

Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Health Plan, Inc.

2017 Provider Manual



MEMORIAL
HERMANN
Health Plan

Introduction/Overview

Memorial Hermann Health Plan on behalf of Memorial Hermann Health Solutions, Inc., Memorial Hermann Insurance Company and Memorial Hermann Health Plan, Inc. (collectively "MHHP") welcomes you to the MHHP network of providers. This provider manual is designed to help participating providers understand plan policies, procedures, and other protocols offered by MHHP.

Providers are independent and solely responsible to members for the delivery and quality of health services. MHHP does not have an employer-employee, principal-agent, partnership, joint venture or similar arrangement with any provider. Providers have a duty at all times to exercise independent medical judgment to make independent healthcare treatment decisions regardless of whether a health service is determined to be a covered service. MHHP has no right to intervene in a provider's medical decision making regarding a member and does not endorse or control the clinical judgment or treatment recommendations made by providers.

If you have any questions or concerns, please contact the Provider Relations department at 713-338-4801 or providerservices@memorialhermann.org. Calls are answered from 8 a.m. to 5 p.m., Monday through Friday (CST).

Thank you for your participation.

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Section 1: General Information
KEY CONTACT & KEY ADMINISTRATIVE INFORMATION

Function/Department	Hours	Contact Information
Customer Service <i>SELF FUNDED GROUPS</i>	7am - 6pm, Mon - Fri	713-338-6535 888-642-5040
Customer Service <i>INSURED GROUPS</i>	6am - 6pm, Mon – Fri 9am – Noon, Sat – Sun, All Holidays	713-338-4683 888-594-0671
Customer Service <i>MEDICARE ADVANTAGE</i>	8am - 8pm, Mon – Fri, 2/15 – 9/30 (except Memorial Day, July 4 th , and Labor Day) 8am – 8pm, 7 Days a Week (except Thanksgiving and Christmas)	844-550-6886 (HMO) 844-550-6896 (PPO) TTY – 711
RX Customer Service <i>SELF FUNDED and INSURED GROUPS</i>	OptumRx 24 hours, 7 days a week	877-633-4461
RX Customer Service <i>MEDICARE ADVANTAGE</i>	Envision Rx 24 hours, 7 days a week	844-860-6750 (HMO) 844-782-7672 (PPO) customerservice@envisionrx.com
Medical Management <i>SELF FUNDED GROUPS</i>	8am - 5pm Mon - Fri	888-738-8778 713-338-6588 713-338-6494 (fax)
Medical Management <i>INSURED GROUPS</i>	6am - 6pm Mon - Fri 9am - Noon Sat - Sun and Major Holidays	888-252-7680 713-338-5594 713-338-6494 (fax)
Medical Management <i>MEDICARE ADVANTAGE</i>	8am - 5pm Mon - Fri	844-550-6886 (HMO) 844-550-6896 (PPO) 713-338-6982 (fax)

Behavioral Health Prior Authorization MEDICARE ADVANTAGE <i>Through 12/31/2017</i>	8am - 8pm, Mon – Fri, 2/15 – 9/30 (except Memorial Day, July 4 th , and Labor Day) 8am – 8pm, 7 days a week (except Thanksgiving and Christmas)	844-809-5890 (HMO) 844-809-5891 (PPO) TTY – 711
Behavioral Health Prior Authorization MEDICARE ADVANTAGE <i>Effective 1/1/2018</i>	8am - 8pm, Mon – Fri, 2/15 – 9/30 (except Memorial Day, July 4 th , and Labor Day) 8am – 8pm, 7 days a week (except Thanksgiving and Christmas)	888-280-3557 TTY – 711
Provider Relations <i>All Products</i>	8am - 5pm Mon - Fri	713-338-4801 713-338-4107 (fax) providerservices@memorialhermann.org

Key Administrative Information			
Prior Authorization	<p><i>Information required for complete notification/prior authorization if calling in your request:</i></p> <ul style="list-style-type: none"> • Member Name & ID number • Name of referring provider • Name of facility, if applicable • Diagnosis • Expected services/CPT Code(s) • Number of visits/services requested • Date(s) of service <p>Clinical staff is available from 8am - 5pm. Clinical information is required for prior authorization.</p> <p>The Prior Authorization Form is located on the MHP website: healthplan.memorialhermann.org/providers/resource-center/</p>		
Claims Submission Timeliness	<p>Claims filed after the specified time frame will be denied with no appeal rights.</p> <p>For claims that include span several dates of service, filing timeliness is determined as follows:</p> <ul style="list-style-type: none"> • The “through date” is used to determine the date of service for institutional claims • The “from date” is used to determine the date of service for professional claims 		
Paper Submission <i>Self-Funded and Fully Insured</i>	Memorial Hermann Claims Department P.O. Box 660303 Dallas, TX 75266-0303		
Paper Submission <i>MEDICARE ADVANTAGE</i>	Memorial Hermann Advantage Claims P.O. Box 226526 Dallas, TX 75222-6526		
Claims Submission Electronically	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;"><u>Clearinghouse</u> Avality/THIN WebMD/Emdeon</td> <td style="padding: 2px;"><u>Payer ID</u> MHHNP TH 92</td> </tr> </table>	<u>Clearinghouse</u> Avality/THIN WebMD/Emdeon	<u>Payer ID</u> MHHNP TH 92
<u>Clearinghouse</u> Avality/THIN WebMD/Emdeon	<u>Payer ID</u> MHHNP TH 92		
National Provider Identifier (NPI)	<p>The NPI is a 10-digit intelligence-free numeric identifier. All MHP participating providers must have an NPI number. Providers can apply for an NPI by completing an application:</p> <ul style="list-style-type: none"> • Online or by downloading a paper copy at: https://nppes.cms.hhs.gov • By calling 1-800-465-3203 and requesting an application 		

Key Administrative Information - continued

Administrative Contracted Provider Complaints/Disputes complaints and	Administrative payment disputes must be filed within 180 days of the initial MHHP decision and mailed to: MHHP Claims Department Attention:
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Scenarios that fall under the Administrative Complaints/Provider Dispute process:

- If the claim denial is due to a provider's incorrect or inaccurate claim information, the provider should make applicable corrections and resubmit the claim via routine claim-processing channels.
- For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim.
- Timely Filing Disputes– For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons.
- The claim was paid incorrectly per contract terms.
- *Contracted provider disputes are not handled through the appeals process and should be addressed through the administrative Provider disputes*

Contractual Denials

Contractual denials are not considered adverse determinations or actions. As a result, contracted Providers have complaint rights, which include, but are not limited to:

- Denials for failure to obtain prior authorization.
- Denials for failure to notify MHHP of a hospital admission within stated time frames.

The contracted provider disputes process is outlined on the website. The online [Claims Payment Review Form](#) is located on the Resource Center page of the Provider section of the MHHP website (<http://healthplan.memorialhermann.org/providers/resource-center/>) and should be submitted with all requests for contracted provider payment disputes.

Key Administrative Information - continued

Medicare Advantage Member Appeals	Please refer to the denial letter or explanation of payment (EOP) issued to determine the correct appeals process to follow. All MA member appeals should be sent to: MHHP Medicare Advantage Appeals and Grievances Department 929 Gessner Road, Suite 1500 Houston, Texas 77024 Fax: 713-338-5811 (HMO) 713-338-5812 (PPO) Website: healthplan.memorialhermann.org/Medicare
<p>Medicare Advantage plan members have the right to appeal decisions about payment for services and failure to arrange or continue to arrange for services they believe are covered (including non- Medicare covered benefits) under Medicare Advantage.</p> <p>Pre-Service Appeals:</p> <p>A provider may expedite a reconsideration request (appeal) on behalf of a member if they feel the standard reconsideration timeframe adversely affects the member's life, health or ability to regain maximum function. Upon providing notice to the member, a treating physician may request a standard service reconsideration (appeal) on that member's behalf. Providers do not need to obtain an appointment of representation document from the member, nor are they required to execute a waiver of enrollee liability.</p> <p>Examples of commonly appealed coverage decisions include:</p> <ul style="list-style-type: none">• Services not yet received, but which the member feels Medicare Advantage is responsible for paying or for arranging.• Discontinuation of services the member believes to be medically necessary.	

Customer Service

Customer Service representatives are available to assist members and providers with benefits and claim information, including:

- Member eligibility
- Benefit inquiries
- Plan limitations and/or exclusions
- Claim status
- Participating provider information
- Provider network status.

The contact information for Customer Service is found in the Key Administration Information table on page 6. Email questions to:

mhhealthcustomerservice@memorialhermann.org

Customer Service can also assist providers with:

- Change of address or other demographic information
- Appeals
- Complaints
- Online web access
- Prior authorization confirmations.

Claim Status

Providers who require claim status for 3 or more members are asked to visit the website with their user ID and password or, if submitting the request by fax, use the Claims Status Form (available online or via fax). While many requests are handled the same day, providers should allow 24 to 48 hours for a representative to respond with all necessary information. Upon request, Customer Service can trace checks that are more than 60 days old.

Eligibility

Providers contacting Customer Service for eligibility verification will receive the member's plan type, effective date and eligibility status at the time of the call. The information received is not a guarantee of coverage. If coverage terminates after eligibility is verified, MHHP may not be responsible for services rendered after the date of termination.

Benefit Inquiries

Customer Service verifies benefits based on member eligibility and provider network participation. Benefit inquiries include information regarding covered expenses, as well as plan limitations and exclusions. Benefits include plan specifics, such as applicable copays, deductibles and coinsurance amounts.

Participating Provider Information

Information regarding MHHP participating providers is available at:

<http://healthplan.memorialhermann.org>

Customer Service is also available to assist providers and members with participating provider information upon request.

Section 2: Member-Related Information

There are 2 ways to verify a member's eligibility:

Access the Provider Portal. To access the portal, please download and complete the Authorized User Access Request Form that is located on the Resource Center page of the Provider section of the MHHP website. The Provider Portal User Manual and FAQs are also located on the Resource Center page of the Provider section of the MHHP website.

- Calling Customer Service at the number on the member's ID card.

All MHHP members receive a Memorial Hermann Health Plan ID card. Members should present their card when seeking medical services. Check the member's healthcare card at each visit and keep a copy of both sides of the card for your records.

MHHP maintains a formulary of preferred drugs, which is available in the provider section of the MHHP website.

- Physicians should obtain benefit prior authorization for non-formulary drugs by phone. See page 6 for specific details on where to call.
- Members also have a mail order prescription drug benefit for maintenance drug.

Medicare Advantage Products

- MHHP utilize the Pharmacy Benefit Manager (PBM) Envision Rx for Medicare Advantage members. Envision provides an extensive pharmacy network, pharmacy claims management services, complete drug formulary and pharmacy claims adjudication.
- MHHP maintains a formulary of preferred drugs, which is available in the provider section of the MHHP website.

Self-Funded and Fully Insured Products

- MHHP utilizes the PBM Optum Rx to manage pharmacy benefits for commercial fully insured members. Contact Customer Service if you have questions about a specific member's coverage.

Section 3: Billing and Payment

MHHP uses standard claim guidelines that are current as of the date of service. These guidelines have been developed in part using such references as the guidelines developed by the American Medical Association (AMA), found in the Current Procedural Terminology (CPT) reference manual. MHHP reserves the right to change its guidelines from time to time without notice.

In the evaluation of claims, MHHP uses various sources including, but not limited to the AMA position statements from its official publication "CPT assistant," which is published monthly. The AMA also publishes other official publications, such as "CPT changes," annually. Additional sources of information include Medicare Guidelines, which is updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, the American College of Cardiology and the American College of OB/GYN.

Claims submission requirements for various MHHP products are noted below.

Claims Filing Deadline – Fully Insured Members

Texas Senate SB418 creates a statutory filing deadline of 95 days, which may be extended only by contract. Providers forfeit payment for claims not filed within the statutory deadline. MHHP accepts proof of filing the claim with another carrier within the statutory deadline for this provision. A copy of the primary carrier's explanation of benefits form should be submitted with the claim.

There are exceptions to the filing deadline for catastrophic events. Per your provider contract, the statutory filing deadline overrides any contractual provisions that provide a shorter filing deadline.

"Clean claims", as defined by Texas Department of Insurance regulations, will be processed within 30 days of receipt if submitted electronically and within 45 days of receipt if submitted on paper. Duplicate claims may not be submitted before day 46.

Claims Filing Deadline – Self-Funded Plans

Self-funded/ERISA plan requirements vary by employer group.

Claims Filing Deadline – Medicare Advantage

Claims must be received no later than 1 calendar year from the date of service. Claims filed after the specified time frame will be denied with no appeal rights. For claims that include span dates of service, claims-filing timeliness is determined as follows:

- The "through date" is used to determine the date of service for institutional claims. The "from date" is used to determine the date of service for professional claims.

Exceptions to the timely filing requirement include:

- Administrative error if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare Administrative Contractor or agent of the U.S. Department of Health and Human Services who performed Medicare functions and acted within the scope of his/her authority
- Retroactive Medicare entitlement involving state Medicaid agencies and dually eligible beneficiaries
- Retroactive dis-enrollment from Medicare Advantage plan or program.

Claims Address

Claims should be submitted electronically or mailed to the address indicated on the member's identification card. The payer identifier for the electronic submission of claims is **MHNP**.

Clean Claim Requirements

Commercial claims should be completed as required under the Texas Department of Insurance Clean Claims regulations, 28 TAC sections 21.2801, et seq.

Healthcare providers must submit claims to the plan as outlined in their Provider Participation Agreement. Failure to comply with applicable requirements may result in denial of a claim for payment. In the event that a claim is denied, the member is to be held harmless (i.e., not billed).

On request by Provider, MHHP's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. Batch submission means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPPA) standard ACS X12N 837 Transaction Set and identified by a batch control number."

For claims that involve coordinating benefits with another carrier or Medicare, the date of the other carrier's Explanation of Payment (EOP) or Medicare's EOP may be considered by MHHP when determining the eligible submission period. A copy of the primary carrier's EOP is requested to be submitted with the claim.

Reconsideration Appeals

You may request an appeal when MHHP health plan denies an enrollee's request for an item or service in whole or in part (issues an adverse organization determination). You can appeal our decision if a service was denied, reduced, or ended early. The reconsiderations process is for **Adverse Determination**: A denial, reduction, termination, or failure to make payment (in whole or in part) of a benefit.

Scenarios that fall under the Reconsideration Appeals Process

- Service does not meet, or no longer meets, the criteria for medical necessity, based on the information provided to us
- Service is considered to be experimental or investigational (rare disease and out-of-network services)
- Service is approved, but the amount, scope or duration is less than requested
- Service is not a covered benefit under the member's benefit plan
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service

A claim appeal is a formal written request from a provider for reconsideration of a claim already processed by MHHP and denied. You must submit a written appeal for reconsideration of a denied claim within 180 days from the date on the EOP for commercial members, along with a copy of the claim and any supporting documentation. Use the Claims Appeal Form on the website or include a detailed cover letter and mail to:

**MHHP
Attention: Appeals and Grievances
Department 929 Gessner Road, Suite 1500
Houston, Texas 77024**

The following information must accompany the request in order to be reconsidered:

- The appeals claim form located online
- A copy of the original EOP indicating the claim being disputed by the provider
- The specific reason for the reconsideration request.

If applicable, also include the following:

- Authorization number
- Copy of claim
- Copy of corrected claim.

****Please note, payment disputes for contracted providers are not handled through the appeals process. Please follow the Administrative Complaints/Provider disputes process noted above. ****

Requests will be reviewed by the Appeal and Grievance Department within 30 days of receipt of all information and documentation. The timeframe for Medicare Advantage is 60 days for payment denial appeals. The provider will receive a determination via an EOP or resolution letter.

Requests for reconsideration involving denials due to an expired authorization or an authorization with exhausted visits, or denials due to lack of authorization, will be forwarded to the Appeal and Grievance Department. If the department determines that additional clinical information is required prior to retrospective review, the provider will be notified. However, if the department determines that the request cannot be authorized, the provider will receive notification of the determination. If a Provider is not satisfied with the decision of the Appeal and Grievance Department, an appeal may be submitted in writing to:

**MHHP
Attention: Appeals and Grievances
929 Gessner Road, Suite 1500
Houston, Texas 77024**

Please indicate that you are requesting a second level appeal. You should also include any initial determinations that confirms the reason for your appeal.

MHHP will provide a determination within 30 days of receipt of the appeal. Requests for appeal must include the same information as presented for review and reconsideration, as well as any additional information the provider would like to present to further support the appeal. Appeals must be submitted within 30 days from the notification to the provider regarding the determination received from the Appeal and Grievance Department. Appeals will be reviewed according to the standard policy and process of MHHP for all products.

Medicare Advantage-Specific

If the decision is not favorable to the provider, the appeal case is sent to the Independent Review Entity (IRE) within 60 calendar days of receipt of the appeal and written notice is sent to the provider. If the IRE reverses the MHHP decision to not pay the claim, MHHP shall pay for the service within 30 calendar days of receipt of the IRE notice of reversal.

