2023

PROVIDER MANUAL

MEMORIAL HERMANN Health Plan

2023 Volume 2

Introduction

Memorial Hermann Health Plan on behalf of Memorial Hermann Health Solutions, Inc., Memorial Hermann Insurance Company, Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Plan, Inc. (collectively “MHHP”) welcomes you to the MHHP network of participating providers. This provider manual is designed to help participating providers understand MHHP’s policies, procedures, and protocols.

Providers are independent providers of health services and solely responsible to members for the delivery and quality of health services. 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 (800) 429-6396 or providerservices@apex4health.com. Calls are answered from 8 a.m. to 5 p.m., Monday through Friday (CST).

Thank you for your participation.

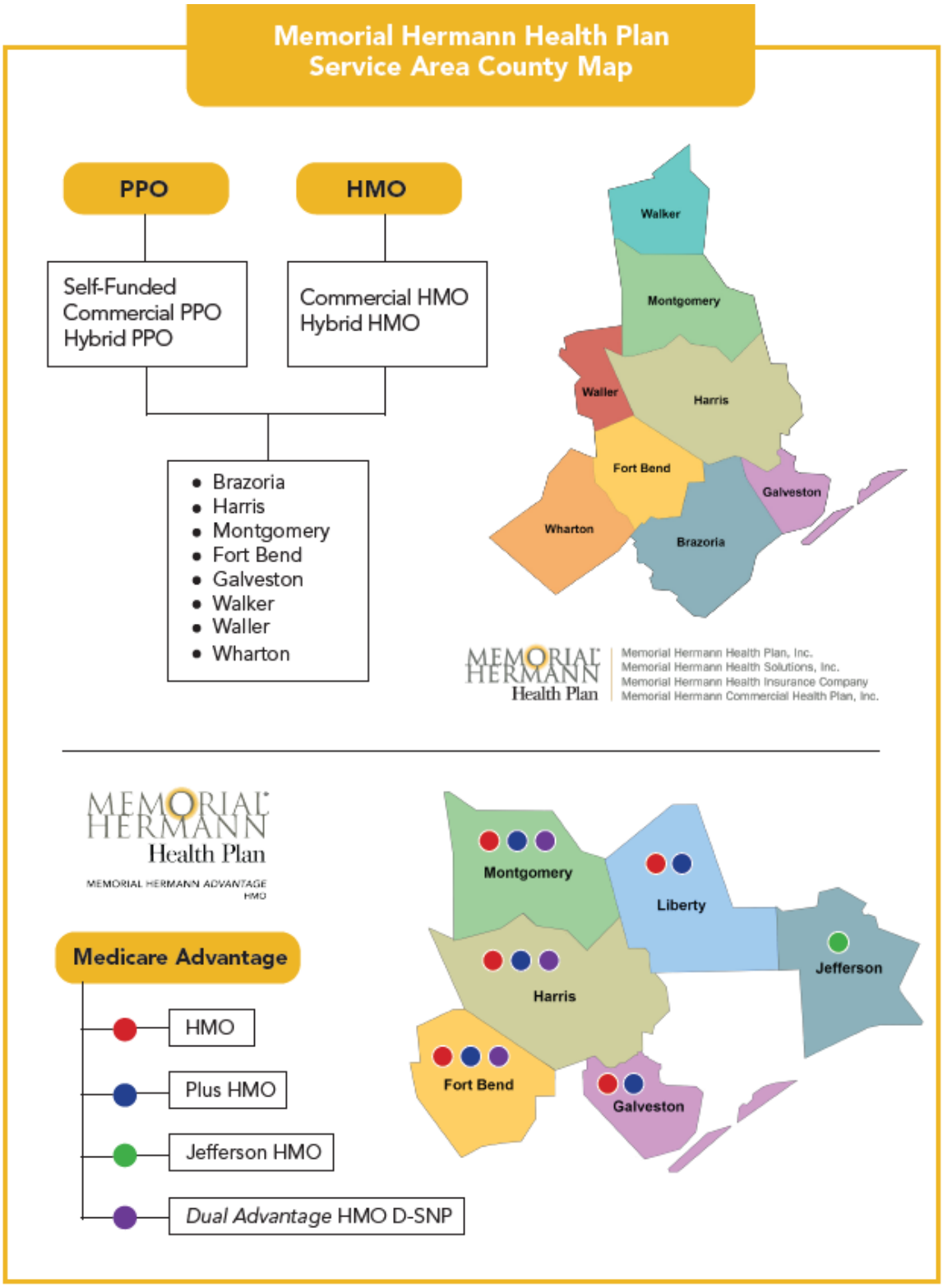
Contents

General Information

How to Contact Memorial Hermann Health Plan

Health Plan Mailing Address	**Memorial Hermann Health Plan** **929 Gessner Rd Ste 1500** **Houston, TX 77024-2317**
Claims Address	**Memorial Hermann Health Plan** **Attn: Claims Department** **929 Gessner Rd Ste 1500** **Houston, TX 77024-2317**
Provider Relations	**(800) 429-6396** **Providerservices@apex4health.com**
Provider Services	**(855) 645-8448** ***follow prompts***
Medical Management **Commercial Prior Authorization** **Fax (713) 338 6494**	**(855) 645-8448** ***follow prompts*** **Medicare Advantage/D-SNP Prior Authorization** **Fax (713) 338-6982** **ALL Hospitalizations & Post-Acute Requests** **Fax (713) 338 6381**
Member Services	**(855) 645-8448** ***follow prompts***
Behavioral Health	**Optum BH (888) 280-3557**
Pharmacy **Commercial** **Navitus Health Solutions** **(866) 333-2757**	**Medicare Advantage** **Navitus Health Solutions** **(866) 270-3877**
Pharmacy Appeals **Commercial** **Navitus Health Solutions** **(866) 333-2757** **Fax (855) 673-6507**	**Medicare Advantage** **Navitus Health Solutions** **(866) 270-3877** **Fax (844) 268-9791**
MHHP Appeals and Grievances	**(855) 645-8448** ***follow prompts*** **Fax (713) 704-0884**
TDD/TYY Services	**711 (800) 947-3529**

Service Areas



Member Rights and Responsibilities

Members have rights and responsibilities when covered by MHHP. Member Services representatives serve as advocates for MHHP members.

