Pulp Cap treatment.

D3120 Pulp cap-indirect (excluding final restoration)

The fee for a pulp cap-indirect is included in the fee for the restoration if done the same date or if done less than four (4) weeks of the treatment.

Note: Payment for Final restoration is covered if done after four (4) weeks of Pulp Cap treatment.

D3220 Therapeutic Pulpotomy (excluding final restoration)

GP: D3220 not to be as part of root canal therapy

D3221 Pulpal debridement, primary and permanent teeth

GP: D3221 not to be used when endodontic treatment is completed on the same day.

7.5.1.2 Endodontic therapy (incl. treatment plan, clinical procedures & follow-up care)

GP: Root canal therapy is only a covered benefit on permanent teeth once in a lifetime

D3310 Root canal therapy-anterior (excluding final restoration)

D3320 Root canal therapy-bicuspid (excluding final restoration)

D3330 Root canal therapy – molar (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - premolar

D3348 Retreatment root canal - molar

1. A paste type root canal filling is not a benefit.

2. Palliative treatment in conjunction with root canal therapy by the same provider is to be included in the fee for the root canal.
3. X rays are included as part of treatment and payment of the root canal therapy, except the initial x ray for diagnostic and the final x ray for payment and assurance of complete treatment (D0220, D0230 or D0270).
4. Unsuccessful attempts of Endodontic treatment are not payable or chargeable to the patient.
5. Retreatments are covered in permanent teeth only and 1 treatment per tooth per life.
6. Retreatments requires predetermination for General Dentists only and must be accompanied by a detailed report of the clinical findings and possible causes to redo the root canal and the pre- and post-operative radiographies that will be allowed for payment.
7. Retreatment will be approved if it is performed by a different dentist and/or different dental office and must be sent with a by-report and X-rays for evaluation.

8. A retreatment will be covered by the same dentist/ same dental office, only if the service was performed before 2 years of the original endodontic treatment. For evaluation and final determination, must be sent to pre-authorize with radiographs and a by-report.

9. Incompletely filled root canals are not payable.

7.6 Periodontics

7.6.1 D4000-D4999 V. PERIODONTICS

7.6.1.1 Periodontal Scaling and root planning

GP: Local anesthesia is considered to be part of periodontal procedures.

GP: Periodontal treatments require X rays and periodontal chart and must be preauthorized.

GP: Covered every 24 months per quadrant.

GP: D4210, D4211, D4240 and D4241 are indicated for cases of gingival hyperplasia with no or minimal bone loss.

GP: Full mouth debridement is covered (1) one every (12) twelve months

**D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

**D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant

**D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.

**D4241 Gingival flap procedure, including root planing – one to three contiguous teeth or teeth bounded spaces. per quadrant

GP: Codes D4240 and D4241 only covered for Periodontists

**D4260 Osseous surgery (4 or more teeth)

**D4261 Osseous (3 or less teeth)

GP: Codes D4260 and D4261 only covered for Periodontists

**D4341 Periodontal scaling and root planning (four or more teeth per quadrant)

**D4342 Periodontal scaling and root planning (one to three teeth per quadrant)

D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit

***Means services requires preauthorization and X-rays. See Fee Schedule for more details*

7.6.1.2 Other Periodontal Services

D4910 Periodontal maintenance

GP: Covered every six (6) months.

GP: Periodontal Maintenance will be limited by other prophylaxis or vice versa.

GP: Periodontal Maintenance will be covered if patient has a previous periodontal treatment.

7.7 Prosthodontics

7.7.1 D5000-D5999 VI. Prosthodontics (Removable)

Note:

Once a denture is completed, is very important billed to MSO with the date it was inserted or delivery and not earlier, and the dentist and patient signatures.

GP: Any characterization, staining, over dentures or metal bases are specialized techniques and an allowance will be made for a conventional denture. Any additional fee is the patient's responsibility.

GP: Full or partial dentures include any reline/rebase, adjustment or repair required within 6 months of delivery; except in the case of immediate denture, relines may be a benefit after 3 months.

GP: Codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284 and D5286, do not need preauthorization.

GP: Prosthetics (removable) are subject to a 5-years limitation for replacement and prior payments under this plan or any other will be taken into consideration with respect to the limitation.

GP: Immediate dentures are subject to a 3 years limitation for replacement. *Exception may apply by report

GP: Diagnostic Cast (D0470) is considered to be part of the fees for prosthodontics services.

7.7.1.1 Complete dentures (including routine post-delivery care)

D5110 Complete denture-maxillary . This service does not need preauthorization

D5120 Complete denture-mandibular. This service does not need preauthorization

D5130 Immediate denture-maxillary. This service does not need preauthorization

D5140 Immediate denture-mandibular. This service does not need preauthorization

GP: Partial dentures are subject to a five (5) year limitation for replacement.

GP: Flexible base (Valplast) will be limited to one per arch every eight (5) years and will be limited by any other removable prosthesis and vice versa

GP Flexible base (Valplast) will not be covered for full dentures.

GP All removable unilateral dentures made with flexible material (valplast) will be limited up to two (2) unilateral per arch every eight (5) years and must include tooth number.

D5211 Maxillary partial denture-resin base (including any conventional clasp, rests and teeth) This service does not need preauthorization

D5212 Mandibular partial denture-resin base (including any conventional clasp, rests and teeth) This service does not need preauthorization

D5213 Maxillary partial denture-metal base with resin saddles (including any conventional clasps, rests and teeth) This service does not need preauthorization

D5214 Mandibular partial denture-metal base with resin saddles (including any conventional clasps, rests and teeth) This service does not need preauthorization

D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)

D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)

GP: Unilateral partial dentures (cast metal) will be limited up to two (2) per arc every five (5) years and must include tooth number.

D5282 Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary

D5283 Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular

D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant

D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant

***Means services requires preauthorization and X-rays. See Fee Schedule for more details*

7.7.1.2 Adjustments to dentures

GP: Full or partial dentures include any adjustment or repair required within 6 months of delivery.

GP: Adjustments to dentures are limited to 2 adjustments per denture per 12 months after 6 months of partial dentures delivery.

GP: Denture adjustments are covered in the basic level benefit.

GP Adjustments, rebase on complete dentures, repair or replace clasps or relines for unilateral dentures in flexible base (valplast) are not covered. *Exception may apply by report

D5410 Adjust complete denture-maxillary

D5411 Adjust complete denture-mandibular

D5421 Adjust partial denture-maxillary

D5422 Adjust partial denture-mandibular

7.7.1.3 Repairs to complete dentures (By Report)

GP: Fee for repair of a full denture cannot exceed one-half of the fees for a new appliance.

GP: Repairs to complete dentures are limited to (1) one repair per denture per 12 months after (6) six months of complete dentures delivery

GP: Code D5520 has a limitation of replacement up to three (3) teeth per arc every five (5) years.

D5511 Repair broken complete denture base, mandibular

D5512 Repair broken complete denture base, maxillary

D5520 Replace missing or broken teeth-complete denture (each tooth) D5511, D5512, D5520 require a report describing necessity for the procedure along with the claim.

7.7.1.4 Repairs to partial dentures (By Report)

GP: Fee for repair of a partial denture cannot exceed one half of the fee for a new appliance.

GP: Code D5640 has a limitation of replacement up to three (3) teeth per arc every five (5) years.

GP: Repairs to partial dentures are limited to (1) one repair per denture per twelve (12) months, after (6) six months of complete dentures deliver

D5611 Repair resin partial denture base, mandibular

D5612 Repair resin partial denture base, maxillary

D5630 Repair or replace broken clasp

D5640 Repair or replace broken tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5611, D5612, D5630, D5640, D5650 and D5660 require a by report describing necessity for the procedure along with the claim.

7.7.1.5 Dentures rebase procedures

GP: Rebase is a benefit once in a 24-month period.

GP: Rebase includes the fee for relining.

GP: Rebase includes adjustment required within 6 month of delivery.

GP: Denture rebases are covered under the prosthodontics level.

D5710 Rebase complete maxillary denture

D5711 Rebase complete mandibular denture

D5720 Rebase maxillary partial denture

D5721 Rebase mandibular partial denture

7.7.1.6 Denture relines procedure

GP: Relines are benefits once in a 24-month period.

GP: Relines include adjustment required within 6 months of delivery.

GP: Relines Complete Dentures (indirect) require by report and are covered 1 per denture every 5 years.

Relines includes all necessary adjustments within 6 months of insertion date.

GP: Relines are covered under prosthodontics level.

D5730 Reline complete maxillary denture (direct))

D5731 Reline complete mandibular denture (direct))

D5740 Reline maxillary partial denture (direct))

D5741 Reline mandibular partial denture (direct))

D5750 Relines Complete Maxillary Dentures (indirect))

D5751 Relines Complete Mandibular Dentures (indirect))

7.7.1.7 Other removable prosthetic services

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular

GP: Tissue conditioning is not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided.

GP: Tissue conditioning is not a benefit more than twice per denture unit in 24 months.

7.8 Implants and Prosthodontics, fixed

7.8.1 D6000-D6999 Fixed

***Implants will be covered when performed by a certified dentist, except for specialists.**

1.8.1.1 Implants

GP: Implants require pre-authorization.

GP: Local anesthesia is considered part of implant services.

GP: Surgical placement of the implant body, endosteal implant (D6010) and Second Stage of Implant Surgery (D6011) are covered 1 per tooth per life.

GP: Implant Abutments, codes (D6056 and D6057) are covered 1 per tooth per life.

GP: Crowns on implants (D6058 - D6059 - D6060 - D6065 – D6066 – D6067) covered 1 per tooth every 5 years.

GP: The tooth number to be used to identify the place of insertion of the crown on an implant will be the area of the absent tooth replaced by the corresponding implant.

GP: The implant where the crown will be inserted must radiographically show osseointegration and comply with the most recent standards established by the dental profession.

GP: Replacement of crowns on implants will be considered after 5 years with appropriate justification.

GP: Partials and implant dentures are mutually exclusive and cannot be replaced for 5 years.

GP: Constructing a complete or partial removable denture on an implant includes all procedures, techniques and materials. It also includes all adjustments, repairs and overruns up to 6 months after the date of insertion.

GP: Interim implants and/or Implants of less than 3mm in diameter are not covered.

GP: Implant Body is considered part of the implant procedure (D6010).

D6010 Surgical Placement of Implant body; endosteal implant

D6011 Surgical access to an implant body (second stage implant surgery)

This procedure, also known as second stage implant surgery, involves removal of tissue that covers the implant body so that a fixture of any type can be placed, or an existing fixture be replaced with another. Examples of fixtures include but are not limited to healing caps, abutments shaped to help contour the gingival margins or the final restorative prosthesis

D6056 Prefabricated Abutment - includes placement

D6057 Custom Abutment - includes placement

GP: Codes D6056 and D6057 not to be used as abutment for removable prosthetics over Implants

D6058 Abutment supported porcelain/ceramic crown

D6059 Abutment supported porcelain to metal (high noble)

D6060 Abutment supported porcelain to metal (noble)

D6065 Implant supported porcelain/ceramic crown

D6066 Implant supported porcelain crown (ceramic)

D6067 Implant supported metal Crown (Titanium, Alloy, High Noble Metal)

D6068 Abutment supported retainer for porcelain/ceramic FPD

D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)

D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)

D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6075 Implant supported retainer for ceramic FPD

D6077 Implant supported retainer for metal FPD – high noble alloys

D6085 Provisional implant crown

GP: For procedure codes D6110 – D6113 the following must be submitted: Periapical radiograph of integrated implant(s) with abutment placed

GP: Incisal or Occlusal photo of healed abutment showing healthy gingiva

GP: Implant must be approved by (FDA) and approval label must be submitted for payment.

D6110 Implant/Abutment supported removable denture for edentulous arch – maxillary.

D6111 Implant/Abutment supported removable denture for edentulous arch – mandibular

D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary

D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular

D6191 Semi-precision abutment – placement

This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.

D6192 Semi-precision attachment – placement

This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.

GP: Codes D6191 and D6192 are to be used only for removable prosthetics over implants

7.8.1.2 Prosthodontics, fixed

Notes:

Once Fixed Bridges is completed, it must be sent with a post-operative radiograph for payment and dentist and patient signatures.

Once a Fixed Bridges is completed, is very important billed to MSO with the date it was inserted or delivery and not earlier.

GP: Only pontics and retainers will be covered in some coverage. For more details see benefits table.

GP: Each retainer and each pontic constitutes a unit in a fixed partial denture.

GP: Local anesthesia is considered part of fixed prosthodontic procedures.

GP: Diagnostic Cast (D0470) is considered part of the fees for prosthodontics services.

GP: Pontics and Retainer Crowns are covered (1) one per tooth per life up to (2) two – (4) four or (8) eight units per year. The number of units may vary per coverage. For more details see benefits table.

GP: Re-cement or re-bond fused to high noble metal fix partial dentures covered every 5 years and will be covered after 6 months from the date of insertion. Does nor need preauthorization

**D6240 Pontic porcelain fused to high noble metal

**D6241 Pontic- porcelain fused to predominantly base metal

**D6242 Pontic – porcelain fused to noble metal only

**D6245 Pontic – porcelain/ ceramic

**D6740 Retainer crown – porcelain/ ceramic

**D6750 Retainer crown porcelain fused to high noble metal

**D6751 Retainer crown - porcelain fused to predominantly base metal

**D6752 Retainer crown – porcelain fused to noble metal only

D6930 Re-cement or re-bond fix partial denture

***Means services requires preauthorization and X-rays. See Fee Schedule for more details*

7.9 Oral and Maxillofacial Surgery

7.9.1 D7000-D7999 VII. ORAL AND MAXILLOFACIAL SURGERY

GP: The fee for all oral and maxillofacial surgery includes routine postoperative care.

GP: Extractions includes local anesthesia, suturing, if needed, and routine postoperative care.

GP: Infection control measures, tray or tray preparation and/or any prescription are included in the fee for the oral surgery provided.

D7140 Single tooth

Each additional tooth

Root removal-exposed roots

GP: Impaction codes are based on anatomical position rather than the surgical procedure necessary for removal.

GP: Removable of impacted tooth – soft tissue Occlusal surface of tooth covered by soft tissue covered (1) one per teeth per life and only covered for specialists.

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth includes cutting of gingival and bone, removal of tooth structure, and closure.

D7220 Removal of impacted tooth-soft tissue

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 Removal of impacted tooth-partially bony

Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentation of tooth.

D7240 Removal of impacted tooth-completely bony

All of the crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentation of tooth.

D7241 Removable of impacted tooth – soft tissue Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7250 Surgical removal of residual tooth roots (cutting procedure)- not exposed and covered by bone and/or gingival. Includes cutting of gingival and bone, removal of tooth structure, and closure.

Fee for root recovery is included in the fee for surgical extraction if done by the same dentist/dental office.

7.9.1.1 Excision of bone tissue

GP: Removal of Torus are covered 1 per quadrant, per life.

Require by report.

D7471 Removal of lateral exostosis (maxilla and mandible) 1 per quadrant, per life

D7472 Removal of Torus Palatinum

D7473 Removal of Torus Mandibularis

7.9.1.2 Surgical incision

GP: Incision and drainage procedures are covered (1) one per quadrant per year.

D7510 Incision and drainage of abscess – intraoral soft tissue

D7511 Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

D7520 Incision and drainage of abscess – extraoral soft tissue

D7521 Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

7.9.1.3 Other repair procedures

GP: Frenectomy, is covered 1 per arch, per life. Require by report indicating the need for the frenectomy. In addition, photos should be included as a diagnostic aid.

D7961 Buccal/ labial frenectomy

D7962 Lingual frenectomy

7.9.1.4 Adjunctive General Services

D9000-D9999 VIII. ADJUNCTIVE GENERAL SERVICES

Unclassified treatment

D9110 Palliative (emergency) treatment of dental pain-minor procedure. D9110 require a report describing necessity for the procedure along with the claim.

Palliative treatment is not a benefit when any other service is done on the same date except limited radiographs and tests necessary to diagnose the emergency condition.

Emergency palliative treatment is payable on a per visit basis, once on the same date. The diagnosis and all procedures necessary for relief of pain are included. Palliative treatment in conjunction with root canal therapy by the same dentist is included in the fee for the root canal.

Documentation should be submitted with claims for this procedure. If the procedure performed is a procedure with a specific code established by the ADA and/or CDT, it will be processed accordingly and not as a D9110.

7.10 General Anesthesia

GP: Deep Sedation/ General Anesthesia is covered (1) one per visit

GP: D9222 (Deep sedation/General Anesthesia-First 15 minutes) Is payable when billed with, (D6010 -D7210 - D7220, D7230, D7240, D7250, D7471, D7472 and D7473) and the same date of service.

GP: D9223 (Deep Sedation/General Anesthesia - each subsequent 15-minutes increment – up to forty-five (45) minutes) and is payable when billed with, (D9222) and the same date of service.

GP: D9222 and D9223 are payable up to 60 minutes in a combination of both codes (D9222 once and D9223 up to 3 times) and the same date of service.

GP: Some restriction may apply.

D9222 Deep Sedation/ General anesthesia – First 15 minutes (Once (1))

D9223 Deep Sedation/ General anesthesia – each subsequent 15 minutes increment up to forty-five (45) minutes. (Up to three (3) times)

7.11 Professional visits

GP: House/ extended care facility call includes visits to nursing homes, hospice sites, institution, etc.

GP: Hospital or ambulatory surgical center call – care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center.

GP: Must be sent with by report.

D9410 House/ extended care facility call

D9420 Hospital or ambulatory surgical center call

** Any other service not mentioned in this manual is not covered.

8. PHARMACY

8.1 Pharmacy Services Department

The Pharmacy Services Department is responsible for ensuring the quality of drug procurement and usage through effective pharmacy practice for the Medicare Advantage (MMM) membership. Our department employs a significant number of strategies focused on drug Formulary Management, Medication Therapy Management (MTM), Adherence Program and other clinical programs and tools aimed at improving drug benefits, and monitoring drug safety, while maintaining operations in compliance with CMS and any other applicable law or statute. Ultimately, our focus is to provide care coordination and improve health outcomes of all health plan members.

Pharmacy Clinical Operations are carried out by a team comprised of experienced doctors in medicine and pharmacy, as well as certified pharmacy technicians and registered nurses that leverage clinical interventions and discussions with healthcare providers. The Clinical Operations Team is composed of the following units:

1. Pharmacy Call Center Unit: offers technical support to pharmacies and provides guidance to pharmacies and providers to understand drug benefits, assure quality measures are addressed, establish safety controls, and discuss the most cost-effective prescription drug options available.
2. Pharmacy Clinical Unit: responsible for the clinical evaluation of all coverage determination requests received from members, physicians or member representative based on current clinical guidelines and CMS approved formularies and protocols.
3. Pharmacy Rejects Monitoring Unit: daily revision of claims that were rejected at the point of service (the pharmacy). The objective of the monitoring is to ensure appropriate adjudication of CMS approved Formulary products and MMM protocols. During their interventions with members, pharmacies and physicians, the unit seeks to close possible gaps in care and ensures the appropriate benefit determination and routing to the corresponding unit (Part B or Part D) in a timely manner.
4. Pharmacy Quality Unit: responsible for the monitoring of clinical operational processes to ensure that the requirements and expectations are accomplished according to internal Policies and Procedures and in compliance with CMS guidelines.
5. Pharmacy Utilization Unit: dedicated to continuous drug utilization review and supporting pharmacy initiatives such as: under and over utilization, polypharmacy, and CMS star rating measures. CMS Star Rating Measures include medication

adherence, high risk medication management, and the Medication Therapy Management Program, among others. To assure quality of care, the Pharmacy Utilization Unit centers its approach on educating healthcare providers, encouraging the use of cost-effective formulary medications included in the P&T approved drug formulary. Reports and profiles with benchmarking regarding drug utilization reviews are also provided to physicians.

6. Formulary Management Unit: In coordination with the Pharmacy & Therapeutic Committee, integrates patient care process to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes. This unit designs, structures and maintains a selected drug list that is a continually updated and supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. The Formulary Management Unit is also responsible of the appropriate adjudication of MMM Formulary and Utilization Management (UM) edits through the Pharmacy Benefit Manager's (PBM) system.

   All processes pertaining to the use of medications, including pharmacy programs, must be reviewed following clinical guidelines, and are approved by the Pharmacy and Therapeutics Committee, in accordance with CMS-approved requirements and protocols. This process includes, but is not limited to drug formulary Exceptions, Specialty drug and Utilization Management criteria, such as Prior Authorizations (PA), Quantity Limits (QL), Step Therapy (ST) and Safety Edits.

7. Pharmacy Operations Support Unit: assists all initiatives involving monitoring of operations' compliance to CMS and internal requirements, as well as project management of technology initiatives pursuing efficiency and customer satisfaction. The unit also supports daily operations with data analytics and oversees the delegated entities and vendors to ensure they remain compliant with current regulations and their contract agreements. The Pharmacy Operations Support team works with the Finance Department and the PBM to monitor reconciliation and ensure compliance with the payment process established by contract with CMS and the PBM. Finally, they provide operations support on all pharmacy back-end processes including but not limited to: PDE, COB, FIR, and EOB management.

8.2 Relevant information to our providers

8.2.1 What is the Drug Formulary?

A drug formulary is a list of prescription drugs, both generic and brand name, covered by a plan. For Medicare, the drug formulary and utilization management edits are reviewed and approved by CMS. The formulary is developed by a Pharmacy and Therapeutics Committee composed of pharmacists and physicians from various medical specialties. The committee reviews new and existing medications and selects drugs to be included in the health plan's formulary based on efficacy, safety, utilization, and cost effectiveness. When a generic becomes available for a brand drug already included in formulary, the health plan may immediately substitute the

brand version following CMS regulation. The continuing inclusion of the brand drug is reviewed by the committee. The list of selected drugs represents the prescription therapies that are necessary as part of a quality pharmacologic treatment program. Pharmacologic Categories and Classes need to be approved by CMS. The plan will generally cover the drugs listed in the formulary if the drug is medically necessary. All prescriptions should be filled at plan network pharmacies and following other plan rules.

8.2.2 Can the Formulary change?

In general, the formulary is updated yearly, although it is subject to maintenance changes throughout the year. Some changes are additions of new drugs, and others occur if the FDA deems a drug to be unsafe or if CMS requests a removal.

Negative changes to the formulary are not permitted by CMS, except when brand medications are removed from the formulary when their generic equivalents become available, or when a medication is removed from the market by the manufacturer, the FDA or by CMS. Annual formulary changes and additions of new utilization management rules (such as Prior Authorization, Step Therapies and Quantity Limits, among others) require approval from CMS. In addition, CMS requires that negative changes to the formulary or utilization management rules that will impact members be notified to the affected members 30 days before the change comes into effect.

The exception is the immediate substitution of a brand drug when its generic version is added to the formulary. In these instances, the notification can be retroactively.

8.2.3 Are there any restrictions on drug coverage?

There are coverage rules (known as utilization management rules) to make sure certain drugs are used correctly and only when medically necessary. These rules may include prior authorization, step therapy, and quantity limits as described below.

8.2.3.1 Prior authorization:

For certain drugs, the plan may require obtaining an approval prior to granting coverage for a medication on the formulary. Most often, these are medications that may have a safety issue, have a high potential for inappropriate use, or have lower-priced alternatives on the formulary. Prior authorization criteria and formulary status can vary for one drug with different indications depending on the indication to which the drug is being used. This means the plan will cover a certain drug only after a specific criterion approved by CMS has been met. Prior authorization criteria may also apply to some drugs that can be covered by Part D or Part B depending on the administration.

8.2.3.2 Step Therapy:

In some cases, the plan requires a member to first try certain drugs to treat a medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, the plan may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, the plan will then cover Drug B. Step therapy criteria can include as

a prerequisite the use of a Part D drug before authorizing a Part B drug and vice versa.

8.2.3.3. Quantity Limits**:**

For certain drugs, the plan limits the amount of the drug that will be covered based on maximum daily doses approved by the FDA or dose optimization approved by CMS, for a typical 30- or 90-day supply.

There are several types of exceptions that physicians can request.

1. Coverage for a Non-Formulary Medication (some Non-Formulary drugs may also be subject to safety quantity limits, based on maximum FDA dose).
2. Exception to Prior Authorization, Step Therapy program or Quantity Limits
3. Copay Tier exception

8.2.3.4 All Formularies,

Notification of Formulary Changes and the complete list of drugs that require Prior Authorization, Step Therapy Criteria, and Quantity Limits, are published on the health plans' websites:

www.mmmpr.com/planes-medicos/formulario-medicamentos

Or in the Tools section of our provider portal:

www.innovaMD.com

8.3 Transition Coverage Process

The Centers for Medicare and Medicaid Services (CMS) require Part D Plan Sponsors, like MMM, to have a transition of coverage (TOC) process. Members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements can get a transition supply of their drug in certain circumstances. This gives members the opportunity to work with their doctor to complete a successful transition and avoid disruption in their treatment. A transition coverage process is necessary for:

1. New members in the plan;
2. Newly eligible Medicare beneficiaries from other coverage;
3. Individuals who switch from one plan to another after the start of the contract year;
4. Members residing in LTC facilities;
5. In some cases, current members affected by formulary changes from one contract year to the next.
6. Members going through a change in level of care, such as discharge from a hospital.

For all Non-formulary drugs or drugs with Utilization Management programs, the transition process will automatically cover a temporary fill for up to a 30-day supply and a letter will be provided to the member and prescriber indicating that the next fill will require prior authorization or an exception process.

Members who are residents in a long-term care facility will receive a temporary fill for up to a 31-day transition supply, for the first 91 days and may be up to 98 days of enrollment.

Transition also applies to members with a change of "level of care", for example, that are released from a hospital, psychiatric hospital or other care facility to their home. The plan will provide up to a temporary 30-day supply for Non-Formulary drugs and drugs with utilization management (prior authorization, step therapy or quantity limit not at maximum FDA approved dose). In such instances, a coverage determination can also be requested. Safety edits are exempt of the transition benefit. For example: Opioids Naïve edit and Duplicate therapies.

8.4 Coverage Determination

8.4.1 A Coverage determination is any decision made by the plan regarding payment or benefit to which a member believes he or she is entitled.

1. A request related to satisfy prior-authorization criteria for a drug.
2. An exception request related to a non-formulary drug.
3. An exception request related to the drug cost Tier.
4. An exception request related to the drug quantity limits (or doses).
5. An exception request related to the step therapy requirements.
6. An exception request related with a prior-authorization or utilization management requirement.
7. A request related to payment of a drug already bought.

8.4.2 How to request a Coverage Determination

1. A Coverage Determination can be requested (standard or expedite) by the prescribing physician, or other member prescriber, the member, or the member's authorized representative.
2. Standard and expedited requests can be requested verbally, through the Part D sponsor's website or in writing via mail, email, walk-in or fax.
3. Written requests can be done using the Model Coverage Determination Request Form for Physicians, the exception form of the plan or other entity, or another written document prepared by the requester. If a request involves reimbursement for a Part D drug that has already been received, the request must be filed in writing.
4. All requests must have the following: the drug requested including its formulation, presentation, potency, frequency, date, diagnosis, signature, NPI number and active licenses of the physician, member's information (ID, complete name, and DOB) and any other clinical information and/or medical justification as applicable.