MHHP Fee Schedule, Reimbursement, Coding and Bundling Guidelines

Once a claim is determined to be payable, the maximum allowable rate is the fee schedule associated with each code or such other payment arrangement specified in the provider's participation agreement.

For all products, MHHP follows the Medicare Guidelines for "not otherwise specified codes".

Providers must implement mechanisms to ensure that: (a) billing forms, CPT codes, ICD-10 codes, modifiers, "medical necessity", etc. are supported by appropriate and timely medical record documentation; (b) all claim forms and patient statements are transmitted properly; (c) instances of "code gaming", "unbundling", "upcoding", and other improper activity designed to increase reimbursement, which may constitute fraud, waste or abuse, are avoided; (d) arrangements with other providers adhere to anti-kickback and self-referral statutes; and (e) all provider marketing efforts do not improperly induce patients to utilize services and are conducted with adherence to any and all applicable state and federal regulations.

In the event of a claim denial or a request for information by MHHP, changes to the original claim form must be supported by documentation in the medical record at the time of the MHHP denial or request for more information. A provider's billing staff shall not routinely change CPT or diagnostic codes or attach modifiers to bypass MHHP claims processing edits without warranted justification; any code changes must be supported by documentation in the medical record. Providers are expected to cooperate with MHHP's Claims Department when questions arise.

Providers should ensure that compensation for billing department coders and billing consultants does not provide a financial incentive to upcode claims improperly. In

addition, all compensation arrangements with physicians on the provider's staff must comply with "Stark II" and applicable state laws.

HCPCS and CPT Codes

Current HCPCS and CPT Code manuals must be used, since many changes are made to these codes annually. These manuals may be purchased at any technical bookstore and various online bookstores or by contacting the American Medical Association at <https://commerce.ama-assn.org/store/> or at (800) 621-8335.

MHHP is in compliance with 5010 mandates. The following are MHHP reminders related to 5010:

- The billing provider address must be a physical address that equates to Box 33 on the CMS 1500 form. As a MHHP provider and according to 5010 rules, your billing provider/pay to provider address can no longer be a P.O. Box or lock box. Therefore, if you have a P.O. Box or Lock Box, please confirm with your clearinghouse or billing software vendor that this is mapped correctly; i.e., to the appropriate loop designated as your "pay to provider" (which can be a P.O. Box or Lock Box). Otherwise, your claims will be rejected by MHHP.
- Claims must have valid 4 digits on the ZIP code. Claims submitted to MHHP without them will be rejected and returned to providers. Go to <http://ZIP4.usps.com/ZIP4/welcome.jsp> to obtain your valid ZIP code.
- Anesthesia claims must be reported in minutes, not units, unless the procedure code has minutes in its description. All time should be in minutes; i.e., 1 hour 15 minutes equals 75 minutes on the bill. A new quantity (QTY) segment called "Obstetric Unit Anesthesia Count" is used to report additional complexities beyond those reported in the procedure and anesthesia segments for service line information.

Claim Filing

Electronic claims filing is preferred but if you must file a non-electronic claim, you will need to use the current standard UB-04 or CMS-1500 (02/12) claim form. Obtain forms by calling the American Medical Association at 800-621-8335.

Providers must submit a clean claim. A clean claim includes all the data elements specified by the TDI in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate, and complete.

For non-electronic submissions by institutional providers, a claim should be submitted using the current Centers for Medicare and Medicaid Services (CMS) Form UB-04. The UB-04 claim form must include all the required data elements set forth in TDI rules, including, if applicable, the amount paid by the primary plan. For non-electronic submissions by professional providers, a claim shall be submitted on a current standard CMS Form 1500 (02/12) claim form.

Electronic claims by professional or institutional providers must be submitted using the ASC X12N 837 format in order to be considered a clean claim. Providers must submit the claim in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to electronic health care claims,

including applicable implementation guidelines, companion guides, and trading partner agreements.

A claim that does not comply with the applicable standard is a deficient claim. When MHHP is unable to process a deficient claim, it will notify the provider of the deficiency and request the correct data element.

The following sections apply only in the event Provider is required to electronically submit the following:

- health care claims or equivalent encounter information;
- referral certifications; and/or
- any authorization or eligibility transactions.

MHHP will give 90 calendar days written notice prior to requiring electronic filing of any information described above. The electronic filing requirements described here are not applicable to Medicare Advantage claims or self-funded claims. This information applies to contracted providers for fully insured HMO and PPO claims. It is applicable to non-contracted providers for fully insured HMO and PPO claims in the very limited circumstances of providing emergency care or providing specialty care at the request of MHHP because such services are not reasonably available in network.

In the event of a systems failure, or a catastrophic event as defined in TAC 28 Section §21.2803, that substantially interferes with the business operations of Provider, Provider may submit non-electronic claims in accordance with the requirements in this Agreement and for the number of calendar days during which substantial interference with business operations occurs as of the date of the catastrophic event or systems failure. Provider shall provide written notice of the Provider's intent to submit non-electronic claims to MHHP within five calendar days of the catastrophic event or systems failure.

MHHP may waive the electronic submission requirements in any of the following circumstances:

- a. No method available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C.F.R., Parts 160 and 162) do not support all of the information necessary to process the claim.
- b. The operation of small physician and provider practices. This exception applies to those physicians and providers with fewer than ten full-time-equivalent employees, consistent with 42 C.F.R. §424.32(d)(1)(viii).
- c. Demonstrable undue hardship, including fiscal or operational hardship.
- d. Any other special circumstances that would justify a waiver.

Provider's request for a waiver must be in writing and must include documentation supporting the issuance of a waiver.

Upon receipt of a request for a waiver from Provider, MHHP shall, within 14 calendar days, issue or deny a waiver.

A waiver or denial of a waiver shall be issued in writing to Provider containing any restrictions, conditions or limitations related to the waiver. A written denial of a request for a waiver or the issuance of a qualified or conditional waiver shall include the reason for the denial or any restrictions, conditions or limitations, and notice of the Provider's right to appeal the determination to the Texas Department of Insurance.

If Provider is denied a waiver of the electronic submission requirements, or granted a waiver with restrictions, conditions or limitations, Provider may, within 14 calendar days of receipt, appeal the waiver determination. The request for appeal and accompanying documentation shall be sent to the Deputy Commissioner, HMO Division, P.O. Box 149104, Austin, Texas 78714-9104 and to the issuer of the health benefit plan. The information shall include:

- a. Provider's initial request for a waiver sent to MHHP, including the documentation required by subsection (D) of this section;
- b. the waiver determination received from MHHP;
- c. any additional documentation supporting issuance of a waiver or removal of restrictions, conditions or limitations of a granted waiver; and
- d. any additional information necessary for the determination of the appeal.

Upon receipt of notice of a request for appeal under this section, an issuer of a health benefit plan shall, within 14 calendar days, submit to the Deputy Commissioner of the HMO Division and to Provider:

- a. documentation supporting the waiver determination issued to the physician or provider; and
- b. any additional information necessary for the determination of the appeal.

The Deputy Commissioner of the HMO Division may request additional information from either party and may request the parties to appear at a hearing. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone. Upon receipt of all information required of this section, the Deputy Commissioner of the HMO Division shall issue a determination within 14 calendar days of the later of the receipt of all necessary information or the conclusion of the hearing.

Either party may request a hearing before the Senior Associate Commissioner of the Life, Health and Licensing Program for reconsideration of the Deputy Commissioner of the HMO Division's determination. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone. A request for reconsideration must be received by the Senior Associate Commissioner at P.O. Box 149104, Austin, Texas 78714-9104 within 14 calendar days of receiving notice of the

appeal determination.

If Provider is requesting or receiving a waiver, appealing a waiver determination, or requesting reconsideration of an appeal determination under this section, Provider may elect to file the required electronic transactions in a non-electronic format until a final determination on the request is made.

MHHP may not refuse to contract or to renew a contract with Provider based in whole or in part on Provider requesting or receiving a waiver, appealing a waiver determination, or requesting reconsideration of an appeal determination under this section.

PROFESSIONAL SERVICES

Correct Coding

Use the appropriate CPT and ICD codes on all claims.

National Drug Code (NDC) Billing Guidelines for Professional Claims

MHHP requests the use of National Drug Codes (NDCs) and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.

CMS-1500 Claim Form

MHHP requires a CMS-1500 (02/12) Claim form as the only acceptable document for participating physicians and professional providers (except hospitals and related facilities) for filing paper claims.

Return of Paper Claims with Missing NPI Number

Paper claims that do not have the billing provider's NPI number listed correctly in the appropriate block on the claim form will be returned to the provider. To avoid delays, please list your billing provider's NPI number in block 33 on the standard CMS-1500 (02/12) claim form.

INSTITUTIONAL SERVICES

UB-04 Claim Form

The electronic ANSI X12N 8371-Institutional or the Uniform Bill (UB-04) is the standardized billing form for institutional services. For information on the UB-04 billing form, or to obtain an Official UB-04 Data Specifications Manual, visit the National Uniform Billing Committee (NUBC) website at www.nubc.org.

All claims must include all information necessary for adjudication of claims according to the contract benefits.

Failure to Submit Necessary Data Elements

Failure to submit data elements that MHHP has identified as potentially necessary for claim adjudication could result in payment delays as MHHP may need to request the information from the provider in order to adjudicate the claim. All claims must include all information necessary for adjudication of claims according to the contract benefits.

NPI

Some facilities may have several NPI numbers (i.e., substance abuse wings, partial psychiatric day treatment). It is important to bill with the correct NPI for the service you provided or this could delay payment or even result in a denial of a claim.

Patient Status

The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.

Occurrence Code/Date

All accident, emergency and maternity claims require the appropriate occurrence code and the date.

Medical Review of Claims

Upon receipt, complex claims are evaluated by MHHP's Medical Management Department physician reviewers prior to processing. The medical review, supported by claims system software, focuses on procedures that may be cosmetic, evidence of coverage exclusions or limitations and possible coding irregularities. Medical reviewers may approve the billed services for processing, suggest re-coding in order to expedite payment, request additional documentation and/or recommend denial of payment of specific services.

An Explanation of Payment (EOP) letter will provide details of the determination. Providers may request a redetermination or reconsideration of claims payment determinations, including re-coding recommendations, by calling the Customer Service phone number on the member's ID card or the number on the EOP letter.

In the evaluation of claims, MHHP uses various sources including, but not limited to the AMA position statements from its official publication "CPT assistant", which is published monthly. The AMA also publishes other official publications, such as "CPT changes" annually. Additional sources of information include Medicare Guidelines, updated quarterly, and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, the American College of Cardiology and the American College of OB/GYN.

Reimbursement

This section provides information about claim pricing and reimbursement, including MHHP payment and third-party liability and coordination of benefits. Procedures for recovery of excess claim payments are also included.

Certification, Payment Determination and Explanation of Payment (EOP)

The Claims system searches the Medical Management system when a claim requiring prior authorization is received.

Claims that lack this authorization will be reviewed retrospectively upon appeal for benefit approval based upon the terms in the member's Evidence of Coverage. Benefit certification of treatment or services or a determination of medical necessity

based upon criteria in the applicable Evidence of Coverage does not guarantee payment and is subject to review by appeal.

Once a claim is determined to be payable, the maximum allowable amount is determined from the provider's agreement or the maximum allowable plan amount for non-contracted providers. Payment is the lesser of the maximum allowable amount or the provider's billed charges, less any applicable member responsibility. An explanation of payment statement (EOP) is generated when a claim is finalized and includes: a summary of the payment; and the member's responsibility, non-payment or additional information that may be required.

Member Liability for Covered Services

The only charges for which the member may be liable and billed by a MHHP participating hospital, physician or practitioner are:

- Deductibles, copayments and coinsurance amounts required by the member's evidence of coverage
- Medical services not covered by the member's evidence of coverage where the member has specifically agreed in advance, in writing, to accept financial responsibility.

MHHP plan designs generally include a deductible that must be met before benefits are payable. Some plans may also have benefit-specific deductibles. The member is financially responsible for the deductible amount(s). In addition, the member is generally responsible for paying a copayment or coinsurance for services received after all required deductibles have been satisfied. Copayments and deductibles may be collected at the time the services are rendered or upon receipt of the MHHP EOB.

To determine the member's financial responsibility (i.e., the copayment amount or whether any required deductible has been satisfied), contact the toll-free customer service number listed on the member's ID card. This information is valid as of the time this information is provided but may change as additional claims are processed.

If Provider receives an overpayment from a Member, Provider must refund the amount of the overpayment to the Member not later than the 30th day after the date Provider determines that an overpayment has been made.

Member Liability for Services that are Not Medically Necessary

Participating physicians and practitioners may not charge a member for medical services denied as not medically necessary under the member's Evidence of Coverage unless the member has provided written agreement of financial responsibility in advance of receiving such services.

The member's written agreement of financial responsibility must be specific to the services rendered. If the amounts collected exceed the member's responsibility, the physician or provider must issue a prompt refund once the EOP is received.

Coordination of Benefits

The Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing insurance coverage to the member. When a member has more than 1 health insurance, the primary and secondary are normally determined in accordance with the primary carrier rules or as required under the laws of the state where the member's Evidence of Coverage (EOC) was issued.

Primary carrier rules are often used by insurance carriers industry wide and have been incorporated into appropriate MHHP Evidence of Coverage's. These rules determine the payment responsibilities between MHHP and other applicable group insurers by establishing the primary carrier and the secondary carrier.

NOTE: The MHHP payment will not exceed the maximum allowable amount as set forth in the provider's participation agreement, total charges or the member's responsibility for covered services, whichever is less, except as otherwise required by law.

The primary carrier rules normally do not apply to:

- Non-group policies (individual policies)
- Auto insurance policies
- Medicaid
- CHAMPUS/CHAMPVA.

Third-Party Liability

Third-party Liability (TPL) occurs when a person or entity other than the MHHP member is or may be liable or legally responsible for the member's illness, injury or other condition and is, therefore, responsible for the costs associated with the member's illness, injury or condition. MHHP may be entitled to reimbursement from the member from any settlement he/she may receive from a third party in those situations.

Overpayment and Recovery Procedures

In the event of an overpayment, MHHP seeks recovery of all excess claim payments from the payee to whom the MHHP check was made payable. If the payee disagrees with the request for a refund, he/she may contact MHHP in writing at:

**MHHP Claims Department
929 Gessner Road, Suite 1500
Houston, Texas 77024**

Contact Customer Service with any questions concerning overpayment recovery. In the event the terms of your agreement differ from the process outlined above, the terms of your participation agreement will prevail.

Section 4: General Administrative Requirements

Participating providers agree to follow and adhere to the policies and procedures in this manual, billing guidelines, Medical Management guidelines and other policies and procedures established and revised by MHHP from time to time.

Provider Responsibility for Notification of Change

Please remember to notify Memorial Hermann Health Plan of changes to the following demographic information no less than 30 calendar days prior to the effective date of the change:

- TIN changes (include copy of W-9 Form)
- Address additions, changes or deletions
- Phone number or fax number changes
- Additions or departures of healthcare providers from your practice

Your notification must include the effective date of the change and a W-9 Form (if change involves TIN or business entity name). Please submit your request on the Provider Data Update Notification Form – found in the provider resource center of our website – with supporting documents via fax (713.338.4102) or email to providerservices@memorialhermann.org. If requesting termination from a provider network, please contact Provider Relations at the email address above.

MHHP Provider Website

Visit the MHHP provider website at <http://healthplan.memorialhermann.org> to obtain additional information on:

- Provider Portal
- Provider Manual
- Forms
- Prior authorization list and forms
 - News and Updates
- Appeal Rights and Process
- Frequently Asked Questions
- Fraud, Waste and Abuse
- Provider Newsletter

Provider Roles and Responsibilities

This section describes the expectations for specialists, hospitals and ancillary providers:

- CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, culture and reading comprehension capabilities.
- MHHP encourages providers to freely communicate with members regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations.
- Providers must utilize MHHP's participating providers and facilities.

Specialty Care Providers

Specialty Care Providers are responsible for:

- Rendering services requested by the PCP
- Communicating in writing with the PCP regarding findings
- Obtaining any required authorizations prior to rendering services
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult
- Providing the lab or radiology provider with the prior authorization number and the member's ID number.

Hospital Providers

Hospital Providers are responsible for:

- Coordination of discharge planning with the Medical Management staff
- Coordination of mental health and substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization before rendering services
- Communication of all pertinent patient information to MHHP and the PCP
- Communication of all hospital admissions to the Medical Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members.

Ancillary Providers

Ancillary Providers are responsible for:

- Confirming member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions and/or benefit extensions applicable to MHHP members
- Obtaining the required prior authorization before rendering services
- Communicating all pertinent patient information to MHHP and the PCP.

MHHP Appointment/After-Hours Care Monitored Access Standards

Type of Service	Access Standard
Preventive Care	Within 4 weeks
Regular/Routine Care Appointment	Within 14 days
Urgent Care Appointment	Same day
Emergency Care	Immediate
After-Hours Care	24 hours, 7 days a week for primary care physicians

These are general MHHP guidelines. State regulations may require more stringent standards. Contact your Provider Relations representative for more information.