Members have the right to:

- Be treated respectfully and with due consideration for dignity and privacy.
- Have privacy during a visit with their doctor.
- Talk about their medical record with their provider, ask for a summary of that record and request to amend or correct the record as appropriate.
- Be properly educated about and helped to understand their illness and available health care options, including a candid discussion of appropriate clinically or medically necessary treatment options, including medication treatment options regardless of the cost or benefit coverage.
- Participate in decision-making about the health care services they receive.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint, seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time regarding the kinds of care they want if they become sick, injured or seriously ill by making a living will.
- Expect their records (including medical and personal information) and communications will be treated confidentially.
- If under age 18 and married, pregnant or have a child, be able to make decisions about his or her own health care and/or his or her child's health care.
- Choose their PCP or specialist from the MHHP network of participating providers.
- Make a complaint to MHHP and get a response within 30 days.
- Have information about MHHP, its services, practitioners, and providers and member rights and responsibilities.
- Receive information on the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).
- Get a current Member Handbook and a directory of health care providers within the MHHP network.
- Be referred to health care providers for ongoing treatment of chronic disabilities.
- Have access to their PCP or Specialist or a backup 24 hours a day, 365 days a year.
- Receive immediate care from any hospital when their medical condition meets the definition of an emergency.
- Receive post-stabilization services following an emergency condition in some situations.
- File a grievance or appeal if he/she is not happy with the results of a grievance and received acknowledgement within 30 days.
- Ask MHHP to reconsider previously denied coverage; upon receipt of the member's medical information, MHHP will review the request.

- Freely exercise the right to file a grievance or appeal such that exercising of these rights will not adversely affect the way the member is treated.
- Receive notification to present supporting documentation for their appeal.
- Examine files before, during and after their appeal.
- Request an administrative hearing when dissatisfied with the MHHP's decision.

Members have the responsibility to:

- Treat their providers, their providers' staff and MHHP employees with respect and dignity.
- Not behave in a disruptive manner while in the provider's office.
- Respect the rights and property of all providers.
- Cooperate with people providing health care.
- Tell their provider about their symptoms and problems and ask questions.
- Get information and consider treatments before they are performed.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Discuss anticipated problems with following their provider's directions.
- Consider the outcome of refusing treatment recommended by a provider.
- Follow plans and instructions for care they have agreed on with their providers.
- Help their provider obtain medical records from the previous provider and help their provider complete new medical records as necessary.
- Supply information (to the extent possible) to MHHP and its practitioners and providers need to provide care.
- Respect the privacy of other people waiting in providers' offices.
- Call MHHP to change their PCP selection before seeing a new PCP.
- Make and keep appointments and arrive on time; members should always call if they need to cancel an appointment, change an appointment time or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their provider how they want to receive their health information.
- Learn and follow MHHP's policies outlined in the Member Handbook.
- Read the Member Handbook to understand how MHHP works.
- Notify MHHP when a member or family member who is enrolled in MNHHP has died.
- Be involved in their health care and cooperate with their provider(s) about recommended treatment.
- Learn the correct method by which his or her medications should be taken.
- Carry his or her MHHP ID card at all times and quickly report any lost or stolen cards or information changes to MHHP; members should contact MHHP if information on the ID card is wrong.
- Show their MHHP and other applicable insurance ID cards to each provider.
- Tell MHHP about any providers they are currently seeing.
- Provide true and complete information about their circumstances.
- Report change(s) in their circumstances.
- Notify his or her PCP as soon as possible after they receive emergency services.
- Go to the emergency room only when they have an emergency.
- Report suspected fraud and abuse.

MHHP Pharmacy Information

MHHP utilizes the Pharmacy Benefit Manager (PBM) Navitus Health Solutions for Commercial and Medicare Advantage products. Navitus Health Solutions 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 at the following websites:

PRODUCT	FORMULARY LINK
All Commercial Products	2022 Comprehensive Drug Formulary
Medicare *Advantage* HMO	Navitus Medicare *Advantage* HMO Formulary
Medicare *Advantage* HMO *PLUS*	Navitus Medicare Advantage HMO Plus Formulary
Medicare *Advantage* HMO Jefferson	Navitus Medicare *Advantage* HMO Jefferson Formulary
Medicare *Dual Advantage* HMO D-SNP	Navitus Medicare *Dual Advantage* HMO D-SNP Formulary

Providers should obtain prior authorization for non-formulary drugs by contacting Navitus.

- For Commercial Members call (866) 333-2757
- For Medicare *Advantage* Members call (866) 270-3877

Commercial Members and Medicare Advantage members also have a mail order prescription drug benefits available for maintenance medications. Members can contact the Navitus Health Solutions Customer Services phone number on their ID card for additional information.

Formulary Disclaimer: Coverage for some drugs may be limited to specific dosage forms and/or strengths. The benefit design determines what is covered and the applicable co-payment. The medications listed on this formulary are subject to change pursuant to the formulary management activities of Navitus Health Solutions. The presence of a medication on the formulary list does not guarantee coverage. To determine the most up-to-date formulary status, please visit the Navitus Provider website or call Navitus member services at the number listed on the Member's ID card.

Commercial Pharmacy Appeals

A commercial pharmacy appeal can be submitted within 180 days from the date of the notice of adverse coverage determination. To start a commercial pharmacy appeal, submit a please call (866) 333-2757.

Medicare Advantage Pharmacy (Part D) Appeals

A pharmacy appeal (request for redetermination) can be submitted within 60 days from the date of the notice of the adverse coverage determination (date printed or written on the notice). Additional information regarding Medicare Advantage Pharmacy Appeals can be found on the MHHP Part D Appeals website.