8.4.3 Evaluation Process of a Coverage Determination Request:

1. If the request does not involve an exception or is a part B drug, the member will be notified of the decision within 24 hours (expedited request) or in 72 hours (standard requests).
2. If the request involves an exception, time will start when the physician provides the supporting statement to the plan.

3. If the request involves a part D drug reimbursement, the member will be notified of the decision within 14 days.

When an exception request is received, the plan makes the necessary outreach attempts as per the coverage determination process to contact the physician and assess for: relevant clinical information, necessary medical justification (supporting statement for exceptions requests), possible therapeutic interchange to formulary drugs and formulary utilization management programs.

1. If the request is denied, the decision must include the necessary information to request a redetermination.
2. If the physician or member does not agree with the decision, there is a process to request an appeal.

8.5 Exception Request

8.5.1 A type of coverage determination that can be requested by:

a. The member.

b. The prescribing physician or other prescriber.

c. Staff of said prescriber's office acting on said prescriber's behalf (e.g., request is on said prescriber's letterhead or comes from the prescriber office fax machine).

d. A representative authorized by the member.

8.5.2 Types of exceptions:

1. Tier Exception

Request to obtain a non-preferred drug at the more favorable cost sharing terms applicable to drugs in the preferred tier. The prescribing physician needs to provide a supporting statement indicating that all the preferred drugs are not as effective as the drug requested to treat the patient's condition, or that the preferred drugs can cause adverse effects to the member, or both.

2. Formulary exception

The prescribing physician or other prescriber must submit the supporting statement of the request. If the pharmacy sends the prescription by fax, it is not necessarily considered as an exception request if lacks the prescriber's supporting statement.

An exception request that includes all the relevant clinical information and necessary supporting statement will be approved if the plan determines that it is medically necessary for the member. The following are considered as Formulary exceptions:

a. Drug not included in the Formulary

   The prescribing physician or other prescriber must submit the supporting statement of the request indicating that all covered part D drugs on any tier of the plan's formulary would not be as effective for the enrollees as the requested non-formulary drug and/or would have adverse effects.

b. Step therapy (ST)

The prescribing physician or other prescriber must submit the supporting statement of the request indicating that the pre-requisite drug required to be used in the Step therapy requirements has been ineffective or is likely to be ineffective or, adversely affect the drug's effectiveness or patient compliance; or has caused or, it is likely to cause an adverse reaction or other harm to the enrollee.

c. Quantity limit (Request a higher amount)

   The prescribing physician or other prescriber must submit the supporting statement of the request indicating that the number of doses available under a dose restriction for the requested drug has been ineffective in the treatment of the enrollee's disease or, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

d. Asking to waive a PA, ST or UM (Utilization Management) criteria.

   The prescribing physician or other prescriber must submit the supporting statement.

8.5.3. Submitting supporting statements:

The prescribing physician or other prescriber must provide an oral or written supporting statement. The physician can use the Model Coverage Determination Request Form for Physicians, the plan's exception form, or any document written by the physician (ex. letter).

8.5.4 Exception request process

When an exception request is received, the plan makes the necessary outreach attempts as per the coverage determination process to contact the physician and assess for: relevant clinical information, necessary medical justification (supporting statement), possible therapeutic interchange to formulary drugs and formulary utilization management programs.

When the plan receives the physician's supporting statement, the member is notified of the coverage determination decision in a term of 24 hours (for expedited requests) or 72 hours (for standard requests).

1. If the request is denied, the decision must include the necessary information to request a redetermination.
2. If the physician or member does not agree with the decision, there is a process to request an appeal.

8.6 Drug Coverage – Part B

8.6.1. The drugs that are currently under the Part B coverage include:

1. Drugs that are administered as part of the services offered in the physician's office. Includes Injectable, intravenous drugs, administered "incident to" a physician service and considered "not usually self - administered".

2. Immunosuppressant drugs (drugs that are used to reduce the risk of rejection in patients with organ transplant only if the transplant has been covered by Medicare).
3. Products Administered in Durable Medical Equipment (DME): Nebulized Drugs Only · Drugs that are administered with an infusion pump, or that need to be prepared before patient's administration following aseptic techniques.
4. Some anticancer drugs.
5. Anti-emetics, Oral. If oral anti-emetic is used as full therapeutic replacement for intravenous (IV) anti-emetic drugs and administered immediately before, at, or within 48 hours after IV chemotherapy administration.
6. Vaccines. Hepatitis B for intermediate and high-risk patients, Influenza and Pneumococcal vaccines as well as certain vaccines necessary for the treatment of an illness or injury.
7. Diabetic Supplies, glucose test strips, lancets and other diabetic supplies that are currently supplied under the Medicare Part B will continue to be covered under Part B.
8. Hemophilia clotting factors. Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.
9. Parenteral nutrition or intradialytic parenteral nutrition (IDPN) (for individuals with a non-functioning digestive tract).

10. Intravenous immune globulin (IVIG) provided in the home for individual with diagnosis of primary immune deficiency disease.
11. Other

    Part B drugs may have a prior-authorization, step therapy or quantity limit criteria associated according to clinical criteria established in the Local Coverage Determinations (LCD), Micromedex, Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), National Coverage Determination (NCD) or MMM Healthcare, LLC Internal Coverage Criteria such as prescriber specialty requirements.

Visit the drug formulary or our provider portal at www.innovamd.com for more information.

8.7 Drug Coverage-Part D

Subject to specific exclusions, a Part D drug means a drug that may be dispensed only upon a prescription and is being used for an FDA approved indication.

8.7.1 All Medicare plans for drug prescriptions will include:

1. Drugs only available with a prescription: brand and generic.
2. Biologic products.
3. Insulin.

4. Medical supplies associated with the administration of insulin: syringes, needles, gauzes, and alcohol swabs.
5. Vaccines (except for Influenza and pneumococcal vaccines that are covered by the Part B benefit).

8.7.2. The following drugs or classes of drugs are excluded from Part D:

1. Agents being used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., morbid obesity)). Exception: Megestrol acetate and growth hormone, when used for AIDS wasting and cachexia.
2. Agents being used to promote fertility.
3. Agents being used for cosmetic purposes or hair growth. Exception: Part D drugs indicated for the treatment of psoriasis, acne, rosacea, or vitiligo are not considered cosmetic.
4. Agents being used for the symptomatic relief of cough and colds. Exception: Cough and cold medications are eligible to meet the definition of a Part D drug in clinically relevant situations other than those of symptomatic relief of cough and/or colds. For example, when "cough" medications are used to treat a medical condition that causes a cough, such as the use of bronchodilators for the treatment of bronchospasm in asthma, CMS does not consider these "cough" medications as excluded drugs and, therefore, these medications may be covered under Part D.
5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Exceptions:

a. Vitamin D analogs such as calcitriol, doxercalciferol, and paricalcitol when used for a medically-accepted indication as defined by section 1927(k)(6) of the Act, are not excluded because CMS interprets the exclusion of prescription vitamin D products as being limited to products consisting of ergocalciferol (vitamin D2) and/or cholecalciferol (vitamin D3).

b. Prescription Niacin products.

6. Nonprescription drugs (OTC). Exception: Supplies associated with the injection of insulin, including syringes, alcohol wipes, insulin pens and pen needles, gauze, and alcohol.
7. Covered outpatient drugs where the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
8. Agents being used for the treatment of sexual or erectile dysfunction (ED). ED drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension). ·

The plan may provide additional coverage for some drugs that normally are not included in the Medicare drug coverage.

Drug categories in which substantially all drugs must be included in the Drug Formulary (Protected class) are:

1. Antineoplastic Cancer drugs

2. Antiretrovirals HIV/AIDS' drugs
3. Antidepressants
4. Antipsychotics
5. Anticonvulsants
6. Immunosuppressant

8.8 OTC Drugs Benefit ("Non-Medicare Part D")

Our Medicare Advantage Programs provide the benefit of OTC for some benefit designs. Some conditions may be treated using an over-the-counter drug rather than a prescribed medication. Using an over the counter (OTC) drug is convenient and may save money. MMM's OTC Catalog offers a vast variety of products under several categories such as cold and allergy, first aid, nutritional supplements, vitamins, pain relief, sleep aids, bandage and support aids, smoking cessation, diabetes care, skin care, incontinence, safety devises for home and bathroom, among others.

8.8.1 To obtain the OTC benefit.

1. Members can obtain their OTC products by placing an order directly to the OTC vendor "OTC a Tu Puerta", at a retail pharmacy, via the OTC Vending Machines and/or thru the Members App, without the need of a prescription from their physician.
2. The OTC item will be dispensed with $0 copay until the member reaches the maximum quantity allowed as per the benefit design.

3. Coverage will apply to OTC items included on the list of covered drugs under the OTC benefit.
4. Through the Service of "OTC a Tu Puerta", items are delivered directly to members at their home or preferred delivery site.
5. The OTC Catalog is published on the health plans' website: www.mmmpr.com/planes-medicos/formulario-lista de medicamentos fuera del recetario.

For questions regarding this benefit please contact the health plans' Pharmacy Provider Call Center.

8.9 Medication Therapy Management Program

The Medication Therapy Management Program (MTMP) is designed to help members manage their drugs and optimize medication use improving their therapeutic outcomes. This program enhances the communication among Physicians and other Healthcare Professionals as a way of reducing adverse drug events, improving medication use for the benefit of the members, identifying gaps in care and the assurance of patient safety. For calendar year 2023, any Health Plan's member is eligible for automatic participation in the program if they meet the criteria of at least one of the following two groups, according to the criteria established by the Centers for Medicare and Medicaid Services (CMS):

1. Members that meet the following three (3) criteria:

- Have incurred in expenses of Part D drug coverage up to $1,174 in the last three (#) months or $4,696 during the last 12 months.
- Have at least three or more of the following chronic conditions: Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Respiratory Disease- Asthma, Rheumatoid Arthritis or End-Stage Renal Disease (ESRD).
- Use at least eight medications covered under Medicare Part D included in the following therapeutic classes: ACE-Inhibitors, Alpha Blockers, Angiotensin II Receptor Blockers (ARBs), Anti-hyperlipidemic, Anti-hypertensives, Antiarrhythmics, Beta-Blockers, Bronchodilators, Calcium Channel Blockers, Disease Modifying Anti-Rheumatic Drugs (DMARDs), Diuretics, Inhaled Corticosteroids, Insulins, Oral and injectable hypoglycemics, Tumor Necrosis Factors (TNFs) and others: Digital glycosides, GLP-1, or Leukotrienes.

2. Members considered at risk of opioid overutilization with an active coverage limitation of any of the drugs under the Drug Management Program (DMP).

Members that meet all the inclusion criteria for the MTMP will receive a *Welcome Letter* with initial information about benefits that the program could provide for their health, including a comprehensive evaluation about the proper use of their current medication. This program is completely voluntary, individualized, and complementary to the Health Plan's pharmacy benefit; information about how to refuse to participate

in this program is also provided. The MTMP provides several interventions for the participants and their providers. Some of the members' interventions include:

a. A Welcome Letter to the program with general information about program expectations and how they can engage to participate in it. With this letter each member receives information about the safe disposal of prescription drugs, as required by CMS.
b. An annual Comprehensive Medication Review (CMR) that is performed face to face, by Tele-health or by phone by a Qualified Health Professional.
c. Follow-up evaluations, including quarterly Targeted Medication Reviews (TMR).
d. Conduction of knowledge/motivational surveys to improve drug adherence.
e. Summary of the completed interview, including an updated medication list and action plan to be taken regarding the member's drug therapy, will be mailed 14 days after the initial interview.
f. Provider's interventions that are targeted to resolve medication related problems or to optimize therapy.
g. Referrals to other Health Plan's Clinical Programs are offered, as needed.

8.10 Opioid Drug Management Program (DMP)

The Pharmacy Department establishes a Retrospective Drug Utilization Review (DUR) and Case Management Program to monitor the implementation of required Part D controls and to assess potential patient's safety risks as result of overutilization of drugs, including opioids and their potentiators. The Opioid Overutilization Program focuses on potentially at-risk beneficiaries (PARB) as defined by the OMS minimum criteria. Beneficiaries must meet criteria 1, criteria 2 or both. In addition, beneficiaries meeting OMS supplemental criteria are included in the DMP.

Minimum OMS Criteria:

1) Beneficiaries whose morphine milligram equivalent (MME) average daily dose is greater than or equal to 90mg and who used 3 or more opioid prescribers AND 3 or more opioid dispensing pharmacies OR more than 5 prescribers regardless of the number of opioid dispensing pharmacies.
2) A medical claim with a primary diagnosis of opioid-related overdose within the most recent 12 months; AND a part D opioid prescription (not including Medication Assisted Treatment - MAT) within the most recent 6 months.

Supplemental OMS Criteria:

Use of opioids regardless of the average daily MME during the most recent 6 months; AND 7 or more opioid prescribers OR 7 or more opioid dispensing pharmacies.

Providers whose patients are identified as potentially at risk will receive a letter notification to provide additional information regarding the beneficiary's opioid utilization.

If the beneficiary is deemed at risk, a limitation will be implemented. There are three types of limitations: Pharmacy limitation, prescriber limitation or a point-of-sale limitation. The Pharmacy Department has implemented some edits to prevent opioid overutilization:

a. Hard reject when the cumulative daily MME is greater than or equal to 200mg MME and 3 or more opioid prescribers.
b. Care coordination edit when the cumulative daily MME is greater than or equal to 90mg and 3 or more opioid prescribers.
c. Hard Reject when a therapy exceeding a 7-day supply is detected for naïve patients within a 90-day lookback period.
d. Soft edit with concurrent use of opioids and benzodiazepines.
e. Soft edit with concurrent use of two long acting (LA) opioids.

Beneficiaries with cancer, Sickle Cell Anemia, in Long Term Care or receiving hospice care are excluded from the program. All buprenorphine products are excluded for the MME conversion factor.

8.11 Medication Adherence Program (PAM)

The Medication Adherence Program (*Programa de Adherencia de Medicamentos (PAM)*) is performed in collaboration with participating community Pharmacies. The main goal of this program is to promote a close relation between the member and pharmacists to improve patient's health and safety concerning the correct use of their medications. Pharmacies are evaluated under HEDIS Adherence measures and receive incentives when 4 and 5 stars are achieved. Pharmacists perform bi-annual medication reconciliations for members, which include the provision of patient education on the

proper use of medications and the importance of adhering to the prescribed therapy. Medication Reconciliations also occur within 30-days of a hospital discharge to make certain any changes in therapy are identified in a timely manner.

Through these interventions, pharmacists identify drug therapy problems such as potential drug interactions, inappropriate dosage or duplicity of therapy, among others.

PAM pharmacies also offer medication home delivery and prescription synchronization services.

8.12 Pharmacy Department Contact Information

Pharmacy Provider Call Center
MMM- 1-877-776-7706 **Fax 787-300-5503** **Seven days a week, 24 hours a day**

Pharmacy Clinical Unit	
MMM Fax **787-300-5503**	**MTM Program** **787-523-2397 (Metro Area)** **1-844-660-1660** **(Toll Free)**
Monday through Friday, from 8:00 a.m. to 5:00 p.m.	
Websites	
www.mmmpr.com	**www.innovamd.com**

8.13 Reference Information

Visit www.innovamd.com for additional information about Part D drug coverage or about the following:

1. Part D Drug Formulary
2. Part B Drug List
3. Step Therapy Criteria
4. OTC Drug List
5. Prior Authorization Criteria
6. Quantity Limit
7. Effective Pharmacotherapy Care (EPC)
8. Pharmacy Adherence Program (PAM) participating pharmacies
9. Clinical References (Beers Drug List)

9. CONNECTIVITY

9.1 InnovaMD

9.1.1 Introduction

InnovaMD is a Care Coordination Platform that has been designed to join patients, providers and partners allowing them to work together. InnovaMD utilizes a highly secure, powerful, and efficient network platform that serves as a rendezvous point for all sectors within the healthcare industry. Upon joining, members of InnovaMD have the liberty of exchanging medical and administrative information instantly, while operating under strict regulations that guarantee compliance privacy and confidentiality.

Through a formula based on increased interoperability coupled with the effective flow of medical information, InnovaMD becomes an extremely valuable tool that keeps the healthcare industry well prepared while providing patients with high quality services, so they receive the best quality treatment.

It is also the preferred communication channel between the providers and the MSO.

9.1.2 Benefits

1. Enables the providers to manage their medical panel more efficiently by using the Beneficiary Center functionality.
2. Facilitates an efficient communication platform among the group of health professionals who work with the patient.
3. Search and filter options are available across all enhanced applications allowing an intuitive and uniform use.
4. Capability to manage multiple sessions of selected beneficiaries during the creation and submission of services, encounters, etc.
5. Integrated functionalities to request services such as Referrals and Pre-authorizations.
6. Info Center serves as a centralized repository of administrative documents: Document Center, Learning Center (learning modules), Support Center, News, Events, 5 Stars Quick Reference Guide.
7. Providers have more options to grant their office staff access to InnovaMD transitioning their initial role from contacts to delegates.

8. Logged user is displayed more information regarding their role or roles within InnovaMD to facilitate switching between them.
9. Both GHP and Group Administrators can benefit of the availability of the Beneficiary Center functionality.
10. PCPs can enter additional contact information of their beneficiary's profile.
11. Easy manner to switch between Medicare Advantage and GHP lines of business.
12. Secure and personalized access to clinical and financial information.
13. Streamlined, secure and confidential communication with the provider.
14. Interoperability platform.
15. Protects patient's clinical information as required by HIPAA regulations.

For more information visit the InnovaMD portal at www.innovamd.com, or contact InnovaMD Support Team at 787-993-2317 or 1-866-676-6060 or by email at InnovaMDAlert@mmmhc.com

9.2 Available Application Tools and Functionalities

The following is a list of some of the tools and functionalities available to contracted providers:

1. Beneficiary Center – Allows PCPs to manage their medical panel more efficiently by having an easy access to a Clinical Profile and requests services such as Referrals, Preauthorizations, etc. for one or more beneficiaries simultaneously.
2. Beneficiary Eligibility - Allows all providers to validate patient eligibility by searching with the Beneficiary ID and obtaining Demographic Information, Eligibility Status,

including MOOP (Maximum Out of Pocket Used and Limit), Benefit Plan Information, Patient Coverage Information, Product and PCP History, and access to print the Eligibility status.

3. Practice Center – Allows all providers the access to centralized view of services referred to their practice and encounters. In the Profile tab the provider can attest and edit their general information, affiliations, hospital privileges information, and view their coverage. They can also Opt In and Opt Out of the Government Health Plan of Puerto Rico provider network
4. Provider Directories – Allows all providers the access to all active and contracted network providers. Providers can be sorted by Plan, Product, Doctors and Health Care Professionals, Medical Facilities. Searches can be performed by Service Facility (Specialty), IPA groups, Name, Location, ZIP Code, etc. Results include information such as office addresses, office telephone and map, and other details.
5. Office Advantage – Providers can view and manage what incentives correspond to their office staff. Also, allows office staff to view a dashboard that contains information about their incentive payments received for using the InnovaMD portal.
6. Office Advantage Rewards – Office staff can view and redeem prizes to use InnovaMD portal.
7. ICD10 Aid Tool – Facilitates providers and staff while performing search with coding translation.

8. Formulary Search – Provides the drugs covered by the plan according to the category and/or name of the drug selected.
9. Claims Documents – Providers can attach claims documents to Inmediata clearinghouse.
10. Claims Viewer -Providers can verify status of claims submitted. Allows search by Beneficiary and Claim number, line of business, from-and-to dates. It also displays charged and paid amounts.
11. Document Center – Providers can view and search their Documents, Clinical Guidelines, General Documents and Digital Publications published.
12. Learning Center – Providers can view lessons published.
13. News – Providers can view and search important news published.
14. Events – Providers can view upcoming events and they can register if required.
15. Quality Improvement Monthly Statement (QIMS)
    a. Allows providers to:
        - View Raw Quality Rating – this is the outcome of Part C, Part D and Overall ratings. It also allows providers to view a YOY (Year over Year) chart: this chart compares provider performance based on their star result at current time compared to same time, last year.
        - View Raw Rating Progress YTD (Year to Date): this chart shows how their execution has moved between Part C & Part D.

- View all measures in evaluation for the Rating Year, identifying which of them are classified in Below Target, On Target and Display Measure.

b. Displays a list of non-compliance beneficiaries for selected measure. Other non-compliance measures for selected beneficiary are displayed.

c. Save and Print statement.

d. Export statement in Excel format.

16. Hospital Census – This functionality allows providers to follow up patients during and after an admission in a hospital level. In addition, they can identify if the patients were admitted, discharged or readmitted.

Providers can view the following:

- List of beneficiaries admitted
- List of beneficiaries discharged
- List of beneficiaries readmitted
- Type of hospital contract with the plan
- Clinical notes transcribed on admission by the MSO auditor
- Export Census in Excel document

17. Clinical Viewer - Allows providers access through InnovaMD using the Clinical functionality. This functionality has the capability to transmit electronically clinical information among a variety of health care systems to consolidate clinical data that gains a new meaning in patient treatments and medical outcomes by improving the care offered by MMM.

Benefits:

1. Provides updated and accurate overview regarding the beneficiary clinical data.
2. Allows the provider to directly access information regarding the patients results directly from the laboratories, x-rays, etc. and reduces delay in receiving these results from their patients.
3. Avoids duplicity of therapies, doses, tests and procedures.
4. Ensures the accuracy and clarity of diagnoses and prescriptions.
5. Is aligned with Federal Government requirements in the management of electronic health records.
6. The information is updated daily and is composed by the following categories:
    a. SMART Paper - Presents a summarized manageable report with actionable items identified by information provided in a reliable and timely manner.
    b. Annual Health Assessment – Allows providers access to updated clinical profile of their patients. Access by providers to other patients or specialists, ancillaries, etc. The information presented includes: Medication, Encounters, List of Problems, Procedures and Laboratories, etc.
    c. Encounters - Allows providers to view encounters registered for the selected beneficiary.

d. Equipment – Allows providers to view Medical Equipment registered for the selected beneficiary.

e. Immunizations – Allows providers to view vaccines registered for the beneficiaries.

f. Laboratory Results – Allows providers to view lab results in real time.

g. Medications – Allows providers to view pharmacy claims registered for the selected beneficiary.

h. Problems – Allows providers to view diagnosis for the selected beneficiary.

i. Procedures – Allows providers to view CPTs for the selected beneficiary.

j. Healthcare Providers – Allows providers to view a list of all providers that the selected beneficiary has visited.

k. Radiology Results – Allows providers to view radiology report.

9.3 How to Register

To register in the portal, enter the following URL address in your browser:

www.innovamd.com

To be able to register in the portal, you will need the following information:

1. Email address
2. Billing NPI
3. Rendering NP

4. Social Security Number or Federal Tax ID

With this information, the system will automatically validate you as a contracted provider with MSO.

Once validated, an email will be sent to the email provided in the first step with instructions to finish the registration process.

How to register to InnovaMD 2.0?

From your browser, go to www.innovamd.com and press the Register button.

A. Pre- Registration: Complete the provided fields:

1. Billing NPI
2. Rendering NPI
3. SSN or Federal Tax ID
4. Complete the Captcha
5. Read and accept the terms and conditions.

B. Pre-Registration Confirmation: A message confirms the provider that the Pre-registration process was completed successfully. Then, press OK.

C. Provider actions to confirm the registration: Once pre-registration is completed, you will have 24 hours to access your email and complete the process. The user must click on the link of his email that will take him/her to a validation page. If you cannot access the email to which the pre-registration confirmation will be sent, you should call InnovaMD Support.

D. Provider Validation: Enter the NPI Billing and NPI Rendering to confirm that you are the provider.

E. Registration: Fill in the following fields to create your account:

1. *Username* = User account name it will have to comply with the rules shown).
2. *Password* = Password (it will have to comply with the rules shown)
3. *Confirm Password* = Confirm the password previously entered
4. *Security Questions* = Three (3) security questions which you must select and answer).

F. User Account*:* The user completes the required fields and presses the complete button.

G. Registration Confirmation: A message confirms to the user that the registration process was completed successfully. Then, press OK.

Portal introduces the home page for user to enter their credentials.

Download the user education manual at www.innovamd.com. For more information, call:

InnovaMD 2.0 Support Group

Monday to Friday

7:00 a.m. – 7:00 p.m.

787-993-2317 (Metro Area)

1-866-676-6060 (Toll Free)

9.4 System Requirements

To be able to fully appreciate InnovaMD, we recommend using a computer with the following minimum configuration:

1. High Speed Internet Connection.
2. Comply with the browsers and operating system versions included in the table below:

Browser	Operating System	Version
Internet Explorer	Windows 8, 8.1, 10	IE-11 & Edge
Chrome	Windows 8, 8.1, 10 Mac OSX 10.9, 10.10, 10.11	51+
Firefox	Windows 8, 8.1, 10 Mac OSX 10.8, 10.9, 10.10, 10.11	45+
Safari	Mac 10.11	Safari 9 +

3. Email
4. Adobe Flash Player 10
5. Adobe Reader

Some InnovaMD functionalities use multiple windows (pop-up windows) to display information in some sections of the system. It's possible that your browser has a pop-up

blocker activated. If this is the case, you will need to deactivate this functionality to be able to use the site.

10. BEHAVIORAL HEALTH / SUBSTANCE ABUSE SERVICES UTILIZATION MANAGEMENT PROGRAM

10.1 Introduction

The Utilization Management (UM) Program of the Integrated Mental Health Department (IMHD) serves to implement a comprehensive, integrated process that ensures patients receive timely, safe, and appropriate medical care in the most efficient and cost-effective manner. The Program provides a reliable mechanism to review, monitor, evaluate, recommend, and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

The IMHD UM program ensures that appropriate, high quality cost-effective utilization of health care resources is available to all members. The program is designed to provide a complete process of review of inpatient, outpatient, partial hospitalization programs and intensive outpatient programs. This process: assures the delivery of medically necessary and quality patient care through appropriate utilization resources, in timely manner, and actively pursues identified opportunities for improvement. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed, providing results that ensure equitable access to high quality health care across the network of providers for all eligible members.

Managing the behavioral health benefits of our members allows the opportunity to demonstrate this commitment by recognizing overall needs and providing better care. Behavioral health services are interdisciplinary and multidisciplinary. The MSO's network is comprised of mental health and substance abuse physicians, facilities, and ancillary providers that are critical to this mission's success. Integration and communication among providers are most important. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care. Our operations are designed to ensure that behavioral health services are available and provided for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. The Program encompasses services rendered in ambulatory, inpatient, partial hospitalization, and intensive outpatient settings. We consider the management of care from admission through discharge and after discharge services coordination. The main purpose is to position members to achieve their recovery goals by promoting and facilitating the continuity of services while managing available resources. Member's follow-up is essential. High risk members are evaluated and encouraged to participate in the behavioral health focused case management program where education, care coordination, and support is provided to increase member's knowledge and encourage compliance with treatment and medications.