After-Hours Care

MHHP asks that you and your practice establish a mechanism to make sure every member calling your office after hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to ***hang up and dial 911 or its local equivalent or go to the nearest emergency room.***

In non-emergent circumstances, MHHP prefers that you advise callers who are unable to wait until the next business day to:

- Go to an in-network urgent care center
- Stay on the line to be connected to the physician on call
- Leave a name and number with your answering service (if applicable) for a physician or qualified healthcare professional to call back within a specified time frame
- Call an alternative phone or pager number to contact you or the physician on call.

Arrange Substitute Coverage

If you are unable to provide care and are arranging for a substitute, MHHP asks that you arrange for care from other physicians and healthcare professionals who participate with MHHP so that services may be covered under the member's in-network benefit.

Continuity of Care Following Termination of Participation

If your network participation agreement terminates for any reason, you are required to assist in the transition the care of members to another physician or healthcare professional who participates in the MHHP network.

This may include providing services for a reasonable time at the MHHP contracted rate during the continuation period, as further described in your participation agreement with MHHP. Staff is available to help you and members with the transition. At least 30 calendar days prior to the effective date of your departure from the network or as otherwise required by law, MHHP will send notification to affected members.

Access to Records

MHHP may request copies of medical records from you in connection with the utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your participation agreement with MHHP and with appropriate billing practices. All requested medical records will be provided free of charge.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to members within 14 calendar days of the request or sooner for cases involving alleged fraud and abuse, a member's grievance/appeal, or a regulatory or accreditation agency requirement.

Medical Record Standards

A comprehensive, detailed medical record is vital to promoting high-quality medical care and improving member safety. In accordance with applicable regulations, these records must be maintained and protected for confidentiality for 10 years (or longer if required by applicable statutes or regulations) and shall not be disclosed to any person except as authorized by applicable state and federal laws or regulations.

You must maintain and provide MHHP with access to medical records, even after termination or expiration of a participation agreement for this same time period.

Privacy

Providers must comply at all times with the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), the requirements set forth in the provider participation agreement and all applicable state privacy laws. Please remember that in the event applicable privacy laws are violated, a civil action or criminal action may be brought against the individual or organization involved.

Cultural Considerations/Nondiscrimination

You must ensure that services are provided to all members in a culturally competent manner, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. You must not discriminate against any member with regard to quality of service or accessibility of services, on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any member in need of the services you provide.

Failure to Establish Provider Patient Relationship

Reasons a provider may terminate his/her professional relationship with a subscriber/patient include, but are not limited to, the following:

- Fraudulent use of services or benefits;
- Threats of physical harm to a provider or office staff;
- Non-payment of required copayment for services rendered or applicable coinsurance and/or deductible;
- Evidence of receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or necessary;
- Refusal to accept a treatment or procedure recommended by the provider, if such refusal is incompatible with the continuation of the provider subscriber/patient relationship. Provider should also indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists;

- Repeated refusal to comply with office procedure in accordance with acceptable community standards;
- Other behavior resulting in serious disruption of the provider subscriber/patient relationship.

Reasons a provider may not terminate his/her professional relationship with a subscriber/patient include, but are not limited to, the following:

- Subscriber's/patient's medical condition (i.e., catastrophic disease or disabilities);
- Amount, variety, or cost of covered health services required by the subscriber/patient; patterns of over utilization, either known or experienced;
- Patterns of high utilization, either known or experienced.

The request for termination of the provider patient relationship must be submitted to MHHP's Chief Medical Office for review and approval. Please include the rationale for the termination request.

Memorial Hermann Health Plan
 Attention: Chief Medical Officer
 929 Gessner Road, Suite 1500
 Houston, Texas 77024

If the termination of the provider patient relationship is approved by the Chief Medical Officer, the provider must mail a notification letter (see sample below) to the subscriber/patient and must include:

- Name of subscriber/patient– if it involves a family, list all patients affected;
- Subscriber identification number(s);
- Group number; and
- Effective date of termination. The effective date must be no less than 30 calendar days from the date of the provider's notification letter to the subscriber/patient.

A copy of the letter to the subscriber/patient must be sent to the MHHP Medical Management Department.

The provider must continue to provide medical services for the subscriber/patient until the termination date stated in the provider's letter.

Sample of Letter from Provider to Subscriber

Current Date

Patient Name*

Address

City/State/Zip

Phone Number

Subscriber Number

Group Number

Dear Patient:

I will no longer be providing services to you. I will continue to be available to you for your health care until ____ (date). (**Note:** end date must be no less than 30 calendar days from the date of this letter. After this date, I will no longer be responsible for your medical care.

Upon proper authorization I will promptly forward a copy of your medical record to your new provider. The MHHP Customer Service Department is available to assist you in selecting another provider to provide your care. Please call the customer service phone number listed on the back of your subscriber identification card.

Sincerely,

John Doe, M.D.

cc: MHHP Medical Management Department

**If the provider is terminating the relationship with a family, all subscriber names should be listed in this area.*

Section 5: Credentialing and Recredentialing

Prior to acceptance into the MHHP network, healthcare facilities, ancillary providers and practitioners must undergo a formal credentialing process. This section describes the credentialing and recredentialing processes, the MHHP Credentialing Committee and the appeal process for providers whose network participation has been terminated. Providers have the right to request the status of their application; and to correct any incomplete, inaccurate, or conflicting credentialing information.

Confidentiality

Information obtained during the credentialing or recredentialing process is confidential. Discussions of the Credentialing Committee are protected by federal and state peer-review laws. All Credentialing Committee meeting minutes and provider files are stored in a secure manner accessible only to authorized personnel and are not reproduced or distributed except for credentialing/recredentialing purposes or peer review.

Medical Professionals

MHHP has identified and developed minimum acceptable criteria for the following types of medical professionals:

- Medical Doctors (M.D.)
- Doctors of Osteopathy (D.O.)
- Podiatrists (D.P.M.)
- Behavioral Health Providers (PhD., L.C.S.W.)
- Licensed Physical Therapists, Occupational Therapists
- Optometrists, Audiologists, Speech and Language Pathologists
- Registered Dieticians
- Chiropractors
- Acupuncturists
- Audiologists
- Physician Assistants, Advanced Practice Nurses and Certified Midwives.

Credentialing Process

Collection of application and verification of credentials and documentation, including, but not limited to:

- Work history
- State medical license or certification
- Education
- History of state and/or federal sanctions
- History of professional liability claims
- Assessment of board certification for applicable providers
- Eligibility for payment under Medicare
- Current Malpractice Insurance Policy Face Sheet

Review of completed credentialing files by the Credentialing Committee, which is comprised of participating network physicians and meets at least quarterly. MHHP will provide formal notification to the provider of the credentialing decision.

If MHHP declines to include a given provider or group of providers, it will furnish the provider(s) with written notice.

Ancillary/Facility

Collection of application and verification of credentials and documentation, including, but not limited to:

- State Facility License
- CMS or State Department of Health survey report or an approval letter from the CMS or State Department of Health stating the facility's review date and inspection results
- Accreditation or most recent survey results from the State Department of Health, if not currently accredited
- Professional Liability and General Liability Insurance Certificate, which list amounts and coverage dates
- Entity W-9 or copy of IRS 540 or 941
- CLIA (Lab Certification)
- Pharmacy License
- FDA ACR Certification (Mammography)
- State Inspection Certification (X-ray)
- Bedding/Upholstery License
- State Professional License
-

Review of completed credentialing files by the Credentialing Committee. Formal notification to the facility/ancillary provider of the credentialing decision. If MHHP declines to include a given provider or group of providers, it will furnish written notice to the affected provider(s).

Recredentialing Process

A provider's continuing participation in the MHHP network depends upon the successful completion of the recredentialing process at least once every 36 months. This process includes, but not limited to:

- Verification of continued state licensure
- Verification of current board certification (if applicable)
- Review of history of state and/or federal sanctions
- Query to the National Practitioner Data Bank
- Review of professional liability claims history.

Termination of Network Participation Status

A provider's status may be terminated at any time when information is obtained that indicates the provider did not continue to meet MHHP's standards. Issues that are brought to MHHP's attention about professional performance, licensure status and federal sanctions will be investigated by MHHP in a fair and impartial manner. The MHHP Credentialing Committee will decide ongoing participation status.

Grievance and Appeal Process

MHHP provides a fair opportunity and process for any participating provider to appeal unfavorable actions taken by the Credentialing Committee that relate to the provider's network status and for any action taken by the plan related to the provider's professional competency or conduct.

All grievances and appeals will be processed following the policies and procedures as approved by the Credentialing Committee.

In compliance with the Civil Rights Act of 1964, MHHP will not discriminate against any provider on the basis of age, race, color, ethnicity, national origin, sex, or religion/creed.

Any participating provider who is denied participation, suspension or terminated for cause by MHHP shall receive written notification within 10 days of the decision, including the reasons for rejection, suspension or termination, by the MHHP Chief Medical Officer. If a provider receives notice of an adverse action by the MHHP Credentialing Committee upon recommendation by the MHHP Executive Committee, the provider is entitled to:

- A review by a Grievance Panel
- A review that permits the participating provider to appear before the Credentialing Committee panel and present relevant information.

If dissatisfied with the decision of the grievance panel, a right to an appeal with individuals other than those members of the Credentialing Committee upon written request up to two cycles, if requested. The request must be in writing, addressed to the Chief Medical Officer and include a brief description of the reasons for grievance. If the request for grievance is not received within 30 days of notice, both parties shall be deemed to have accepted the decision of the Credentialing Committee and it shall become final and effective immediately.

Within 10 days of receipt of a request for grievance, the Chief Medical Officer shall schedule and arrange for a grievance panel review and send notice to the provider. The grievance panel, comprised of the Credentialing Committee and Executive Committee, will discuss the matter with the participating provider. Every attempt shall be made to conduct the review within 30 days from receipt of the request. The review process is intended to offer the participating provider an opportunity to address any special circumstances that may apply and to respond to questions the grievance panel may have. The participating provider is deemed to have waived his/her appearance rights with the panel should he/she not appeal nor send written notification of the request to reschedule the grievance review date. The rescheduled date cannot be more than 30 days from first scheduled grievance review date. If a clinical peer of the provider is not represented on the Credentialing Committee, an ad hoc appointment of a peer-matched provider who is not otherwise involved in network management will be made.

The notice shall be sent to the participating provider, at the address shown on the application, by certified mail, return receipt request, of the place, time and date of the hearing. Within 30 days after receipt of the review panel recommendations, the MHHP Credentialing Committee shall render its decision. The decision will be forwarded to the participating provider in writing by certified mail, return receipt requested. This notification will be approved and signed by the MHHP Chief Medical Officer.

Section 6: Provider Rights and Responsibilities

Provider Rights

Provider rights and responsibilities are as follows:

- You are encouraged to let MHHP know if you are interested in serving as a member of the MHHP Clinical Quality Management Committee or other committees that may be formed by MHHP.
- MHHP encourages your feedback and suggestions on how service may be improved for providers and members. Suggestions and feedback can be sent to Provider Relations or the Physician Advisory Committee.
- If an acceptable patient-physician relationship cannot be established with an MHHP member who has selected you as his/her physician, you may request that the member be removed from your care.
- You may have any claim submission that you feel was not paid appropriately reconsidered for re-adjudication.
- You may appeal any action taken by MHHP that affects your status with the network and/or that is related to professional competency or conduct. Please see "Grievance and Appeals Process" for more information.
- MHHP encourages your attendance at meetings and participation in its activities as requested.

General Responsibilities of the Provider

Provider responsibilities are as follows:

- Primary Care Providers (PCPs) must provide continuous 24 hour, 7 days a week access to care for MHHP members. The PCP is responsible for arranging for a backup PCP when he/she is not or will not be available and for assuring that the covering physician will abide by plan policies and procedures.
- In the event that the PCP is temporarily unavailable, or unable to provide patient care or referral services to MHHP members, he/she must arrange for another physician (the "Covering Physician") to provide such services. This coverage cannot be provided by an emergency room. The PCP shall provide MHHP with the name of his/her covering physician so that claims will be processed correctly.
- A provider must treat MHHP members the same as all other patients in the provider's practice, regardless of the type or amount of reimbursement.
- A provider must not discriminate on the basis of race, age, religion, sex, national origin, marital status, source of payment, or disability of any member.
- A provider must agree to provide continuing care to participating members.

- A provider must utilize MHHP's participating physicians, laboratories and facilities when services are available and can meet the patients' needs. Based on the members' plan benefits, prior approval may be required when referring members to providers who are outside the contracted network (non-network providers).
- A provider must abide by MHHP's quality improvement, utilization management, credentialing, peer review, grievance and other policies and procedures established and revised by MHHP from time to time. This includes participation in evidence-based patient safety programs.
- A provider may not balance bill a member for services that are covered by MHHP. He/she may only bill members for applicable deductibles, co-payments and/or co-insurance amounts. A provider may not bill for charges that exceed contractually allowed reimbursement rates.
- A provider may bill a member for a service or procedure that is not a covered benefit in two instances:
 - If the member did not inform the provider that he/she was an MHHP member
 - If the member was informed that the services were non-covered and he/she agreed in advance (in writing) to pay for the services. An agreement to pay must be evidenced by written records that include: 1) provider notes written prior to receipt of the services demonstrating that the member was informed that the services were non-covered and the member agreed to pay for them; and 2) a statement and/or letter signed by the member prior to receipt of the services acknowledging that the services were non-covered and the member agreed to pay for them.
- The provider agrees to prepare and complete medical and other related records in a timely fashion for all members in his/her care and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment and the outcome at completion or discontinuation of treatment.
- The provider agrees to abide by MHHP rules and regulations and all other lawful standards, policies, rules and regulations.
- Medical records for members must be maintained for 10 years from the last date in which service was provided.
- The provider agrees to allow access to medical records for review by appropriate committees of MHHP and, upon request, must provide the medical records to representatives of governmental entities and/or their contracted agencies.

- The provider agrees to inform MHHP, in writing, within 24 hours of any revocation or suspension of his/her Drug Enforcement Agency (DEA) number, certification or other legal credential authorizing him/her to practice in the state of Texas or any other state. Failure to comply with the above could result in termination from the plan.
- The provider agrees to inform MHHP immediately, in writing, of any changes in licensure status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance, eligibility for payment under Medicare and any other change that would affect his/her status with MHHP.
- Unless otherwise indicated in the participation agreement with MHHP, the provider agrees to provide or assist MHHP in obtaining Coordination of Benefits/Third-party Liability information.

Dispute Resolution Process

MHHP distinguishes disputes by the following categories:

- Administrative
- Issues concerning professional competence and conduct.

Administrative Disputes

Administrative disputes may include, but are not limited to, a participating provider's written notice to MHHP challenging, appealing or requesting reconsideration of a claim denial or payment, factual determinations by Utilization Management and/or contractual concerns.

The dispute resolution process is available to any participating provider who wishes to initiate it. Participating providers have the right to have their administrative disputes reconsidered by an authorized representative of the plan who was not involved in the initial decision. Administrative disputes involving the categories below have specific resolution processes that can be found in the following sections of the manual:

- Claims disputes – **See “Claim and Reconsideration Appeal”**
- Determination by Utilization Management – **See “Claim and Reconsideration Appeal”**.

Disputes involving contractual concerns or other administrative disputes not addressed in the above categories, such as contractual disputes, can be initiated by the provider. The provider should submit written notification to the plan that includes the following:

- Provider's name and/or practice
- Contact's name and telephone number
- Clear explanation of the issue
- Provider's position on that issue
- Additional information or documentation that supports the provider's position.

The written notification should be forwarded to:

MHHP
Attention Appeals - Administrative Disputes
929 Gessner Road, Suite 1500
Houston, Texas 77024

MHHP will provide written determination to the provider within 30 days of receipt. However, if the issue requires more than 30 days to resolve, the provider will be notified by the plan and given the projected time frame for resolution.

Note: Participating provider disputes are not subject to the plan's dispute resolution processes if the provider's dispute involves a plan requirement explicitly stated within the agreement (this includes the manual by incorporation).

Disputes Concerning Professional Competence or Conduct

No administrative disputes involve actions by the plan that relate to a participating provider's status within the plan's provider network and any action by the plan related to a participating provider's professional competency or conduct. For disputes related to actions taken by the plan regarding a participating provider's network status and/or professional competency or conduct, please see "Appeal and Grievance Process" and "Provider Rights and Responsibilities".

Delegation/Delegated Entities

Delegation is typically defined as the means by which a health plan grants a provider group the authority to perform plan functions; e.g., credentialing, utilization management and claims management. Full or partial designation is how most plan delegations are described. Typically, the MHHP provider agreement will determine the level of delegation.

If performing delegated activities, the provider is required to comply with all laws, rules, regulations and accrediting standards that MHHP is required to meet. If providers perform a delegated function on behalf of MHHP via their contract with the MHHP, the providers shall not delegate, assign or otherwise transfer the performance of any of the delegated functions to any person or entity without the prior written consent of MHHP. Any further delegation, assignment or transfer shall not release providers from liability for performance under the delegated activities and shall be in writing and shall subject the person or entity to whom tasks are further delegated, assigned or transferred to the identical terms contained within the participation agreement with MHHP and shall be further subject to URAC and any and all accrediting standards that MHHP is required to meet.