To start an online pharmacy appeal, submit a Part D Redetermination form online. The completed Part D Redetermination form can also be mailed or faxed to:

Memorial Hermann Health Plan
C/O Navitus Health Solutions, LLC
Attn: Appeals
P.O. Box 1039
Appleton, WI 54912-1039
Fax: 844-268-9791

Appeals and Grievances

An appeal is a request to MHHP 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. For appeals related to pharmacy services refer to the MHHP Pharmacy Information section of this Provider Manual starting on page 11. For appeals related to behavioral health services contact Optum Behavioral Health at (888) 280-3557.

Adverse Determination Appeals

Members or a person acting on behalf of a member, including a provider, may request an appeal when MHHP denies a request for an item or service in whole or in part ("Adverse Determination"). A Member or person acting on behalf of a member, including a provider, can appeal the decision if a service was denied, reduced, or ended early. The reconsiderations process is for Adverse Determinations: denial, reduction, termination, or failure to make payment (in whole or in part) of a benefit.

Scenarios that fall under the Adverse Determination Appeals Process include, but are not limited to, the following:

- Service does not meet, or no longer meets, the criteria for medical necessity, based on the information provided to MHHP;
- Service is considered to be experimental or investigational;
- Service is approved, but the amount, scope or duration is less than requested;
- Service was approved but the authorization is expired;
- Services were not approved;
- Service is not a covered benefit under the member's benefit plan; or
- Service is a covered benefit under the member's benefit plan, but the member has exhausted the benefit for that service

Claim Appeals

A claim appeal is a formal request from a provider for reconsideration of a claim already processed by MHHP. The provider must submit a formal written appeal request on behalf of a members for reconsideration of a claim within 180 days from the date on the Explanation of Payment ("EOP") for commercial members and 60 days from the date on the EOP for Medicare Advantage members, along with the Claim Appeal Form, a copy of the claim and any supporting documentation. The claim appeal form is available on the MHHP website at Appeal Reference form and can be submitted via fax to (713) 704-0884 or via mail to:

Memorial Hermann Health Plan
Attention: Appeals and Grievances Department
929 Gessner Road, Suite 1500
Houston, TX 77024

Initiating An Appeal

To file an Adverse Determination or a Claim appeal complete the Adverse Determination Appeal Request Form found on the website along with the information listed below and fax to (713) 704-0884 or mail to:

Memorial Hermann Health Plan
Att: Appeals and Grievances Department
929 Gessner Road, Suite 1500
Houston, TX 77024

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

- A complete Adverse Determination Appeal Request form located online
- The specific reason for the reconsideration request; and
- Additional information or documentation to support the request.

If applicable, also include the following:

- Authorization/Referral number
- Copy of the claim
- Copy of the original EOP

MHHP will notify the provider if additional information is required complete the review of the appeal. The will receive notification of the appeal decision in writing within 30 days or the time frames specified below via an EOP, Remittance Advise or resolution letter.

Second Level Appeal

If a Provider is not satisfied with the decision of the Appeals and Grievances Department, the provider may submit a second level appeal. Please indicate that the request is a second level appeal in the Additional Comments section of the Adverse Determination Appeal Form. The second level appeal should include any initial determination that confirms the reason for your appeal.

MHHP will provide a determination within 30 days of receipt of the appeal. Requests for a second level appeal must include the same information as presented for the initial appeal, 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 date on the notification to the provider regarding the initial determination of the Appeals and Grievances Department. Second level appeals will be reviewed according to the standard policy and process of MHHP for all products.

Second Level Appeal Medicare Advantage Specific Provisions

If a Provider is not satisfied with the decision of the Appeals and Grievances Department regarding a Medicare Advantage member, the provider may request to have the appeal case is sent to the Independent Review Entity (IRE) within 60 calendar days of receipt of the initial appeal decision. If

the IRE reverses the initial decision on a claim appeal, MHHP shall reprocess the claim within 30 calendar days of receipt of the IRE notice of reversal.

Untimely Appeal

If an appeal request is filed after the appeal time limit, MHHP may extend the time limit if good cause is shown by the provider. MHHP will resolve the issue of whether good cause exists before taking any other action on the appeal.

Good cause may be found when the record clearly shows, or the provider 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 appeal was furnished by MHHP to the provider; or
- Unavoidable circumstances that prevented the provider from timely filing a request for appeal. Unavoidable circumstances encompass situations that are beyond the provider's control, such as major floods, fires, tornados, and other natural catastrophes.

Note: Failure of a billing company or other consultant that the provider has retained to timely submit appeals or other information is NOT grounds for finding good cause for late filing of an appeal. MHHP 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.

Grievances

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.

MHHP 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 MHHP's receipt of the grievance
Expedited grievance review	Respond within 24 hours of MHHP's receipt of the grievance

Claims

Claims Filing Deadline

Fully Insured Commercial Claims

The Texas Department of Insurance ("TDI") regulations stipulate a claim filing deadline of 95 days, which may only be extended by the Participation Agreement. TDI regulations override any contractual provision in the Participation Agreement that provide for a shorter filing deadline.

Self-Funded Commercial Claims

Self-funded/ERISA plan requirements are outlined in the Provider Agreement.

Medicare Advantage Claims

Claims must be received no later than 1 calendar year from the date of service or as stipulated in the Provider Agreement.

Timeliness of Claims Submission

Providers forfeit payment for claims not filed within the specified deadline and claims filed after the specified deadline will be denied with no appeal rights. For claims that include span several dates of service, filing timeliness is determined as follows:

- The "through date" on the UB claim form is used to determine the date of service for institutional claims
- The "from date" on the HCFA claim form is used to determine the date of service for professional claims

For claims involving coordination of benefits with other insurance carriers or government programs, filing timeliness is determined from the date of the other insurance carriers EOP or remittance advice from Medicare. A copy of the primary carrier's EOP or remittance advice must be submitted to MHHP with the claim.

Claims Address

Claims should be submitted electronically or mailed to the address on the member's ID card. MHHP does not accept claims via fax.