Our operations are guided by a Quality Improvement (QIP) and Utilization Management Program (UMP) and is monitored and evaluated to identify trends and opportunities to improve healthcare services and members experience and to promote the delivery of

high quality, medically necessary, and cost-efficient healthcare for our members, and incorporates the review and evaluation of all aspects of preventive, diagnostic, and treatment services in higher level of care settings.

10.2 Access to Care

The Behavioral Health Program provides multiple channels of access to care for beneficiaries and their family members and providers, who may access the care system through one of the following sources:

- 24-hours toll-free Costumer Call Center.
- Clinical Care Management.
- Face-to-face coordination of evaluations by network providers.
- Emergency services through free-standing psychiatric hospitals, medical, hospitals with psychiatric units and emergency rooms.

Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment or may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals, however, are not required to receive most in-network mental health or substance abuse services. Members and providers can call the Integrated Mental Health Department Customer Service (IMHD) to receive orientation on how to access behavioral health services and provider information.

Members may have access to services that include:

- Mental Health
- Substance Abuse
- Pharmacy Management
- Crisis Line
- Care Coordination
- Case Management
- Customer Service
- Discharge Planning and Transition of Care

The clinical philosophy of the IMHD emphasizes a provision of services that offers easy and immediate access to the most appropriate, high quality, clinically relevant and appropriate mental health and substance abuse program services for members that supports providers in delivering clinically necessary and effective care with minimal administrative barriers.

10.2.1 Outpatient Services

The Integrated Mental Health Department recognizes the benefits of a solid and integrated outpatient service that may include:

- Wellness and prevention
- Diagnosis
- Treatment
- Rehabilitation

Prior approval is always required for the following services:

- Outpatient ECT (electro-convulsive treatment)
- Partial hospitalization
- Intensive outpatient treatment
- Neuropsychological testing
- Psychological testing
- Ambulance service
- Inpatients consults
- Outpatient service for psychologists and social workers
- Home visits

Medically necessary outpatient services for beneficiaries with a mental illness and/or a concurrent substance use disorder must correspond with the frequency and duration of the evidenced-based practice, or the specialty-focused service provided. The guidelines for these practices, along with the individual needs of the beneficiary, will be considered to establish the frequency, duration, and type of treatment service.

10.2.2 Inpatient Services

The clinical integrity of the Behavioral Health UM Program ensures that members receiving care are appropriately monitored and that comprehensive reviews are provided. Our system of care is based on principles of recovery and quality care and is flexible in meeting the needs of the population we serve, through:

1. Ensuring that members have access to the appropriate care and service that is consistent with accepted standards of medical practice.
2. Providing easy and early access to appropriate treatment on the least restrictive level of care.
3. Working collaboratively with providers in delivering quality care according to accepted best-practice standards.
4. Addresses the needs of the elderly.
5. Identifies common illnesses or trends of illness.
6. Target high-risk cases for intensive care management to ensure appropriate care.
7. Establishes a process for medical necessity review; before, during, and after care is provided.

8. Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under- and over-utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service, as well as outcomes.
9. Ensuring that denials related to utilization issues are reviewed and handled efficiently, by the appropriate licensed professionals and according to regulatory timeliness standards.
10. In conjunction with the Case Management Program, identify, educate, and manage members with selected chronic conditions, promoting increased member participation in the self-management of their disease.
11. Monitoring performance to ensure qualified healthcare professionals perform all components of the UM program.
12. Maintain a process that promotes UM staff access to appropriate board-certified specialists as needed in determining medical necessity.

10.3 Clinical Guidelines

The criteria utilized for purposes of Utilization Review; admission, level of care and continuing/concurrent review treatment authorization decisions are nationally developed/recognized criteria by MCG®, formerly Milliman Care Guidelines. The clinical criteria used by the IMHD to make admission, level of care and continuing treatment authorization decisions is MCG® for inpatient services and Medicare Local Coverage Determinations Guidelines (LCD) for partial hospitalization services.

The purpose of the MCG's® care guidelines is to promote evidence-based care and identify benchmark patient care and recovery milestones to enhance the delivery of quality healthcare and promote more efficient resource management across the continuum of care. Consistent with that continuum-of-care approach, Behavioral Health Care provides guidelines for treatment of major psychiatric. The appropriateness of specific psychological, behavioral, and pharmacologic therapies is addressed, and indications are presented for 5 different levels of care to help define the optimal level of care for effective, efficient behavioral health therapy. The guidelines can assist mental healthcare professionals in developing outpatient alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. The care guidelines are developed in accordance with the principles of evidence-based medicine. In general, the care guidelines offer comprehensive recommendations for all steps in a patient's care plan.

10.3.1 The MCG clinical screening criteria are:

1. Explicit, written, objective, clinically valid, and compatible with established principles of healthcare.
2. Based on current clinical principles and processes.
3. Created by practicing clinicians involved in the development of appropriate criteria at all stages, thereby resulting in protocols that minimize data collection and reduce telephone time.

4. Designed to be flexible, allowing deviations from the norm, when justified, on an individual-case basis.
5. Individualized about length of stay (LOS) and review dates for each patient by age, diagnosis, procedure, and co-morbid conditions.
6. Able to be modified as necessary to meet local standards of medical practice.
7. Able to be overridden in the system by reviewers (initial clinical reviewers or psychiatric consultants) to meet the needs of specific cases.

All criteria are reviewed annually by the Quality Improvement Committee and updated or modified, if required and as per their recommendations. Established criteria are made available to practitioners upon request.

10.4 Staff Training and Qualifications

A formal initial program of orientation and ongoing training is provided for clinical staff at all levels. Staff is trained in the appropriate concepts, components and processes of Utilization, Care Management, Compliance, Quality, HEDIS, and any other applicable law or regulation. Additionally, the staff, including those handling denials and appeals, is trained in regulatory timeframes and requirements. All staff involved in clinical decision-making activities holds experience, degrees, and licensure in their field. The clinical staff is multidisciplinary in mental health related field; nursing, social work, psychology and can manage care in all general psychiatric, psychiatric subspecialty, and substance abuse areas.

First-level review staff includes Licensed Nurses with experience in General or Psychiatric Nursing (RN, BSN, or MSN), Licensed Clinical Social Workers, (MSW) or Clinical Psychologists, (MA). These reviewers complete all types of reviews, including pre-certification, on-site and/or telephonic concurrent review, discharge planning and referral to case management. Every service review that does not comply with the criteria to be approved is immediately referred to the Medical Consultant for clinical review, peer-to-peer discussion when applicable, and determination.

10.5 Authorization Process

10.5.1 Pre-Authorization of Services

The IMHD performs pre-authorization for: outpatient electroconvulsive therapy (ECT), partial hospitalization program (PHP), intensive outpatient services (IOP) and electroconvulsive therapy (ECT) services, neuropsychological testing, psychological testing, ambulance services, inpatient consults, outpatient services for psychologists and social workers, and home services.

The utilization management process assures that appropriate care is delivered to members according to clinical criteria in the context of an individualized treatment plan. When authorization is requested by a provider for any of these services, clinical information is obtained from the provider or designee. Once it is established that the member is eligible for benefits, the clinician reviews the clinical data that is provided and applies the applicable clinical guideline for the service requested (MCG, LCD, or internal clinical guideline) to determine if the patient's severity of symptoms meet criteria for the requested level of care.

It is the IMHD policy to authorize payment only for services that are medically necessary, clinically relevant and provided for the identification and/or treatment of a member's presenting symptoms. When a request for services is received, the Utilization Review Care Manager (URCM) registers and documents the case electronically and discusses the clinical needs of the member with the person requesting services and decides the type of request after applying Medicare Clinical Criteria.

The IMHD guarantees the preauthorization to be handled and process and will provide to each beneficiary or provider a pre-authorization number. Care is certified for a specific number of units and days span, typically for shorter intervals, and therefore reviewed more frequently.

For partial hospitalization and IOP initial authorization and verbal notice of authorization is given to the provider. For all levels of care, written confirmation of the certification is sent to provider and/or facility.

When a provider receives a certification for a member's treatment, he/she is instructed to contact the URCM or the IMHD prior to the certification expiration date, leaving enough time for concurrent review and re-certification so as not to interrupt benefit coverage of the member's treatment services.

10.5.2 Service Registration

The IMHD performs case registration for inpatient hospitalization. For each service requested, the Call Center Care Managers (CCCM) registers and documents

electronically the required clinical information and no medical necessity evaluation and or determination is made. The CCCM inform the facility and its designee of the onsite concurrent review process that will be performed by the assigned Utilization Review Care Manager to the facility. At the time of the case registration, no authorization is made, and case continued stay authorization depends on the onsite concurrent review process.

10.5.3 Continued Stay Reviews

The Utilization Review Care Manager conducts the continued stay review with a focus on continued severity of symptoms, appropriateness and intensity of treatment plan, patient progress and discharge planning, according to MCG for inpatient and IOP services and Medicare Local Coverage Guidelines for partial hospitalization services.

The continued stay review is accomplished by reviewing the member's records, discussions with the provider or appropriate facility staff, or other behavioral health practitioners. Cases not meeting the applicable clinical criteria require Medical Consultant referral and discussion. Any questionable or absent treatment plans, discharge plans or questions related to the quality and appropriateness of care being delivered are referred to Medical Consultant Staff for review.

At concurrent review, verbal notice of authorization is given to the provider with the request that the provider agree to notify the member. For all levels of care, written confirmation of the certification is sent to provider, and facility.

10.5.4 Adverse Determinations

The Utilization Review Care Managers are only authorized to certify/ authorize care. Only Psychiatric Medical Staff can make adverse determinations regarding a request for care. If an Utilization Review Care Manager questions the medical necessity and/or appropriateness of the recommended treatment as outlined in Medicare Local Coverage Clinical Guidelines, or if there are quality of care concerns, the case is referred to the Medical Consultant for final determination.

10.5.5 Discharge Planning and Case Management Referrals

Discharge planning begins at the time of admission and discharge plans are reviewed at each subsequent review. In situations where treatment is non-authorized, providers are informed of the implications for care and are assisted in receiving appropriate aftercare.

The Utilization Review Care Manager ensures that there is documentation of coordination of care between behavioral health and medical practitioners as well as between different behavioral health providers at various levels of care as part of the discharge planning process. The URCM ensure appropriate referral to Case Management and that there is involvement of the outpatient providers. In cases where there is a co-morbid physical health condition, the URCM assure that there is appropriate coordination between behavioral and medical providers by completing the Case Management Referral Form to Case Management Program.

10.5.6 Appeals

Providers, facilities, members, or their designated representatives have the right to initiate an appeal of any adverse determination. Such appeal may be made orally, in writing or via fax.

If an IMHD Medical Consultant makes a determination of no medical necessity for requested services, the member or treating provider may initiate the appeal process requesting reconsideration. Clinical reconsiderations are conducted by the Appeals and Grievances Department of the Health Plan. The member, member representative, or provider may submit any information they feel is pertinent to the appeal request and all such information is considered in the appeals review.

10.6 Case Management

The Behavioral Health Intensive Case Management Program (BHICM) is a specialized program designed to proactively manage and coordinate behavioral health care for certain members that have a behavioral health diagnosis and are at risk for admission to higher levels of care due to: low community tenure, decreased levels of functioning and diminished quality of life, among other situations. By assessing their circumstances and needs, developing a care management plan, and furnishing care management services, the program provides additional support to reduce acuity and increase the member's level of functioning, allowing them to maintain their roles in the home, family, and community.

The BHICM program consists of a specific approach to managing the care of clients who have not been able to stabilize with standard care management strategies. By working collaboratively with the UM staff and the Call Center Care managers, the program offers

a preventive activity program, assessment process, discharge planning, post discharge follow-ups, facilitation and advocacy strategies to meet individual needs and promote recovery.

The BHCM Program is focused on persons with severe mental conditions that require interventions in the mental health area. The assigned Case Manager ensures integrated services through ongoing communication with the provider(s) involved in the case, establishing linkages to family, support groups, service agencies, community and government services organizations, and any other appropriate resources. It is the process to connect and integrate physical and mental health systems that will help the person in his/her recovery.

The BHICM Program objectives are to:

- Improve patient health
- Improve patient care and care coordination
- Increase patient engagement
- Improve health outcomes
- Facilitate cross communication among providers, community supports, member and member advocates as needed.
- Assist in securing appropriate care and support service linkages.
- Assuring member safety.
- Manage the overutilization of ER and inpatient hospitalizations
- Provide timely, secure, and appropriate post-discharge follow-up

- Better educated members and providers.

Admission criteria to the program comprehend factors such as clinical presentation including co-morbidities, levels of support as well as utilization data rather than a reactive approach focused only on utilization. In addition to identifying members through inpatient admissions, the program analyzes available data sources to outreach those that may benefit from BHICM program. Data sources include encounter and claims data, utilization reports, readmission reports, ER utilization, utilization review data, or pharmacy data.

Based on the Behavioral Health Assessment, the BHICM program will place the member in care levels as detailed below, which drives the level of intensity of the interaction:

- **Care Level 1: Low Acuity** - Generally, members in this level will have low acuity for both behavioral and medical conditions
- **Care Level 2: Moderate Acuity** - Generally, members in this tier will have low acuity for behavioral health and higher acuity for medical health.
- **Care Level 3: Intermediate Acuity** - Generally, members in this tier will have higher acuity for behavioral health and lower acuity for medical health.
- **Care Level 4: High Acuity** - Generally, members in this tier will have higher acuity for behavioral health and higher acuity for medical health.

The BHICM program will re-assess the stratification level periodically based on changes in the member's needs. Based on the Behavioral Health Assessment the BHICM constructs a Care Plan that identifies the care management interventions to be provided.

The IBHCM will review relevant clinical practice guidelines to ensure goals established are consistent with the practices described in the guidelines. The plan is organized around a Problems-Goals-Intervention format with goals broken down into long term and short term. The BHICM and member set reasonable timeframes around goals that are measurable and achievable. The Care Plan focuses on prevention, continuity and coordination of care and member education regarding their condition and access to services. BHICM staff act as an advocate for and provide linkages to member services based upon their need.

The Care Plan considers and incorporates the evaluation of the social determinants of health, (e. g: the use of transportation, community resources, and natural supports (e.g. friends, family, neighbors, acquaintances, co-workers, volunteers, peers, and church members). Care Plan must be updated monthly at a minimum, but as frequently as indicated as problems are resolved, goals are achieved, or as additional problems are encountered. The care plan is shared with treating providers as appropriate.

Care management decision-making is based on *MCG Health* Level of Care Guidelines to determine an enrollee's appropriate level of care based on medical necessity and clinical needs, and APA (American Psychiatrist Association) Clinical Guidelines for Major Depression, Schizophrenia, and Attention-Deficit Hyperactivity Disorder (ADHD) to determine best practice for specific diagnoses.

10.7 Quality Improvement

The Quality Improvement Program of the IMHD is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. It is vital to the health of our members and our performance as a health plan.

Our Quality Improvement Program determines members' clinical and service needs. We maximize safe clinical practices and enhance member experience by developing, implementing, evaluating, and reporting on the various interventions/programs we use to improve clinical quality, and medical and behavioral health care outcomes.

To ensure that quality improvement activities are in place to monitor and measure the quality-of-care issues, the IMHD has designed an internal monitoring process that addresses quality of care issues to assure appropriate tracking, trending and follow-up. On an annual basis and in conjunction with the health plan Quality Department, we perform quality documentation audits among all behavioral health providers. The objective of these internally designed audits is to evaluate and score the performance of contracted behavioral health providers using an internally designed audit tool based on quality record documentation standards, and to make recommendations for improvement in the quality of behavioral health services provided to members. In our commitment with quality and our responsibility to assure quick and easy access to the right treatment, we also encourage our behavioral health providers to proceed in accordance with appointment access standards from the Centers for Medicare and

Medicaid Services (CMS). Patients should be seen within the timeframes listed below based on the severity of their clinical presentation:

1. **Routine**: Within 10 working days of the request
2. **Urgent**: Within 48 hours of the request
3. **Non-Life-Threatening Emergency**: Within 6 hours of the request
4. **Discharge from Inpatient Care**: Within seven days from the discharge date
5. **Behavioral Health routine follow up visits:** shall be scheduled and continually provided, on average, within 30 days of the previous appointment to evaluate patient's progress and other changes that have taken place since the previous visit.

Behavioral healthcare professionals are asked to make every effort to ensure compliance by seeing members within these standard access timeframes. It is expected that network healthcare professionals have the capability of 24-hour access for members in crisis and that voice mail messages, posters or any other type of communication contain clear instructions for accessing care in the event of a crisis. Those professionals who are unable to schedule a visit within standard access timeframes should immediately refer the member to an alternative referral through the healthcare professional directory or by contacting the Integrated Mental Health Department through our dedicated 24- hour toll free Call Center at 1-877-721-7722.

Quality issues and trends identified either by the Behavioral Health UM Program or the Quality Department and its Provider Quality Audits are measured and reported to the

Quality Improvement Committee (QIC). The QIC is comprised of representatives from key operational units and is responsible for ensuring the quality, cost effectiveness and continuous improvement of utilization review processes, case management, customer service, providers and other services delivered to members.

10.8 Inter-rater Reliability (IRR)

At least annually, the IMHD evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. This process includes physicians, UM clinical staff making medical and behavioral health and or substance use disorder determinations. *MCG Health* IRR test's tool is built to help UM staff to improve the accuracy and consistency of their guideline usage. It aims to measure the necessary skills for selecting and utilizing the guideline(s) most appropriate to the patient's condition and needs. Tests within the *MCG Health* IRR solution are comprised of case studies that challenge the user to review the patient's information, apply critical thinking, and identify the appropriate guideline to inform care decisions. IRR is designed to help users gain proficiency in guideline selection and application for patients with a variety of medical conditions and needs.

The following activities are also done to ensure consistency in clinical decision-making:

- Live supervision/call monitoring
- Documentation audits

The Utilization Review Supervisor administers the audits to all clinical staff involved in clinical decisions.

10.9 Support in UM

The MSO provides support to the UM program with involvement of the Chief Medical Officer, MSO Medical Directors, and the VP of Clinical Services of the Integrated Mental Health Department, who is a psychiatrist. Their support includes the following:

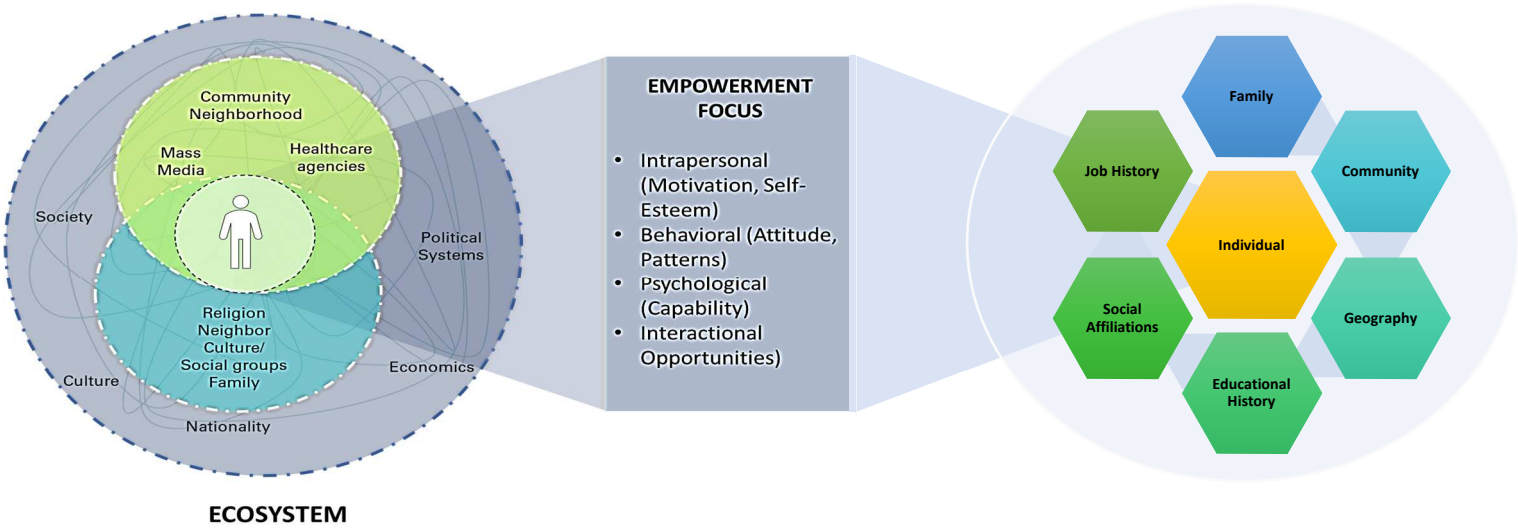
1. Review of medical and behavioral health UM policies.
2. Consultative support for medical and BH UM cases, and decision-making for all UM denials.
3. Engagement with staff on the design and implementation of initiatives which support the goals of the UM program.
4. Coordination with IPA Medical Directors for UM initiatives which require action by IPA physicians.

11. SOCIAL WORK PROGRAM

11.1 Social Work Program Framework

Behavioral and cultural patterns as well as the political and social status have direct impact on Puerto Rico's elderly population health Chronic conditions as Diabetes Mellitus, Heart diseases, among others are some of the comorbilities affecting elderly people in the Island. Adding together these social, demographic and clinical data elements, this population faces social challenges in their way to achieve positive health outcomes, especially due to the highest poverty level in the country and access barriers. Considering the exponential increase of elderly population in Puerto Rico, and the social problems they are facing like nutritional impact and challenges, lack of general resources, lack of support system, family neglect, mobility and functional issues, and housing problems, MSO established the Social Work Program.

The Social Work Program (SWP) promotes a better quality of life and pursue health equity by addressing social determinants of health, social needs and community health. The Social Work Case Managers (SWCM) acts like liaisons, educators, facilitators, linkage, advocates between members/member's relatives and resources and/or services available to remove barriers, improve overall health outcomes, achieve continuity of care and access to available services. The SWP framework is based on the Eco systemic theory which considers the individuals as part of a community or environmental system, in constant interactions with their components and being influenced by them. This model promotes empowerment and also seek to have a preventive approach considering potential future needs or issues. See figure 1:



MSO SWCM are fully inserted in the community and assigned by region in order to go where members are, so they can make accurate evaluation of member's needs, problems, support system and preferences. The purpose is to understand the community and the member's needs while incorporating a multidisciplinary approach to complement or strengthen the planned interventions.

The SWP is an opt-in and opt-out program and is open to the member's community across the board to make a referral or self-referral. A member may access the program through a referral form and other tools established in MSO to identify potential members for the program. The SWCM performs a home visit to complete a biopsychosocial assessment, evaluates available resources in the community and establishes a holistic care plan which includes coordination of services and resources in the community according to members/member's support system preferences, problems and needs. The community-based organizations and resources cannot be forced to assist the members, but the SWCM will exhaust all available resources to increase opportunities by

considering federal funded entities, local funded entities, county funded entities, non-profit private entities and church charity funds. The SWCM integrates the member's primary care physician and other healthcare providers related to members care informing health issues impacted by identified social determinants to facilitate clinical evaluations or service access. The SWCM integrates all community resources in the Interdisciplinary Care Team (ICT) and involves them in the care plan management when applicable to assist members in meeting their established goals.

SWP provides the following benefits and services for our members in order to empower them, provide access to community services and facilitate care coordination and continuity of care:

a. Personalized services and dedicated Social Work Case Manager
b. Direct access to Social Workers through cell phones.
c. Face-to-face visits.
d. Biopsychosocial assessment for better needs identification.
e. Medication management review to promote appropriate management and adherence.
f. Integration of all involved parties in member's health care.
g. Referrals to community organizations.
h. Case discussions to obtain effective solutions and alternatives.
i. Education about home emergency planning.

j. Clinical Programs inclusion (Complex Case Management, Discharge Planning, Disease Management, Telehealth, Caregiver program, Behavioral Health, among others.

k. Telephone follow-up to members, caregivers, providers and community agencies.

l. Other field visits (medical offices, community organizations, etc.)

m. Meetings with family members.

n. Coaching and empowerment of people on condition management, decision making and service access.

To facilitate access to the program, referrals are allowed to be made from different sources (internal and external). This may include hospital staff, physicians, internal clinical staff, members or relatives, medical groups, community resources, among others. The program inclusion criteria are established to identify the most vulnerable members:

Social factors

- No permanent dwelling (homeless)
- Inability to self-care and: does not have a caregiver or does not have support from family or close people
- Feeding or food preparation problems
- Lives in subhuman conditions (extremely unsuitable for a human being)

- Self neglect with healthcare due to: no clinical follow-up, does not comply with clinical recommendations (diet, instructions, treatment or medication)
- Transportation issues to seek medical care and/or cover basic needs
- Unsafe or Inappropriate household infrastructure due to: relocating furniture is required, inappropriate spaces for mobility, have electrical issues, the level of health in the community or surroundings, or other factor, may threaten member's physical safety
- Financial to seek medical care and/or cover basic needs
- Little or no functional ability to perform activities

Other clinical factors related to social issues:

(Must meet at least one social factor)

- Need clinical services coordination
- Multiple admissions
- Multiple visits to the emergency room due to inappropriate care or lack of resources (financial or human)
- Multiple readmissions
- Inappropriate ulcers or wounds care management
- Alzheimer
- Dementia
- Memory loss

- Non-adherent to medication

Non-adherent to treatment: The referral form for the Social Work Program is available in the E-Folder in InnovaMD and can be sent by fax (787-999-2191) or email (sw-referrals@mmmhc.com).

12. PHYSICAL THERAPY & EYE CARE

12.1 Therapy Network of Puerto Rico

Therapy Network of Puerto Rico (TNPR) has been the provider network for Inpatient and Outpatient [2] Physiatrist and Outpatient [2] Physical Therapy, Occupational Therapy, and Speech Therapy services for all MSO clients since 2010. Therapy Network of Puerto Rico is an affiliate of Health Network One, and their back-office operations are NCQA Certified.

Whenever you need to refer a patient for Therapy/Rehab services, all that is needed is a medical order (although using the official MSO referral form is highly recommended) stating the diagnosis to be treated, the therapist will evaluate the patient's condition and

will be responsible for establishing and completing the treatment plan. The therapist will discharge the patient back to the referring provider once the rehab goals have been reached.

TNPR providers are committed to provide the highest quality of service. You should have the patient select a provider from TNPR's contracted provider directory, which is available via InnovaMD. You may also contact TNPR to obtain an updated list of their contracted providers in your area by calling TNPR's Provider Services Department at 1-877-614-5056 Option 2, or via fax at 1-877-403-5544.

Feel free to contact TNPR If you have any suggestions, comments, or feedback of their services.

(1) If you are a physiatrist, or a therapist active on TNPR's Network please refer to TNPR's Provider Manual for an in-depth orientation.

(2) TNPR's Provider Network is contracted for Outpatient and Inpatient Physical Medicine and Rehabilitation services and for Outpatient Therapy services ONLY. Inpatient Therapy services ARE NOT included in the scope of TNPR's Authorization Process and is subject to the patient's Health Plan Authorization Policies and Procedures.