Note: When a situation occurs that is deemed to pose an immediate threat to the health and safety of consumers, the Chief Medical Officer may, on behalf of MHHP, Quality Improvement Committee (QIC) and the Credentialing Committee, act to immediately revoke, limit or suspend the privileges of a participating provider.

The affected provider will be immediately notified, as will other affected parties (i.e., Provider Relations, Utilization Management, Quality Management, and Plan Administration). In such an event, the QIC will assemble at the earliest possible time to hear the situation and support or override the Chief Medical Officer's decision.

Section 7: Quality Improvement

Goal of the Quality Program:

1. Provide a continuous, comprehensive quality improvement program that addresses all dimensions of quality: clinical, service and fiscal.
2. Promote and incorporate quality into the health plan's organizational structure and processes.
 - Facilitate partnerships between members, providers, state agencies, and health plan staff for the continuous improvement of quality health care delivery
 - Clearly define roles, responsibilities and accountability for the quality program
 - Continuously improve communication and education in support of these efforts
 - Promote objective, systematic, measurement, monitoring and evaluation of services, work processes, and implement quality improvement activities based upon the outcomes of those activities.
3. Provide effective monitoring and evaluation of patient care and services to ensure that care provided by the health delivery system meets standards of medical practice, meets the cultural and linguistic needs of membership, and is positively perceived by health plan member and professionals.
 - Evaluate and disseminate clinical and preventative practice guidelines
 - Monitor provider performance against established evidence-based medicine. Develop guidelines for quality improvement activities (access, availability, credentialing, peer review, etc.)
 - Analyze data (performance reports, trend analysis, score cards, etc.) and develop programs to improve satisfaction and preventative services
 - Collect and analyze data for population specific Quality Improvement projects
 - Monitor the integration of care management, disease management and case management services across the MHHP care delivery systems, integrating care management with the Memorial Hermann hospital and provider network.
4. Identify opportunities for improvement, including oversight of implementation, actions and follow-up.
 - Identify and monitor quality indicators, problems, and concerns about health care services provided to members looking for opportunities for improvement
 - Implement and conduct a comprehensive Quality Improvement Program, tracking projects and metrics across the health plan.

5. Monitor compliance with local, state, and federal regulatory requirements and accreditation standards.
 - Tracks laws, rules and regulations
 - Monitor compliance with regulatory requirements for quality improvement and respond as needed
 - Ensure reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies
 - Act promptly to implement improvement activities based upon the measurement, monitoring, analysis and evaluation of the quality activities

Prioritize activities based upon:

 - Immediate impact to membership
 - Patient safety
 - Immediate impact to health plan
 - Long term impact to membership and/or health plan, to include;
 - Considerations of volume impact, problem prone nature of issue
 - Laws, rules, regulations, accreditation standards
 - Stakeholder impact.

Quality Improvement Program Oversight Authority and Accountability

The MHHP Board of Directors is the governing body of the organization and has granted authority for quality management to the Quality Committee. The Board of Directors functions as they relate to the quality improvement program include:

- Annual review and approval of the Quality Improvement Program description
- Review of the annual QI Work Plan, and the annual QI Evaluation
- Provides feedback and recommendations to the Quality Committee no less than annually
- Support commitment to quality and to the Health Plan's Quality Improvement Program
- Designation of the Chief Medical Officer as the Senior Clinical Staff person responsible for all aspects of Quality Management and associated programs.

In order to fulfill the goals and objectives of the Quality Improvement Program, MHHP has integrated quality improvement activities into all health plan functional areas. These include, but are not limited to the following functional areas and departments:

- Medical and Behavioral Health Services, including Population Health, Utilization Management, Case Management, Care Coordination and Pharmacy
- Customer Service
- Grievance and Appeals
- Network/Provider Management
- Credentialing

- Compliance
- Claims
- Quality Management and Improvement
- Patient Safety and Risk Management.

MHHP will monitor, track and trend:

- Performance measures
- High volume specialty utilization
- High risk areas of care
- Access to services and care
- Complaints
- Satisfaction
- Goals and methods used in monitoring and evaluating Quality Management and improvement (satisfaction and outcome) activity
- Use of quantifiable measures to establish acceptable levels of performance
- Measurement of baseline levels of performance, establishment of goals and progress toward those goals
- Annual re-measurement of performance
- Analysis of trends that directly relate to the quality of services that consumers experience
- Develop and implement action plans to correct or improve performance where needed to meet performance goals including the development of a work plan that demonstrates such prioritization, and individual action plans as needed for focus on specific opportunities for improvement.

Additionally, through the Quality Program, MHHP will ensure:

- Methods to communicate these quality activities to the relevant members of the staff related to the results of consumer and client satisfaction surveys best practices for consideration and adoption.

Quality Management Program

MHHP maintains a quality management and improvement program that promotes objective and systematic measurement, monitoring and evaluation of services and work processes and implements improvement activities based upon the outcomes and findings of its measurement, monitoring and evaluation.

The Quality Program includes a quality plan, a quality work plan, quality policies and procedures, a Quality Department, a Quality Committee and subcommittees.

Quality Management Department Qualifications

Chief Medical Officer

Responsible for all aspects of the Quality Management program. Provides oversight and direction to the Quality Management department. The Chief Medical Officer is an M.D. with a current, active, unrestricted license in the State of Texas and possesses additional training as evidenced through board certification.

Director of Quality

The Director of Quality is a Bachelor's prepared Registered Nurse with an advanced degree in business or nursing and at least 10 years of experience in quality and health plan administration. Certification in quality or related field preferred.

Quality Manager

The Quality Manager is Bachelors prepared Registered Nurse with at least 10 years of experience in quality. Certification in quality or related field preferred.

Quality Plan

The Quality Plan is an overarching, comprehensive document that describes the quality program and that covers the areas that fall under its scope. The plan describes the scope, objectives, activities and structure of the program, defines roles and responsibilities of the Quality Management Committee, and how the organization will measure analyze and improve its performance through the use of data.

The program requires performance reporting including reporting from delegates. This information is reviewed by the Quality Committee as part of the oversight responsibilities for the delegation activities. The program is reviewed, updated and approved by the Quality Committee at least annually. As part of the Quality Management Program, the health plan provides written documentation of targeted quality improvement activities initiated in response to analysis of measured performance. This includes:

- Measurement of process, satisfaction or outcome trend information using valid and accurate measurement methods
- Analysis of process, satisfaction or outcome trend information that is directly related and relevant to the services realized by the member
- Implementation of action plans to improve or correct identified problems or to meet acceptable levels of performance on measures
- Mechanisms to communicate to relevant staff the results of such activities and the sharing and integration of best practices
- Mechanisms to communicate the results to the Quality Committee
- Once acceptable levels of performance are met, periodically re-measure levels of performance to ensure sustained improvement.

Separate Business Continuity, Credentialing, Compliance, and Communications and Marketing Plans are maintained.

Quality Work Plan

The purpose of the Quality Work Plan is to describe the quality improvement initiatives of the health plan for the coming year. These initiatives are developed throughout the year as a result of ongoing data gathering and trend review, identification of areas for improvement, prioritization of those areas of identification based upon impact to the health plan and membership based upon:

- Risk
- Intensity
- Volume
- Ability to affect change or improvement.

There are 2 parts to the Quality Work Plan:

- Didactic description of the work plan
- A schedule of work plan activities.

Monitoring Activities

Monitoring activities include measurement of established goals and indicators to ensure that they are conforming to requirements or specifications. These are measured and reported at pre-established intervals. Annually the Quality Improvement Committee evaluates the status of such activities and makes a determination regarding the need for ongoing monitoring, process improvement or other activity.

Improvement Activities

These types of activities are focused on improving current performance. These include QIPS, Quality Improvement Studies, or other Quality Improvement Initiatives.

Quality Improvement Activities

This involves the selection of quality improvement projects, studies and other improvement initiatives. The criteria for selection of Quality Improvement Projects, studies and other improvements initiatives include 1 or more of the following:

- Supports the overall quality management strategy as approved by clinical leadership
- Has potential for measurable impact, to include attainment of performance levels
- Potential to improve consumer health or internal work processes based upon various factors
- The project or study is relevant to the population served by the health plan
- Baseline data are available or can be obtained
- Community or practice standards suggest opportunity for improvement or further analysis
- Benchmarking to best practices suggests the project or study represents an opportunity for improvement
- The project/study/initiative represents an opportunity to reduce error or improve performance related to the services provided
- Promotes and supports organizational efforts to maintain and refine consumer and client/member services
- Promotes/supports strategic, operational, regulatory, accrediting or contractual requirements
- Is high volume, high risk or problem prone for key processes or outcomes.

The project/study/initiative is identified as an “area of concern” on 1 or more of the following sites:

- The Leapfrog Group, www.leapfroggroup.org
- Agency for Healthcare Research and Quality, www.ahrq.gov
- Pennsylvania Patient Safety Reporting System, (PA PSRS), www.psa.state.pa.us
- Institute of Medicine, www.iom.edu
- National Patient Safety Foundation (NPSF), www.npsf.org
- NQF- National Quality Forum, www.qualityforum.org
- NTOCC-National Transitions of Care Coalition, www.ntocc.org
- www.talkingquality.gov
- www.healthypeople.gov
- www.plainlanguage.gov

Quality Improvement Projects (QIPS)

The health plan uses the URAC definition of a Quality Improvement Project (QIP), consistent with their accreditation requirements. A QIP is defined by URAC as an organization-wide initiative to measure and improve the service and/or care provided by the organization. The health plan uses the URAC approved format for recording, tracking and reporting QIPs.

The health plan maintains a minimum of 2 quality improvement projects in keeping with URAC accreditation standards. All projects focus on clinical quality. At least 1 focuses on patient safety.

Projects are selected and prioritized based upon their potential to impact patient quality, ability to implement, and those that are at high risk, high volume and/or problem prone in nature. The projects undertaken are approved annually by the Quality Committee and are subject to change from time to time. A list of the current quality projects is available from the Quality Department upon request.

Quality Improvement and Chronic Care Improvement Projects (Medicare Advantage)

The health plan maintains an additional quality improvement project specifically for the Medicare Advantage Program. There is a CMS QIP for each Medicare Advantage product along with a Chronic Care Improvement Project (CCIP) that specifically targets the needs of the Medicare Population. These projects are selected based upon criteria established by CMS and the potential to impact patient quality in the Medicare population under the guidance and approval of CMS.

Quality Improvement Initiatives and Clinical Quality Studies

Quality improvement activities that do not meet the URAC description of a QIP may be categorized as a Quality Improvement Initiative (QII) or Clinical Quality Study (CQS). Such activities will be implemented when evidence to support their activity is present.

The health plan is not a research institution and as such has limited ability to engage in Clinical Quality Studies.

Clinical Quality Initiatives

These are collaborative efforts with stakeholders to advance health and improve care and services. Clinical Quality Initiatives focus on targeted consumer outreach based upon a combination of segmented techniques that include demographics, health risk, claims history and population health assessments.

Current Clinical Quality Initiatives include:

- Patient Engagement
- Improving Diabetic Self-Management
- Patient Centered Healthcare Homes
- Health Risk Assessments.

Clinical Quality Studies

Clinical Quality Studies include an element of research. The health plan is not a research organization, and as such has limited ability to conduct clinical quality studies. Currently there are no Clinical Quality Studies in progress.

Tools for Clinical Quality Review Analysis

The health plan uses standard quality improvement tools for analysis, including but not limited to: bar graphs, pie charts, variables charts, Pareto analysis, control charts, process flow, percentile ranking, Failure Modes and Effects and Root Cause analysis, confidence intervals, standard deviations and P-value analysis. Data selected and collected for analysis is evaluated for data integrity in order to ensure that the resulting information is valid for drawing conclusions and taking action.

When evaluating the data, the data is benchmarked against the health plan's own performance, against any customer data and against comparative data from sources generally recognized as reputable and reliable. The quality improvement TARGET-PDSA process and cycle are used.

Confidentiality and Conflicts of Interest

The Quality Committee and its related committees and subcommittees follow the Health Care Quality Improvement Act of 1986, the Privacy Act of 1974, 45 CFR Part 160 and Subparts A and E of Part 164 (HIPAA Privacy Rule) and Act 68 of 1998 (Quality Health Care Accountability and Protection Act).

The Quality Committee will follow all MHHP policies and procedures regarding the confidentiality of member information. Committee records are only available to individuals who are authorized in accordance to local, state, federal, and other regulatory agencies. Compliance with mandatory releases does not compromise the claim to the privilege, protected and confidential nature of these proceedings and minutes.

Members may not keep complimentary copies of any documents unless specifically declared by the chairperson as materials that would otherwise be generally available outside of committee.

Committee members will refrain from discussion of the committees' proceedings outside of committee. Release of any proceedings will flow from committee to committee.

Conflicts of interest may arise from time to time due to the nature of the committee and the involved parties. Individuals have a responsibility for identifying when their participation in a discussion or action may represent a conflict of interest, and to recuse themselves from participation in such situations. Committee members have a responsibility to identify conflicts of interest that may arise for other participants if not otherwise identified. Conflicts of interest raised in this way may be subject to further discussion or inquiry. There shall be no retaliation for any concern raised in good faith.

Ensuring Good Faith and Due Process

Quality improvement proceedings are to be founded in:

- Fact
- Freedom from malice
- Freedom from prejudice
- Avoidance of activities related to restraint of trade
- Assurance of due process for any party that may stand to be negatively affected as a result of a Quality Committee decision or sanction.

Committee members will receive training in confidentiality and conflict of interest annually and will be required to sign a confidentiality agreement and a conflict of interest agreement not less than annually.

Quality Review Process

Delegation and Delegation Oversight

The health plan delegates activities of the health plan from time to time in order to best serve the needs of the membership. Prior to delegation, an assessment of the delegate is performed. The purpose of delegation is to assess the potential delegate's capacity to perform the services under consideration for delegation, in compliance with all applicable laws, rules, regulations, accreditation standards and health plan policies.

Quality Referral Process

Identification, Review, Evaluation of Quality Issues and Grievances

Multiple points of entry into the health plan exist for quality issue and grievance identification. Avenues of identification include, but are not limited to the following:

- Member complaints
- Member grievances

- Physician/other provider concerns
- Medical record reviews
- Patient surveys
- Utilization Management activities
- Case Management activities
- Other ancillary reports
- Financial data
- Quality monitors
- Clinical audits
- Special studies
- Focused review
- Quality referrals from other departments, functions.
- Inquiries from external agencies
- AHRQ data
- Utilization of the National Quality Forum Significant Reportable Events (NQF SRE) to identify SRE's in medical record review
- Assessment of every medical record reviewed for any purpose and any care, observed or monitored on an ongoing basis to identify potential quality issues (PQI's).

Any stakeholder may refer a matter for review as a potential quality issue. A form exists to facilitate reporting. In order to facilitate a full and fair review of the problem, all potential quality issues must be submitted in writing and the author of the report must be identified.

The Director of Quality or Chief Medical Officer may request qualified personnel to screen a review or report for potential quality issues. The results of such screens shall be reported to the Director of Quality within 15 days of the referral, with a final report in 30 days. The Director of Quality or designees may refer cases to the Chief Medical Officer for review and recommendations.

The Chief Medical Officer review may result in such determinations as:

- No quality issue exists
- Potential quality concerns exist
- Actual quality concerns exist.

The Chief Medical Officer will recommend action as appropriate to the event, in keeping with MHHP's Quality Plan, MHHP Policies and Procedures, contractual requirements of the Plan, requirements under the terms of the Plan's contract with the clients and any relevant federal, state or local regulatory requirements.

The Director of Quality Services or her designees may refer cases to the Chief Medical Officer for review and recommendations. The Chief Medical Officer review may result in such determinations that “no quality issue exists” (rating level “0”). If a determination is made that a quality issue does exist, a severity rating shall be assigned. (1=minimal impact or potential for harm, Trend; 2=moderate impact or potential for harm, Trend and monitor; 3=significant impact or potential for harm. Requires further review; 4=Sentinel event. Requires exhaustive review).

The Chief Medical Officer will recommend action as appropriate to the event, in keeping with MHHP’s Quality Plan, MHHP Policies and Procedures, contractual requirements of the MHHP and other relevant federal, state or local regulatory or accreditation requirements.

Sentinel Event Review Process

MHHP uses the National Quality Forum criteria for sentinel event detection and reporting. MHHP has a series of audit processes, screening elements and reporting procedures that facilitate the detection of sentinel events. When a Sentinel Event is identified to MHHP or by MHHP, it will be investigated in accordance with the standards as set forth the National Quality Forum’s Report on Sentinel Events.

MHHP will conduct its activities in such a manner as to comply with the Health Care Portability and Accountability Act of 1996 and the Quality Improvement Act of 1986. MHHP will retain the privilege of protection and confidentiality afforded under this act.