Medical Claims		
Electronic		**Paper**
Clearinghouse	Payer ID	All Products
Availity/THIN	MHHNP	Memorial Hermann Health Plan Attn: Claims Department 929 Gessner Rd Ste 1500 Houston, TX 77024-2317

Dental Claims - Liberty Dental		
Electronic		**Paper**
Clearinghouse	Payer ID	LIBERTY Dental Plan
Change Health Care	CX083	Attention Claims
Dental Xchange	CX083	P.O. Box 401086
Tesia	CX083	Las Vegas, NV 89140

Behavioral Health Claims - Optum Behavioral Health		
Electronic		**Paper**
Clearinghouse	Payer ID	Optum Behavioral Health Claims
Availity/THIN	87726	P.O. Box 30757
WebMD/Emdeon	87726	Salt Lake City, UT 84140

Clean Claim Requirements

A clean claim includes all the data elements specified by the Texas Department of Insurance ("TDI") in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate, and complete. 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.

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.

For Medicare *Advantage*, a claim is considered a clean claim if it has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment

that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Healthcare providers must submit claims to the plan as outlined above and/or in the Provider 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 and not billed for the services by the provider.

MHHP's clearinghouse may not refuse to process 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."

National Provider Identifier (NPI)

The NPI is a 10-digit intelligence-free numeric identifier. All MHHP participating providers must have an NPI number and must include the NPI number on the claim.

Coding and Bundling Guidelines

MHHP uses standard claim guidelines that are current as of the date the claim is processed. These guidelines have been developed in part using such references as including, but not limited to, the AMA position statements from its official publication "CPT assistant," which is published monthly; other official AMA publications, such as "CPT changes" which is published annually; Medicare Guidelines, which are 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. MHHP also utilized industry standard claim editing software in the evaluation of a claim.

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", "up-coding", 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.

Changes to the original claim for any reason must be supported by documentation in the member's medical record. 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 member's 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 up-code claims improperly. In addition, all compensation

arrangements with physicians on the provider's staff must comply with "Stark II" regulations and applicable state laws.

HCPCS and CPT Codes

Current HCPCS and CPT Codes must be used since many changes are made to these codes annually. Current HCPCS and CPT Code 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's address must be a physical address that equates to Box 33 on the CMS 1500 form. As an 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 9 digit ZIP code (Zip Code+ 4). Claims submitted to MHHP without a valid ZIP code+ 4 will be rejected and returned to the provider. 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.

Electronic Claim Filing Requirements

Electronic claims filing is preferred but if provider must file a non-electronic claim, use of the current standard UB-04 or CMS-1500 (02/12) claim form is required.

Providers must submit a clean claim as specified in the Clean Claim Requirements section of this Provider Manual.

The following section applies only in the event MHHP requires Provider to submit any of the following electronically:

- 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 only to contracted providers for fully insured commercial claims. It is applicable to non-contracted providers for fully insured HMO

and PPO claims in the 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 by TDI, 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:

- 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.
- 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).
- Demonstrable undue hardship, including fiscal or operational hardship.
- 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.

MHHP shall issue a waiver or denial of a waiver in writing to Provider within 14 calendar days of receipt of a waiver request from a provider. 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 of notice from MHHP, appeal the waiver determination with TDI. The request for appeal and accompanying documentation shall be sent to the following:

Texas Department of Insurance
Deputy Commissioner, HMO Division
P.O. Box 149104
Austin, TX 78714-9104

and to MHHP at

Memorial Hermann Health Plan
Attn: Claims Department
929 Gessner, Ste 1500
Houston, Texas 77024

The following information must be included in the appeal:

- Provider's initial request for a waiver sent to MHHP, including the documentation required by subsection (D) of this section;
- The waiver determination received from MHHP;
- Any additional documentation supporting issuance of a waiver or removal of restrictions, conditions or limitations of a granted waiver; and
- 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:

- Documentation supporting the waiver determination issued to the physician or provider; and
- 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, TX 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.

Claim Requirements for Professional Services

- **Correct Coding -** Use the appropriate CPT, HCPCS and ICD codes including appropriate modifiers on all claims.

- **National Drug Code (NDC) Billing Guidelines for Professional Claims -** MHHP requires 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 professional providers for filing claims.

- **Return of Claims with Missing NPI Number** - 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 the billing provider's NPI number in block 33 on the standard CMS-1500 (02/12) claim form.

Claim Requirements for Institutional Services

- **UB-04 Claim Form** - The electronic ANSIX12N 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.

- **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 additional information from the provider in order to adjudicate the claim. All claims must include all information necessary for adjudication of claims.

- **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 services 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 Institutional claims require the appropriate occurrence code and the date(s) of service.

Medical Review of Claims

Complex claims are evaluated by MHHP's Medical Management Department 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 Management may approve the billed services for processing, request additional documentation and/or recommend denial of payment of specific services.

The EOP will include the details of the medical review determination. Providers may request an appeal in accordance with the Appeals and Grievances section of this Provider Manual.

Reimbursement

This section provides information about claim pricing and reimbursement, including MHHP payment, recovery of excess payment, third-party liability and coordination of benefits.

Certification, Payment Determination and Explanation of Payment (EOP)

The Claims system determines the member's eligibility, benefit coverage and if the services required a prior authorization.

If one or more service on the claim lacks a required prior authorization the claim will be reviewed retrospectively upon appeal for benefit approval based upon the terms in the member's Evidence of Coverage or Certificated of Coverage (collectively "EOC/COC"). Benefit verification of treatment or services or a determination of medical necessity based upon criteria in the applicable EOC/COC does not guarantee payment and is subject to review upon appeal.

Once a claim is determined to be payable, the maximum allowable amount is determined from the provider's Participation Agreement for participating providers or the maximum allowable amount as determined by MHHP for non-participating 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 allowed amount and payment and the member's responsibility; and/or non-payment, reason for denial or additional information that may be required.

Member Liability for Covered Services

The only charges for which the member may be liable for and for which provider may bill the member are:

- Deductibles, copayments and coinsurance amounts as specified in the member's EOC/COC; or
- Medical services not covered by the member's EOC/COC where the member has specifically agreed in advance, in writing, to accept financial responsibility as further described on page 30 of this Provider Manual.