12.2 Eye Management of Puerto Rico

Eye Management of Puerto Rico (EMPR) has been the provider network for all MMM clients since 2019. Eye Management of Puerto Rico of Puerto Rico is an affiliate of Health Network One, and their back-office operations are NCQA Certified. Eye

Management of Puerto Rico (EMPR) is an affiliate of EMI and has been operating in Puerto Rico for 2 years.

EMPR provides routine eye care services and medically indicated eyewear services and benefits and is committed with the provision of comprehensive, integrated, eye care services that support the delivery of quality, cost-efficient health care.

You should have the patient select a provider from EMPR's contracted provider directory, which is available via InnovaMD. You may also contact EMPR to obtain an updated list of their contracted providers. Please, confirm member specific eligibility prior to rendering services. You have three convenient methods for verifying specific individual member benefits and eligibility: through the Inmediata website at (www.inmediata.com), by logging into EMPR provider portal Eye Health Manager (www.envolvevision.com/logon) or calling Evolve Vision's Customer Service at (844) 833-1905.

Feel free to contact EMPR If you have any suggestions, comments, or feedback of their services.

(1) If you are an Optometrist, or an Ophthalmologist active on EMPR's Network please refer to EMPR's Provider Manual for an in-depth orientation.

13. STAR RATING PROGRAM

13.1 CMS Medicare Advantage Star Ratings

Higher quality means better care and value. Therefore, CMS has created a rating system that helps patients select a health plan that offers the best quality services. Reviewing plan quality measures allows beneficiaries to know the overall performance of the plan in different categories. CMS develops Part C and Part D Plan Ratings in advance of the annual enrollment period each fall.

We refer to this program as the 5-Star Rating Program. This rating system covers an array of measures that fluctuate between 46 and 55, hailing from 4 different data sources (HEDIS, Member Surveys, CMS Audits, Plan Administrative Measures) and rates performance in 9 domains (5 for health plans and 4 for drug plans). The rating process is based on a scale from one (1) to five (5) star, 5 stars being the highest quality performance attainable. CMS defines the star system ratings in the following manner:

Every year, CMS reviews the results obtained and adjusts to add or remove measures. It also changes benchmarks, based on results from all Medicare Advantage plans.

13.2 Data Source for Star Measures

Stars measures are derived from three fundamentally different components:

1. Clinical measures:
    a. Healthcare Effectiveness Data and Information Set (HEDIS) measures: It is calculated from administrative (claims), hybrid (record review) data and electronic clinical data systems (ECDS).
    b. Medication use measures:

Different from HEDIS measures Calculated from Prescription Drug Event (PDE) data – contains prescription drug cost and payment data that enables CMS to make payments to plans and administer the Part D benefit.

c. Member survey measures:

This measure uses member responses from annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcome Surveys (HOS).

In addition, this data source is considered subjective, as it relies on the opinion of members. Interestingly, most of the questions made through these surveys are related to the experience of the member with his/her provider(s), and not necessarily with the services of the plan. The surveys are conducted to a sample of members who first receive the document by mail, and then are followed up by phone if no response is received. Both surveys are conducted by an external vendor, not by plan staff.

d. Administrative Plan-level measures:

CMS monitors plan performance in all aspects and activities, considering compliance with guidelines and regulations. Some aspects that form part of these measures include:

i. Appeals and grievance resolution, including the process being done in a timely manner and according to guidelines.

ii. CMS Complaint Tracking Module (CTM) - Volume of complaints registered against the plan.

iii. Call Center Performance

iv. Care Management processes, such as health risk assessments, and comprehensive medication reviews.

v. Data integrity, and overall audit program results

13.3 New Measures

CMS constantly makes changes to the methodology including the addition of new measures. A display measure is one that CMS monitors, and can be included in Stars Rating. Once CMS decides to add a display measure to the methodology, it usually is calculated from past performance, thus the importance to begin measuring them in advance.

13.3.1 The following measures have been announced by CMS as measures that will be included beginning with Measurement Year 2021 but not yet for Star Rating Program:

1. Cardiac Rehabilitation (CRE): The description of the measure is the percentage of members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event. Including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Will measure the adherence to rehabilitation program.
2. *Kidney Health Evaluation for Patients with Diabetes (KED): The description of the measure is the percentage of members 18-85 years of age with diabetes (type1 and type 2) who received a kidney evaluation. Defined by

an estimated glomerular filtration rate (eGFR) **and** a quantitative urine albumin-creatinine ratio (uACR), paired with a urine creatinine test during the measurement year.

3. Osteoporosis Screening for Older Women (OSW): The description is the percentage of women 65-75 years of age who received osteoporosis screening. Will be measured through radiology study claims- Bone Mineral Density tests.

13.3.2 The following describes changes to existing measures:

1. Controlling High Blood Pressure - CBP: NCQA revised the time frame in the event/diagnosis criteria to look for two outpatient encounters with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year to identify the denominator. Added telephone visits, e-visits and virtual check-ins as appropriate settings for BP readings. In addition, now allow BPs taken by any digital device and reading reported or taken by the member (members can't use manual cuff for the readings).
2. Comprehensive Diabetes Care -CDC: Added codes for unilateral eye enucleation and Nebivolol-valsartan to the "Antihypertensive combinations" as ACE inhibitor.

13.3.3 The following are display measures that have a high priority for observation as they may be included in the near future:

1. PBH – Persistence of Beta-Blocker Treatment after a Heart Attack: This measures captures the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-clocker treatment for six months after discharge.
2. AMM – Antidepressant Medication Management: This measure considers the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.
    a. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
    b. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6months).
3. FUH – Follow-Up After Hospitalization for Mental Illness: This measure is based on the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient

encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

a. The percentage of discharges for which the member received follow-up within 30 days of discharge.
b. The percentage of discharges for which the member received follow-up within 7 days of discharge.

4. Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET).

5. Transitions of Care (Part C): CMS is working with NCQA to expand efforts to better evaluate a plan's success at effectively transitioning care from a clinical setting to home. The intent of the measure is to improve the quality of care transitions from an inpatient setting to home, as effective transitioning will help reduce hospital readmissions, costs, and adverse events. The measure includes the percent of discharges for members 18 years or older who have each of the four indicators during the measurement year:

a) Notification of Inpatient Admission
b) Receipt of Discharge Information
c) Patient Engagement after inpatient discharge (encounter)
d) Post-Discharge Medication Reconciliation

TRC measure will be implemented on MY2022 with a weight of 1.

6. Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions -FMC: CMS is adding to the 2020 display page a new HEDIS measure assessing follow-up care provided after an emergency department visit for patients with multiple chronic conditions. FMC will be implemented in MY2022 with a weight of 1.
7. Utilization of PHQ-9 to monitor depression symptoms for adolescents and adults – DMS: The eligible population for the measure is patients 12 years of age or older as of December 31 of the measurement year. This measure requires at least one encounter with a diagnostic of major depression or dysthymia and the result of the PHQ-9 test administered in the same evaluation period as the encounter.

   The measurement period is divided into three specific evaluation periods:

   Evaluation period 1: January 1 to April 30

   Evaluation period 2: May 1 to August 31

   Evaluation period 3: September 1, to December 31

13.3.4 CMS is currently working with the review of potential new measures related to the following:

1. Opioid Overuse including PQA endorsed measures:
   a. Concurrent use of opioids and benzodiazepines
   b. Adherence to non-infused disease modifying agents to treat MS

2. Assessment of Care for People with Multiple High-Risk Chronic Conditions, this new measure would assess the percentage of members who had an expended assessment during the measurement year.
3. Alcohol screening and follow-up.
4. Unhealthy alcohol use screening and follow-up.
5. Readmission for Post-Acute Care.
6. Appropriate Pain Management.
7. Adult Immunization Measure.
8. Anxiety.
9. Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults.
10. Adherence to Non-Warfarin Oral Anticoagulants (ADH-NWOA).
11. Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis.
12. Pain Management.
13. Adherence to Antipsychotic Medications for Individuals with Schizophrenia.
14. Antibiotic Utilization Measures.
15. Diabetes Overtreatment.
16. Cross-Cutting Topic – Measure Digitalization.
17. Physician/Plan Interactions.
18. Interoperability Measures.
19. Patient Reported Outcome Measures.

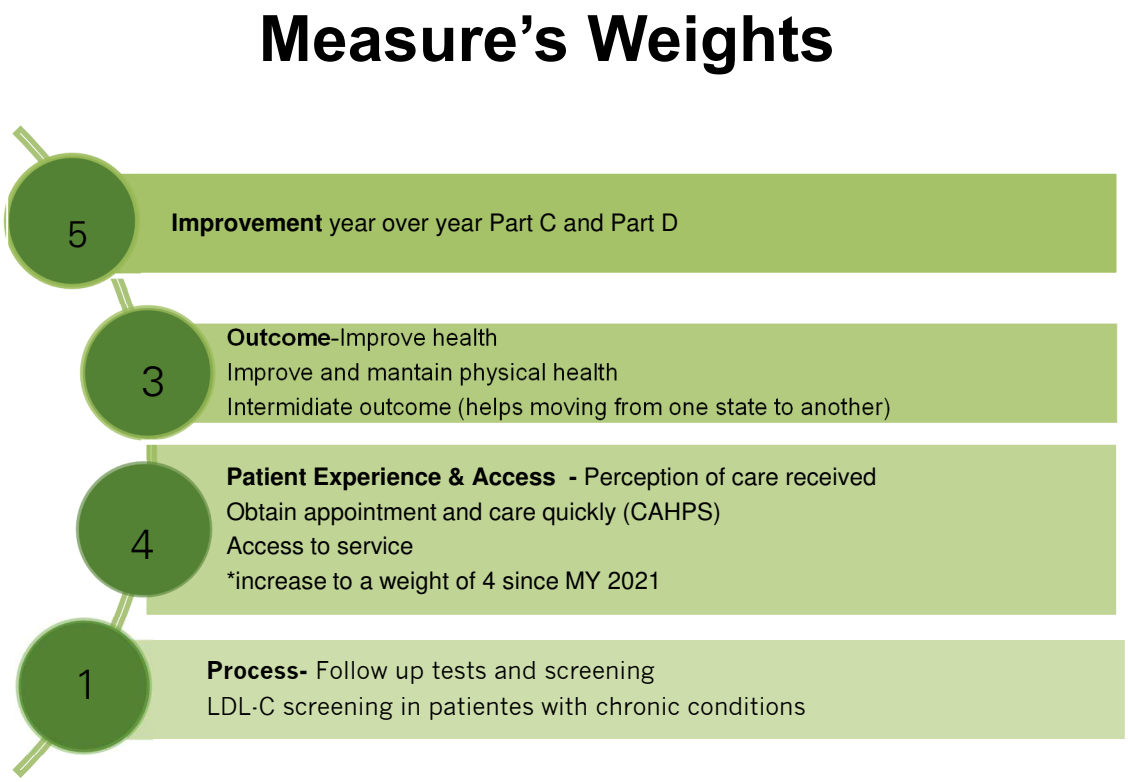
13.3.5. Changes to existing Star Ratings and Display Measures

1. Transitions of Care -TRC: Some of the most important changes are:
    - Notification of Admission – Now allow up to 3 days. Admission day plus 2 additional days.
    - Notification of Discharge – Now allow up to 3 days. Discharge day plus 2 additional days.
    - Patient engagement – Now added e-visits and telehealth
    - Measure will be implemented in MY 2022 with a weight of 1.
2. Follow-Up After Mental Illness -FUH: Added visits in a behavioral healthcare setting and telephone visit to the numerator. See measure description on section 13.3.3.
3. Improving or Maintaining Physical Health: Will be moved to display for the 2024 and 2025 Star Ratings and return to the 2026 Star Rating.
4. Improving and Maintaining Mental Health: Wil be moved to display for the 2024 and 2025 Star rating and return to the 2026 Star Rating.

13.4 Weighting of Measures

CMS assigns weight to the different measures to calculate the overall Star rating of the plan. The highest weights are assigned to health outcome measures (such as Plan All Cause Readmissions), and the lowest weights are assigned to process measures (such as preventive screenings). The following tables indicate the weight assigned to the measures under Medicare Parts C & D. A measure given a weight of 3 counts three times as much as a measure given a weight of 1. Additionally, starting with Rating Year

2016 and beyond, CMS has assigned a weight of 5 to improvement measures, which calculate how much the plan has improved in its measure results year over year.



2022 Medicare Part C and D Star Ratings Weight

Part C or D	Measure	Measure Type	Weight
C	Breast Cancer Screening	Process Measure	1
C	Colorectal Cancer Screening	Process Measure	1
C	Annual Flu Vaccine	Process Measure	1

C	Improving or Maintaining Physical Health	Outcome Measure	Display
C	Improving or Maintaining Mental Health	Outcome Measure	Display
C	Monitoring Physical Activity	Process Measure	1
C	Special Needs Plan (SNP) Care Management	Process Measure	1
C	Care for Older Adults – Medication Review	Process Measure	1
C	Care for Older Adults – Functional Status Assessment	Process Measure	Display
C	Care for Older Adults – Pain Assessment	Process Measure	1
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1
C	Diabetes Care – Eye Exam	Process Measure	1
C	Diabetes Care – Kidney Disease Monitoring	Process Measure	1
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3
C	Controlling Blood Pressure	Intermediate Outcome Measure	3

C	Rheumatoid Arthritis Management	Process Measure	1
C	Reducing Risk of Falling	Process Measure	1
C	Improving Bladder Control	Process Measure	1
C	Medication Reconciliation Post-Discharge	Process Measure	1
C	Plan All-Cause Readmissions	Outcome Measure	1
C	Getting Needed Care	Patients' Experience and Complaints Measure	2
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2
C	Customer Service	Patients' Experience and Complaints Measure	2
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2

C	Care Coordination	Patients' Experience and Complaints Measure	2
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
C	Health Plan Quality Improvement	Improvement Measure	5
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2
C	Reviewing Appeals Decisions	Measures Capturing Access	2
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
C	Statin therapy for Patients with Cardiovascular Disease	Process Measure	1
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2

D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2
D	Drug Plan Quality Improvement	Improvement Measure	5
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2
D	MPF Price Accuracy	Process Measure	1
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3
D	MTM Program Completion Rate for CMR	Process Measure	1
D	Statin Use in Persons with Diabetes	Intermediate Outcome Measure	1

New measures inserted within the methodology are always weighted at 1 during the first year of inclusion, and then weighted according to the measure type at 1, 1.5, 3 or 5.

13.5 Part D Measures

There are multiple components to CMS's evaluation of medication-related quality across Medicare Parts C and D. Medicare Advantage plans that include drug benefits (MAPDs) are subject to performance measures for Parts C and D. Medicare Part D stars are applicable to MAPDs and stand-alone PDPs. The stars are assigned based on performance measures across four domains. The four domains are:

1. Drug Plan Customer Service
2. Member Complaints, Problems Accessing Services, and Leaving the Plan
3. Member Experience with Drug Plan
4. Drug Pricing and Patient Safety

In addition to plan ratings, CMS also uses Display Measures to provide further evaluation of Part D plans on medication safety. The Display Measures are not included in the plan ratings but are used to facilitate quality improvement by the plans. CMS maintains a "safety website" that provides the benchmarks and scores to the plans.

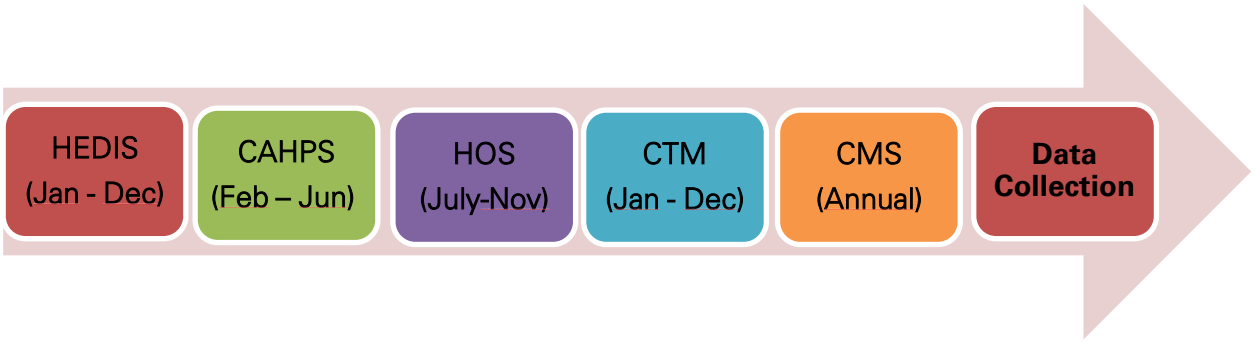
In order to assure appropriate quality programs, health plans design several drug utilization management programs. Some of these programs include prior authorization, step therapies, synchronization of drugs dispensing, and therapy edits among others.

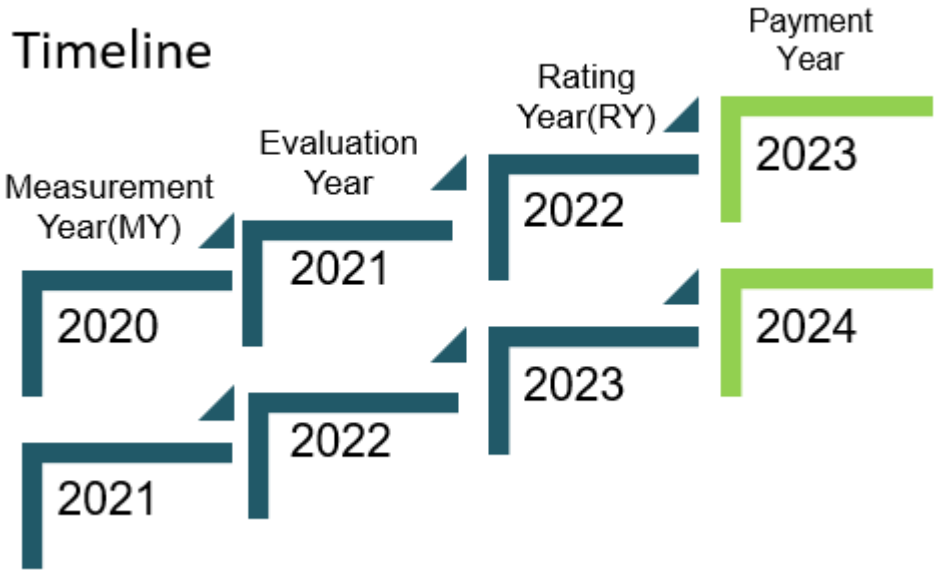
13.5.1 Note to Physicians

Each time your patients visit you, please make sure they are taking their medications as prescribed and are picking up their refills on time. Make use of the adherence reports published through InnovaMD 2.0 and maximize the use of 90 days fills, whenever possible.

13.6 Timeframes for Data Collection:

13.6.1 **Data Collection**





*The Rating is announced in October of the year prior to the Rating Year. For example, the Rating for 2022 will be announced in October of 2021, based upon performance of

2020. Technical Notes from CMS including Cut Points by measure will be made public just one month prior to the rating being announced.

13.7 Main Questions from Member Surveys - CAHPS and HOS

As part of the data collection method and rating system, CMS uses survey tools to identify patient satisfaction and wellness. We encourage you to review the questions below and to evaluate your practice to ensure that your patients can respond favorably if asked about the following:

13.7.1 Health Outcome Survey (HOS):

CMS defines the Medicare Health Outcomes Survey (HOS) as an assessment of a Medicare Advantage Organization's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period, using the best available science in functional status and health outcomes measurement. The survey is used to measure how the care provided by the plan is affecting the functional status of their enrollees. HOS results are included in the CMS MA Quality and Performance Plan Ratings System. The plan contracts an external vendor to perform the survey on its behalf; the results are then sent to CMS. It reports the percent of all plan members whose physical health was the same or better than expected after two years, which means that the results of the survey made this year will be compared to the responses made by the same members two years ago.

1. Monitoring Physical Activity

Percent of senior plan members who discussed exercise with their physician and were advised to start, increase or maintain their physical activity during the year. For Example;

a. In the past 12 months, did you talk with a physician or other health provider about your level of exercise or physical activity? For example, a physician or other health provider may ask if you exercise regularly or take part in physical exercise.
b. In the past 12 months, did a physician or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your physician or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

The survey also reports the percent of all plan members whose mental health was the same or better than expected after two years.

2. Improving Bladder Control

Many people experience problems with urinary incontinence, the leakage of urine.

a. How often, if ever, do you have difficulty controlling urination (bladder accidents)?
b. During the past 6 months, have you accidentally leaked urine? How much of a problem, if any, was the urine leakage for you?

c. There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?

13.7.2 Risk of Falling

Percent of plan members with a problem falling, walking or balancing who discussed it with their physician and got treatment for it during the year. A fall is when your body goes to the ground without being pushed.

1. During the past 12 months, did your physician or other health provider talk with you about falls or problems with balance or walking?
2. Have you fallen in the past 12 months?
3. Has your physician or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might suggest including:
    a. That you use a cane or walker
    b. To check your blood pressure lying or standing
    c. That you follow an exercise or physical therapy program

13.7.3 Consumers Assessment of Healthcare Providers and Systems (CAHPS)

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is a member satisfaction survey conducted annually to assess the experiences of beneficiaries in Medicare Advantage plans. The survey is sponsored by CMS to collect information to fulfill a requirement of Congress (under the Balanced

Budget Act of 1997 and Medicare Modernization Act of 2003). Consumer evaluations of health care, such as those collected through the Medicare CAHPS® surveys, measure important aspects of a patient's experience that cannot be assessed by other means. For scoring and reporting purposes, some questions are combined into the following 6 composite measures:

- Getting Needed Care
- Getting Appointments and Care Quickly
- Doctors Who Communicate Well (reported to contracts – not reported to consumers
- Customer Service
- Getting Needed Prescription Drugs (MA-PD and PDP)
- Care Coordination

In addition, there are questions about members overall ratings for Health Plan, Healthcare quality and Drug Plan. Some examples of the questions are as follows:

1. <u>Getting Needed Care:</u>
    - During the last 6 months, how often was it easy to get appointments with specialists?
    - During the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your healthcare at a physician’s office or clinic as soon as you thought you needed?
    - During the last 6 months, how often did you see the doctor you were scheduled to see within 15 minutes of your appointment?

2. Overall rating of personal physician:

   Using a scale from 0 to 10, where 0 is the worst personal physician possible and 10 is the best personal physician possible, what number would you use to rate your personal physician?

3. Overall rating of specialists:

   We want to know your rating of the specialists you saw most often during the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialists you visited?

4. Medicare-Specific and HEDIS Measures: Influenza Vaccination

   Have you had a flu shot since July 1, of last year?

5. Medicare-Specific and HEDIS Measures: Follow-up with Test Results:

   During the last 6 months, when your personal physician ordered a blood test, X ray, or other test for you, how often did someone from your physician's office follow-up to give you those results?

6. Single Item - After Hours Call:

   During the last 6 months, did you phone a physician's office or clinic with a medical question after regular office hours?

7. Single Item - Answer as soon as needed:

   During the last 6 months, when you phoned your physician's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?

8. Single Item - Timing of Callback:

   During the last 6 months, when you phoned your physician's office or clinic after regular office hours, how long did it take for someone to call you back?

These are just some examples of the questions contained in these surveys. For more information about content and scope of the questionnaires, you may access the following web portals:

a. http://www.hosonline.org/

b. http://www.ma-pdpcahps.org/en/survey-instruments/

As a provider you should orient the patient and caregiver of the importance of completing the survey, clarify doubts and explain how the services that the survey asks for have been offered. Remember that the result of this survey is a reflex of the patient experience in your office.

13.8 Recommendations that Support the Star Ratings

13.8.1 Pre-Visit Actions:

A. For patients with scheduled appointments:

1. Coordinate patient appointments per hour and instruct patients and their caregivers to carry the results of laboratory tests and specialist consultations.
2. Review record prior to visit to identify gaps in preventive screening/Chronic care.

3. Use the Quality Improvement Monthly Statement or access the SMART Profile to identify gaps for those services which have a measurement period of more than 1 year:
    a. Breast cancer screening
    b. Colorectal screening
4. Pre-authorize prior to the date of service, coordination of appointments after hospital discharge and medication reconciliation.

B. Use Pharmacy Adherence Report or SMART Profile to identify patients whose pharmacy record does not demonstrate adherence with prescribed treatment for:
    1. Diabetes medications
    2. ACEI/ARBs
    3. Statins
    4. Establish process for office staff to inquire about recent admissions during the registration process and document any admission information.
    5. Establish process to place checklist (provided by Plan) in all patient records that do not have one.
    6. For walk-in patients, provide a brief questionnaire regarding any health status changes, as well as including the HOS survey questions.

C. During Patient Encounters:
    1. Complete the Annual Health Assessment once per year

2. Conduct medication reconciliation for any patients with hospital discharges less than 30 days prior to office visit. Ask patient if they have seen any specialists, or had a change in medications since the last office visit
3. Based on plan reports or chart information, discuss with patient any gaps in preventive screening/chronic care management/medication adherence
4. Discuss any barriers to complete services/taking prescriptions
5. Provide orders/referrals for gap services/medications
6. For all patients whose record does not indicate discussion during the current calendar year:
    a. Discuss & document current level of exercise or physical activity and offer recommendations to start, increase, or maintain level of exercise or physical activity
    b. Ask patients if they have had any episodes of urinary incontinence and assess if treatment is working. Document discussion and any recommendations.
7. Ask patients if they have had any problems with balance, walking, or falls.
8. As necessary, discuss fall risk avoidance strategies. Document discussion and recommendations.

9. For female patients with a fracture less than 6 months prior to visit, review record for evidence of bone mineral density test or drug for treatment/prevention of osteoporosis and prescribe if not present.
10. For all hypertensive patients, document a Blood Pressure reading. Remember that controlling blood pressure is an essential element of care management. For the purposes of HEDIS, values equal or less than 139/89 indicate control.
11. Discuss test results that have been received since the patient's last visit. Access InnovaMD for information about results.
12. Make it clear to the patient, that through electronic media you do have access to his full clinical information and services provided by other providers.

D. <u>After Patient Visits Encounter</u>

1. Establish and utilize tracking logs, including follow-up to patients for:
    a. Return visits
    b. Specialist referrals
    c. Diagnostic testing (lab work and imaging)
    d. Medication adherence
    e. Identify members with history of non-compliance and refer to Case Management services at MSO.

f. Promote the participation of patients in clinical preventive care, so that they comply and request the results of medical services to be documented in follow-up meetings.

g. Ensure timely submission of your encounters, and other than procedures, include also proper documentation of diagnosis and results using corresponding ICD-10 codes, as well as CPT category II codes (F codes). You may use the Stars Quick Reference Guide (*Guía Rápida de Estrellas* in Spanish) for information about codes related to Stars Rating methodology measures.

Review your claims status and reconcile to make sure all your claims went through your clearinghouse.