Communication will be point to point under the auspices of the Quality Improvement Committee, a Quality Assurance Committee of the Medical Staff. MHHP will require that information provided in compliance with mandatory releases of information will not compromise the protected and privileged nature of the information. Sentinel Events are subject to root cause analysis. Selected employees in Quality Management have received training in both Root Cause Analysis and Failure Mode and Effects Analysis (FMEA). MHHP works closely with the provider(s) involved to ensure that the root cause analysis and associated observations/recommendations are communicated for action.

Special Procedures

Procedure for Unusual Provider Practice Patterns

Whenever a concern regarding the clinical quality of care and services provided arises, all available records and related correspondence are screened by the Quality Improvement Department. The concerns are then forwarded to the Chief Medical Officer for review and determination of any potential quality issues.

Individual concerns that do not represent a pattern of behavior or do not seriously jeopardize patient care/welfare may be individually addressed by the Chief Medical Officer and summarized to the Quality Improvement Committee at its next regularly scheduled meeting.

The Quality Improvement Committee may accept the Chief Medical Officer's assessment and follow up actions, or it may recommend another course of action based upon the information presented.

When individual concerns represent a pattern of behavior, the Chief Medical Officer shall ensure that the matter is addressed through the Quality Improvement Committee.

The Quality Improvement Committee Process is outlined below:

When individual concerns or patterns of behavior represent a serious threat to member care or welfare, the Chief Medical Officer (Medical Director) shall immediately act upon the behalf of the Quality Improvement Committee.

A Quality Improvement Committee meeting will be called at the first possible opportunity, not to exceed 7 business days. The Quality Improvement Committee will review the information available and render a decision on behalf of the health plan regarding the involved provider.

When the Quality Management Program determines that inappropriate or substandard services have been provided or services which should have been furnished have not been provided, the Chief Medical Officer and Quality Improvement Committee shall be notified.

The Quality Improvement Committee is responsible for assuring that corrective actions are implemented and follow-up monitoring occurs.

Additionally, a provider's practice pattern will be considered an exception to the norm or standard if:

- Data indicates that the pattern is greater than two standard deviations above or below the mean for the peer group (for those studies in which such measurement is available and relevant)
- More than 3 complaints or grievances in a single category which have been filed during the review period
- A pattern of documented failures to follow administrative procedures established by the Plan, after counseling by the Chief Medical Officer
- Any action or offense identified as reportable by state or federal law, or contract requirements.

If the Quality Improvement Committee agrees that a deviation exists, the membership may request that the Chief Medical Officer counsel the provider. Such counseling should begin with written notification. The notification will include an opportunity for the provider to respond to the concerns identified.

The provider is given the option to respond either in writing or in person within 30 days of receipt of the letter.

Failure to respond to the letter within the designated timeframe may be interpreted by the Quality Improvement Committee as agreement by the practitioner with the concerns and recommendations contained in the Chief Medical Officer's letter.

Responses by the provider will be reviewed by the Quality Improvement Committee and used for evaluating the situation under review.

The committee may also direct that the Chief Medical Officer and provider develop a jointly agreed to plan of action. The Chief Medical Officer and provider will agree on a time frame for correcting the problem. After evaluating the plan and the time frames for correcting the problem, the Quality Improvement Committee will make both an interim and final recommendation to MHHP regarding continued participation. After the time for correction has passed, the Quality Improvement Committee will review the provider's data again to determine if the practice pattern has been modified. Resolution of the matter which is acceptable to the Quality Improvement Committee will lead to a recommendation to MHHP that continued participation be approved. Failure to resolve the matter (including disagreement by the affected provider as to the committee's assessment and position on the matter) may lead to a recommendation to MHHP that continued participation is denied.

Such a decision is considered a sanction. In such cases an appeal process is available to the provider and is called a Fair Hearing.

The Fair Hearing Process

When a situation occurs that is deemed to pose an immediate threat to the health and safety of consumers, the Chief Medical Officer may on behalf of MHHP, the Quality Improvement Committee and the Credentials Committee, act to immediately revoke, limit or suspend the privileges of a participating provider. The affected provider will be immediately notified as will other affected parties (i.e.: Provider Relations, Utilization Management, Quality Management, and Plan Administration). In such an event, the Quality Improvement Committee will be assembled at the earliest possible time to hear the situation and support or override the Chief Medical Officer's decision. As with all dispute resolution processes, any provider who is the subject of such actions may request access to the dispute resolution process for such an action.

Provider Notification

Providers will be notified by letter, certified mail-return receipt requested, of the decision of the Quality Improvement Committee. Providers may appeal decisions and actions of the Quality Improvement Committee by submitting a written request for an appeal or reconsideration and by providing additional information either in writing or in person. Please review Sanctioning and Fair Hearing / Section 8 for complete information.

Section 8: Sanctioning and Fair Hearing

The Sanctioning Process and Fair Hearing Procedure

PURPOSE

To provide a clear and comprehensive mechanism for provider appeal/dispute in the event of any action or adverse determination related to any participating providers' participation status in matters of quality of care and/or services, to include matters of professional competency or conduct. To provide timeframes from initiation of the dispute resolution mechanism to notification of the outcome for the participating provider.

Note: When a situation occurs that is deemed to pose an immediate threat to the health and safety of consumers, the Chief Medical Officer may, on behalf of MHHP, the Quality Improvement Committee and the Credentials Committee, act to immediately revoke, limit or suspend the privileges of a participating provider. The affected provider will be immediately notified as will other affected parties (i.e.: Provider Relations, Utilization Management, Quality Management, and Plan Administration). In such an event, the Quality Improvement Committee will be assembled at the earliest possible time to hear the situation and support or override the Chief Medical Officer's (Medical Director's) decision. This shall be done on an expedited basis, usually within 7 business days of the suspension.

DEFINITIONS

Fair Hearing: An appeals mechanism by which a provider of service may request review of a proposed adverse action.

POLICY

This policy shall be reviewed not less than annually with the involvement of participating providers minimally through the Quality Improvement Committee.

PROVISIONS

Administrative matters shall be coordinated by Health Plan Administration and are described in Health Plan Administrative policies. There shall be a clear description of the dispute resolution process, including the methods for initiating the process, the right to present relevant information, and explicit time frames from initiation of the fair hearing mechanism, to notification of the outcome to the participating provider.

There shall be written notification of the fair hearing determination. All fair hearings are referred to a first level panel consisting of at least 3 qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute.

Providers may request consideration by a second level panel if the outcome of the first level panel is unfavorable to the provider who is the subject of the determination.

A second level panel shall consist of at least 3 qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute.

PROVIDER NOTIFICATION

Providers will be notified by letter, Certified Mail-Return Receipt Requested, of the decision of the Quality Improvement Committee. Providers may appeal decisions and actions of the Quality Improvement Committee by submitting a written request for an appeal or reconsideration and by providing additional information either in writing or in person.

THE SANCTIONING PROCESS AND FAIR HEARING PROCEDURE

The Sanctioning Process of MHHP will follow the Health Care Quality Improvement Act of 1986. Due process will be conducted according to the procedures that follow.

NOTICE OF PROPOSED ACTION

The provider will be notified at the address included on the provider's application or the address maintained in the MHHP's system for provider payment or communication:

- A professional review action has been proposed
- Reasons for the proposed action
- The provider has the right to request a hearing on the proposed action within 30 days after receipt of the notice
- Summary of the hearing process.

PROCEDURE

Notice of Hearing: MHHP shall provide for notice and a fair hearing to a provider in any case, except in cases of automatic suspension or limitation, in which action is proposed to be taken by MHHP to restrict, suspend or terminate the provider's ability to provide health care services, if same action is based on professional competence or professional conduct which affects or could adversely affect the health, safety or welfare of any patient and/or is reasonably likely to be detrimental to the delivery of quality patient care. If MHHP takes an adverse action against a provider following the conduct of a fair hearing as provided in this Fair Hearing Procedure, MHHP shall report such adverse action to the National Practitioner Data Bank pursuant to the Federal Health Care Quality Improvement Act and, as required by applicable state law, to the applicable state licensing/examining board.

Final Proposed Adverse Action: The procedures described in this Fair Hearing Procedure shall apply whenever an action is proposed to be taken by the MHHP Chief Medical Officer on behalf of the Quality Improvement Committee to restrict, suspend or terminate a provider's ability to provide health care services to patients because of deficiencies in the providers quality of care, professional competence or professional conduct which affects or could adversely affect or is likely to be detrimental to the health, safety or welfare of any patient or to the delivery of quality patient care, the outcome of which if adverse would be required to be reported to the National Practitioner Data Bank under the federal Health Care Quality Improvement Act of 1986 or to the State Licensing Board/Agency under applicable state law. The process is available to any participating provider who is subject to suspension of their participation status.

Role of Chief Medical Officer: The Chief Medical Officer shall appoint a hearing panel on behalf of the Quality Improvement Committee in fulfilling its duties under Fair Hearing Procedure.

Summary Action: Nothing contained in this Fair Hearing Procedure shall limit or otherwise affect the authority of the Chief Medical Officer or Quality Improvement Committee to take action on behalf of MHHP's Policy and Procedure for the restriction, suspension or termination of MHHP's provider, including the duty to respond on an urgent basis to situations that pose an immediate threat to the health and safety of consumers. The terms of the summary action shall remain in effect pending the outcome of any hearing initiated by the provider pursuant to this Section of this Fair Hearing Procedure.

INITIATION OF HEARING

Grounds for Hearing: Any 1 or more of the following actions, when taken or made based upon deficiencies in the quality of care, professional competence or professional conduct of a provider shall constitute "adverse actions" and grounds for a hearing:

- Termination of provider's ability to provide health care services to patients at any time
- Imposition or voluntary acceptance of restrictions on provider's ability to provide health care services to patients for 30 or more cumulative days in any 12 month period
- Imposition for a summary action which remains in effect for a period of more than 30 days.

Notice of Adverse Action: In all cases where an adverse action is proposed to be taken against a provider constituting grounds for a hearing, the Chief Medical Officer shall, within 10 days after making his or her decision to take adverse action, give practitioner written notice of the following:

- That an adverse action has been made or is proposed to be taken against the provider, which if adopted, shall be reported to the National Practitioner Data Bank pursuant to the Federal Health Care Quality Improvement Act of 1986, as amended, and the applicable State licensing board or agency pursuant to applicable state law
- The reasons for the proposed adverse action (a specific statement of charges need not be included in the written notice)
- That the provider has a right to request a hearing on the proposed adverse action in accordance with this Fair Hearing Procedure within 30 days after receipt of the notice
- A summary of the provider's rights in connection with the hearing, as specified in this Fair Hearing Procedure.

Request for Hearing: A provider shall have 30 days following his or her receipt of notice of an adverse action to request a hearing on the proposed action. The request shall be given in writing to the Chief Medical Officer by personal delivery or by certified for registered mail and shall be deemed given upon receipt.

Waiver: Failure of the practitioner to request a hearing within the time and in the manner described above shall constitute a waiver of the hearing and of any review. In the case of such waiver, the provider shall be deemed to have accepted the Quality Improvement Committee proposed action, and the proposed action shall become effective pending final action by the Board of Directors. The Quality Improvement Committee proposed action shall be forwarded to the Board for review and final action of ratification.

HEARING PREREQUISITES

Notice and Time for Hearing: Upon receiving notice, Chief Medical Officer shall set up hearing to occur within 45 days of receipt of the request for hearing. The Chief Medical Officer shall send written notice to the provider of the place, time and date of the hearing at least 15 days prior to the established meeting date.

The notice to the provider shall contain:

- A list of the specific or representative patient records in question or other reasons or subject matter forming the basis for the adverse action
- A list of the witnesses, if any, expected to testify at the hearing. The notice shall specify that the provider may submit to the Chief Medical Officer within 10 days following receipt of the notice a list of witnesses expected to testify on behalf of the provider. The notice may state that the Chief Medical Officer reserves the right to amend the lists of documents, information and witnesses. If so amended, notice shall be given to the provider.

Request for Postponement: A request for a postponement of a hearing and/or extension of time beyond the times stated in this plan shall be permitted only upon mutual agreement of the parties or by the hearing officer upon a showing of good cause.

Failure to Appear or Proceed: The personal presence of the provider who requested the hearing shall be required. Failure of the provider, without good cause, to appear and proceed at the hearing shall constitute a waiver of his or her right to a hearing and a voluntary acceptance of the adverse action, which shall become effective immediately. The matter shall be forwarded to Memorial Hermann's Health Plan Board of Directors for review and final action or ratification.

Hearing Panel and Officer: If a hearing is requested on a timely basis (as per above) the hearing shall be held before a hearing panel of not less than 3 individuals appointed by MHHP who did not participate in the prior decision. One member of the panel members should be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who is the subject of the appeal and who is a clinical peer of the participating provider that filed the dispute.

A hearing officer shall be appointed by MHHP, and shall maintain decorum and ensure that all participants have an opportunity to present relevant oral and documentary evidence. The hearing officer shall determine the order of procedure and make rulings on issues and matters.

A person shall be disqualified from serving as a hearing officer or on a hearing panel if he or she has participated in initiating the matter at issue (including participation in the original decision) or if he or she is in a personal or professional relationship with the provider. An individual serving as a hearing officer or as a member of a hearing panel need not be a physician or other health care provider. A confidentiality and conflict of interest statement will be obtained from this individual as well as panel members.

HEARING PROCEDURES

Representation: The provider who requested the hearing shall be entitled to be represented by an attorney or other person of his or her choice. The Quality Improvement Committee shall also be entitled to be represented by an attorney of choice and shall designate 1 or more persons to represent the facts in support of the adverse action and examine witnesses. The Chief Medical Officer shall appoint a representative of the Quality Improvement Committee to present the committee's proposed action and the facts in support of such action, to examine witnesses and to present evidence.

Rights of Parties at Hearing: Within reasonable limitations, during the hearing parties shall have the following rights: (a) to be provided with all of the information and evidence made available to the hearing officer; (b) to have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation thereof; (c) to call and examine witnesses on relevant matters; (d) to present and rebut any evidence in any format determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; (e) to introduce exhibits and documents relevant to the issues; and (f) to submit a written statement at the close of the hearing, provided, however, that these rights are exercised in an efficient and expeditious manner. If the provider does not testify on his or her own behalf, he or she may be called by the Quality Improvement Committee and examined as if under cross-examination.

Upon completion of the hearing, the provider shall have the following rights: (a) to receive the written recommendation of the hearing panel, including a statement of the basis for the recommendation(s); and (b) to receive a written decision of the Memorial Hermann's Health Plan Board of Directors, including a statement of the basis for the decision.

Admissibility of Evidence, Examination of Witnesses: The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence, and the parties may present any evidence in any mutually acceptable format determined to be relevant by the hearing officer, regardless of its admissibility in a court of law. Any relevant evidence shall be admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of its admissibility in a court of law. The hearing officer may question the witnesses or call additional witnesses if it deems it appropriate. The hearing panel may request that oral evidence be taken only on oath or affirmation administered by a person entitled to notarize documents.

Burdens of Presenting Evidence and Proof: The burden of presenting evidence and the burden of proof during the hearing shall be as follows:

- The Quality Improvement Committee shall have the initial burden of presenting evidence, which supports the final proposed adverse action. The provider shall have the burden of presenting evidence in response
- The provider shall have the burden of proving, by clear and convincing evidence, that MHHP adverse action lacks any substantial factual basis or that the conclusions drawn are arbitrary and capricious or unreasonable.

Record: A record or sufficiently accurate summary of the hearing shall be kept. The hearing officer may select the method to be used for making the record.

Adjournment: The hearing panel may recess, adjourn and reconvene the hearing without further notice for the convenience of the participants or to obtain additional evidence or consultation, with due consideration for reaching an expeditious conclusion to the hearing.

Conclusion of Hearing: At the conclusion of the presentation of evidence, the hearing shall be closed. The parties may, at the close of the hearing, submit a written statement. The hearing panel shall then, at a time convenient to itself, privately conduct its deliberation, reach a decision and adjourn the hearing.

DECISION OF HEARING PANEL

Basis for Decision: The decision of the hearing panel shall be based on the evidence produced at the hearing, including all logical and reasonable inferences drawn from the evidence and the testimony. This evidence may consist of the following: (a) oral testimony of witnesses; (b) briefs or written or oral arguments presented in connection with the hearing; (c) any material contained in the Quality Improvement Committee files regarding the practitioner who requested the hearing; and (d) any other evidence deemed admissible.

Decision of Hearing Panel: Within 15 days after adjournment of the hearing, the hearing panel shall prepare a written decision or report stating its findings of fact and recommendations, including a statement of the basis for the recommendations, and shall forward it to the Quality Improvement Committee who requested the hearing, and the Memorial Hermann's Health Plan Board of Directors. If the provider is currently under suspension, however, the time for rendering the decision shall be 7 days. The notice shall contain information about the right to a second appeal and how to request such a hearing.

If the final proposed action adversely affects the ability of a provider to provide health care services to patients for a period longer than 30 days and is based on deficiencies in the providers quality of care, competence or professional conduct, then the recommendation shall state that the action, if adopted, will be reported to the National Practitioner Data Bank and the applicable State Licensing Board.