If the member's plan includes a deductible, the deductible must be met before additional 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 responsible for paying any applicable copayments 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 MHHPEOP.

To determine the member's financial responsibility (i.e., the copayment amount or whether any required deductible has been satisfied), contact Member Services at the toll-free number listed on the member's ID card. The information is valid only as of the time the information is provided and is subject to 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

Providers may not charge a member for medical services denied as not medically necessary under the member's EOC/COC 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 from the member exceed the member's responsibility, the 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 or receipt of the EOP.

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 EOC/COC was issued.

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

Unsolicited Refunds

Providers have the responsibility to report “unsolicited” overpayments or improper payments to MHHP. Providers must issue a refund to MHHP within 60 days from the date of the “unsolicited” overpayments or as required in the Provider Agreement.

Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the EOP or remittance advice along with affected claims identified), to the following address:

Memorial Hermann Health Plan
Attn: Claims Department
929 Gessner Road, Suite 1500
Houston, TX 77024

Overpayment and Recovery Procedures

In the event of MHHP determination that an overpayment has been made, MHHP may seek recovery of all excess payments from the payee to whom the MHHP check was made payable including, but not limited to, recoupment or off-sets against future payments to payee.

If the payee disagrees with the overpayment, the payee may contact MHHP in writing at:

Memorial Hermann Health Plan
Attn: Claims Department
929 Gessner Road, Suite 1500
Houston, TX 77024

Provider or payee should contact Provider Services with any questions concerning overpayment recovery. In the event the terms of the provider’s Participation Agreement or state or federal laws or regulations differ from the process outlined above, the terms of the Participation Agreement or state or federal laws or regulations will prevail.

Credentialing and Recredentialing

Prior to acceptance into the MHHP network, providers 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 MHHP network participation has been terminated or suspended. Providers have the right to review information obtained by MHHP for evaluating the practitioner's credentialing application and completing primary source verification credentialing, be informed of the status of the credentialing application, and to revise any incomplete, inaccurate, or conflicting credentialing information.

Credentialing Standard

The credentialing standards are in compliance to NCQA credentialing standards and state and federal laws and regulations as prescribed by the state of Texas and CMS:

- The Texas Standardized Credentialing Application or CAQH application is required for the credentialing and recredentialing of providers.

- MHHP has a documented process for selection and retention of contracted providers and providers. The credentialing process complies with NCQA or American Accreditation HealthCare Commission, Inc., standards, to the extent that those standards do not conflict with the laws of the state of Texas. MHHP has a documented process for expedited credentialing of providers, including a documented process for payment of claims during an expedited credentialing process, in compliance with Insurance Code Chapter 1452.

- Delegation of Credentialing. If MHHP delegates the credentialing functions to other entities, the delegated entity's credentialing process must comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of the state of Texas.

Criteria

The health plan utilizes a selective criteria to ensure that providers who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Must have applicable, current and unencumbered licensure in the state of practice as required by state and federal entities.
- Must have a current, valid, and unrestricted federal DEA Provable training in the requested practice specialty.
- Must maintain current malpractice coverage with limits commensurate with the community standard in which practitioner practices.
- Practitioners must be a participating provider in Medicare and have a Medicare number and/or a National Provider Identification number to participate in the Medicare Advantage network.
- Provider cannot be excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

Application Process

Once a provider is approved by the MHHP Network Access and Adequacy Committee (NAAC) to participate in MHHP's network, the provider must complete the TSCA or the CAQH application.

Provider's applications are reviewed by the Credentialing Committee, which meets at least quarterly. The Credentialing Committee will provide formal notification to the provider of the credentialing decision. All final decisions concerning credentialing of a provider are made by the Credentialing Committee.

Practitioners

The verification of credentials and documentation, may include the following 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
- Proof of malpractice insurance

Ancillary Services/Facility

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

- Proof of license to operate
- 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
- Notification if the applicant provides workers compensation

Recredentialing

In network providers must complete the recredentialing process at least once every 36 months. The provider must ensure that a current TSCA or a recently re-attested CQAY application is available to begin the recredentialing process at least 180 days prior to the expiration of the provider's current credentialing period or in a timeframe determined by MHHP as necessary.

Termination of Credentialing Status

A provider's credentialing status may be terminated at any time when information is obtained that indicates the provider no longer meets the minimum credentialing standards. The MHHP Credentialing Committee will decide ongoing credentialing status. Provider's MHHP network participation will be terminated if the provider no longer meet the minimum credentialing standards.

Any participating provider who is denied participation, suspension or terminated for cause by MHHP shall receive written notification within 10 business days of the decision, including the reasons for rejection, suspension or termination, by the MHHP Chief Medical Officer.

Credentialing 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 participation 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 race, gender, sexual orientation, gender identity, age religion/creed, disability, ethnic origin, marital status, or on type of procedures in which the practitioner specializes.

Any participating provider who is denied participation, suspension or terminated for cause by MHHP shall receive written notification within 10 business 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, Provider has a right to an appeal with individuals other than those members of the Credentialing Committee "Independent Review". An Independent Review will only be conducted upon written request from Provider. Provider is limited to two Independent Reviews. 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 business days of receipt of a request for Grievance Panel review, 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 scheduled 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 of the Grievance Panel hearing shall be sent to the provider, at the address shown on the application, by certified mail, return receipt request, inclusive of the place, time and date of the hearing. Within 30 days after receipt of the Grievance Panel review recommendations, the MHHP Credentialing Committee shall render its decision. The decision will be forwarded to the provider in writing by certified mail, return receipt requested. This notification will be approved and signed by the MHHP Chief Medical Officer.

Confidentiality

Information obtained during the credentialing or recredentialing process is confidential. All credentialing processes are privileged and confidential per federal law and state review laws.

Provider Responsibilities and Standards

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.

Checking Benefits and Eligibility

Each provider's office should have a system in place for identifying patient'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.

Providers should check the member's benefits and eligibility before providing care.