14. SUPPORT SERVICE

14.1 Provider Call Center

The Service Operations Department is your connection to MSO and its clients. Our Provider Call Center Representatives will be your liaisons and advocates should you have any questions or concerns regarding your relationship with MSO. In our Provider Call Center, you can reach the InnovaMD Support Team who can assist you in the education and troubleshooting for InnovaMD Portal. We also have a Dental Provider Call Center to assist all dental care providers.

Provider Call Center's service hours are Monday through Friday, from 7:00 a.m. to 7:00 p.m.

14.1.1 Provider Representatives can assist you with:

- Education and Training
- Issues with Claims Payment
- Interpreting Reports and other documents
- Authorization Requests for Health Service

- Understanding your Contract
- Policies and Procedures
- Filing an Appeal or Grievance
- Accessing our Website for Authorization and Claims
- Credentialing and Recredentialing
- Changes in Provider information

The InnovaMD Support Team Call Center service hours are Monday through Friday, from 7:00 a.m. to 7:00 p.m. They can assist you with Technical Support in:

- Portal access problems
- Password Change
- Add or Delete Contacts
- Assign privileges or applications by contacts
- Education
- Registry Process
- Applications
- Pre-authorizations
- Eligibility
- Membership Management
- AHA
- Referrals
- Others

14.1.2 Call Center Claims Adjustment Unit can assist you in the processing at the same call of the following claims denials:

- Service not authorized by network/primary care providers
- The time limit for filling has expired
- Benefit maximum for this time period or occurrence had been reach
- No Enrollment

- Missing Referral Form
- Or any other claims that the PCC Rep identifies an internal error.

Contact your Provider Call Center Representative by calling 1-866-676-6060 (toll free), 787-993-2317, Monday through Friday, from 7:00 a.m. to 7:00 p.m.

For our Dental Provider Call Center 1-877-522-0670 (toll free), 787-522-5699 (toll free), Monday through Friday 7:00 a.m. to 7:00 p.m.

For our InnovaMD Support Team Call Center 787-993-2317 (Metro Area) 1-866-676-6060 (toll free) Monday through Friday 7:00 a.m. to 7:00 p.m.

14.2 Procare Unit

The Procare Unit is a team of highly skilled professionals dedicated to quickly attend and respond to provider issues.

14.2.1 Unit responsibilities:

1. Assisting providers who arrive directly (walk-in) at Kennedy Avenue offices.
2. Conducting research in order to resolve provider claims issues.
3. Acting as liaisons between providers, provider service representatives (External and Internal), Claims Department, Medical Affairs and other internal departments.
4. Drafting confirmation letters regarding claims status and audit results.
5. Offering expert claims and billing orientation to providers.
6. Interpreting reports and other documents.
7. In the Regional Offices, we establish meeting with the Providers in a coordinated manner.

To contact a Procare Representative, you must visit the first floor of the MMM Building at Kennedy Avenue, Monday through Friday, from 7:30 a.m. to 4:30 p.m.

14.3 External Provider Representative

The External Provider Representative Unit is dedicated to attending and responding to a provider's onsite needs. These representatives will act as provider liaisons to address any questions or concerns regarding your relationship with MMM and any other MSO client. This unit can assist providers with:

1. Understanding Your Contract
2. Contracting and Re-contracting
3. Credentialing and Recredentialing
4. Demographic changes
5. Education and Training
    a) Accessing InnovaMD.com for Membership Management: Authorizations, Referrals, Clinical Viewer, Beneficiary Eligibility, Porvider Directory, Hospital Census, Quality Statement (Five Stars, Virtual Appointment, Formulary Search, Claims Status, EOP and Smart Profile among others
    b) New Product Orientation and Benefit Changes.
    c) Managed Care and Quality Seminars responsible for maintaining our provider network fully oriented about company procedures and policies.

6. Model of Care (MOC) Orientations
7. Fraud, Waste and Abuse (FWA) Orientations
8. Filing an Appeal or Grievance
9. Provider Service give orientation of new processes and regulations as required.
10. Provider Service give orientation on Provider Compensation Model.
11. Interpreting Reports, performance and opportunities.
12. Changes in Provider Information and Provider profile.
13. Expert orientation for claims and billing
14. Solve issues in a reasonable timeframe to provide a final answer to Providers.
15. Developing claims reports to assist providers in auditing and reconciliation processes.
16. Distribution of Annual Summary of Benefits information.
17. Invite providers to Educational Activities.
18. Office Advantage Program orientation and enrollment

Contact your External Provider Representative and request a visit by calling:

MSO Provider Services Call Center	
(787) 993-2317 (Metro Area)	1 (866) 676-6060 (toll free)

14.4 InfoMed - Interactive Voice Response System (IVR)

InfoMed is an interactive voice system that allows providers to obtain automatic Information 24 hours a day, 7 days a week. This convenient system is easy to use because there is no need to wait for a Provider Service Representative to answer your phone call. Please note all information submitted to the system will be treated as confidential.

14.4.1 How to use the InfoMed system

To ensure increased security, an upgrade was installed to the system that requires you to include the NPI number and the last 4 digits of your social security number (or the ESN number) to guarantee secure sharing of information. This process ensures that only the provider will have access to the required information. Please follow the instructions provided by the system to obtain the information you need.

AVAILABLE SERVICES

• Verification of eligibility	• Request a Payment History
• Claims Status	• Preauthorization Status
• Verification of last payments	• Request Preauthorization Letters by fax or email

We have designed this system with provider needs in mind. Remember that you always have this option when you need to obtain quick, precise and reliable information.

The advantages of the InfoMed System are:

1. **Available 24 hours a day, 7 days week**
2. **No waiting time – Fully automated**
3. **Easy to use**

14.5 Office Advantage Rewards Program

The Office Advantage Rewards Program is a revolutionary tool focused on the staff of our providers' offices, with the objective of promoting professional performance while increasing the quality of service offered to members. The program has been designed to:

1. Motivate better performance from the staff
2. Recognize the important role that the office staff has over the service that members receive.

Presently, the staff of Primary Care Physicians and Provider Specialists can form part of the Office Advantage Rewards Program. Participation requires the staff to submit an enrollment request through the Office Advantage Application on InnovaMD portal and that the contracted provider for whom they work authorizes participation.

Authorized staff may be eligible to receive incentives based on criteria that may consider some of the following elements and metrics:

1. Quality
2. Technology Adoption
3. Utilization
4. Population Management

PCP Incentives Metrics

Metric	Objective
AHAs	Payment made by tier of membership 1 - 100 = $7.00 101 – 150 =$8.00 150= $10.00
Smart Profile	At least 75% print or download of Smart Paper for the members the same day of the encounter per quarter
PRAI Bonus	Reach 90% of PRAI submission. Payment made by tier of membership: 450+= $500 301 – 449= $300 151 – 300= $200 0 – 150= $100
Transition of Care	Coordinate the appointment of members within 7 days after discharge and submit the reconciliation of medications
Stars	Incentive based on tiers. 4.5 Stars = 50% 5 Stars = 100%
Encounters	Submit 75% of unique encounters per office per quarter
Member Satisfaction	Reach 95% of Member Satisfaction based on CAHPS surveys and measures.

Metric	Requirements
Electronic PA	Required to submit 85% of the preauthorization electronically
Smart Profile	Print or download 60% of Smart Profile for the member the same day of the encounter, each month of the quarter.
Member Satisfaction	Reach 90% of Member Satisfaction based on CAHPS surveys and measures.
Stars	Incentive based on tiers. (Only Value Based providers) 4.5 Stars = 50% 5 Stars = 100%

Specialist Incentives Metrics

Incentives may be paid quarterly or annually depending on the type of incentive to be paid. Incentives are paid per participating office and distributed equitably among staff authorized to participate. The amounts to be paid depend on the administrative effort required to comply with performance metrics, including volume of patients served. The program includes the following features:

1. Educational and Training Events:
    - These events focus on professional development topics as well as operational training for the use of technological tools

2. Rewards Program

For every point metric achieved each month the participant will receive Points.

1. Points: will be used to redeem different prizes that will be available through a catalog.

2. PCP Metrics Points:

Metric	Description
Educational Modules	**Complete 2 educational modules from InnovaMD Learning Center, per month**
Members App	**Ensure that 60% of assigned members are registered in MMM Movile App**
Member Education	**Participation in meetings and support in coordination of seminars to educate members on our products.**

3. PCP Points Accumulation:

AFILIADOS POR OFICINA	MEMBERS APP*	MÓDULOS EDUCATIVOS	EDUCACIÓN AL AFILIADO	PUNTOS MENSUALES
0 - 99	10	300	200	**510**
100 - 149	15	400	200	**615**
150 - 199	20	500	200	**720**
200 - 249	25	600	200	**825**
250 - 299	30	700	200	**930**
300+	50	800	200	**1,050**

Puntos por Afiliado

3. Specialist Metrics Points

Metric	Description	Points
Educational Modules	**Complete 2 educational modules from InnovaMD Leraning Center, per month**	**200**
Clinical Documentation	**Submit Progress Notes through the InnovaMD Portal.**	**200**
Member Education	**Participation in meetings and support in coordination of seminars to educate members on our products.**	**100 per seminar**

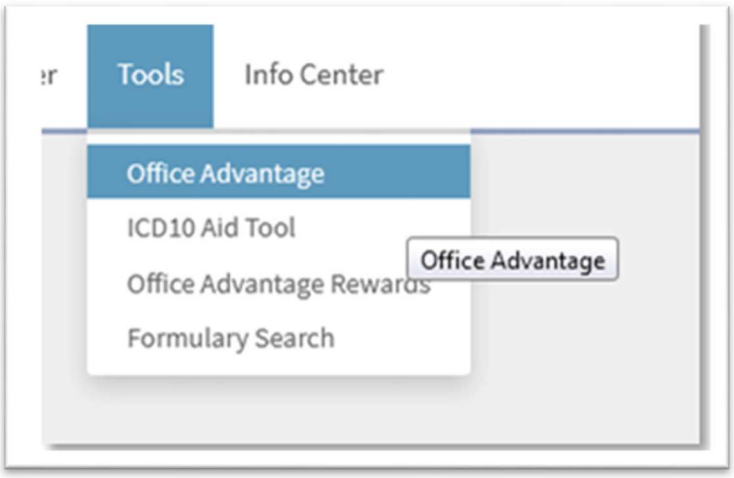
Participant can redeem points from the prize catalog at any time. Points will expire every year on February 15, if participant is enrolled in the Office Advantage Rewards Program. If participant leaves program and then comes back, participant will start at 0. They will not be able to regain any previous points.

This program is for office staff that works in the office.

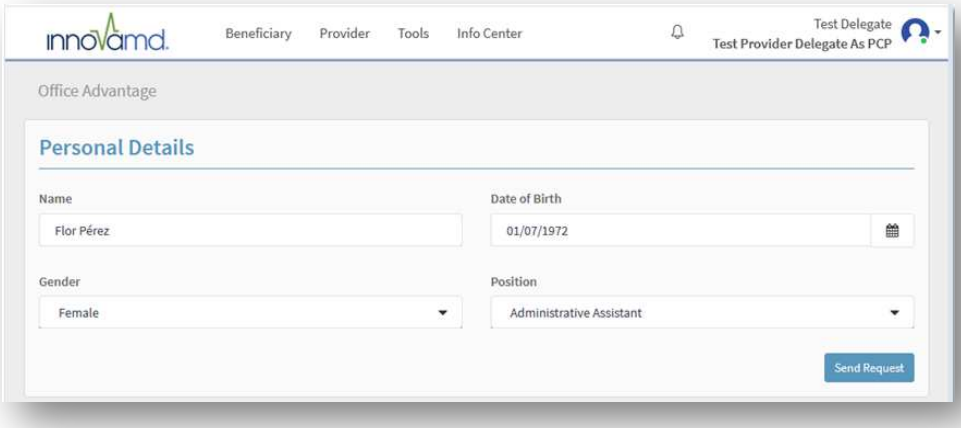
1. Mailings with informational material
2. Special Events, raffles, and presents
3. Points Program
4. Educational seminars and workshops

Enrollment to the Office Advantage Rewards Program can be done through www.innovamd.com.

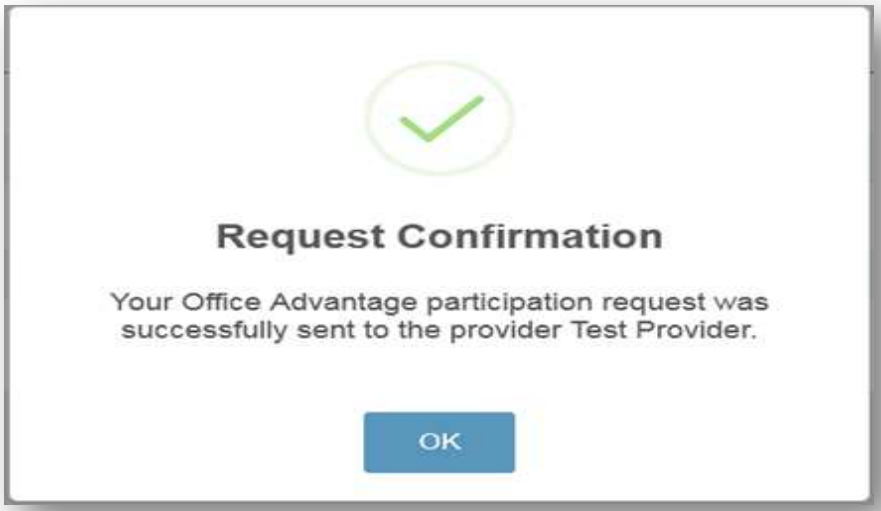
1. After successfully login to InnovaMD, go to the Tools menu option.



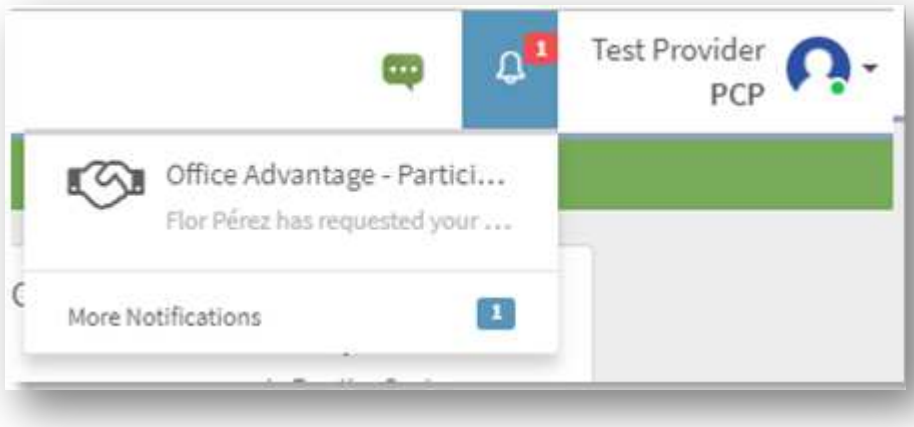
2. Fill the required fields and click the "Send Request"button (each participant is requiered to have an authorized contact for the portal).



3. Click the 'OK' button in the Request Confirmation pop-up message to go back to the Home Screen.

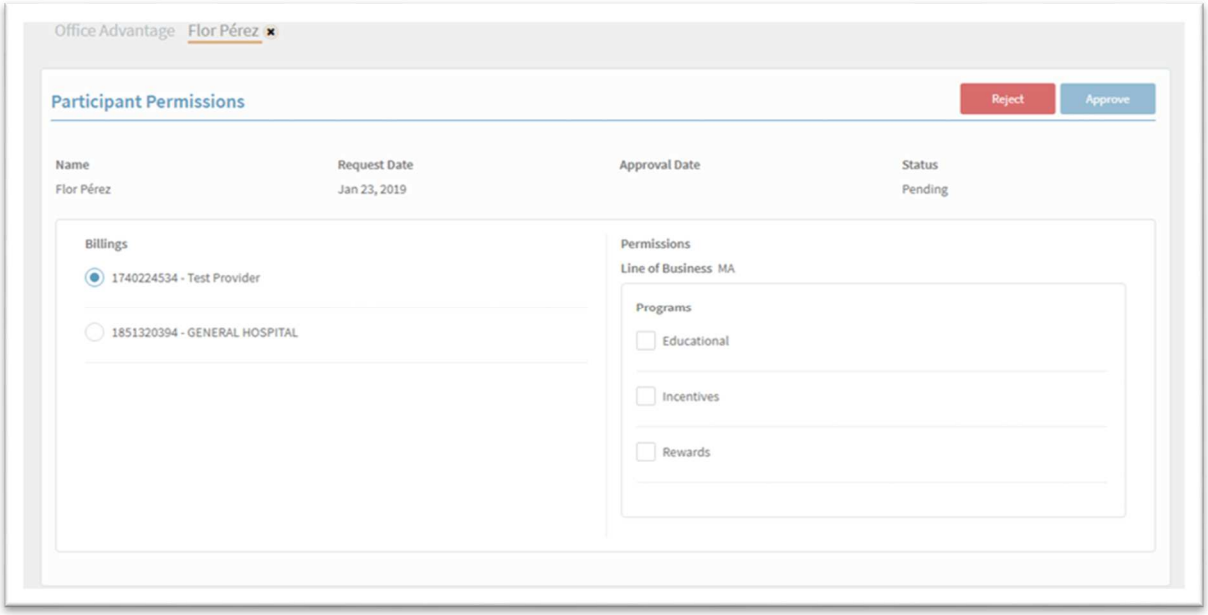


4. The Provider will receive a notification with the Participant's Office Advantage participation request. Click on it to be redirected to the Notification inbox. At the Notifications Inbox, the provider can click on the notifications link to be redirected to the Participant ś permissions screen.

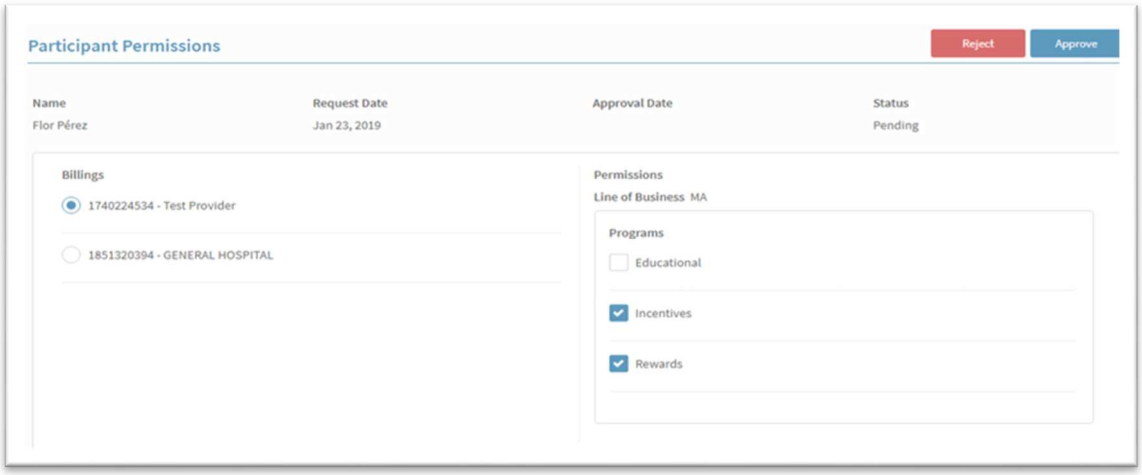


1. The Provider will also receive an email with the Participation Request with a link to InnovaMD.

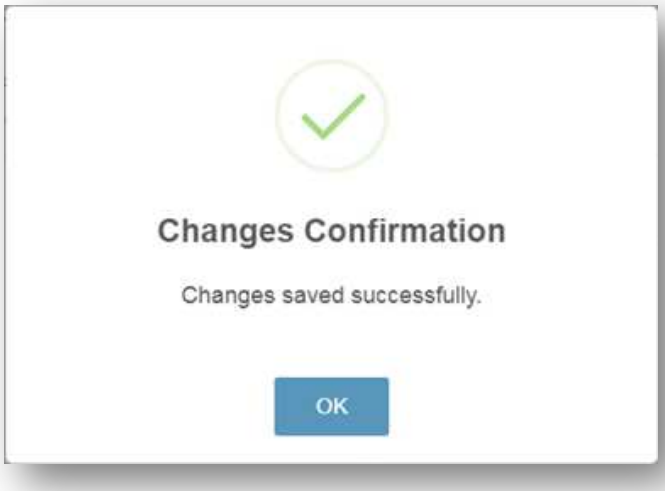
2. The provider can select the corresponding Billing(s), assign the Programs and then click the 'Approve' button to grant the Participation's Request. The 'Approve' button will be disabled until a program is selected. The provider may Reject the Participation Request by selecting the 'Reject' button.

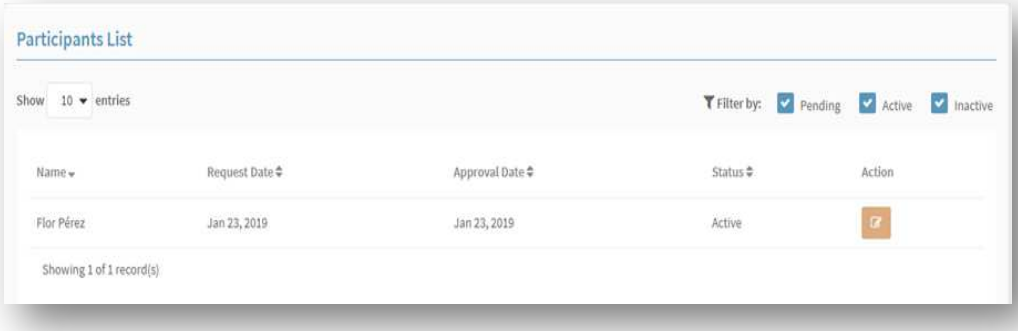


3. Check the boxes for the incentives you wish your staff to be authorized to receive.



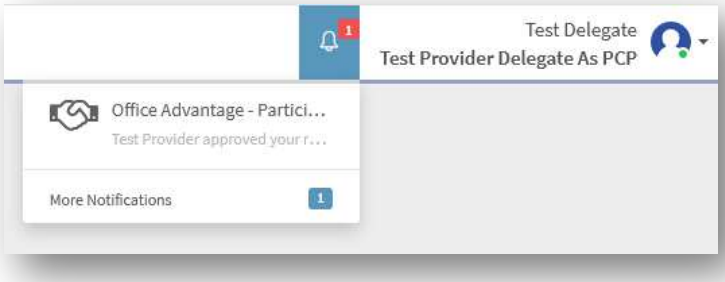
4. After the 'Approve' or 'Reject' button is selected, a Confirmation pop-up will be displayed. Click the 'OK' button in the Confirmation pop-up message to be returned to the Participant's List Screen



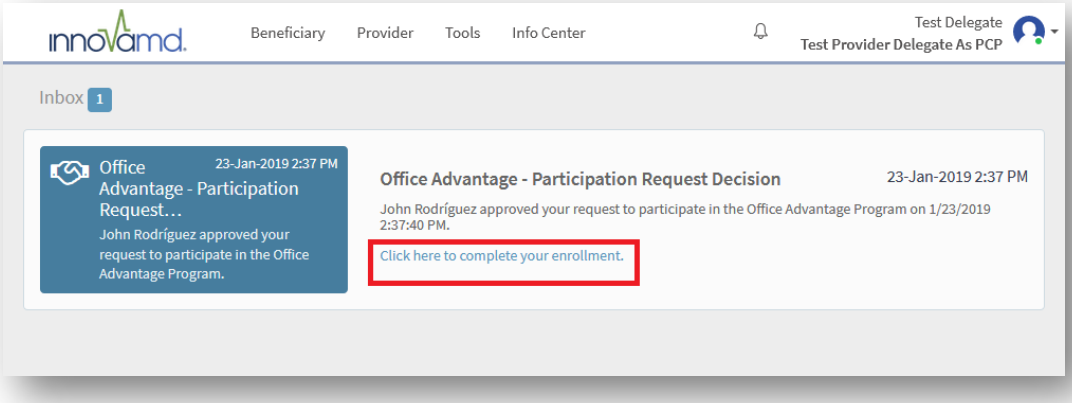


Office Advantage – Complete Participant's Information

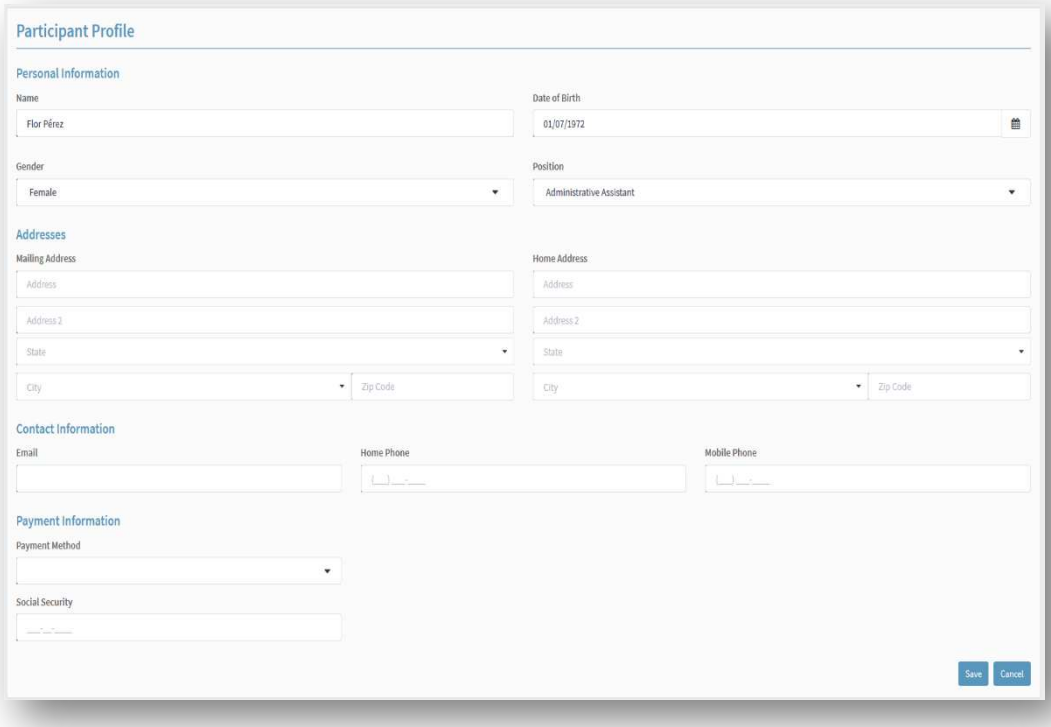
1. The Requester will receive a notification with the Provider's decision. Click on it to be redirected to the Notifications inbox.