Right of Second Appeal: There shall be a second appeal of the decision of the hearing or panel upon request of the provider that was sanctioned by the MHHP Quality Improvement Committee. The hearing panel and hearing officer shall consist of 3 qualified individuals who have not participated in prior decisions in this matter. At least 1 member of the panel shall be a participating provider who is not otherwise involved in network management and who is a clinical peer of the provider who is the subject of the appeal.

Time frames for request, notice and conduct of meeting shall be as per the first appeal (hearing). New relevant information may be presented by the appealing party as per guidelines.

Failure of the provider to request a second appeal within the specified timeframe 30 days will constitute an agreement with the decision rendered.

NOTICE OF DECISION TO THE MHHP QUALITY IMPROVEMENT COMMITTEE

Review by the Quality Improvement Committee: At its next regularly scheduled meeting, after receipt of the written recommendation of the hearing panel, the Quality Improvement Committee shall (a) review the report and recommendation of the hearing panel, the hearing record, any written statements and all other documentation relevant to the matter; and (b) consider whether to affirm or reject the recommendation of the hearing panel, or to refer the matter back to the hearing panel for further clarification.

Final Decision by Quality Improvement Committee: Upon completion of its review of the Hearing Panel's information and recommendations, Quality Improvement Committee shall render a final decision concerning the restriction, suspension or termination of the provider's ability to provide health care services to patients, or any other corrective action the Quality Improvement Committee.

The decision of the Quality Improvement Committee shall (a) be in writing, (b) specify the reasons for the action taken, (c) include the text of the report which shall be made to the National Practitioner Data Bank and the applicable state licensing board, if any, and (d) be delivered to the provider under review and the Chief Medical Officer at least 10 days prior to submission of a report to the National Practitioner Data Bank or the state licensing board.

Except where the matter is referred for further review and recommendations, the decision of the Quality Improvement Committee following completion of the procedures set forth in this Fair Hearing Procedure shall constitute the final action of MHHP against the provider, shall be immediately effective and final and shall not be subject to further hearing or appellate review.

Further Review: If the matter is referred back to the Quality Improvement Committee or the hearing panel for further review, the Quality Improvement Committee or hearing panel shall promptly conduct its review and make its recommendation to the hearing panel and the Memorial Hermann's Health Plan Board of Directors. This further review process and report back to the hearing panel and board shall in no event exceed 30 days in duration except as the parties may otherwise stipulate. The board shall provide written final notice to the provider in this case within 10 days of a final determination.

No Further Appeal Rights: No provider shall be entitled as a matter of right to more than 2 appeals fair hearings on any single matter which shall have been the subject of an adverse action.

Section 9: Medical Management

MHHP's Medical Management Department works with contracted network providers to promote delivery of health services that are medically necessary to meet professionally recognized quality standards and are provided in the most appropriate setting. The member Evidence of Coverage (EOC) or Certificate of Coverage (COC) describes specific conditions and services that are not eligible for benefits. Benefit agreements may limit or exclude a service that is "medically necessary" as that term is defined in the Member EOC/COC.

Nevertheless, all decisions regarding care or treatment remain with the member and provider.

MHHP's Medical Management benefit decision-making is based upon the terms set forth in the member's EOC/COC. Through the MHHP Medical Management program, MHHP strives to avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. MHHP does not reward staff for issuing denials and does not offer incentives to encourage inappropriate underutilization.

Case Managers on the Medical Management staff are available to discuss care and benefit options for catastrophic cases, as well as care that may require multidisciplinary or community services. These options can maximize benefits for members and providers.

Medical Necessity Criteria

Medically necessary services as defined in most EOC/COCs are those that are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice of the organized medical community
- Not primarily for the convenience of the member, the member's provider or any other medical professional
- Provided in the most appropriate setting.

Medical Management Process

The Medical Management staff, comprised of licensed providers and nurses, determines benefits according to the criteria for medical necessity set forth in the member's EOC/COC. These benefit determinations may be made prospectively, concurrently or retrospectively. The review criteria consider local, regional and national professionally acceptable standards for quality medical care in accordance with state or federal law or regulation.

In general, MHHP uses standard guidelines for both inpatient and outpatient services based, in part, on well-established medical practice protocols, such as *McKesson Interqual*, *CMS National Coverage Determinations (NCD)* and *Local Coverage Determinations (LCD)* for inpatient and surgical care. Some services that providers may recommend are not necessarily covered as a part of a member's health benefit plan.

Following the benefit determination, the treating provider will receive a letter advising that the service was or was not authorized. Members will also receive a letter advising them that the service was authorized or not authorized.

Medical Management Requirements for Prior Authorization

MHHP encourages providers to initiate prior authorization, since clinical information is required. Providers should call the customer service phone number on the member's ID card with questions concerning plan requirements. Requirements for benefit prior authorization may vary among plans and a lack of prior authorization may result in a denial or a reduction of benefit coverage for the member. The authorization process is also referred to as precertification, which is the terminology used to refer to medically necessary services such as hospitalizations when "days" are pre-certified.

Prior authorization should be initiated as soon as possible, but not less than 3 working days prior to a scheduled inpatient hospitalization or outpatient service. Providers may call Medical Management or fax a prior authorization form to request a service or procedure. The form can be found at:

<http://healthplan.memorialhermann.org/providers/resource-center>

If Medical Management determines that additional clinical information is needed to make an informed determination, an outreach call and/or faxed request will be made by Medical Management. At that time the provider will be notified of the timeline needed for a response. Medical Management will respond to the request according to standard timelines set by the state and federal regulatory requirements. Non-urgent/standard certification/authorization requests for fully insured will be responded to within 3 calendar days; self-insured will be within 3 business days; and Medicare Advantage within 14 calendar days.

Emergent care requests for fully insured and self-insured members must be responded to within 2 hours and expedited requests for Medicare Advantage members must be responded to within 72 hours. Again, Medical Management will engage with the provider to obtain the needed additional clinical information to ensure these timeframes are met. Exceptions to the timeframes are subject to state and federal regulatory requirements.

Prior Authorization Request Process

This section assists MHHP in determining the urgency of the provider's request for authorization.

Emergent Requests

Any medical problem with a sudden onset of symptoms requiring intervention and prior authorization of services within a 24 hour period are handled as a priority and will be processed and return authorization to the provider's office within a 2 hour period, unless additional information is needed.

No prior authorization is required for life-threatening inpatient admissions. Notify MHHP retrospectively within 2 business days for self-insured members and 24 hours for fully insured and Medicare Advantage members after they have been stabilized and admitted.

In no instance will a retroactive denial be issued for an emergency admission in the following circumstances:

- Prior authorization was rendered by MHHP for an ER admission based on severity of symptoms or illness
- The member met McKesson Interqual or NCD/LCD criteria at the time of ER admission notification
- Findings from the initial concurrent review indicate that the member no longer meets criteria for continued stay. Then a denial determination may be made by the Medical Director, but only for continued stay days, which begin at the point of the notification or at the time of the initial concurrent review.

After the initial review of clinical information, the Medical Director may determine that the member did not meet the medical necessity criteria for continued stay beyond the certification/authorization date and a denial from that date forward may be issued.

Urgent/Expedited Requests

Requests will be processed as soon as feasible or no later than 72 hours from the date of the request, provided MHHP has all of the information to render an authorization decision.

Non-Urgent/Standard Requests

Non-urgent/Standard requests are routine and will be processed within 3 business days from the date of the request for self-insured members; 3 calendar days for fully-insured members; and 14 calendar days for Medicare Advantage members, provided MHHP has all the information to render a decision.

Patient Information/Insurance Information

Each provider's office should have a system in place for identifying each member's primary and secondary health insurance coverage. MHHP also recommends that providers have a system in place at the time of member check-in to verify if there have been any changes in health insurance coverage since the last time the member was seen.

Provider Information and Requested Services

If the request for prior authorization is for health care services, the following information is required in order to process a request. Requests for services or procedures may be called in or faxed.

- For self-insured and fully-insured members, the Texas Standard Prior Authorization Request Form for health care services is to be used for faxed requests.
- For Medicare Advantage members, use the appropriate prior authorization form for faxed requests.

Prior authorization forms are available on the Memorial Hermann website:

<http://healthplan.memorialhermann.org/providers/resource-center>

Provider information includes the name of requesting provider or facility complete with the NPI#, fax, phone, location, and specialty if applicable.

Requested Services information includes the following:

- **Date requested:** The provider should add the date he/she is submitting the request to MHHP.
- **CPT/ICD-10 Codes:** Completion of the diagnosis and procedure codes is optional. However, a description of the diagnosis and procedure codes is needed to complete the prior authorization request. MHHP reserves the right to request those codes if the level, extent or type of services requested is not clear.
- **Surgery/medical procedure:** If the member is to have a surgery or other medical procedure, note the name of the procedure and indicate if it will be inpatient (I/P) or outpatient (O/P). Also note the name of the facility where the surgery or procedure will be performed. The hospital's abbreviations may be used for surgeries and medical procedures to be scheduled at Memorial Hermann Hospital System facilities.
- **Imaging/invasive diagnostic procedures:** For procedures requiring prior authorization, note the procedure(s) being performed and include the CPT or HPCS codes.

Note: If multiple procedures are requested for the same date of service to support a diagnostic impression, MHHP's Medical Director may recommend 1 primary procedure based on McKesson Interqual, NCD/LCD or other nationally recognized clinical protocols, unless the treating provider can substantiate the clinical rationale for requesting multiple procedures (i.e., requests for an upper GI series and endoscopy on the same date of service). Such requests will be handled on a case-by-case basis, taking into account any special medical needs or considerations of the member. Special needs could include things such as durable medical equipment (DME)/prosthetics/supplies.

Authorization for DME/prosthetics is to be initiated by the requesting provider in

order to determine if the member meets DME/prosthetic criteria and specific health plan benefit limitation requirements.

MHHP reserves the right to authorize either a rental or purchase, depending upon the type of DME and the length of time the DME may be needed. Coverage for prosthetics is dependent upon health plan benefit coverage limitations. If authorized, MHHP will provide the name of contracted vendors to be utilized.

Other services requiring authorization include:

- **Injectable drugs:** Some injectable medications require authorization; contact MHHP with questions regarding prior authorization of any drugs.
- **Outpatient rehabilitation:** Indicate type of O/P rehabilitation (PT, OT, ST) service requested. MHHP reserves the right to initially authorize an “evaluation only” to determine whether the member meets criteria for rehabilitation services based on health plan benefit requirements and/or to determine the rehabilitation potential of the member. Some MHHP plans have yearly limitations for these services.
- **Home health/infusion therapy services:** Prior authorization is to be obtained by the requesting provider. MHHP reserves the right to initially authorize an “evaluation only” to determine whether the member meets criteria for home health/infusion therapy services based on health plan benefit requirements.

MHHP will make authorization considerations based on whether the requested facility is a contracted provider for the services to be provided and if the facility has the capabilities to appropriately meet the needs of the member.

Member Clinical Information

All requests for prior authorization require clinical information about the member to appropriately render a determination of medical necessity. Instructions are as follows:

- **Primary diagnosis:** Indicate the primary diagnosis. It may be that which is related to the need for the requested service.
- **Additional diagnosis:** Indicate any of the member’s secondary diagnoses.
- Supporting clinical information must be faxed to support the medical necessity of the requested service. Send the completed prior authorization request form to:

MHHP Medical Management Department
Fax: 713-338-6494

Denial Rationale

MHHP’s Medical Director will issue an adverse determination (denial) with the rationale to the provider via a written “adverse determination letter.” The provider may appeal a denial by notifying MHHP’s Appeal and Grievance Department in writing, within 30 calendar days for fully-insured and self-insured members and 60

calendar days for Medicare Advantage members.

Assigned Authorization Number

MHHP will assign an authorization number for internal tracking and to facilitate billing. Please note that this authorization number is not a guarantee of coverage. A final claim determination will be made in writing following receipt and review of the claim and verification of benefits and eligibility. Reference the authorization number for the claim.

The following information is required when requesting authorization:

- Patient name and ID number
- Patient's age and sex
- Name and telephone number of requesting provider
- Hospital or facility name
- Diagnosis code (ICD-10) and diagnosis description
- Reason for admission, service or procedure
- Scheduled date of admission, service or procedure
- Planned procedure or surgery (CPT code)

Providers/Facilities must contact Medical Management if the inpatient stay requires additional days beyond those authorized in response to the initial call for prior authorization.

Prospective Review

Prior authorization of benefits is required for any elective (non-urgent, non-emergent) admission to a hospital or facility, including:

- Medical and surgical services, except for normal vaginal and C-section deliveries
- Skilled nursing services (including a skilled nursing facility)
- Psychiatric and substance abuse services (behavioral or mental health).

Note: If there is an unplanned admission for early or threatened labor, premature birth or another high-risk situation or complication, the provider must call Customer Service at the phone number listed on the member's ID card to determine if prior authorization is required. Many outpatient services performed in hospital, ambulatory surgical and provider office settings require prior authorization.

A complete list of these services may vary by member EOC/COC, but may include:

- Surgical procedures (such as breast surgery, surgery of head/face/nose/mouth/throat/external ears and eyelids, gastric bypass, abdominoplasty/panniculectomy, lipectomy/liposuction, injection of collagen, vein stripping/injection of sclerosing agents and cochlear implants)

- Diagnostic procedures (such as MRIs, CT scans, PET scans and nuclear cardiac scans)
- Home health care.

Call Customer Service to determine if a service or procedure requires benefit prior authorization.

Concurrent Review

Concurrent review is the process that determines coverage during the inpatient stay (including, but not limited to, acute care hospital (medical/surgical, behavioral, drug, alcohol use, a skilled nursing facility (SNF), long-term acute care hospital (LTACH) and inpatient rehabilitation). This is also necessary when the inpatient stay will exceed the previously approved benefits for length of stay. Providers should contact Medical Management to obtain additional prior authorization days. Contact information is available on pages 6 and 7.

Concurrent review affirms benefits for continuing medical necessity and appropriateness of continued treatment, services or hospitalization. Reviews of ongoing care are conducted for inpatient hospitalizations that were previously certified, as well as for outpatient procedures and ongoing outpatient care that require benefit prior authorization. Concurrent review may also occur in situations where benefit prior authorization was not obtained prior to the hospitalization.

Retrospective Review

Retrospective review is rendered when a service was performed but not previously authorized by Medical Management. Retrospective requests may be submitted for clinical review if the claim has not been submitted. MHHP **will not** rescind previous prior authorizations except in cases of fraud, misrepresentation or where the medical records differ from the information previously provided to MHHP.

Case Management

Case Managers work with providers to coordinate benefits for complex catastrophic cases and are available to consult with providers about difficult or unusual situations. In the event that a member needs services not available through the MHHP network, the Case Management staff can work with the provider to locate an appropriate setting. Call the Customer Service phone number on the member's ID card to reach a Case Manager.

Examples of services appropriate for Case Management include:

- Potential organ and bone marrow transplantation
- Ventilator dependency
- Chronic pain management programs
- Difficult post-discharge placement or post-discharge cases requiring multiple services
- High-risk obstetrics.

Appeal of Clinical Non-Prior Authorization by Medical Management

Providers may request an appeal of a clinical benefit non-prior authorization for up to 180 days by submitting a written request for appeal to the following address:

MHHP

Attention: Medical Management - Appeals

929 Gessner Road, Suite 1500

Houston, Texas 77024

Additional clinical documentation may be requested to review the case. The MHHP physician conducting the review will not be the reviewer who made the initial determination.

If MHHP reverses the decision not to authorize benefits, a written notice will be issued. If the initial determination not to authorize benefits is upheld, MHHP will mail an explanation to the provider and the member.

If the appeal outcome is unfavorable, the provider may submit a written request for an additional level of appeal, which involves a review completed by the same specialty as the requesting provider, preferably within 180 days. Additional supporting documentation or explanations upholding the non-prior authorization should be sent to the address on the letter.

Subsequent appeal rights may be available, depending on the arrangement with self-funded employer groups and state laws.

If the member's condition is life-threatening, the member is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. The decision based on this review is final.

Note: A participating provider may not bill the member for services determined to be non-medically necessary or inappropriate under the member's Evidence of Coverage unless the member has specifically agreed in writing, in advance, to pay these charges and MHHP has denied coverage.

Section 10: Memorial Hermann Medicare Advantage HMO/PPO

Memorial Hermann Medicare Advantage Overview

Memorial Hermann Health Insurance Company and Memorial Hermann Health Plan, Inc. (MHHP), has contracted with the Centers for Medicare and Medicaid Services (CMS) to provide physical, behavioral health and prescription drugs coverage to enrollees within the health plans service area.

MHHP offers 2 benefit plans:

- Memorial Hermann Medicare Advantage – HMO (offered by Memorial Hermann Health Plan, Inc.)
- Memorial Hermann Medicare Advantage – PPO (offered by Memorial Hermann Health Insurance Company).

Customer Service

October 1 – February 14

Customer Service is available from 8 a.m. to 8 p.m., 7 days a week to assist members and providers with benefits and claim information. For contact information, reference the chart at the beginning of this manual on page 6.