Checking benefits and eligibility:

- Helps ensure that you submit the claim to the correct payer
- Allows you to collect copayments
- Determines if a referral, prior authorization or notification is required; and
- Reduces denials for non-coverage.

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information.

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

- Provider Portal. To access the Provider Portal, click "Register" on the MHHP Provider Portal website. The Provider Portal User Manual and FAQs are located on the Provider Portal Training section of the MHHP website
- Call Member Services at the number on the member's ID card.

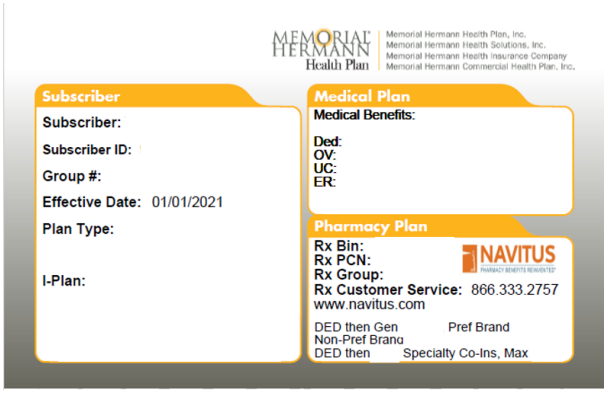
Providers should contact Member Services at the number on the member's ID card to verify benefits.

Providers contacting Member Services 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.

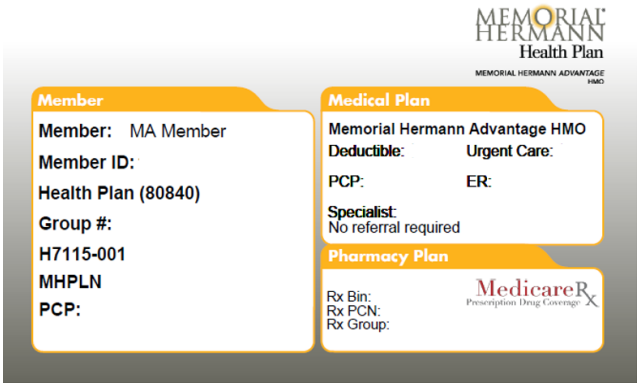
All MHHP members receive a MHHP ID card. Members should present their card when seeking medical services. Check the member's healthcare card at each visit and keep a copy of both sides of the card for your records.

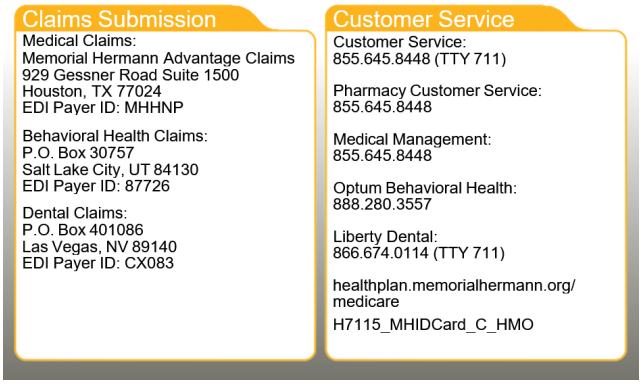
The following are **examples** of some ID cards used by MHHP.

Commercial:



Medicare Advantage:





Provider Responsibility for Notification of Change

Providers must notify MHHP of changes to the following 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
- Office hours
- Hospital Affiliations
- Specialty
- State License Number
- NPI number
- Additions or departures of providers or locations from a group practice or ancillary/facility group

Provider must notify MHHP of any changes in ownership, Tax Identifications Number (TIN), Federal Employer Identification Number (FEIN) or business entity name no less than 30 days prior to

the effective date of the change. Any changes to a provider's ownership, TIN/FEIN or W-9 will suspend provider's network participation status until approved in writing by MHHP.

The network participation status of any new providers to a group practice or new locations for Ancillary/Facility providers will be effective upon approval from MHHP and as of the date of successful completion of credentialing. Provider should complete a Request for Participation Form found on the MHHP website to start the approval process.

Failure to notify MHHP of any of the above changes may result in payment denials.

Requests for demographic changes must be submitted on the Provider Data Update Notification Form found in the provider resource center of the MHHP website. The notification must include the effective date of the change, and a W-9 form if the change involves TIN or business entity name change. Supporting documents should be sent by email to providerservices@apex4health.com or via fax (713) 338-4102. If requesting termination from a provider network, please refer to the Termination section of the Participation Agreement. Questions can be sent to Provider Relations at providerservices@apex4health.com.

MHHP Provider Resources

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

- Provider Portal Information: https://healthplan.memorialhermann.org/for-providers/resource-center/provider-portal-training
- Provider Portal: https://mhhp.healthtranzform.com/tzf/provider/uiprovider/
- Appeal Rights and Process: https://healthplan.memorialhermann.org/about-us/legal-notices/appeal-rights-and-process
- Provider Resource Center & Forms: https://healthplan.memorialhermann.org/for-providers/resource-center
- News and Updates: https://healthplan.memorialhermann.org/for-providers/resource-center
- Prior authorization list:
- https://healthplan.memorialhermann.org/for-providers/resource-center Fraud, Waste and Abuse: https://healthplan.memorialhermann.org/about-us/legal-notices/fraud,-waste-and-abuse-(fwa)
- Provider Newsletter: https://healthplan.memorialhermann.org/for-providers/resource-center/provider-newsletter

Provider Expectations

This section describes MHHP's expectations for providers:

- Provide care to members in a culturally competent manner, being sensitive to language, culture and reading comprehension capabilities.
- Freely communicate with members regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations.
- Utilize MHHP's participating providers and facilities.

Provider Responsibilities

Provider responsibilities include but are not limited to the following:

- 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 providers 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 network of participating providers (out-of-network providers).
- A provider must abide by MHHP's quality improvement, utilization management, credentialing, peer review, appeals, 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 prior to receiving services or within a reasonable time after receiving emergency services.
    - 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 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.