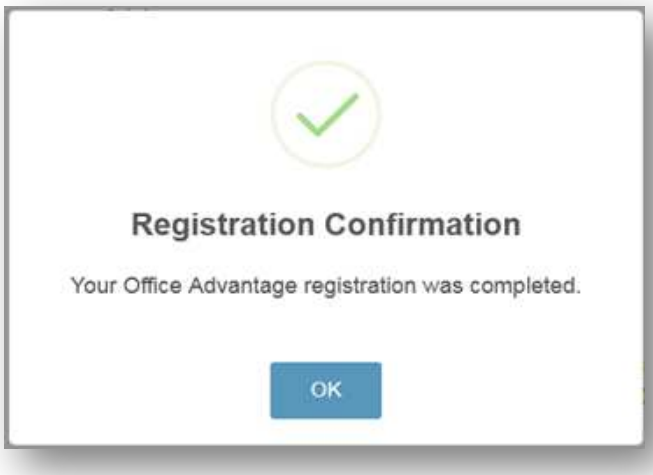
2. At the Notifications Inbox, the requester (delegated user) can click on the Notification's link to be redirected to the Participant's Profile screen in order to complete the enrollment



3. Complete participant profile

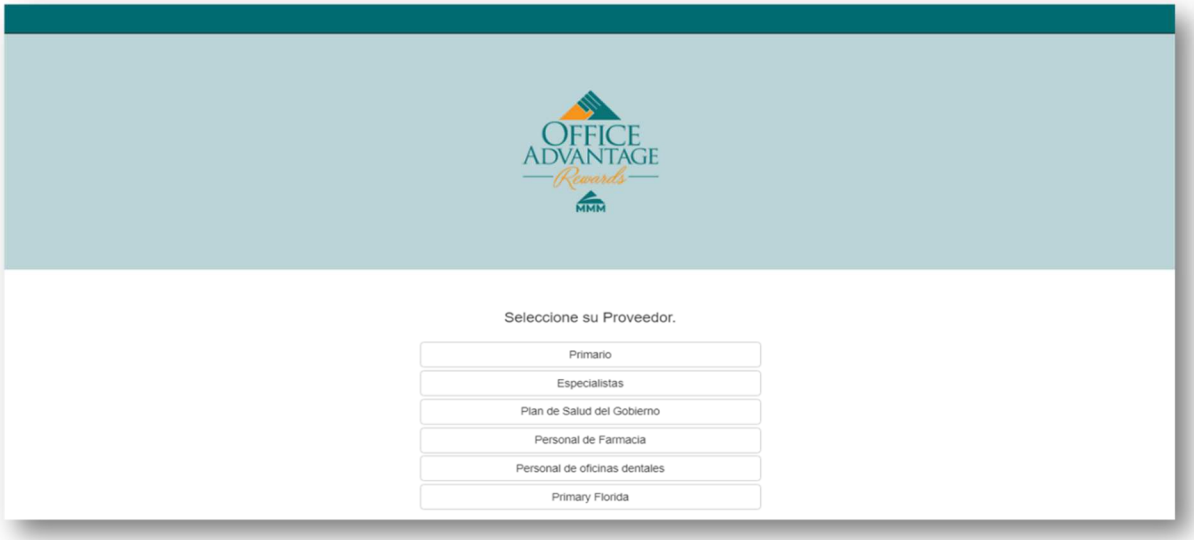


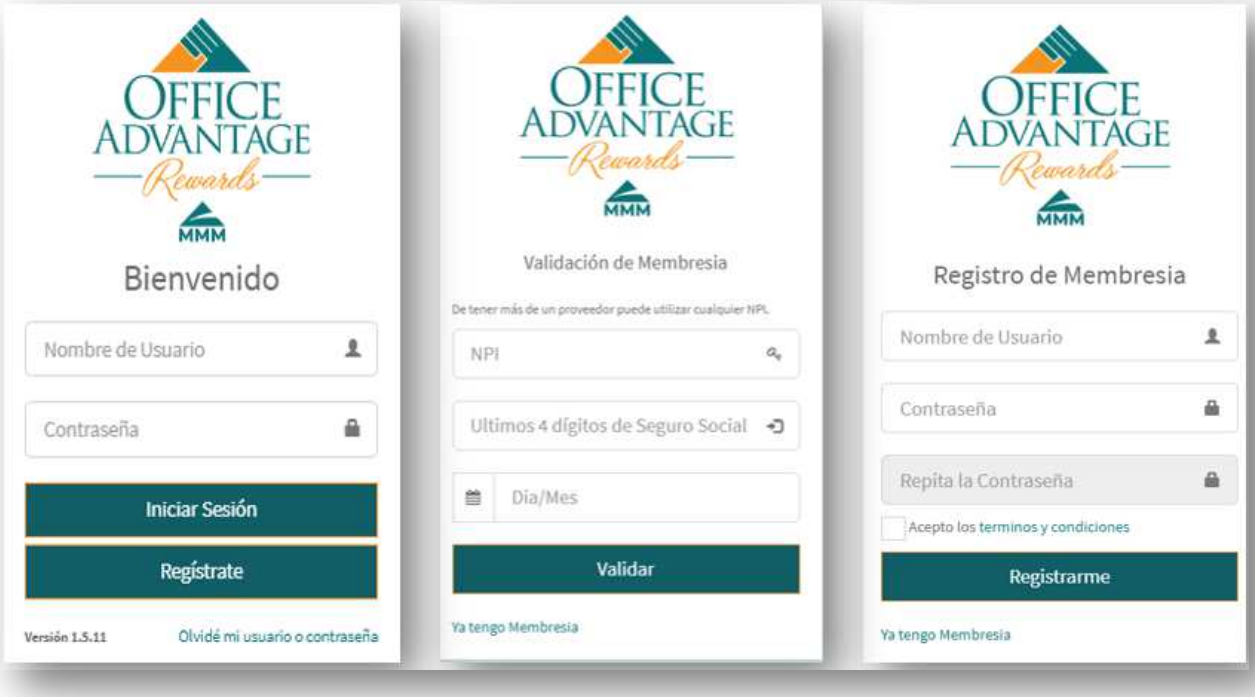
4. After completing the required fields, click the Save button and a confirmation pop-up message will be displayed.



Enrollment to the Points Program can be done the next month after the registration in InnovaMD, through the following link: www.officeadvantagerewards.com.

1. The staff will register by selecting their provider type and completing the requested information.
    a) Click *Regístrate*
    b) Insert providers NPI
    c) Insert last 4 digits of the SS and day and month of the participant's birthday (include slash). Then press *Validar*
    d) Create user and password
    e) Read and accept Terms and Conditions
    f) Click *Registrarme*


OFFICE ADVANTAGE Rewards MMM
Seleccione su Proveedor.
Primario
Especialistas
Plan de Salud del Gobierno
Personal de Farmacia
Personal de oficinas dentales
Primary Florida


OFFICE ADVANTAGE Rewards MMM
Bienvenido
Nombre de Usuario
Contraseña
Iniciar Sesión
Regístrate
Versión 1.5.11
Olvidé mi usuario o contraseña
OFFICE ADVANTAGE Rewards MMM
Validación de Membresia
De tener más de un proveedor puede utilizar cualquier NPI.
NPI
Ultimos 4 dígitos de Seguro Social
Dia/Mes
Validar
Ya tengo Membresia
OFFICE ADVANTAGE Rewards MMM
Registro de Membresia
Nombre de Usuario
Contraseña
Repita la Contraseña
Acepto los terminos y condiciones
Registrarme
Ya tengo Membresia

14.6 Provider Education Department

The Provider Education Department oversees and manages all education efforts regarding providers rendering services to members of MMM Healthcare, LLC (MMM). The educational efforts made by the department includes Provider's Newsletter, modules, New MSO Provider Onboarding Process (MSO University), trainings, continuum education, summit, workshops, webinars, and PMG Group monthly health

education, among others. Through these, we can teach about topics that are related to our industry and comply with our regulatory agencies. We are committed to contribute to the acknowledgement of our providers and guide them efficiently about any other topics. In addition, our department is in charge to assure all providers complete regulatory trainings (Model of Care, Compliance, Fraud, Waste and Abuse and Cultural Competencies) required by CMS and ASES. We also ensure that our network of providers has an anti-discrimination protocol in their offices to serve the entire population including the LGBTT + community. Given the challenges we confront daily in the health industry and in the current social and historical context, we need professionals that continuously educate themselves and maintain themselves at the cutting edge of healthcare. Our vision is to offer different ways of learning by promoting the use of our provider portal, InnovaMD.

Education through InnovaMD will be an integral part of information and education to the provider network. We invite you to access the portal and visit sections such as Learning Center, Latest News, and the Document Center. These three areas will be used by the Provider Education Department to publish educational information that you need to know. Register in our provider portal through www.innovamd.com.

15. PLATINO PROGRAM

15.1 Medicare Platino Program

15.1.1 Medicare Platino is only for dual eligible beneficiaries from Government Health Plan; you cannot subscribe other beneficiaries under this product. The model for the 2023 Medicare Platino product continues to be a preferred network. All members in the Platino Directory must select a Primary Care Physician (PCP) from the Platino Directory to have access to their medical services. Members may refer to the Evidence of Coverage for details about the cost sharing's.

15.1.2 Please refer to ASES Normative Letter - Amended Platino General Information 2023. See addendum #9.

15.1.3 Wrap-Around Coverage Table 2023, 1Coordination of Medicaid with Medicare Puerto Rico Health Insurance Administration (ASES) Medicare Platino Program.

COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN*** *(Limited to the State Plan Covered Services)*
INPATIENT HOSPITAL SERVICES *Co- Payment Code* ***100-$0.00 / 110-$4.00 /120- $5.00 /130- $8.00***	
Medicare Part A. ***Covers Hospitalization care.*** Covers hospital services, including semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. Costs in Original Medicare: Part B Medicare is responsible for the costs of that inpatient stay.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year. Coverage includes: • Isolation room for medical reasons. • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized. • Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy. Blood: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated Complex (Auto flex and Feiba) per authorization of a certified hematologist.
INPATIENT HOSPITAL FOR MENTAL HEALTH DISEASES *Co-Payment Code* ***100-$0.00 / 110-$4.00 /120- $5.00 /130- $8.00***	

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
Medicare Part A Covers Hospital Inpatient Mental Health. Covers your room, meals, and nursing care. Medicare limited 190 days lifetime limit in psychiatric hospital.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.
INPATIENT SUBSTANCE USE DISORDER *Co- Payment Code* ***100-$0.00 / 110-$4.00 /120- $5.00 /130- $8.00***	
Medicare Part A. ***Covers* Inpatient Substances Abuse.** Covers medically necessary inpatient substance abuse treatment services can be covered in Medicare certified hospital. Services provided in facilities that are not Medicare certified are not covered by Medicare.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.
OUTPATIENT SUBSTANCE USE DISORDER *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare Part B **Covers Partial Hospitalization.** Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed,	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
medically necessary, and directly related to the reason for admission.	
OUTPATIENT MENTAL HEALTHCARE & PROFESSIONAL SERVICES *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare Part B **Cover Mental Health Services and Visits**. Covers with these types of health professionals (deductibles and coinsurance may apply): Psychiatrist or other doctor, Clinical psychologist, Clinical social worker, Clinical nurse specialist, Nurse practitioner and Physician assistant. One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use. • Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services. • Family counseling, if the main purpose is to help with your treatment. • Testing to find out if you're getting the services you need and if your current treatment is helping you. • Psychiatric evaluation. • Medication management. • Certain prescription drugs that aren't usually "self-administered" (drugs you would normally take on your own), like some injections. • Diagnostic tests. • Partial hospitalization. • A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your potential risk factors for depression.	All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
• A yearly "Wellness" visit. This is a good time to talk to your doctor or other health care provider about changes in your mental health so they can evaluate your changes year to year.	
LABORATORY AND HIGH-TECH LABORATORIES *Co-Payment Code* ***100-$0.00 / 110-50¢ /120- $1.00 /130- $1.50***	
Medicare Part B **Covers *Clinical Diagnostic Laboratory Services.*** Covers that are ordered by your doctor or practitioner. Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests. They must be provided by a laboratory that meets Medicare requirements. **Medicare doesn't cover most Health Certificates**	Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.
EPSDT UNDER 21 YEARS *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare doesn't cover most EPSDT	EPSDT requirements non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. EPSDT Checkups must include all of the following: A comprehensive health and developmental history; Developmental assessment, including mental, emotional, and Behavioral Health development; Measurements (including head circumference for infants); An assessment of nutritional status; A comprehensive unclothed physical exam; Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices (ACIP) (the vaccines themselves are provided and paid for by the Health Department for the Medicaid and CHIP Eligible. Certain laboratory tests; Anticipatory guidance and health education; Vision screening; Tuberculosis; Hearing screening; and Dental and oral health assessment.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
	(Reference must be made to the corresponding CMS EPSDT guidelines and ASES policy).
FAMILY PLANNING *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare doesn't cover Family Planning	Family Planning services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations: • Contra-indication with drugs that the Enrollee is already taking, and no other methods covered/available that can be used by the Enrollee. • History of adverse reaction by the Enrollee to the contraceptive methods covered. • History of adverse reaction by the Enrollee to the contraceptive medications that are covered.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
TOBACCO CESSATION *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part B (Medical Insurance) covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.	Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.
MATERNITY SERVICES *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Maternity Services Medicare Part A and B Covers Prenatal and Maternity Care. Covers medically necessary services and Inpatient services Abortions are only covered when the life of the mother would be in danger if the fetus is carried to term.	Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Abortions when the pregnancy is a result of rape or incest as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term as certified by a physician.
MEDICAL AND SURGICAL *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare Part B **Covers Ambulatory Surgery**. Covers the facility and professional service fees related to approve surgical procedures provided in an ambulatory surgical center.	Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form included as Appendix (O) (18) of the Contract.
VISION **SERVICES** *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare Part B - Medicare does not normally cover routine vision services, such as eyeglasses and eye exams.	Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
Covers Glaucoma Tests every 12 months under certain circumstances. For people with diabetes: It covers eye exam to check for diabetes retinopathy.	Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be preauthorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.
DENTAL SERVICES PREVENTIVE & RESTORATIVE *Co-Payment Code* **Preventive (Child)*100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00*** **Preventive (Adult)*100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00*** **Restorative *100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare doesn't cover most dental care, Part A can pay for inpatient hospital care to have emergency or	Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. The following are the benefits included in the GHP; • All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy; • Preventive dental services for Adults; • Restorative dental services for Adults; • One (1) comprehensive oral exam per year; • One (1) periodical exam every six months; • One (1) defined problem-limited oral exam; • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography; • Up to five (5) additional periapical/intra-oral radiographies per year; • One (1) single film-bite radiography per year;

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
complicated dental procedures, even though the dental care isn't covered	• One (1) two-film bite radiography per year; • One (1) panoramic radiography every three (3) years; • One (1) adult cleanse every six (6) months; • One (1) child cleanse every six (6) months; • One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old; • Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies; • Amalgam restoration; • Resin restorations; • Root Canal; • Palliative treatment; and • Oral Surgery
HEARING* EXAMS** *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00	
Medicare Part B Covers Diagnostic Hearing and balance exams if the physician or other health care provider orders these tests to see if you need medical treatment. Medicare covers audio logic diagnostic testing provided by an audiologist when a physician or non-physician practitioner (nurse practitioner, clinical nurse specialist, or physician's	Hearing related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Hearing aids for beneficiaries over 20 years old are excluded from coverage. Refer to ESPDT for hearing cover services.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
assistant) orders the evaluation for the purpose of informing the physician's diagnostic medical evaluation or determining appropriate medical or surgical treatment of a hearing deficit or related medical problem Medicare doesn't cover, hearing aids, or exams for fitting hearing aids.	
PREVENTIVE* SERVICES** *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00	
Immunizations Medicare Part B **Covers Normally covers one Immunizations** shot per: Influenza (Flu); Hepatitis B; and Pneumococcal shots. Also cover tetanus and rabies shots when expose or at-risk episode. Vaccines coverage according to the Medicare Benefit Package.	Immunization services non-covered by; 1- Medicare Part B. 2- MAO Part D drug formulary. 3- MAO supplementary plan benefits. 4- Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00***	
Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services. Medicare law no longer limits how much Medicare pays for your medically necessary outpatient therapy services in one calendar year. However, your therapist will need to add information to your therapy claims and your medical record if your therapy services reach these amounts in 2023: $2,119 for physical therapy (PT) and speech-language pathology (SLP) services combined $2,119 for occupational therapy (OT) services	Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
Once your therapy services reach these amounts, your therapist will need to add a special code to your therapy claim. By adding this code, your therapist confirms that: Your therapy services are reasonable and necessary Your medical record includes information to explain why the services are medically necessary A Medicare contractor may also review your medical records to be sure your therapy services were medically necessary. This review may happen if your therapy services reach these amounts in 2023: $3,000 for PT and SLP services combined $3,000 for OT services Your therapist or therapy provider must give you a written notice before providing services that aren't medically necessary. This includes therapy services that are generally covered but aren't medically reasonable and necessary for you at the time. This notice is called an "Advance Beneficiary Notice of Non coverage" (ABN). The ABN lets you choose whether or not you want the therapy services. If you choose to get the medically unnecessary services, you agree to pay for them.	

PRESCRIPTION DRUGS

Co-Payment Code	***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	***Preferred (Children 0-21)***
Co-Payment Code	***100-$0.00 / 110-$1.00 /120- $2.00 /130- $3.00***	***Preferred (Adult)*******
Co-Payment Code	***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	***Non-Preferred (Children 0-21)***
Co-Payment Code	***100-$0.00 / 110-$3.00 /120- $4.00 /130- $6.00***	***Non-Preferred (Adult)*******

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN* *(Limited to the State Plan Covered Services)*
Co-Payment Code ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	***Outpatient Substance Abuse***
Drugs and biologicals are covered only if all of the following are met: they meet the definition of drugs or biologicals; they are not the type that are usually self-administered; they meet all of the general requirements for coverage of items as incident to a physician's services; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; they are not excluded as immunizations; and they have not been determined by the FDA to be less than effective.	Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings: • All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution. • Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap-Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category. • Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.

[1]Medicare Platino cannot establish copayments higher than the ones specified in the Wrap Around table.

Platino wrap services are subject to the maximum co-payments in the table with exemptions and zero co-payments for Medicaid/CHIP beneficiaries and certain services as follows:

Medicaid/CHIP Beneficiaries

- Children from 0 to less than 21 years of age;
- Pregnant woman (during pregnancy and the 60-day post-partum period);
- American Indians and Alaskan Natives (AI/AN)
- Institutionalized Individuals; and
- Individuals receiving hospice care.

Services

- Emergency services, including ambulatory, hospital and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a);
- Family planning services and supplies;
- Preventative services provided to children less than 18 years of age
- Pregnancy related services and counseling and drugs for cessation of tobacco use;
- Provider-preventable services as defined in 42 CFR 447.26(b); and
- Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.

Notes: 1. Wrap around table is subject to change in 01/01/2023.

2. N/A= Medicare fulfill or exceeds PSG benefit

15.1.3 Referrals

To comply with regulations from the Puerto Rico Health Insurance Administration (ASES), starting January 1, 2009 Medicare Advantage Plans will implement a referral form. The purpose of this referral form is to guarantee access of medical services to our Platino Network, promoting communication between PCP's and Specialists, and to guarantee the continuity of coordinated medical care.

It is important that the Specialist informs the PCP about treatments offered to the member regarding the use of the referral form. A referral form under any circumstance represents a guarantee of payment, this need to comply with all applicable payment guides and politics.

15.1.4.1 The Primary Care Physician has two ways to generate Referrals.

1. Through our web portal InnovaMD (www.innovamd.com).

Using the Quick Guide to create an Electronic Referral.

a) Description:

- It allows the provider to create and search for referrals or prior consultations of their patients.

b) Benefits:

- The creation of the encounter will be as a Wizard, directing the user step by step in a more orderly way for their transaction to be successful.
- Maintains history and prints encounters with the authorization number.
- It allows the provider with more than one line of business to hold meetings for their Medicare Advantage patients and the Government Health Plan.

c) ¿How to create an electronic referral?

- Access to the InnovaMD 2.0 portal at the following address: www.innovamd.com. Log in to your account.
- Select from the Beneficiary menu the Beneficiary Center option.
- Search and select the patient using the ID, name or surname.

	**Create:** Go to the Services tab and click the create button
	**Requesting Provider*:*** Select Billing and Rendering of the provider requesting the referral. Then press the Next button.
	**Diagnostics*:*** Select the corresponding diagnostics or diagnostics. It is required to identify the primary diagnosis

	**Type of Service (Procedures)***:* To generate a referral select the Refer to a Specialist option. Then press the Next button
	**Select Servicing Provider**: Find and select the provider that will offer the service. Then press the Next button.
	**Additional information:** Select the date of the referral
	**Service Review:** Presents screen with summary of the entered date. Supplier approves the data and presses the button of Submit.
	**Service Submit confirmation**: Ask the provider if he/she is interested in submitting the service.
	**Confirmation** (**Service request Number):** Under the patient Profile, the application generates an identifier number for the requested Service in InnovaMD 2.0.
	**Print (Service Request Number)**. It is under the Service Reque Number that the Service Provider can view and print the service

2. **Paper** – using the Referral / Consultation For

   a) Paper

- The referral form consists of 4 pages.
- The original page (white) is for the Primary Care Physician. The yellow one is for the Specialist to send it attached with the claim. The pink page is for the beneficiary to return to their PCP. The blue one is for the Specialist's medical records.

b) In the Referral Form, the following sections need to be completed:

- Patient Name
- Member ID#
- Name of Primary Care Physician
- Physician's NPI number
- Date of Referral
- Name and specialty of the referred Specialist

15.2 General Rules to Request Referral

General Rules to Request Referral – Platino Plan			
No Referral Required	**Referral Required (Platino Network)**	**Referral Required (Health Plan Network)**	**Referral Required (Non-Par)**
PCP	Others PCP's (Non-MSO)	Preauthorization:	Preauthorization:
Urology	Initial visits:	All other Specialists	Referral

Gynecology	All other Specialists	All procedures	
Specialist in the Preferred Provider Network – MSO	All procedures		
Pathological Laboratories			
Chiropractic	Follow up visit:		
Initial visit/ FU visit with the initial same Dx	All other Specialists		
Cardiology	All procedures		
Endocrinology	Magnetic Resonance Imaging (MRI)		
Ophthalmology	Tomography Computerized (CT Scan)		
Psychiatry	PET Scan		
Pulmonologist	Nuclear Medicine Studies		
Orthopedics			
Rheumatology			
Gastroenterology			
Podiatry			
Diseases – Special Coverage			
1. HIV / AIDS			
2. Tuberculosis			
3. Leprosy			

4. Systemic Lupus Erythematosus (SLE)			
5. Cystic Fibrosis			
6. Cancer			
7. Hemophilia			
8. ESRD (level 3,4 & 5)			
9. Multiple Sclerosis			
10. Scleroderma			
11. Pulmonary Hypertension			
12. Aplastic Anemia			
13. Rheumatoid Arthritis			
14. Austism			
15. Skin Cancer			
16. Skin Cancer Carcinoma IN SITU			
17. Skin Cancer; Invasive Melanoma or squamous cells with evidence of metastasis.			
18. Phenylketonuria			
19. Chronic Hepatitis C			
CHF Class III and IV NYHA in a potential candidate for transplant			
Other Services that do not require Referral			

Preventive Service	Laboratory	Medications	Conventional, Diagnostic Radiology and Sonography
Immunizations	Refraction and Eye Glass	Hearing Aids	Use of Facility where a procedure is realized

15.3 Referrals Requirements

1. The Medicare Platino product must ensure the transition of care, will not require referrals within the medical group network, including specialists, so long as the specialist id contracted by the medical group.

2. The conditions ASES classifies as special coverage and that do not require referral for Medicare Platino are:

✓ HIV/AIDS	✓ Pulmonary Hypertension
✓ Tuberculosis	✓ Aplastic Anemia
✓ Leprosy	✓ Rheumatoid Arthritis
✓ Systemic Lupus Erythematosus (SLE)	✓ Autism
✓ Cystic Fibrosis	✓ Skin Cancer
✓ Cancer	✓ Skin Cancer, carcinoma IN SITU

✓ Hemophilia	✓ Skin Cancer; Invasive Melanoma or squamous cells with evidence of metastasis
✓ ESRD=>Levels 3,4, and 5	✓ Phenylketonuria
✓ Multiple Sclerosis	✓ Chronic Hepatitis C
✓ Scleroderma	✓ CHF Class III and IV NYHA in a potential candidate for transplant

2. The treatments for the special conditions mentioned above do not need a referral from the PCP once the diagnosis is established.
3. When a patient is referred to a specialist by a PCP and the specialist prescribes medications, a countersignature will not be required from the PCP. This is a CMS requirement.
5. In cases where a Medicare Advantage Organization (MAO) contracts an independent practice association (IPA) that have a particular network with specialists directly contracted by the IPA, it is not required to obtain a referral from the PCP when the specialist is part of the group network that manages the primary care coordination, but it will be the specialist's obligation to inform the PCP on medical services provided.
6. Patients may visit, without a referral from the PCP, specialists in Gynecology, Obstetrics and Urology. Referrals for laboratories, diagnostic exams and others will be managed as established above.

7. The services related to pathological laboratories will not require a referral

15.4 Other Provisions

1. The duty to verify eligibility, all contracted providers under MMM Multi Health can validate a patient's eligibility with their enrollee ID. It also provides the patients coverage history and access to print the Certificate of Eligibility. The verification of eligibility warrants that all its network providers will verify the eligibility of enrollees before the provider provides covered services. This verification of eligibility is a condition of receiving payment. It's required that the provider verify the enrollee's eligibility before providing services or making a referral. The systems that support the eligibility verification process are:

InnovaMD Access – (www.innovamd.com)

MSO Provider Call Center Telephones:

787-993-2317 (Metro Area)

1-866-676-6060 (toll free)

Monday through Friday, 7:00 a.m. to 7:00 p.m.

2. Selection of Providers by the enrollees when a person signs up with MMM Healthcare, LLC, they must choose a Doctor or "Primary Care Physician" (PCP). The PCP is the main person to see for health care. This includes checkups, treatment for colds and flu, health concerns and screenings. The PCP can find and treat health problems early. He or she will have the patient's medical

records. The PCP has the complete visibility about health care. The PCP keeps track of all the care the patient gets.

The following practitioners can be considered Primary Care Physicians (PCPs):

- General Practitioners;
- Family Physicians;
- Internal Medicine Specialists

The patient must choose a PCP for each enrollee. To choose a PCP, the enrollee must call MMM Healthcare, LLC at 1-866-333-5470 (Toll free), TTY 1-866-333-5469 (For the hearing impaired). **If the enrollee does not select a PCP, MMM Multihealth will assign one.**

A Primary Medical Group (PMG) is a group of doctors that coordinate health care services and work with the Health Plan to make the patient get the care they need. Enrollees' ID card shows the name of the PCP and the patient's IPA name.

How can a patient see their PCP?

If a patient needs an appointment, they must call their PCP and arrange an appointment. It is important to keep appointments with the PCP. If that is not possible, for any reason, the patient must call the PCP's office right away to let them know. The patient should get to know the new PCP, especially if they've been getting care or treatment from a different doctor. If the patient is feeling good, they should call to get a follow-up checkup with the PCP.