February 15 – September 30

Customer Service is available from 8 a.m. to 8 p.m., Monday thru Friday to assist members and providers with benefits and claim information. For contact information, reference the chart at the beginning of this manual on page 6 and 7.

For questions about Memorial Herman Advantage benefits, visit the “Our Plans” section at:

<http://healthplan.memorialhermann.org/medicare/our-plans>

Accessing Services

Medicare Advantage members obtain covered services by choosing a Primary Care Provider (PCP) who is part of the MHHP Medicare Advantage network to assist and coordinate their care. Members are encouraged, but not required, to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral health care).

Although a referral to a specialist for a consult is not required, some services provided by a specialist may require prior authorization.

When referring a member to a specialist, it is critical to select a participating provider within MHHP’s Medicare Advantage network to maximize the member’s benefit and minimize the out-of-pocket expenses. Note: HMO members have no out-of-network benefits except for urgent or emergent care.

If you need help finding a participating provider, you may call the Customer Service number listed on the back of the member's MHHP ID card or use our online Provider Directory search at:

<http://healthplan.memorialhermann.org/medicare>

Part D (Pharmacy) benefits are covered for MA beneficiaries who have enrolled in one of MHHP's MA Plans. For more details on the formulary, cost-sharing amounts, and any applicable deductibles, please visit

<http://healthplan.memorialhermann.org/medicare>

Benefits and Coverage

In addition to covering all traditional Medicare benefits, both HMO and PPO Medicare Advantage plans include full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other health care services, including, but not limited to:

- Hearing aid benefits* (*limitations may apply)
- Routine vision and eyewear* (*limitations may apply)
- Readmission prevention benefits.

Optional Supplemental Benefits (*Advantage Pack*)

The Memorial Hermann Advantage HMO and PPO Pack (MHAP) is an enhancement package of benefits: Dental, Eyewear, Hearing Aids, Chiropractic, and Worldwide Emergent and Urgent services that members can buy as a single optional benefit. At the time of enrollment, members will be given the opportunity to choose the Memorial Hermann Advantage HMO or PPO Pack as an optional benefit, in addition to the basic plan benefits, by indicating their preference on the enrollment form. Enrollment for this optional package occurs only one time a year, either during the CMS Annual Enrollment Period (AEP) or outside of the AEP timeline if members are new to the plan and eligible for a Special Election Period (SEP).

For complete details please see the Evidence of Coverage or Summary of Benefits document at:

<http://healthplan.memorialhermann.org/medicare>

Organization Determination

Organization Determination is when the health plan makes a determination either prior to Part B medical services being rendered or when the claim is submitted for payment.

There are specific services that require prior authorization in order to be a covered benefit. Please see the Resource Center in the Provider section of the MHHP website for the most current list of services that require prior authorization.

To request prior authorization for medical services for Memorial Hermann Medicare Advantage members:

Call:

MA HMO: (884) 550-6886
 Advantage MA PPO: (844) 550-6896

Write

Memorial Hermann
 Medical Management
 929 Gessner Road, Suite 1500
 Houston, Texas 77024

Fax:

MA HMO: 713-338-5811
 MA PPO: 713-338-5812

Organizational Determination Decision Timeframes - Medicare Part C	
Expedited Review – Pre-service only	72 hour time limit
Standard – Pre-service	14 calendar day time limit
Standard – Payment	Network – Per contract Non-contract Clean Claim 30 day time limit Non-contract Unclean Claim 60 day time limit

Coverage Determination

Coverage Determination is when the health plan makes a determination regarding a Part D drug request. There is a list of drugs that require pre-authorization prior to dispensing. To request a coverage determination for Part D drugs you may:

1. Go to the Memorial Hermann Medicare Advantage website, search for “Coverage Determination” and click on the “Online Coverage Determination” link
2. Print and complete the “Request for Coverage Determination Form” (found just below the “Online Coverage Determination” link and mail or fax your coverage determination request to:

Envision Rx Options

Attn: Coverage Determinations
 (Clinical Services) 2181 E. Aurora
 Rd, Suite 201 Twinsburg, OH 44087
 Fax: (877) 503-7231, or;

3. Call us at:
 - Memorial Hermann *Advantage* HMO members should call (844) 860-6750
 - Memorial Hermann *Advantage* PPO members should call (844) 782-7672
 - TTY/TDD users can call 711.

Coverage Decision Timeframes - Medicare Part D (Prescription Drug)	
Expedited Review - Pre-service only	24 hour time limit
Standard – Pre-service	72 hour time limit
Standard – Payment	14 calendar day time limit

Special Billing Practices for Dual Eligible Beneficiaries

The term Dual Eligible refers to individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the following “Medicare Savings Program” (MSP) categories:

- **Qualified Medicare Beneficiary (QMB) Program** – Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments;
- **Specified Low-Income Medicare Beneficiary (SLMB) Program** – Helps pay for Part B premiums;
- **Qualifying Individual (QI) Program** – Helps pay for Part B premiums; and
- **Qualified Disabled Working Individual (QDWI) Program** – Pays the Part A premium for certain people who have disabilities and are working.

Medicare and Medicare Advantage providers may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability. The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers--not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Providers who inappropriately bill QMB individuals are subject to sanctions.

To determine if your patient has dual coverage, please contact the Customer Service phone number listed on the back of the member’s card.

Claims

Providers are required to submit claims to Memorial Hermann Medicare Advantage for payment, either on paper or electronically.

Before payment can be made for Medicare-covered services, claims must be received no later than 1 calendar year from the date of service. Claims filed after the specified time frame will be denied with no appeal rights. Refer to Billing and Payment Section 3 for detailed information regarding claims submission requirements. The paper form used for submission of medical charges is the Health Insurance Claim Form CMS 1500. Use CMS Claim Form 1450 for facilities.

Submit paper claims to:
 Memorial Hermann Advantage
 Claims
 P.O. Box 226526
 Dallas, TX 75222-6526

Submit electronic claims to:
 Clearinghouse
 TTPS

Appeals and Grievances

Memorial Hermann Advantage members have the right to file an appeal and/or grievance. The plan must maintain meaningful procedures for timely hearing and resolving of both standard and expedited appeals. An appeal is a request to the Plan by a member, member’s authorized representative, or a provider to reconsider an initial adverse organization determination (denial) of a pre-service request or a service/procedure that has been provided.

Part C Medical Appeals (60 calendar days to file)	
Pre-service expedited reconsideration	Reconsideration decision within 72 hours of Plan’s receipt
Pre-service standard reconsideration	Reconsideration decision within 30 calendar days of Plan’s receipt
Payment reconsideration	Pay or deny within 60 calendar days of Plan’s receipt

Part D Appeals (60 calendar days to file)	
Pre-service expedited redetermination	Redetermination decision within 72 hours of Plan’s receipt
Pre-service standard redetermination	Redetermination decision within 7 calendar days of Plan’s receipt

To file an appeal, contact MHHP within 60 calendar days of the denial notification date located on the EOP or adverse determination letter and provide the following information:

- Provider name
- Address
- Phone number
- Member ID number
- Reason for appeal
- Any additional supporting information or evidence to support the request.

To initiate an expedited appeal or a grievance:

Call:
 MA HMO: 844-550-6886
 MA PPO: 844-550-6896
 Hours are 8 a.m. to 8 p.m. (CST),
 Monday through Friday

Fax:
 MA HMO: 713-338-5811
 MA PPO: 713-338-5812

To initiate a standard appeal or grievance:

Write:

Memorial Hermann Medicare Advantage
Attention: Appeals and Grievances
929 Gessner Road, Suite 1500
Houston, Texas 77024

If an appeal request is filed late, MHHP may extend the time limit for filing an appeal if good cause is shown. The Plan resolves the issue of whether good cause exists before taking any other action on the appeal.

Below are conditions and examples that may establish good cause for late filing by providers, physicians, or other suppliers. Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by the Plan to the provider, physician, or other supplier; or
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompass situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.

Note: Failure of a billing company or other consultant (that the provider, physician, or other supplier has retained) to timely submit appeals or other information is NOT grounds for finding good cause for late filing. The Plan does not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.

A "grievance" is a complaint that does not involve a coverage decision. Members or their authorized representative may file a grievance if they are dissatisfied with the quality of care or services received from MHHP or a provider.

An expedited grievance may include a complaint if MHHP refused to expedite or invoked an extension time frame for an organization determination/coverage determination or reconsideration/redetermination. MHHP will provide written notice explaining the reasons for such a decision and explaining the member's right to file an expedited grievance.

The Plan maintains procedures for the timely hearing and resolution of a member concerns as shown below:

Grievances	
Standard grievance review	Respond within 30 calendar days of Plan's receipt
Expedited grievance review	Respond within 24 hours of Plan's receipt

Pharmacy Benefit Management (PBM)

Both Memorial Hermann MA plans utilize the PBM Envision Rx to manage member pharmacy benefits. As the PBM, Envision Rx provides MHHP members with an extensive pharmacy network, pharmacy claims management services, and a complete drug formulary and pharmacy claims adjudication.

Medication Therapy Management (MTM) Information

The Memorial Hermann MA plans offer a Medication Therapy Management (MTM) program at no additional cost to members. Some members who take several medications for different medical conditions may qualify to participate in this program, which is designed for their specific health and pharmacy needs. The MTM program is developed by a team of pharmacists and doctors to assist members who may benefit from additional support with their Part D medications.

For general inquiries, call EnvisionRx at the phone numbers found on page 6 of this manual.

Obligations of Recipients of Federal Funds

Providers participating in Medicare Advantage are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including, but not limited to:

- Title VI of the Civil Rights Act of 1964
- Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Americans with Disabilities Act of 1990.

MHHP is prohibited from issuing payment to a provider or entity that appears on the “List of Excluded Individuals/Entities” as published by the Department of Health and Human Services Office of the Inspector General or on the “List of Debarred Contractors” as published by the General Services Administration (with the possible exception of payment for emergency services under certification circumstances as defined by CMS).

The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities is at:

<https://exclusions.oig.hhs.gov>

The General Services Administration List of Debarred can be found at:

<http://www.sam.gov/portal/SAM#1>

Additional information about the program can be found at:

<http://www.gsa.gov/portal/content/193147>

Claims Filing Deadline – Medicare Advantage

As noted, payments for Medicare-covered services can only be made if claims are received no later than 1 calendar year from the claim's date of service. Claims filed after the specified time frame will be denied with no appeal rights.

For claims that include span dates of service, filing timeliness is determined as follows:

- The “through date” is used to determine the date of service for institutional claims.
- The “from date” is used to determine the date of service for professional claims.

Exceptions to the timely filing requirement include the following:

- Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare Administrative Contractor (MAC), or agent of the U.S. Department of Health and Human Services that performed Medicare functions and acted within the scope of its authority
- Retroactive Medicare entitlement
- Retroactive Medicare entitlement involving state Medicaid agencies and dually-eligible beneficiaries
- Retroactive disenrollment from a Medicare Advantage Plan.

Prompt Payment

In accordance with CMS Guidelines, MHHP will process all clean claims as defined in this manual within 30 days of receipt. All claims from non-contracted providers will be paid or denied within 60 calendar days.

Medicare Advantage Star Ratings Performance Program

The Centers for Medicare and Medicaid Services (CMS) introduced the Star Ratings Quality Performance program in an effort to improve the quality of care and services for Medicare Advantage (MA) beneficiaries across all MA health plans, with an emphasis of quality of care outcomes and patient experience. CMS evaluates health and drug plans on quality and performance each year based on a 5 Star rating system. Ratings may change from one year to the next.

MHHP's STARS program is a comprehensive program dedicated to being a highly-rated plan, and is designed to foster provider and member engagement aimed to encourage wellness and preventive services that support continuous health care improvement. As a Memorial Hermann provider, your commitment to providing quality care and services notably contributes to our achievement of high ratings.

CMS utilizes the following data sources to measure a plan's performance:

Source	Measure Description
HEDIS™ (Healthcare Effectiveness Data)	Claims data and medical record reviews used to validate those members are getting recommended medical services and that their chronic conditions
CAHPS® (Consumer Assessment of Healthcare Providers and Systems)	Annual CMS random patient experience survey results are utilized to measure member-perceived experiences and satisfaction with their healthcare providers and plan.
HOS (Health Outcomes Survey)	Patient-reported outcomes measure used in Medicare managed care utilizing a sampling of set survey results of members' health status over 2 years. Each spring a random sample of Medicare beneficiaries is drawn and surveyed from each participating Medicare Advantage Organization (MAO), with a minimum of 500 enrollees and resurveying 2 years later.
CMS Administrative Measures	These are measures that assess MHHP's operations such as information from member complaints made directly to 1-800-MEDICARE, voluntary disenrollment, availability of foreign language interpreters and TTY, appeals timeliness, and appeals overturned by CMS' independent review entity (IRE).
Pharmacy Measures	Drug plans are compared to each other for outcomes and patient safety. Part D Star measures assess how often members with certain conditions get prescription drugs that are considered safer and clinically recommended for their condition. Also, how well the drug plan prices prescriptions and provides updated information on the Medicare plan finder website.

Star Rating Tips for Providers:

- Encourage patients to obtain preventive screenings when recommended by the U.S. Preventive Services Task Force (USPSTF).
- Implement processes to identify and intervene with noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Utilize CPT Category II codes to help ease the administrative burden of chart review for HEDIS™ performance measures.
- Understand how you impact each measure.
- Incorporate HOS questions into each visit. Sample surveys can be obtained

from <http://www.hosonline.org/en/survey-instrument/>

- Review the sample CAHPS® survey to identify opportunities for you or your office to have an impact: <https://www.ahrq.gov/cahps/surveys-guidance/index.html>

For additional information regarding the Star Ratings Performance program, email StarsMatter@MemorialHermann.org.

Specific Medicare Advantage Plan Requirements

Providers must remain neutral when assisting with enrollment decisions and may not:

- Offer scope of or appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interest of the provider
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities
- Distribute materials or applications within an exam room.

Providers may:

- Provide the names of plan sponsors with which they contract and/or participate
- Provide information and assistance in applying for the low-income subsidy
- Make available and/or distribute plan marketing materials in common areas
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIPs), Plan marketing representatives, their state Medicaid office or local Social Security office, CMS' website, at <http://www.medicare.gov/> or 1-800-MEDICARE
- Share information with patients from CMS' website, including the "Medicare and You" handbook or "Medicare Options Compare" or other documents that were written by or previously approved by CMS.

Medicare Marketing Literature and Provider-Sponsored Activities

For the purposes of this manual, "Medicare Marketing" includes any information, whether oral or in writing, that is intended to promote or educate prospective or current MHHP Medicare Advantage (either PPO or HMO) or Prescription Drug plan members about MHHP or its Medicare Advantage plans, products or services. This includes any promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include, but are not limited to letters, advertisements, invitations and announcements using MHHP or any MHHP affiliate's name or logo. All Medicare marketing activities conducted by a provider must be approved in advance by MHHP. MHHP's review process includes review by Legal and Compliance to ensure compliance with CMS marketing guidelines, and as applicable may require filing with CMS. To obtain approved Medicare marketing materials or to arrange for a provider-sponsored activity, contact MHHP's Marketing Department at 713-338-4759. Any misrepresentation of a MHHP Medicare product or service, intentional or not, is a serious violation of MHHP's agreement with CMS.

Provider Affiliations

Providers may announce new or continuing affiliations for specific sponsors of Medicare Advantage or Prescription Drug plans through general advertising (e.g., radio, television and websites). For these purposes, providers entering into a new contractual relationship with the sponsor of a Medicare Advantage or Prescription Drug plan are considered to be a new affiliation. Providers may make such affiliation announcements within the first 30 days of the new agreement. An announcement to patients of a new affiliation that names only one Medicare Advantage plan may occur only once, when that announcement is conveyed through direct mail, email or phone. Subsequent direct mail and/or email communications from providers to their patients regarding affiliations must clearly state that the provider may also contract with other Plans/Part D Sponsors. Any affiliation communication materials that describe Memorial Hermann Advantage plans in any way, (e.g., benefits and formularies) must be approved in advance by MHHP and CMS.

Disenrollment Medicare Advantage HMO and PPO Coverage/Liability

If a Medicare Advantage HMO member disenrolls from a Medicare Advantage plan while in a Skilled Nursing Facility (SNF), costs for SNF services are covered by a new health plan or Medicare as of the effective date of the disenrollment. If a MHHP Medicare Advantage member's effective date of disenrollment occurs while the member is hospitalized (including, but not limited to, hospitalization in a rehabilitation hospital and long-term care facility), MHHP is responsible for paying the contracted rate through the date of discharge, unless otherwise specified in the agreement.

As long as the Medicare Advantage HMO member resides in the service area, he/she is covered for services until the effective date of disenrollment. When a member is temporarily out of the service area (for up to 6 months), coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency and renal dialysis until the member returns to the service area or the effective date of dis-enrollment.

Memorial Hermann Advantage PPO members may receive covered benefits from any participating provider nationwide, as well as out-of-network benefits, but may incur higher out of pocket costs.