- Medical records for members must be maintained for a minimum of 10 years from the last date in which service was provided.
- The provider agrees to abide by MHHP rules and regulations and all other lawful standards, policies, rules and regulations.
- 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 MHHP, 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, change in eligibility for payment under Medicare and any other change that would affect his/her status with MHHP.
- The provider agrees to provide or assist MHHP in obtaining Coordination of Benefits/Third-party Liability information.

Primary Care Providers Responsibilities include but are not limited to:

- 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 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. Covering physician information should be sent to Provider Relations at providerservices@apex4health.com.
- Primary Care Physicians shall provide follow-up care to patients that have been in the hospital setting within ten (10) days of hospital discharge.
- All providers are required to actively promote and participate in all quality initiatives inclusive of any and all chart audits, patient preventive care, and patient satisfaction activities.
- Confirm member eligibility and benefits prior to rendering services.

Specialists Responsibilities include but are not limited to:

- Specialists must provide specialty services upon referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the patient is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for patients.
- Specialist are required to obtaining any required authorizations prior to rendering services. Specialists are required to coordinate referrals and authorizations with MHHP for further care that they recommend. This responsibility does not revert back to the PCP while the care of the patient is under the care of the Specialist.

- Specialists agree to participate in the health plans peer review activities as they relate to the Quality Management/Utilization Review program.
- Confirm member eligibility and benefits prior to rendering services.
- Provide a consultation report to the PCP within 60 days of the consult.
- Provide lab or hospital based providers with the prior authorization number and the member's ID number.

Institutional Providers Responsibilities include but are not limited to:

- Coordination of discharge planning with the Medical Management staff.
- Coordination of behavioral health and substance abuse care as required with MHHP, MHHP Vendors, state agency and other providers.
- Obtain the required prior authorization before rendering services including but not limited to authorization for continued length of stay for inpatient admissions.
- Communication of all pertinent patient information to MHHP and the PCP.
- Notification of all hospital admissions to the Medical Management staff within one business day of the admission.
- Confirm member eligibility and benefits prior to rendering services or within 1 business day for emergency services.

Ancillary Providers Responsibilities include but are not limited to:

- Confirm member eligibility and benefits before rendering services including but not limited to 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, the member's Specialist as applicable and the member's PCP.

Accepting New Patients

To the extent that provider is accepting new patients, provider must also accept new patients who are MHHP members. If provider decides to no longer accept new patients, Provider must notify MHHP in writing 45 days prior to closing his/her practice to new patients. In no event will an established patient of Provider be considered a new patient. If Provider's practice is closed to new patients, Provider is obligated to continue providing services to members receiving services at the time the practice is closed to new patients. Providers should send notification to Provider Relations at providerserivces@apex4health.com.

Provider Appointment Standards

MHHP has established the following access standards for member appointments with a provider:

Appointment Type	Access Standard
New Patient Visit	Within 30 days of request
Preventive Care with PCP & annual physical	Within 30 days of request
Routine Primary Care	Within 5 days of request
Urgent Care	Within 24 hours of request
Emergency Care • During Office Hours • After Office Hours	Immediate
After Hours Care • Urgent Care • Alternative Care	24 hours per day, 7 days per week
In Office Wait Time	Within 30 minutes of appointment time
Specialist Visit • Urgent Care • Routine Care	 • Within 5 days of request • Within 21 days of request

Definitions:

New Patient Visit: An initial visit to establish a patient-provider relationship with a primary care provider (PCP), specialty care provider or professional provider for non-urgent condition.

Preventive Care: A health evaluation, without medical symptoms, to prevent or screen for a disease for which there is an effective treatment when discovered in an early stage. Preventive Care may include recommended health screenings such as well-person exams and well-child exams.

Routine Care: Symptomatic non-routine medical care to treat symptoms, which are non-life or limb threatening and may include, but are not limited to, intermittent headache, fatigue, colds, minor injuries and joint/muscle pain.

Urgent Care: Medical care provided to treat symptoms that are non-life threatening, but which, if left untreated, within 24 hours could lead to a potentially harmful outcome such as acute abdominal pain.

Emergency Care: A medical condition of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine

and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care would result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any bodily organ or part;
d. Serious disfigurement; or
e. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

After Hours Care/Access: Providers will have a verifiable mechanism in place, for immediate response, for directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician or on-call physician; a recorded message that directs the patient to call the answering service and the phone number is provided; or a recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

In-Office Wait Time: The average amount of time a member must wait from the scheduled appointment time until the time the member is seen by the provider.

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 Appeals"**
- Medical Management Determination Disputes – **See "Adverse Determination Appeals"**

Disputes involving contractual concerns or other administrative disputes not addressed in the above categories, 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:

Memorial Hermann Health Plan
Attention Appeals - Administrative Disputes
929 Gessner Road, Suite 1500
Houston, TX 77024

Unless otherwise specified in the Participation Agreement, MHHP will use best efforts to 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 MHHP and given the projected time frame for resolution.

Disputes Concerning Professional Competence or Conduct

Administrative disputes do not include actions by MHHP that relate to a participating provider's status within MHHP's participating provider network or any action by MHHP 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 "Appeals and Grievances" and "Credentialing Appeals and Grievances".

Delegation/Delegated Entities

Delegation is typically defined as the means by which a health plan grants a provider group the authority to perform health plan functions such as credentialing, utilization management, and claims management. Full or partial designation is how most plan delegations are described. Typically, the MHHP Delegation Agreement will determine the health plan functions that are delegated.

Provider's participating in MHHP's network of participating providers through a delegated entity should contact the delegated entity regarding participation status, demographic changes, claim processing and appeals and grievances.

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.

Quality Improvement

Goal of the Quality Program

- Provide a continuous, comprehensive quality improvement program that addresses all dimensions of quality: clinical, service and fiscal.
- Promote/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
- 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
- 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.
- Monitor compliance with local, state, and federal regulatory requirements and accreditation standards.
- Tracks laws, rules and regulations as it relates to health plan clinical operations
- 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
- Member Services
- 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. The Chief Medical Officer ("CMO" provides oversight and leadership to MHHP's Quality Management Program. The CMS is an MD, licensed in the state of Texas, with a current, active unrestricted license. He or she possess additional training as evidenced through board certification as well as experience in health plan administration, quality, and public health.