3. Require that Medically Necessary Services shall be available twenty-four (24) hours per day, seven (7) days per Week, to the extent feasible; Prohibit the Provider from operating on a different schedule for Medicare Platino Enrollees than for other patients, and from in any other way discriminating in an adverse manner between Medicare Platino Enrollees and other patients.
4. The prohibition on denial of Medically Necessary Services or any denial, unreasonable delay, or rationing of Medically Necessary Services to Enrollees is expressly prohibited. MMM Healthcare will ensure compliance with this prohibition from Network Providers, or any other entity related to the provision of Health Services to Enrollees.
5. The population of sixty-(60) years or older may select a Geriatrician as a PCP.
6. Prescribed drugs that are bioequivalent are mandatory.
7. Specialists are required to send the beneficiary's PCP a report on the patient's health condition.
8. Providers may not charge the Platino Beneficiaries for the provision of certifications required for the Puerto Rico Medicaid Program.
9. Those providers interested in servicing the Medicare Platino beneficiaries can do so, as long as they provide services to the beneficiaries of the Government Health Insurance Plan as well.
10. Preferential Turns: The policy of requiring Network Providers to give priority in treating Enrollees from the island municipalities of Vieques and Culebra, so that they may be seen by a Provider within a reasonable time after arriving at the

Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for their residents to seek medical attention.

11. InnovaMD is a Care Coordination Platform that has been designed to join patients, providers and partners allowing them to work together. In the InnovaMD Portal the provider will be able to obtain updated information on the eligibility of the beneficiaries and the network of providers; in addition, they will be able to access the updated drug formularies, the clinical guides and service protocols. You can also access the Normative Letters of ASES, among others. It is also the preferred communication channel between the providers and the MSO.

16. MODEL OF CARE (MOC)

MMM Healthcare, LLC (MMM) has Medicare Advantage plans focused on individuals with special need known as Special Needs Plans (SNPs) created under the Medicare Modernization Act of 2003 (MMA). The Special Needs Plans (SNPs) were allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized (I-SNP) for beneficiaries who live in certain types of institutions; 2) dual eligible (D-SNP) for beneficiaries eligible for Medicare and Medicaid); and 3) individuals with severe or disabling chronic conditions (C-SNP). MMM company provides care under two SNP types for a total of 2 Dual SNP and 1 Chronic SNP.

As required by the 2008 Medicare Improvements for Patients and Providers Act of 2008" (MIPPA), MMM has evidence-based Model of Care with appropriate networks of providers and specialists. Our Model of Care includes requirements with respect to each beneficiary enrolled in the SNP:

1. Conduct an initial health risk assessment (HRA) and an annual reassessment that identify the medical, functional, cognitive, psychosocial, and mental health needs for each SNP beneficiary.
2. Development of an Individualized Care Plan in consultation with the beneficiary and usual practitioner as feasible, that identifies goals and objectives, as well as specific services and benefits to be provided.
3. Use of an Interdisciplinary Care Team (ICT) for beneficiaries for the management of care that includes but is not limited to the beneficiary or caregiver, Care Manager, Social Worker, Behavioral Health Practitioner, Primary Care Physician, Physician specialist, Ancillary providers, Hospitals among others.
4. Support to beneficiary through care transitions by having staff available in the Care Management Program; coordinate and facilitate communication between healthcare settings, member's usual practitioner and the beneficiary or their caregiver.

MMM has an established Quality Improvement Program to monitor health outcomes and performance of the Model of Care by collecting, analyzing, reporting data, and acting on opportunities of improvement.

What is the Provider's Role in MMM's Model of Care?

MMM expects from all providers to encourage members to complete the HRA and to participate in the Individualized Care Plan discussion, collaborate with the Care Manager in goal statement and follow-up, engage members in self-management care, participate actively in the ICT, provide support during care transitions, follow-up and communicate changes in member's health status.

The Model of Care training for providers can be downloaded through our provider web portal www.innovamd.com in the Learning Center section.

17. FRAUD, WASTE AND ABUSE

17.1 Fraud, Waste and Abuse (FWA)

MMM will not tolerate fraudulent or abusive activities, behavior or conduct against State and Federal health care programs. The organization has established methods for the prevention, detection, investigation and correction of potential fraud, waste, and abuse, in accordance with all applicable laws and regulations, through adequate education and the implementation of a Fraud, Waste and Abuse Compliance Program, policies and procedures, and a Program Integrity Plan.

17.1.1 Definitions:

1. **Fraud** - refers to an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It affects adversely insured enrollees, health plans and professionals and entities that render health services.

   The most common types of fraud and abuse include:

   - Medical identity theft;
   - Billing for unnecessary services and items;
   - Billing for services or items not rendered;
   - Upcoding, or billing for services at a level of complexity that is higher than the service provided;
   - Unbundling, it refers to the practice of a physician billing for multiple components of a service that must be included in a single fee;
   - Billing for non-covered services, as a covered service;
   - Kickbacks; defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for referral of items or services reimbursable by a Federal health care program;
   - Beneficiary fraud, e.g. eligibility fraud, card sharing, doctor shopping, and drug diversion.

2. **Abuse** - is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically

necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. Some examples are:

- Overuse of services that are not medically necessary, such as constantly using the emergency room instead of going to the Primary Care Physician;
- Excess in the orders for diagnostic tests that do not have a medical justification;
- Waiving health plan Copayments or Coinsurances to attract customers.

3. **Waste** - is the overutilization of services, misuse of resources or other practice that, directly or indirectly, result in unnecessary costs. Some examples are:

- Prescribing high cost medications instead of similar generic or lower cost medication;
- Billing errors due to inefficient billing systems;
- Inflated prices on services or devices.

17.1.2 Protection for "Whistleblowers":

If any provider has knowledge or information that a FWA activity may be occurring or may have taken place, the provider must notify the Plan through the Ethics Point line at 1-877-307-1211 or by writing to the following e-mail address siu@mmmhc.com. Information may be reported anonymously.

In addition, federal regulation and MMM policy prohibits any retaliation against persons who in good faith report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she and been subject to any such retribution or retaliation should also report this to Ethics Point.

17.2 Clinical Audit Process Manual of Provider and Supplier Service Billing

17.2.1 Introduction

The Clinical Audit Process Manual for Providers and Suppliers has been developed to help MMM Healthcare, LLC (MMM). MMM and its healthcare service providers and suppliers, undertake the clinical audit process of services rendered and billed to MMM. It also helps comply with established federal and local regulatory agencies' requirements for the accurate and timely submission and payment of claims. As a result, Section **4.3** of MMM Provider Manual is amended to include this clinical audit process of provider and supplier service billing.

17.2.2 Purpose

To outline standards and steps to follow as consistent framework while undertaking clinical audits of providers and suppliers that render healthcare services to MMM members.

The clinical audit process will assist in improving performance and effectiveness in the provider's clinical practice. It will also assist health care providers to contribute to improvements in the delivery and quality of healthcare services rendered to MMM

members and Medicare beneficiaries overall, through systematic review of care against explicit criteria and the change implementation.

17.2.3 Applicability

MMM subcontract their provider network from a third party, MSO of Puerto Rico, LLC (MSO). MSO being considered a delegated entity, the legal and delegation oversight implications of the content, actions, terms, conditions and determinations made in this clinical audit process must be consistent and or adjusted to the provisions, terms, and other conditions set forth in the delegation contract with the MSO and consequently in the Provider Services and/or Facilities Services Agreement between the MSO and its network.

17.2.3.1 This process applies to:

1. All healthcare providers and suppliers that render services to MMM members.
2. Every claim paid by MMM during a maximum period of three (3) years; notwithstanding the above MMM in its sole discretion shall request claim history for up to five (5) years, and;
3. All healthcare providers and suppliers that, whether in individual or group practices, display billing patterns that do not match the billing patterns of their peers.

17.2.4 Scope

Clinical audits take place as a result of information extracted from the following sources:

1. Internal referrals.
2. External referrals.
3. Usage profiles culled from proactive data analyses.
4. Information requested from federal or state regulatory agencies.
5. Other sources of information that focus on the provider or supplier.

17.2.5 Responsible Staff

Clinical audits are conducted by qualified MMM Compliance Department staff and are performed according to required confidentiality and professional standards.

17.2.6 Procedure

17.2.6.1 Selection of the provider or supplier that will be audited

1. Selection of a provider or supplier for a clinical audit is based on the sources described in Section IV (Scope) of this manual.
2. Once the provider or supplier is selected, a claim payment history is compiled to serve as basis for the audit:
    a. The paid claim history will (except under certain conditions) generally encompass a period of at least three (3) years starting on the date of selection.
    b. The paid claim history is defined as the universe of all claims received by MMM and submitted by providers and suppliers.
3. A statistically representative random sample is selected from the universe of claims for auditing purposes using the RAT-STAT statistical software package, which was created by the office of the Inspector General (OIG).

This package is the primary statistical tool for OIG's office of Audit Services. The software assists users in selecting random samples and estimating improper payments.

a. Confidence intervals, margins of error and power used in the sample selection will depend on the nature and scope of the audit.
b. The sample is documented as part of the audit process for the provider or supplier selected.
c. Audit sample varies depending on the following factors:
    1) **Universe size** – actual claims submitted for payment and paid by the Plans.
    2) **Number of services and procedures -** selected for review.
    3) **Type of sample**: statistically valid random sample vs. targeted.
    4) **Audit period** – typically 3 years back.
d. The selection parameters follow established protocols and are summarized below:
    1) **Confidence level** - How certain we want to be that the population figure is within the sample and its associated precision. MMM uses a standard of 95%.
    2) **Margin of error** – This is the standard deviation or error of the statistic. MMM uses a standard of 5%.

3) **Anticipated Rate of Occurrence** - This is the proportion of items in the population we anticipate will display the attribute value that we are seeking. MMM uses a value that varies between 50% and 85%.

4) **Desired Precision Rate** - This is the desired precision or amount of sampling error that can be tolerated but will still permit the results to be useful. MMM uses 20% of the Anticipated Rate of Occurrence, varies between 10 to 17%.

17.2.6.2 Audit notification to provider or supplier

1. The healthcare provider or supplier that is subject to an audit is notified in writing and sent by certified mail with proof of delivery. Upon coordination with provider or supplier, the notice can also be sent via fax, InnovaMD or e-mail.
    a. The letter is sent at least ten business (10) days prior to the visit.
    b. The notification letter includes, among other things, the date the provider or supplier's facilities will be visited, the name of the MMM staff in charge of conducting the audit, the list of selected members in the sample, and the kind of information required for the audit.
2. The MMM staff member in charge of conducting the audit calls the provider or supplier at least two business (2) days in advance to confirm the visit.

3. In the event the healthcare provider or supplier refuses to be audited after a second attempt by MMM audit staff member in charge refers the case to the Compliance Committee's attention in order to consider the following:
    a. Temporary suspension or termination of contract.
    b. Recovery of services subject to an audit, such as services that were not rendered.
4. Suspension or termination of a contract does not prevent MMM from obtaining, through legal means and in accordance with the provider or supplier's contractual obligation, the necessary information to perform the audit.
5. MMM audit staff retains the right to re-schedule audit date changes requested by providers or suppliers.
6. However, no extension will be granted that exceeds ten (10) calendar days from the original audit date.

17.2.6.3 Visits to providers' or suppliers' facilities

1. The MMM staff member assigned to conduct the audit will visit the provider or supplier's facilities on the previously arranged date and time. He/she will identify himself/herself as an employee of MMM.
2. The MMM staff member in charge of the audit will request an initial interview with the provider or supplier, or the designated person in order to:
    a. Explain the scope and purpose of the audit.

b. Review the list of requested medical records.

c. Answer questions related to the audit.

3. For the audit visit, the healthcare provider or supplier must have all medical records and documents requested in the audit notification letter available.
4. The MMM staff member in charge of the audit will scan or copy the medical records and any supporting documentation required for the selected sample under the scope of the audit.
5. The MMM staff member in charge of the audit will prepare a list of the requested records and documents that were and were not provided during the visit. Copy of this list will be given to the provider or supplier, as requested.
6. The MMM staff member in charge of the audit will request an exit interview with the provider or supplier, or their designee, in order to point out the following:

    a. The requested information that was not provided.

    b. The report with the results of the audit. The report is issued within thirty calendar (30) days from the date of the visit.

    c. The right to a written rebuttal of the audit's results if there is disagreement about its conclusions.

17.2.6.4 Review of medical records

1. The staff member in charge of the audit will finish reviewing the documents scanned or received from the medical records and prepare a report of the findings.
2. As part of the review, the MMM staff member in charge of the audit will take the following into consideration:
    a. Requested information that was not provided.
    b. Undocumented billed services.
    c. Overbilled services, using guidelines set by CMS, ASES and any other regulatory agencies.
    d. Incorrectly paid services.
    e. Coverage application.
    f. Application of medical and payment policies established by MMM.
    g. Application of federal and state regulations.
    h. Contract terms.
    i. Billed services that do not correspond to the medical specialty.
    j. Double billing of services.

17.2.6.5 Calculation of over and under payments resulting from the audit, if applicable

1. Results of the review of medical records gathered from the selected sample are used to determine the amount of overpayment to each audited provider or supplier related to the sample. The calculated overpayment

amount, determined through the findings of the document review, is itemized and quantified by type of finding and dollar amount.

2. Results obtained from the selected sample are used to extrapolate using the RAT- STAT statistical software package to the total universe of paid claims during the time period examined by the audit.
3. The overpayment projection is documented as part of the audit process for the provider or supplier selected.
4. If during the review of the requested information payments made below the corresponding rate are detected, adjustments that favor the provider or supplier will be made.

17.2.6.6 Compliance Committee

1. Reports of findings and recommendations issued by staff in charge of the audit are presented to MMM Compliance Committee.
2. The following actions can be recommended to the Compliance Committee:
    a. Education for the provider or supplier.
    b. A cease-and-desist letter regarding the detected practices.
    c. A notification of results and recovery of the verified overpayment.
    d. Temporary suspension or contract termination.
    e. Prepayment review.
    f. Referrals to the law enforcement agencies.
    g. Referrals to Medicare Drug Integrity Contractors (MEDICs) for Part D cases.

h. Closing the case.

i. Any other action, as outlined in the provider or supplier services contract.

3. The Compliance Committee, as part of its duties, examines the findings and recommendations to determine what actions will be taken in each case.

17.2.6.7 Notification of results to provider or supplier

1. The MMM staff in charge of the audit will notify the provider or supplier of audit results and actions to be taken, as determined by the Compliance Committee generally, within thirty calendar (30) days of the Committee's decision.
2. Notification of results is made by certified mail with proof of delivery. Additional copies of the notice can be sent via fax, InnovaMD or e-mail, as arranged with the provider or supplier.
3. The result notice shall include, among other things, the following:
   a. A summary of the findings.
   b. Actions to be taken.
4. The total and calculation of any overpayment/underpayment based on the selected.
   a. Sample, including its projection onto the universe total amount of claims.
   b. Provider or supplier's responsibilities resulting from the findings.

5. Rebuttal and appeal instructions for the provider or supplier.

17.2.6.8 Right to rebut established conclusions

1. The healthcare provider or supplier has thirty calendar (30) days to rebut the audit's findings and conclusions, starting on the date of receipt of the certified letter that notifies the results.
2. The audited provider or supplier may request a meeting to discuss the results of the audit.
    a. The meeting must be requested within the thirty calendar (30) days allowed to rebut determinations taken in the case.
3. The rebuttal must be issued in writing, and it should establish the reasons why it is being presented along with any additional documents that the plan should consider before enforcing corrective action, recoupment or closing the audit.
4. MMM staff in charge of the audit will examine the additional documents presented by the provider or supplier within a period that shall not exceed fifteen (15) calendar days from the date of receipt of the rebuttal.
5. MMM staff in charge of the audit notifies the audit's final determination to the provider or supplier by certified mail with proof of receipt.
6. If the staff in charge of the audit doesn't receive verbal or written communication from the provider or supplier within thirty (30) calendar days

from the date of receipt of the certified letter that notifies the results, the following will be done:

a. The case will be referred to the Claims Department to begin the overpayment recovery, or underpayment process as established by submitted claims that are pending payment.

b. The case will be referred to the corresponding departments to take whichever actions the Compliance Committee has determined.

7. The MMM staff in charge of the audit will grant the provider or supplier a meeting within the fifteen (15) calendar-day term, which will start on the date of the request. The purpose of the meeting is to:

a. Explain the overall auditing process.

b. Inform the reason for the audit and the usage profile.

c. Explain the findings that resulted from the audit.

d. Advise the provider or supplier of determinations.

e. Offer payment options to settle the determined overpayment.

17.2.6.9 Recovery of determined overpayment

In the case an overpayment is determined, the audited provider or supplier will have the following options to settle the determined overpayment:

2. Execute remittance to MMM of the determined overpayment by certified check within the thirty calendar (30) days of the overpayment notification.

3. Request a payment plan with MMM based on monthly installments paid to the Plan. The suggested payment plan needs to be approved by the Compliance Committee.

4. Request a payment plan based on adjustment of ready to pay and future claims payable. The suggested payment plan needs to be approved by the Compliance Committee.

a. The Compliance Department will monitor audited cases until overpayments to providers or suppliers have been fully recovered.

b. If an established overpayment recovery is interrupted, it will be referred to MSO's Legal Department so that appropriate action can be taken.

17.2.6.10 Arbitration

Any dispute, controversy or claim arising out of, relating to or in connection with any overpayment recovery process, shall be settled by arbitration under and in accordance with the Rules of the American Arbitration Association in effect on the date of this Agreement (the "Rules"). All disputes submitted to arbitration in accordance here with shall be finally settled by arbitration conducted in San Juan, Puerto Rico. A party wishing to submit a dispute to arbitration shall give written notice to such effect to the other parties here to and to the American Arbitration Association (the "AAA"). Each of the two parties shall designate one arbitrator and the two designated arbitrators shall choose a third arbitrator, who shall also be the chairman of the panel. The AAA shall confirm the appointment of such third

arbitrator. If one of the two parties appoints an arbitrator but the other party fails to nominate its arbitrator within thirty (30) days from another party's notice of such a request for arbitration, then the appointment of such second arbitrator shall be made by the AAA upon the request of the other party; and in the event that the appointed arbitrators shall fail to appoint the third arbitrator within sixty (60) days after the date of appointment of the most recently appointed arbitrator, the AAA upon the request of either party shall appoint the third arbitrator.

a. The arbitrators shall be legal practitioners having at least fifteen (15) years' experience in commercial legal matters in the twenty years immediately preceding commencement of the arbitration.

b. The arbitrators shall be conducted under and in accordance with the Rules, which Rules are deemed incorporated by reference.

c. The site of the arbitration shall be in San Juan, Puerto Rico, any award shall be deemed made there and the language to be used in the arbitration proceedings shall be the English language.

d. The decision of and/or the award rendered by the arbitration panel shall be final and binding upon all parties, and judgment upon the award may be entered by any court having jurisdiction thereof.

e. The Federal Arbitration Act, 9 U.S.C. §1-16, shall govern all matters relating to the enforceability of this arbitration agreement and any decision or award rendered pursuant to this agreement.

f. Apply the substantive law of the Commonwealth of Puerto Rico, exclusive of any conflict of law rules.

g. Each party shall be required to continue to perform its other obligations under this Agreement not affected by the dispute pending final resolution of any dispute arising out of or relating to this Agreement, unless to do so would be impossible or impracticable under the circumstances.

h. Any claim by either party shall be time-barred unless the asserting party commences an arbitration proceeding with respect to such dispute within one year after the dispute or claim arose. The arbitrators shall resolve all issues relating to the timeliness of claims.

i. Any award shall be in writing in the English language. The arbitrators shall neither have nor exercise any power to act as *amiable compositeur* or decide *ex aequo et bono;* or to award special, exemplary, indirect, consequential or punitive damages. All expenses, costs and legal fees incurred by each party shall be paid by the party incurring them. The cost of the arbitration (including the filing fees) fixed by the Rules shall be shared equally by all the parties to the arbitration.

j. Notwithstanding the foregoing, the provisions of this Section shall not apply to any injunctive relief sought against the Provider under the Confidentiality Agreement signed by the parties.

17.2.6.11 Additional reviews

The cases of providers or suppliers subject to clinical audits will be reviewed six (6) months after the dates of final determinations in order to ascertain compliance with agreed upon recommendations and detect any instance of repeated behavior or practices that prompted the original audit.

Non-compliance with agreed upon recommendations or evidence of further or additional billing pattern anomalies, will be enough cause to trigger additional or expanded audits.

17.3 Sanctions or fines applicable in cases of non-compliance

The Credentialing Department verifies excluded providers and the Medicare/Medicaid Opt-Out list, on monthly basis, prints and files copy of the reports available in the following links:

a. http://oig.hhs.gov/fraud/exclusions/supplement_archive.asp
b. http://medicare.fcso.com/Opt_out/

If a Credentialing Department becomes aware that a provider has been excluded or has opted-out, the Coordinator informs the Network Operation Departments start the process of removing that provider from MSO Provider network. The specific reasons to consider the exclusion of a provider are as follow:

1001.201 - Conviction relating to program or healthcare fraud.

1001.301 - Conviction relating to obstruction of an investigation.

1001.401 - Conviction relating to controlled substances.

1001.501 - License revocation or suspension.

1001.601 - Exclusion or suspension under a Federal or State healthcare program.

1001.701 - Excessive claims or furnishing of unnecessary or substandard items and services.

1001.801- Failure of HMOs and CMPs to furnish medically necessary items and services.

1001.901 - False or improper claims.

1001.951 - Fraud and kickbacks and other prohibited activities.

1001.952 - Exceptions.

1001.1001 - Exclusion of entities owned or controlled by a sanctioned person.

1001.1051 - Exclusion of individuals with ownership or control interest in sanctioned entities.

1001.1101 - Failure to provide payment information.

1001.1301 - Failure to grant immediate access.

1001.1401 - Violations of PPS corrective action.

1001.1501 - Default of health education loan or scholarship obligations.

1001.1601 - Violations of the limitations on physician charges.

MMM will not make a payment to any Provider who has been barred from participation based on existing Medicare, Medicaid or CHIP sanctions, except for Emergency Services.

Audits and monitoring activities are performed to address non-compliance, fraud, waste and/or abuse activities. In the event a provider l found to be non-compliant administrative

actions may take place including but not limited to: (a) service agreement cancelation, (b) referral to state and federal agencies and/or (c) recoveries of overpayments.

18. ADDENDUMS

Annex 1 **Provider Quick References**

Annex 2 **Claims Adjustment Reason Codes**

Annex 3 **Direct Deposit Authorization Form**

Annex 4 **Member ID cards**

Annex 5 **Adjustment Form**

Annex 1. Provider Quick References

PROVIDER QUICK REFERENCES		
Provider Services Metro Area – 787-993-2317 Toll-Free – 1-866-676-6060 Fax – 787-300-5508 Monday through Friday 7:00 am to 7:00 pm	Provider Portal www.Innovamd.com InnovaMD Support Group Metro Area 787-993-2317 Toll Free - 1-866-676-6060 Monday through Friday 7:00 am to 7:00 pm	Provider Interactive Voice Response System Infomed Metro Area - 787-993-2317 Toll Free - 1-866-676-6060 Automated System 24 hours 7 days a week
Preauthorization – MMM Metro Area – 787-993-2317	Health Services Discharge Planning	Transportation

Toll-Free – 1-866-676-6060 Monday through Friday 7:00 am to 7:00 pm Non DME Fax – 787-620-2388 Toll-Free Fax Non DME – 1-877-227-3778 DME Fax 787-999-1743	Metro Area – 787-993-2321 Toll-Free – 1-877-556-5506 Fax 787-300-5506 Monday through Friday 8:00 am to 5:00pm Weekend 9:00 am to 6:00pm	Metro Area - 787-993-2307 Toll-Free – 1-866-517-0703 Fax 787-3000-5500 Monday through Friday 7:00 am to 7:00 pm
Pharmacy Pharmacy Providers MMM Toll-Free- 1-877-776-7706 24 hours 7 days a week Fax – 787-625-3370	Mental Health Department Toll Free – 1-877-721-7722 24 hours 7 days a week	

Annex 2. Claim Adjustment Reason Codes

1	**Deductible Amount** *Start: 01/01/1995*
2	**Coinsurance Amount** *Start: 01/01/1995*
3	**Co-payment Amount** *Start: 01/01/1995*
4	**The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
5	**The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
6	**The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
7	**The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
8	**The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
9	**The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
10	**The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*

11	**The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
12	**The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
13	**The date of death precedes the date of service.** *Start: 01/01/1995*
14	**The date of birth follows the date of service.** *Start: 01/01/1995*
15	**The authorization number is missing, invalid, or does not apply to the billed services or provider.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
16	**Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 11/01/2013*
18	**Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)** *Start: 01/01/1995 | Last Modified: 06/02/2013*
19	**This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
20	**This injury/illness is covered by the liability carrier.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

21	**This injury/illness is the liability of the no-fault carrier.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
22	**This care may be covered by another payer per coordination of benefits.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
23	**The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)** *Start: 01/01/1995 | Last Modified: 09/30/2012*
24	**Charges are covered under a capitation agreement/managed care plan.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
26	**Expenses incurred prior to coverage.** *Start: 01/01/1995*

27	**Expenses incurred after coverage terminated.** *Start: 01/01/1995*
29	**The time limit for filing has expired.** *Start: 01/01/1995*
31	**Patient cannot be identified as our insured.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
32	**Our records indicate that this dependent is not an eligible dependent as defined.** *Start: 01/01/1995*
33	**Insured has no dependent coverage.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
34	**Insured has no coverage for newborns.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
35	**Lifetime benefit maximum has been reached.** *Start: 01/01/1995 | Last Modified: 10/31/2002*
39	**Services denied at the time authorization/pre-certification was requested.** *Start: 01/01/1995*
40	**Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
44	**Prompt-pay discount.** *Start: 01/01/1995*

45	**Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)** *Start: 01/01/1995 | Last Modified: 11/01/2015*
49	**This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 11/01/2013*
50	**These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
51	**These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*

53	**Services by an immediate relative or a member of the same household are not covered.** *Start: 01/01/1995*
54	**Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
55	**Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 04/01/2015*
56	**Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
58	**Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
59	**Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
60	**Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.** *Start: 01/01/1995 | Last Modified: 06/01/2008*

61	**Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
66	**Blood Deductible.** *Start: 01/01/1995*
69	**Day outlier amount.** *Start: 01/01/1995*
70	**Cost outlier - Adjustment to compensate for additional costs.** *Start: 01/01/1995 | Last Modified: 06/30/2001*
74	**Indirect Medical Education Adjustment.** *Start: 01/01/1995*
75	**Direct Medical Education Adjustment.** *Start: 01/01/1995*

76	**Disproportionate Share Adjustment.** *Start: 01/01/1995*
78	**Non-Covered days/Room charge adjustment.** *Start: 01/01/1995*
85	**Patient Interest Adjustment (Use Only Group code PR)** *Start: 01/01/1995 | Last Modified: 07/09/2007* *Notes: Only use when the payment of interest is the responsibility of the patient.*
89	**Professional fees removed from charges.** *Start: 01/01/1995*
90	**Ingredient cost adjustment. Note: To be used for pharmaceuticals only.** *Start: 01/01/1995 | Last Modified: 07/01/2009*
91	**Dispensing fee adjustment.** *Start: 01/01/1995*
94	**Processed in Excess of charges.** *Start: 01/01/1995*
95	**Plan procedures not followed.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
96	**Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*