Medicare Disenrollment for Cause

CMS guidelines allow a physician to request a member's disenrollment "for cause" only if the member's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the provider's ability to provide health services to that particular member or other patients. A member may be disenrolled for other reasons, including, but not limited to, if he/she fails to qualify for Medicare benefits or fraudulently permits others to use his/her member ID card for services. A member cannot be disenrolled based on the member's utilization (or lack of use) of services or because of mental or cognitive conditions, (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions or as retaliation for a member's complaint, appeal or grievance. Before initiating a request to disenroll a member for cause, the provider and MHHP shall undertake a serious effort to resolve the problems, such as encouraging the member to change his/her behavior, and must document the result(s) of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the member by submitting a request for disenrollment for cause to MHHP. CMS requires MHHP to notify a Medicare member that the consequences of continued disruptive behavior could include disenrollment from the plan. MHHP and the provider must reasonably demonstrate that the member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition or use (or lack of use) of the provider's medical services.

Procedure for Requesting Disenrollment

A written request for disenrollment for cause must be sent to MHHP along with this supporting documentation:

- A description of the member's age, diagnosis, mental status, functional status and social support systems
- A complete and detailed description of the member's behavior
- The efforts taken to resolve any problems and modify behavior
- Any extenuating circumstances
- A summary of the case and reason for dis-enrollment
- A copy of the medical records
- Statements, as applicable, from other providers, office staff, members or law enforcement agencies describing their experiences with the member.

A letter confirming receipt of the disenrollment request will be sent to the provider. The information will be reviewed for completeness and compliance with the Medicare member's Evidence of Coverage. If the issues are resolved, the request may be withdrawn.

If the request is deemed to have merit, it will be forwarded to the MHHP Medical Director for review and a decision. The provider will be notified of the decision and may appeal it by resubmitting the request along with additional supporting documentation for a subsequent review.

CMS requires the plan to notify the member of its intent to request CMS permission to disenroll the member and the plan's grievance procedures. The plan will then notify CMS, which makes the final decision on whether to allow disenrollment for cause.

Member's Right to Report a Grievance

The member may request a review of the disenrollment decision by filing a grievance in writing.

Member Disenrollment

The disenrollment is effective the first day of the calendar month after the month in which the health plan gives the member written notice of the disenrollment or as provided by CMS. The member remains the responsibility of the PCP until the effective date of disenrollment.

Section 11: Compliance/Ethics

MHHP takes compliance with all applicable federal and state laws and the prevention of fraud, waste and abuse very seriously. It emphasizes the common values for actions and establishes resources to help resolve questions about compliance issues. Please review this section thoroughly. The need for each provider's adherence to its spirit and specific provisions cannot be overemphasized. All providers and their employees and agents have important responsibilities, including a duty to report compliance concerns.

Providers or staff members who have questions regarding anything found in this section or who encounter a situation they believe violates its provisions should notify MHHP immediately. This section provides ways to express a compliance concern and it can be done anonymously. Be assured, there will be no retribution for asking questions or raising compliance concerns.

Providers should take great care to ensure all claims submitted to MHHP reflect accurate information and conform to applicable federal and state laws and regulations. No provider or their employee or agent should knowingly present, or cause to be presented, claims to MHHP for payment or approval that are false, fictitious or fraudulent.

MHHP reserves the right to conduct periodic audits and monitoring of a provider to confirm that compliance goals are being maintained and assist in the reduction of any identified problem areas. Auditing and monitoring activity will include periodic profiling to identify any changes in billing patterns that may indicate improper activities.

Providers should periodically conduct educational programs for their staff so as to assure continued compliance with all applicable laws. It is imperative that providers require their professional staff and all other employees to attend compliance education programs and they agree to abide by all applicable codes of conduct adopted by the provider. A similar education requirement should be made of all independent contractors and agents providing healthcare-related services to the provider.

Fraud, Waste and Abuse

In addition to compliance with applicable federal and state laws and regulations, MHHP has strong compliance expectations of its providers regarding matters pertaining to fraud, waste and abuse (FWA), as generally defined below. These expectations should be adhered to whether or not the provider participates in a MHHP Medicare Advantage Plan.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or another person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is defined as the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. It involves the taxpayers not receiving reasonable value for money in connection with any government-funded activities due to an inappropriate act or omission by individuals or organizations with control over or access to government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and generally is not considered to be caused by criminal negligence. Waste relates primarily to mismanagement, misuse of resources, inappropriate actions and inadequate oversight.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and may directly or indirectly result in an unnecessary cost to the Medicare 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 recipient practices that result in unnecessary costs to the Medicare or Medicaid program.

MHHP requires that participating providers and members, as our partners, immediately report all cases of suspected FWA. Failure to do so may result in sanctions ranging from education and corrective action, termination of a provider's participation in the network or reporting to the appropriate regulatory agency.

Examples of Fraud, Waste and Abuse include, but are not limited to:

- Billing more than once for the same service (double billing)
- Billing for services never performed or medical equipment and supplies that were never ordered or delivered
- Performing inappropriate or unnecessary services
- Providing lower-cost or used equipment while billing for higher-cost or new equipment
- A specialty or ancillary provider completing an authorization log form or a PCP authorization for a PCP
- Using someone else's identity
- Using an altered or false pharmacy prescription.

Compliance Requirements

Providers should monitor and audit the compliance of all subcontractors who provide services or support related to administrative or healthcare services provided to a member of any MHHP Plan.

Disclosure/Approval of Relationships Outside of the United States

Providers must obtain MHHP's written approval regarding relationships with Downstream Entities/Vendors. MHHP must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicare member-protected health information in oral, written or electronic form. For more information regarding relationships with vendors please visit: <http://healthplan.memorialhermann.org/compliance/fdr/>

Reporting of Suspected or Detected FWA

Providers should report any instances or serious suspicions of FWA to MHHP as soon as they become known. Memorial Hermann Health Plan maintains confidentiality to the extent possible, allows anonymity if desired, and ensures non-retaliation against those who report suspected misconduct in good faith.

The Memorial Hermann Corporate Compliance and Ethics Hotline is:

713-338-4140
877-448-4140

An online form is available at:

<http://healthplan.memorialhermann.org/compliance/providers/>

You may contact us in writing at:

**Memorial Hermann Health Plan Compliance/Fraud
Department
929 Gessner Road
Suite 1500
Houston, Texas 77024**

Policies and Procedures

Providers should ensure they have policies and procedures for preventing, detecting, correcting and reporting FWA in place, including:

- Requiring their employees and downstream entities to report suspected and/or detected FWA
- Safeguarding MHHP's confidential and proprietary information at all times
- Providing accurate and timely information and data to MHHP in the regular course of business
- Screening all employees and downstream entities against federal government exclusion lists, including the Office of Inspector General (OIG) list of Excluded Individuals and Entities and the General Services Administration (GSA) Excluded Parties Lists System. Any person listed on one or both of these lists is not eligible to support MHHP's Medicare Advantage and Prescription Drug plans and must be removed immediately from providing services or support to MHHP, who must be notified upon such identification.

Cooperation

Providers must cooperate fully with any investigation of alleged, suspected or detected violations of this manual, MHHP policies and procedures or applicable state or federal laws or regulations or remedial actions.

Administration and Compliance Training

Providers shall require their employees and all downstream contractors to undergo annual compliance and FWA training and should be able to document to MHHP that these training requirements have been met; and a system is in place to collect and maintain records of compliance and FWA training for a period of at least 10 years.

Disciplinary Action

Providers must institute disciplinary standards and take appropriate action upon discovery of FWA or actions likely to lead to FWA and report these actions to MHHP in a timely manner. In addition, the provider must publicize these disciplinary standards to their employees and downstream entities.

Conflicts of Interest

All providers, their employees and downstream entities must avoid conflicts of interest. Providers should never offer or provide anything of value, including but not limited to, cash, bribes or kickbacks to any MHHP associate, representative or customer or government official in connection with any MHHP procurement, transaction or business dealing. This prohibition also applies to any family members or significant others.

Providers must obtain conflicts of interest statements from all employees and Downstream Entities within 90 days of hire or contract and annually thereafter. This statement must certify that the employees or downstream entities are free from any conflict of interest that would prevent them from administering or delivering Medicare benefits or services. All providers must review potential conflicts of interest and either remove the conflict or, if appropriate, obtain approval from affected parties to continue work despite the conflict.

MHHP reserves the right to obtain certification from all providers and require that certification conflicts be removed, or that the applicable individuals or entities be removed, from supporting MHHP.

Providers are prohibited from having any financial relationship relating to the delivery of or billing for covered services that:

- Violate the federal Stark Law, 42 U.S.C. § 1395nn, if healthcare services delivered in connection with the relationship were billed to a federal healthcare program or would violate comparable state laws
- Violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if healthcare services delivered in connection with the relationship were billed to a federal healthcare program or would violate comparable state laws
- In the judgment of MHHP, could reasonably be expected to influence a provider to utilize or bill for covered services in such a way that is inconsistent with professional standards or norms in the local community.

Providers are subject to termination by MHHP for violating this prohibition. MHHP reserves the right to request such information and data, as it may be required to certify ongoing compliance with these provisions.

Expression of Compliance Concerns

The cornerstone of this manual is the expectation that all providers and support staff members feel free to report compliance concerns to MHHP or applicable regulatory authorities without fear of reprisal or disciplinary action. Providers and their staff are expected to report any compliance concerns they may have, including activity by another employee, physician or contractor that appears to violate applicable laws, rules, regulations or this manual.

Providers are also encouraged to submit suggestions on ways to improve MHHP's compliance programs. MHHP will not take, nor allow, reprisals or disciplinary action against anyone solely because they express a compliance concern.

How Providers Should Express a Concern

There are several alternatives for reporting compliance concerns. They include MHHP's toll-free hotlines and other mechanisms that should be equally effective and allow providers to report a concern anonymously.

Call the Memorial Hermann Corporate Compliance and Ethics Hotline at:

Phone: 713-338-4140

Phone: 877-448-4140

Report potential or actual non-compliance through an online form at (you may report anonymously using the form):

<http://healthplan.memorialhermann.org/compliance/providers/>

A provider may also report a compliance concern directly to the Compliance Department at fax number 713-338-4151 or email address:

mhhealthsolutionscompliance@memorialhermann.org

Should you wish to remain anonymous, you may send your concern in writing to the address below, marking the envelope "Confidential".

**Memorial Hermann Health Plan Compliance - FWA
Department
929 Gessner Rd., Suite 1500
Houston, TX 77024**

While formal submission of a compliance concern report is the preferred method of expressing a concern or complaint, a written explanation or verbal report (even one made anonymously over the telephone) is acceptable. Upon receipt, a reported compliance concern will be documented by the MHHP Compliance Department and will include a summary and a preliminary analysis of the issue.

In the event the compliance concern is determined to present a significant issue with respect to compliance, a special meeting of the Compliance Committee will be held.

Anonymity

MHHP will strive to keep the reporting provider or staff member's identity confidential but, despite its best efforts, there may be instances where the individual's identity will become known or may have to be revealed.

An assertion of FWA by an employee who may have participated in the activities being reported raises numerous complex legal and management issues that must be examined on a case-by-case basis. MHHP personnel will be admonished to work closely with legal counsel to ensure that the rights of the reporting person, as well as those of the provider organization, are protected during the investigation and ultimate resolution of such issues.

Violations and Investigations

Failure to comply with applicable federal or state laws, rules, regulations and program instructions threatens MHHP and its subsidiaries' status as reliable, honest and trustworthy organizations.

Detected, but uncorrected, misconduct can seriously endanger the mission, reputation and legal status of this organization. Consequently, upon receiving a report or becoming aware of suspected non-compliance, the Compliance Department and the Compliance Officer will promptly investigate the conduct in question. If a violation has occurred, steps will be taken to correct the problem. They may include a referral to criminal and/or civil law enforcement authorities, a report to the government and/or a corrective action plan.

Disciplinary Actions for Failure to Follow Compliance Policies

An effective compliance program depends upon providers and their staffs fulfilling their duties and responsibilities. Physicians, managers, supervisors and support staff will be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, laws and procedures that are within the scope of their job duties and responsibilities.

Cooperation with Investigations

All providers are expected to cooperate in any investigation conducted by a government regulatory agency or a Medicare Administrative Contractor. Similarly, cooperation is required for internal investigations whether conducted by MHHP staff or an outside firm.

It is a violation of this manual to hide, alter, destroy or otherwise modify or withhold documents subject to an investigation. During a government inquiry, never conceal, destroy or alter documents or lie or mislead the government representative. Do not prevent any other employee or agent of MHHP from providing accurate information or obstruct, divert or delay the communication of information or records to which government authorities may be entitled.

Compliance Training and Education

Training and education are important parts of MHHP's compliance efforts. It is the policy of MHHP to require each provider to require training and educational programs for all of its employees, staff and contractors. People providing the training shall be knowledgeable about the subject area. Training may be provided through a variety of sources (e.g., CME classes, hospitals, associations and carriers), as well as appropriate computer-based training approaches, which shall include:

- Reviewing departmental recommendations for standardized medical records for submission to the provider's governing body
- Developing and maintaining a system to solicit, evaluate and respond to complaints and problems
- Making appropriate recommendations to the provider's governing body on revisions and improvements to the program, any disciplinary actions related to the compliance program, conducting periodic audits internally or by a consulting firm with expertise in compliance programs, a compliance program budget and the salary and status of a Compliance Officer.

Background and Exclusion Policy

Subject to applicable laws, it is MHHP's policy to prohibit providers from employing individuals who have been recently convicted of a criminal offense related to health care or who are listed as excluded or otherwise ineligible for participation in federal healthcare programs. Such individuals or contractors shall be deemed "ineligible persons" for purposes of employment or contractual relationships with compliance implications.

To the extent known, MHHP will not execute contracts with companies that recently have been convicted of a criminal offense related to health care or that are listed by a federal agency as excluded or otherwise ineligible for participation in federal healthcare programs.

In addition, MHHP requires providers to conduct background checks for all professionals, including a screening by:

- The HHS/OIG List of Excluded Individuals/Entities (available at <http://oig.hhs.gov>)
- The General Services Administration's List of Parties Excluded From Federal Programs (available at <http://www.sam.gov/portal/SAM#1>)
- Any other database or source deemed appropriate by the provider.

Collectively, all of the above are referred to as the "**Exclusion Lists**."

MHHP screens all new provider applicants against the Exclusion Lists prior to admitting them in a MHHP plan and, as part of the contracting process, shall require such persons to disclose whether they are an "Ineligible Person." MHHP periodically shall screen all current providers against the Exclusion Lists.

All providers and contractors should implement a program to immediately disclose any debarment, exclusion, suspension or other event that makes that person an ineligible person under applicable laws.

Removal Requirement

Once MHHP has actual notice that an employee or contractor of a provider has become an ineligible person, MHHP shall remove such person from responsibility for, or involvement as, an approved provider business operation related to the federal healthcare programs and shall remove such person from any or all provider panels or plans.

Pending Charges and Proposed Exclusions

If MHHP has actual notice that a screened person is charged with a criminal offense that falls within the scope of 42 U.S.C.1320a-7(a), 1320a-7(b)(1)-(3), 31 U.S. Code § 3729 or is proposed for exclusion during his/her provider contract term, MHHP shall take all appropriate actions to ensure that the responsibilities of that person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient or resident or the accuracy of any claims submitted to any federal healthcare program.

Section 12: HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) seeks to reduce healthcare administrative costs, protect individuals' privacy and insurability and enhance measures to limit fraud and abuse. The act contains several components mandating continuing health benefit coverage in certain situations, privacy, electronic data submission and code sets and medical record security.

MHHP strives to be in full compliance with all applicable state and federal requirements to protect our members' confidential information. You, as a provider, play a vital role in protecting the privacy and security of patient information. MHHP expects you to do your part to remain HIPAA compliant and protect members' sensitive information.

The Department of Health and Human Services (HHS) expects plans and providers to:

- Notify patients about their privacy rights and how their information can be used
- Adopt and implement privacy procedures for its practice, hospital, or plan
- Train employees so that they understand the privacy procedures
- Designate an individual to be responsible for seeing that the privacy procedures are adopted and followed
- Secure patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

HIPAA gives flexibility for providers and plans to create their own privacy and security procedures, tailored to fit their size and needs. For example:

- The privacy official at a small physician practice may be the office manager, who will have other non-privacy related duties; the privacy official at a large health plan may be a full-time position, and may have the regular support and advice of a privacy staff or board
- The training requirement may be satisfied by a small physician practice's providing each new member of the workforce with a copy of its privacy policies and documenting that new members have reviewed the policies; whereas a large health plan may provide training through live instruction, video presentations, or interactive software programs
- The policies and procedures of small providers may be more limited under HIPAA than those of a large hospital or health plan, based on the volume of health information maintained and the number of interactions with those within and outside of the health care system.

If you have any questions or concerns, or need to report a HIPAA breach please contact Compliance at 713-338-6357 or via email at:

mhhealthsolutionscompliance@memorialhermann.org

Calls are answered during normal business hours Monday through Friday (CST).

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