97	**The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
100	**Payment made to patient/insured/responsible party/employer.** *Start: 01/01/1995 | Last Modified: 01/27/2008*
101	**Predetermination: anticipated payment upon completion of services or claim adjudication.** *Start: 01/01/1995 | Last Modified: 02/28/1999*
102	**Major Medical Adjustment.** *Start: 01/01/1995*
103	**Provider promotional discount (e.g., Senior citizen discount).** *Start: 01/01/1995 | Last Modified: 06/30/2001*
104	**Managed care withholding.** *Start: 01/01/1995*
105	**Tax withholding.** *Start: 01/01/1995*

106	**Patient payment option/election not in effect.** *Start: 01/01/1995*
107	**The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
108	**Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
109	**Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.** *Start: 01/01/1995 | Last Modified: 01/29/2012*
110	**Billing date predates service date.** *Start: 01/01/1995*
111	**Not covered unless the provider accepts assignment.** *Start: 01/01/1995*
112	**Service not furnished directly to the patient and/or not documented.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
114	**Procedure/product not approved by the Food and Drug Administration.** *Start: 01/01/1995*
115	**Procedure postponed, canceled, or delayed.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
116	**The advance indemnification notice signed by the patient did not comply with requirements.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
117	**Transportation is only covered to the closest facility that can provide the necessary care.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

118	**ESRD network support adjustment.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
119	**Benefit maximum for this time period or occurrence has been reached.** *Start: 01/01/1995 | Last Modified: 02/29/2004*
121	**Indemnification adjustment - compensation for outstanding member responsibility.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
122	**Psychiatric reduction.** *Start: 01/01/1995*
128	**Newborn's services are covered in the mother's Allowance.** *Start: 02/28/1997*

129	**Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 02/28/1997 | Last Modified: 01/30/2011*
130	**Claim submission fee.** *Start: 02/28/1997 | Last Modified: 06/30/2001*
131	**Claim specific negotiated discount.** *Start: 02/28/1997*
132	**Prearranged demonstration project adjustment.** *Start: 02/28/1997*
133	**The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).** *Start: 07/01/2014 | Last Modified: 03/01/2015*
134	**Technical fees removed from charges.** *Start: 10/31/1998*
135	**Interim bills cannot be processed.** *Start: 10/31/1998 | Last Modified: 09/30/2007*
136	**Failure to follow prior payer's coverage rules. (Use only with Group Code OA)** *Start: 10/31/1998 | Last Modified: 07/01/2013*
137	**Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.** *Start: 02/28/1999 | Last Modified: 09/30/2007*

138	**Appeal procedures not followed or time limits not met.** *Start: 06/30/1999 | Last Modified: 09/30/2007*
139	**Contracted funding agreement - Subscriber is employed by the provider of services.** *Start: 06/30/1999*
140	**Patient/Insured health identification number and name do not match.** *Start: 06/30/1999*
142	**Monthly Medicaid patient liability amount.** *Start: 06/30/2000 | Last Modified: 09/30/2007*
143	**Portion of payment deferred.** *Start: 02/28/2001*
144	**Incentive adjustment, e.g. preferred product/service.** *Start: 06/30/2001*
146	**Diagnosis was invalid for the date(s) of service reported.** *Start: 06/30/2002 | Last Modified: 09/30/2007*

147	**Provider contracted/negotiated rate expired or not on file.** *Start: 06/30/2002*
148	**Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 06/30/2002 | Last Modified: 09/20/2009*
149	**Lifetime benefit maximum has been reached for this service/benefit category.** *Start: 10/31/2002*
150	**Payer deems the information submitted does not support this level of service.** *Start: 10/31/2002 | Last Modified: 09/30/2007*
151	**Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.** *Start: 10/31/2002 | Last Modified: 01/27/2008*
152	**Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 10/31/2002 | Last Modified: 09/20/2009*
153	**Payer deems the information submitted does not support this dosage.** *Start: 10/31/2002 | Last Modified: 09/30/2007*
154	**Payer deems the information submitted does not support this day's supply.** *Start: 10/31/2002 | Last Modified: 09/30/2007*
155	**Patient refused the service/procedure.** *Start: 06/30/2003 | Last Modified: 09/30/2007*
157	**Service/procedure was provided as a result of an act of war.** *Start: 09/30/2003 | Last Modified: 09/30/2007*
158	**Service/procedure was provided outside of the United States.** *Start: 09/30/2003 | Last Modified: 09/30/2007*
159	**Service/procedure was provided as a result of terrorism.** *Start: 09/30/2003 | Last Modified: 09/30/2007*
160	**Injury/illness was the result of an activity that is a benefit exclusion.** *Start: 09/30/2003 | Last Modified: 09/30/2007*
161	**Provider performance bonus** *Start: 02/29/2004*
163	**Attachment/other documentation referenced on the claim was not received.** *Start: 06/30/2004 | Last Modified: 06/02/2013*
164	**Attachment/other documentation referenced on the claim was not received in a timely fashion.** *Start: 06/30/2004 | Last Modified: 06/02/2013*

165	**Referral absent or exceeded.** *Start: 10/31/2004 | Last Modified: 09/30/2007*
166	**These services were submitted after this payers responsibility for processing claims under this plan ended.** *Start: 02/28/2005*
167	**This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
168	**Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
169	**Alternate benefit has been provided.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
170	**Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
171	**Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
172	**Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*

173	**Service/equipment was not prescribed by a physician.** *Start: 06/30/2005 | Last Modified: 07/01/2013*
174	**Service was not prescribed prior to delivery.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
175	**Prescription is incomplete.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
176	**Prescription is not current.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
177	**Patient has not met the required eligibility requirements.** *Start: 06/30/2005 | Last Modified: 09/30/2007*

178	**Patient has not met the required spend down requirements.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
179	**Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
180	**Patient has not met the required residency requirements.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
181	**Procedure code was invalid on the date of service.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
182	**Procedure modifier was invalid on the date of service.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
183	**The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
184	**The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
185	**The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/30/2005 | Last Modified: 09/20/2009*
186	**Level of care change adjustment.** *Start: 06/30/2005 | Last Modified: 09/30/2007*
187	**Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)** *Start: 06/30/2005 | Last Modified: 01/25/2009*
188	**This product/procedure is only covered when used according to FDA recommendations.** *Start: 06/30/2005*
189	**'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service** *Start: 06/30/2005*
190	**Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.** *Start: 10/31/2005*

192	**Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.** *Start: 10/31/2005 | Last Modified: 09/30/2007*
193	**Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.** *Start: 02/28/2006 | Last Modified: 01/27/2008*
194	**Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.** *Start: 02/28/2006 | Last Modified: 09/30/2007*
195	**Refund issued to an erroneous priority payer for this claim/service.** *Start: 02/28/2006 | Last Modified: 09/30/2007*
197	**Precertification/authorization/notification absent.** *Start: 10/31/2006 | Last Modified: 09/30/2007*
198	**Precertification/authorization exceeded.** *Start: 10/31/2006 | Last Modified: 09/30/2007*
199	**Revenue code and Procedure code do not match.** *Start: 10/31/2006*
200	**Expenses incurred during lapse in coverage** *Start: 10/31/2006*

201	**Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 10/31/2006 | Last Modified: 09/28/2014* *Notes: Not for use by Workers' Compensation payers; use code P3 instead.*
202	**Non-covered personal comfort or convenience services.** *Start: 02/28/2007 | Last Modified: 09/30/2007*
203	**Discontinued or reduced service.** *Start: 02/28/2007 | Last Modified: 09/30/2007*
204	**This service/equipment/drug is not covered under the patient's current benefit plan** *Start: 02/28/2007*

205	**Pharmacy discount card processing fee** *Start: 07/09/2007*
206	**National Provider Identifier - missing.** *Start: 07/09/2007 | Last Modified: 09/30/2007*
207	**National Provider identifier - Invalid format** *Start: 07/09/2007 | Last Modified: 06/01/2008*
208	**National Provider Identifier - Not matched.** *Start: 07/09/2007 | Last Modified: 09/30/2007*
209	**Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)** *Start: 07/09/2007 | Last Modified: 07/01/2013*
210	**Payment adjusted because pre-certification/authorization not received in a timely fashion** *Start: 07/09/2007*
211	**National Drug Codes (NDC) not eligible for rebate, are not covered.** *Start: 07/09/2007*
212	**Administrative surcharges are not covered** *Start: 11/05/2007*
213	**Non-compliance with the physician self referral prohibition legislation or payer policy.** *Start: 01/27/2008*
215	**Based on subrogation of a third party settlement** *Start: 01/27/2008*
216	**Based on the findings of a review organization** *Start: 01/27/2008*
219	**Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).** *Start: 01/27/2008 | Last Modified: 10/17/2010*
222	**Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/01/2008 | Last Modified: 09/20/2009*
223	**Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.** *Start: 06/01/2008*

224	**Patient identification compromised by identity theft. Identity verification required for processing this and future claims.** *Start: 06/01/2008*
225	**Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)** *Start: 06/01/2008*
226	**Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 09/21/2008 | Last Modified: 07/01/2013*
227	**Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 09/21/2008 | Last Modified: 09/20/2009*
228	**Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication** *Start: 09/21/2008*
229	**Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)** *Start: 01/25/2009 | Last Modified: 07/01/2013*
231	**Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 07/01/2009 | Last Modified: 09/20/2009*
232	**Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.** *Start: 11/01/2009*
233	**Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.** *Start: 01/24/2010*
234	**This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 01/24/2010*
235	**Sales Tax** *Start: 06/06/2010*
236	**This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.** *Start: 01/30/2011 | Last Modified: 07/01/2013*

237	**Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 06/05/2011*
238	**Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)** *Start: 03/01/2012 | Last Modified: 07/01/2013*
239	**Claim spans eligible and ineligible periods of coverage. Rebill separate claims.** *Start: 03/01/2012 | Last Modified: 01/29/2012*
240	**The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 06/03/2012*
241	**Low Income Subsidy (LIS) Co-payment Amount** *Start: 06/03/2012*
242	**Services not provided by network/primary care providers.** *Start: 06/03/2012 | Last Modified: 06/02/2013* *Notes: This code replaces deactivated code 38*
243	**Services not authorized by network/primary care providers.** *Start: 06/03/2012 | Last Modified: 06/02/2013* *Notes: This code replaces deactivated code 38*
245	**Provider performance program withhold.** *Start: 09/30/2012*
246	**This non-payable code is for required reporting only.** *Start: 09/30/2012*
247	**Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.** *Start: 09/30/2012* *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*

248	**Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.** *Start: 09/30/2012* *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*
249	**This claim has been identified as a readmission. (Use only with Group Code CO)** *Start: 09/30/2012*

249	**This claim has been identified as a readmission. (Use only with Group Code CO)** *Start: 09/30/2012*
250	**The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).** *Start: 09/30/2012 | Last Modified: 06/01/2014*
251	**The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).** *Start: 09/30/2012 | Last Modified: 06/01/2014*
252	**An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).** *Start: 09/30/2012 | Last Modified: 06/02/2013*
253	**Sequestration - reduction in federal payment** *Start: 06/02/2013 | Last Modified: 11/01/2013*
254	**Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.** *Start: 06/02/2013*
256	**Service not payable per managed care contract.** *Start: 06/02/2013*

257	**The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)** *Start: 11/01/2013 | Last Modified: 06/01/2014* *Notes: To be used after the first month of the grace period.*
258	**Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.** *Start: 11/01/2013*
259	**Additional payment for Dental/Vision service utilization.** *Start: 01/26/2014*
260	**Processed under Medicaid ACA Enhanced Fee Schedule** *Start: 01/26/2014*
261	**The procedure or service is inconsistent with the patient's history.** *Start: 06/01/2014*

262	**Adjustment for delivery cost. Note: To be used for pharmaceuticals only.** *Start: 11/01/2014*
263	**Adjustment for shipping cost. Note: To be used for pharmaceuticals only.** *Start: 11/01/2014*
264	**Adjustment for postage cost. Note: To be used for pharmaceuticals only.** *Start: 11/01/2014*
265	**Adjustment for administrative cost. Note: To be used for pharmaceuticals only.** *Start: 11/01/2014*
266	**Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.** *Start: 11/01/2014*
267	**Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 11/01/2014 | Last Modified: 04/01/2015*
268	**The Claim spans two calendar years. Please resubmit one claim per calendar year.** *Start: 11/01/2014*
269	**Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 03/01/2015*
270	**Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.** *Start: 07/01/2015*

271	**Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)** *Start: 11/01/2015*
272	**Coverage/program guidelines were not met.** *Start: 11/01/2015*
273	**Coverage/program guidelines were exceeded.** *Start: 11/01/2015*
274	**Fee/Service not payable per patient Care Coordination arrangement.** *Start: 11/01/2015*
275	**Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)** *Start: 11/01/2015*

276	**Services denied by the prior payer(s) are not covered by this payer.** *Start: 11/01/2015*
277	**The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)** *Start: 11/01/2015* *Notes: To be used during 31 day SHOP grace period.*
A0	**Patient refund amount.** *Start: 01/01/1995*
A1	**Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)** *Start: 01/01/1995 | Last Modified: 09/20/2009*
A5	**Medicare Claim PPS Capital Cost Outlier Amount.** *Start: 01/01/1995*
A6	**Prior hospitalization or 30 day transfer requirement not met.** *Start: 01/01/1995*
A8	**Ungroupable DRG.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B1	**Non-covered visits.** *Start: 01/01/1995*
B4	**Late filing penalty.** *Start: 01/01/1995*
B5	**Coverage/program guidelines were not met or were exceeded.** *Start: 01/01/1995 | Last Modified: 11/01/2015 | Stop: 05/01/2016* *Notes: This code has been replaced by 272 and 273.*
B7	**This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
B8	**Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcar Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
B9	**Patient is enrolled in a Hospice.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

B10	**Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.** *Start: 01/01/1995*
B11	**The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.** *Start: 01/01/1995*
B12	**Services not documented in patients' medical records.** *Start: 01/01/1995*
B13	**Previously paid. Payment for this claim/service may have been provided in a previous payment.** *Start: 01/01/1995*
B14	**Only one visit or consultation per physician per day is covered.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B15	**This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
B16	**'New Patient' qualifications were not met.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
B20	**Procedure/service was partially or fully furnished by another provider.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

B22	**This payment is adjusted based on the diagnosis.** *Start: 01/01/1995 | Last Modified: 02/28/2001*
B23	**Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.** *Start: 01/01/1995 | Last Modified: 09/30/2007*
P1	**State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 162*
P2	**Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 191*
P3	**Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)** *Start: 11/01/2013* *Notes: This code replaces deactivated code 201*
P4	**Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only** *Start: 11/01/2013* *Notes: This code replaces deactivated code 214*
P5	**Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 217*
P6	**Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 218*

P7	**The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 220*
P8	**Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 221*
P9	**No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 230*
P10	**Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code 244*
P11	**The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)** *Start: 11/01/2013* *Notes: This code replaces deactivated code 255*

P12	**Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W1*
P13	**Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W2*

P14	**The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W3*
P15	**Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W4*
P16	**Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)** *Start: 11/01/2013* *Notes: This code replaces deactivated code W5*
P17	**Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W6*
P18	**Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W7*
P19	**Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W8*

P20	**Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code W9*
P21	**Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code Y1*

P22	**Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code Y2*
P23	**Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.** *Start: 11/01/2013* *Notes: This code replaces deactivated code Y3*

Annex 3. Direct Deposit Authorization Form

Autorización para Depósito Directo (requisito incluir copia de cheque void o carta del banco)
Authorization for Direct Deposit (must inlcude copy of voided check o bank letter)

Nombre del Proveedor / Provider Name:
Dirección Postal / Mailing Address:
Número de Teléfono / Telephone Number:
Correo electrónico / Email:

Número de Seguro Social o Tax ID / Social Security or Tax ID Number:	National Provider Identifier (NPI) Number:

Autorizo a MSO of Puerto Rico, LLC, MMM Healthcare, LLC y/o MMM Multihealth, LLC a acreditar mi pago de reclamaciones a la cuenta bancaria que se indica a continuación.
I authorize MSO of Puerto Rico, LLC, MMM Healthcare, LLC y/o MMM Multihealth to credit my claim payment to the bank account stated below.

Nombre de Institución Financiera / Name of Financial Institution:
Número de Ruta / Routing Number:
Número de Cuenta / Account Number:
☐ Ahorros / Savings
☐ Cheque / Checking

Esta autorización prevalecerá hasta tanto MSO, MMM o MMM Multihealth haya recibido una notificación escrita de mi parte, para dar de baja el servicio de Depósito Directo. Entiendo que debo enviar la notificación para cancelar el servicio con 30 días de antelación a la fecha de efectividad.

This authorization will remain in effect until MSO, MMM or MMM Multihealth receives a written notification canceling the Direct Deposit service. I understand that I shall send my direct deposit's cancellation request 30 days in advance of the desired effective date.

Firma del Proveedor / Provider Signature _____ Fecha / Date _____

Para uso interno de MSO/MMM solamente / For MSO/MMM internal use only
☐ Capitado / Capitated (si el proveedor es capitado favor enviar copia al Departamento de Finanzas / If the provider is capitated please send a copy to the Finance Department)
Firma del representante de MMM / MMM Signature _____ Fecha / Date _____

Annex 4. Member Identification Cards

MMM Platino

PMC Platino


<Plan Name>
<Plan Type> 2022
<Member Name>
ID: <Member ID Number>
<IPA Name>
Dr. <Primary Physician Name>
<Primary Physician Telephone Number>
Copays:
PCP <$>
Specialist <$>
Urgency <$>
Emergency <$>
Prev Dental <$>
Hospital <$>
PMC Medicare Choice
medicare PLATINO
Issuer: <insert>
RxPCN: <insert>
RxGrp: <insert>
RxBIN: <insert>
Pharmacy:
Covered Drugs <$>
MedicareRx
<#Contract> <#PBP>
Sample


Member Services:
1-866-333-5470 (toll free)
1-866-333-5469 TTY (hearing impaired)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Emergency Assistance)
1-866-677-7779
Mental Health:
1-877-721-7722 (toll free)
1-855-622-5602 TTY (hearing impaired)
Provider Services:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Mental Health Provider:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Postal Address:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Sample


<Nombre del Plan>
<Tipo de Plan> 2022
<Nombre del Afiliado>
ID: <Número de Identificación>
<Nombre IPA>
Dr. <Nombre del Médico Primario>
<Número de Teléfono del Médico Primario>
Copagos:
PCP <$>
Especialista <$>
Urgencia <$>
Emergencia <$>
Prev Dental <$>
Hospital <$>
PMC Medicare Choice
medicare PLATINO
Issuer: <insertar>
RxPCN: <insertar>
RxGrp: <insertar>
RxBIN: <insertar>
Farmacia:
Medicamentos Cubiertos <$>
MedicareRx
<#Contrato> <#PBP>
Sample


Servicios al Afiliado:
1-866-333-5470 (libre de cargos)
1-866-333-5469 TTY (audio impedidos)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Asistencia en Emergencia)
1-866-677-7779
Salud Mental:
1-877-721-7722 (libre de cargos)
1-855-622-5602 TTY (audio impedidos)
Servicios al Proveedor:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Proveedor Salud Mental:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Dirección Postal:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Sample

PMC MAPD


<Plan Name>
<Plan Type> 2022
<Member Name>
ID: <Member ID Number>
<IPA Name>
Dr. <Primary Physician Name>
<Primary Physician Telephone Number>
Copays:
PCP <$>
Specialist <$>
Urgency <$>
Emergency <$>
Prev Dental <$>
Hospital <$>
PMC Medicare Choice
Issuer: <insert>
RxPCN: <insert>
RxGrp: <insert>
RxBIN: <insert>
Pharmacy:
<Level 1> <$>
<Level 2> <$>
<Level 3> <$>
<Level 4> <$>
<If applicable-Level 5> <$>
MedicareRx
<#Contract> <#PBP>
Sample


Member Services:
1-866-333-5470 (toll free)
1-866-333-5469 TTY (hearing impaired)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Emergency Assistance)
1-866-677-7779
Mental Health:
1-877-721-7722 (toll free)
1-855-622-5602 TTY (hearing impaired)
Provider Services:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Mental Health Provider:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Postal Address:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Sample


<Nombre del Plan>
<Tipo de Plan> 2022
<Nombre del Afiliado>
ID: <Número de Identificación>
<Nombre IPA>
Dr. <Nombre del Médico Primario>
<Número de Teléfono del Médico Primario>
Copagos:
PCP <$>
Especialista <$>
Urgencia <$>
Emergencia <$>
Prev Dental <$>
Hospital <$>
PMC Medicare Choice
Issuer: <insertar>
RxPCN: <insertar>
RxGrp: <insertar>
RxBIN: <insertar>
Farmacia:
<Nivel 1> <$>
<Nivel 2> <$>
<Nivel 3> <$>
<Nivel 4> <$>
<Si aplica-Nivel 5> <$>
MedicareRx
<#Contrato> <#PBP>
Ejemplo


Servicios al Afiliado:
1-866-333-5470 (libre de cargos)
1-866-333-5469 TTY (audio impedidos)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Asistencia en Emergencia)
1-866-677-7779
Salud Mental:
1-877-721-7722 (libre de cargos)
1-855-622-5602 TTY (audio impedidos)
Servicios al Proveedor:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Proveedor Salud Mental:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Dirección Postal:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Ejemplo

MMM MAPD


MMM
<Plan Name>
<Plan Type> 2022
<Member Name>
ID: <Member ID Number>
<IPA Name>
Dr. <Primary Physician Name>
<Primary Physician Telephone Number>
Copays:
PCP <$>
Specialist <$>
Urgency <$>
Emergency <$>
Prev Dental <$>
Hospital <$>
Issuer: <insert>
RxPCN: <insert>
RxGrp: <insert>
RxBIN: <insert>
Pharmacy:
<Level 1> <$>
<Level 2> <$>
<Level 3> <$>
<Level 4> <$>
<Level 5> <$>
<If applicable-Level 6> <$>
MedicareRx
Prescription Drug Coverage
<#Contract> <#PBP>
Sample


Member Services:
1-866-333-5470 (toll free)
1-866-333-5469 TTY (hearing impaired)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Emergency Assistance)
1-866-677-7779
Mental Health:
1-877-721-7722 (toll free)
1-855-622-5602 TTY (hearing impaired)
Provider Services:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Mental Health Provider:
787-993-2317
(Metro Area)
1-866-676-6060
(toll free)
Postal Address:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Sample


MMM
<Nombre del Plan>
<Tipo de Plan> 2022
<Nombre del Afiliado>
ID: <Número de Identificación>
<Nombre IPA>
Dr. <Nombre del Médico Primario>
<Número de Teléfono del Médico Primario>
Copagos:
PCP <$>
Especialista <$>
Urgencia <$>
Emergencia <$>
Prev Dental <$>
Hospital <$>
Issuer: <insertar>
RxPCN: <insertar>
RxGrp: <insertar>
RxBIN: <insertar>
Farmacia:
<Nivel 1> <$>
<Nivel 2> <$>
<Nivel 3> <$>
<Nivel 4> <$>
<Nivel 5> <$>
<Si aplica-Nivel 6> <$>
MedicareRx
Gobertura Para Recetas Médicas
<#Contrato> <#PBP>
Sample


Servicios al Afiliado:
1-866-333-5470 (libre de cargos)
1-866-333-5469 TTY (audio impedidos)
mmm@mmmhc.com
www.mmmpr.com
Haciendo Contacto:
(Asistencia en Emergencia)
1-866-677-7779
Salud Mental:
1-877-721-7722 (libre de cargos)
1-855-622-5602 TTY (audio impedidos)
Servicios al Proveedor:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Proveedor Salud Mental:
787-993-2317
(Área Metro)
1-866-676-6060
(libre de cargos)
Dirección Postal:
MMM Healthcare, LLC
PO Box 71114
San Juan, PR 00936-8014
Sample

Annex 5. Adjustment Form

Hoja de Ajustes (Anejo B)

Información del Proveedor

A. ☐ **Participante** ☐ **No participante**

B. ☐ Médico ☐ Facilidad ☐ Otro (especifique): _____

C. **Tipo de solicitud**

☐ Annual Form (AHA)

☐ Claim Adjustment ☐ Otro (especifique): _____

D. Nombre de proveedor : _____

Tax ID: ☐☐☐☐☐☐☐☐☐ Teléfono: _____

Rendering NPI : ☐☐☐☐☐☐☐☐☐☐ Email: _____

Billing NPI: ☐☐☐☐☐☐☐☐☐☐

Nombre del afiliado	Número del afiliado	Código de diagnóstico (ICD 9/10)	Número de Reclamación	Fecha de Servicio	Fecha De Pago o Denegación	Razón de Ajuste	Comentario

Razón de Ajuste

1 No aplica copago 3 Diferencia de Unidad 5 Proveedor incorrecto 7 Lugar de servicio incorrecto 9 Eliminar Diagnóstico

2 Pago insuficiente 4 Diagnóstico incorrecto 6 Proveedor con cuota incorrecta 8 Otro (Explicar en detalles): _____

Comentarios Adicionales: _____

Instrucciones Importantes (Este documento debe ser completado en su totalidad para que sea procesado)

1. Favor incluir copia de la reclamación o explicación de pagos (conocido por sus siglas en inglés EOP).

2. Si el caso requiere cambios en diagnósticos, lugar de servicio, modificador, HCPS o CPT favor colocar sus comentarios en el espacio correspondiente.

3. Favor incluir todo documento necesario para su solicitud de reconsideración para posible ajuste.

4. Si la reclamación fue denegada por código 29 (expiró tiempo para someter) someta "voucher" de denegación.

5. Si marcó la Razón de Ajuste 9 favor enviar esta hoja al fax 787-625-2133 o al email Coding.Unit@mmmhc.com

Nombre del Solicitante **Firma del solicitante** **Fecha:**

Instrucciones a seguir para reclamar ajuste

Importante: **Límite para someter un ajuste desde la última fecha de pago de la reclamación son 90 días.**

Enviar a la siguiente dirección:

MMM Healthcare, LLC
Att. Departamento de Reclamaciones
PO Box 71305
San Juan, PR 00936-8405

PMC Medicare Choice
Att. Departamento de Reclamaciones
PO Box 361550
San Juan PR 00936-1550

Sometidas en forma HCFA 1500 / UB-04

1. Incluya copia de la reclamación.

2. Adjunte copia de la explicación de pago a ajustarse e identifique las líneas de servicio pagadas incorrectamente con un marcador en color.

3. Redacte una breve explicación con la razón del ajuste en cada hoja de reclamación o explicación de pago.

4. Si la reclamación fue denegada por código 29 (expiró tiempo para someter) someta "voucher" de denegación.

Nota:

Es de suma importancia siga todas estas instrucciones para que no se afecte el resultado del análisis.
Recuerde que los ajustes están sujeto a evaluación del departamento de reclamaciones.