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, 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

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.

Quality Improvement Activities

The criteria for selection of Quality Improvement Projects 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

Quality Improvement and Chronic Care Improvement Projects (Medicare Advantage)

In accordance with CMS guidelines, the health plan maintains a quality improvement project specifically for the Medicare Advantage Program. There is a CMS Chronic Care Improvement Project (CCIP) that specifically targets the needs of the Medicare Population. These projects are selected by MHHP 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 initiatives are informal activities completed by MHHP to improve member health outcomes. These activities support broader quality improvement functions such as HEDIS® and STARs.

Clinical Quality Initiatives

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

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 CFRPart 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. 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.

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.

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 by contacting MHHP Provider Services.

The Director of Quality or Chief Medical Officer may request qualified personnel to screen a review or report for potential quality issues. 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
- Referral to Provider Advisory Sub-committee (PAS)

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.

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 of1986. MHHP will retain the privilege of protection and confidentiality afforded under this act.

Communication will be managed by PAS, a division of the Quality Improvement Committee. MHHP will require that information provided in compliance with mandatory releases of information will not compromise the protected and privileged nature of the information. MHHP works closely with the provider(s) involved to ensure that 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. The Quality Improvement Committee will review the information available and render a decision on behalf of MHHP regarding the involved provider within 7 business days.

In non-emergent situations, 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 in emergent or non-emergent situations.

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 previous 6 months
- 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

Quality Appeals and Grievances - 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

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 within30 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.

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 three 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.

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 Credentialing 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 Credentialing 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 Credentialing 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 one 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 Credentialing Committee proposed action, and the proposed action shall become effective pending final action by the Board of Directors.

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 Credentialing Committee 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 3individuals 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 Credentialing 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 Credentialing 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 Credentialing 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 Credentialing Committee, 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 Credentialing 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 Credentialing 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 Credentialing Committee who requested the hearing, and the MHHP 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 Credentialing Committee. The hearing panel and hearing officer shall consist of three qualified individuals who have not participated in prior decisions in this matter. At least one 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 Credentialing Committee: Upon completion of its review of the Hearing Panel's information and recommendations, Credentialing 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 Credentialing Committee.

The decision of the Credentialing 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 Credentialing 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 Peer Review Committee or the hearing panel for further review, the Peer Review Committee or hearing panel shall promptly conduct its review and make its recommendation to the hearing panel or Credentialing Committee. 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 Credentialing Committee 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 two appeals fair hearings on any single matter which shall have been the subject of an adverse action.

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 EOC/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's EOC/COC.

Regardless of the member's benefits and coverage, 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.

Medical Management staff is available to discuss care and benefit options for catastrophic cases, as well as care that may require multidisciplinary or community services.

Medical Necessity Criteria

Medically necessary services as defined in MHHP's EOC/COCs are those that are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition
- Provided for 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.

The Prior Authorization Requirements, Prior Authorization Code List, and Prior Authorization Forms can be found on the MHHP website under the Provider Resource Center.

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 laws and regulations.

In general, MHHP uses standard guidelines for both inpatient and outpatient services based, in part, on well-established medical practice protocols, 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.

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 Member Services 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 Provider Services to determine if a service or procedure requires benefit prior authorization.

Medical Management Requirements for Prior Authorization

MHHP requires authorization of certain services prior to rendering the services (Prior Authorization). Providers should call the Member Services phone number on the member's ID card with questions concerning prior authorization requirements. Requirements for prior authorization may vary among benefit 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 term used to refer to authorization of medically necessary services, such as hospitalizations, when a number of "days" are pre-certified.

Provider should request a prior authorization as soon as possible, but not less than ten working days prior to a scheduled inpatient hospitalization, outpatient service or other service requiring prior authorization. Providers may call Medical Management or fax a prior authorization form to request a service or procedure. The Prior Authorization Forms can be found at the Provider Resource Center.

If Medical Management determines that additional clinical information is needed to make a 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 the standard timelines set forth below or by the timeline specified by state and federal regulatory requirements.

Prior Authorization Request Process

This section outlines the process utilized by MHHP to determine processing timelines based on the urgency of the provider's request for authorization. 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.

Emergent (Concurrent) 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.

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.

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 Preservice Requests

Requests will be processed as soon as feasible from the date and time of the request, provided MHHP has all of the information to render an authorization decision. Urgent or expedited care requests for fully insured and self-insured members will be processed within 72 hours and expedited requests for Medicare Advantage members will be processed to within 72 hours.

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.

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 Medicare *Advantage* Prior Authorization Form for faxed requests.

Prior authorization forms are available on the Memorial Hermann website:

Commercial: http://healthplan.memorialhermann.org/providers/resource-center
Medicare *Advantage*: https://healthplan.memorialhermann.org/medicare-advantage/resource-center

The following information should be included in the Prior authorization request: Provider information including the name of requesting provider or facility and name of the servicing 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 one primary procedure based on 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 other considerations of the member. Special needs could include things such as durable medical equipment (DME)/prosthetics/supplies.

Other services requiring authorization include:

- **DME, Orthotics, Prosthetics:** Authorization for DME/prosthetics is to be initiated by the requesting provider with a physician's order 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.
- **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 with a physician's order. 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:

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

The following patient 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)

Send the completed prior authorization request form to:

Memorial Hermann Health Plan
Attn: Medical Management Department
Commercial Fax: (713)-338-6494
Medicare Advantage Fax: (713)-338-6982

Denial Rationale

MHHP's Medical Director will issue an adverse determination (denial) with the reason for the denial 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 provider billing. Please note that this authorization number is not a guarantee of coverage or payment. A final determination will be made following receipt and review of the claim and verification of benefits and eligibility. To avoid denial of the claim, the authorization number must be referenced on the claim.

Concurrent Review

Concurrent review is the process that determines coverage during the inpatient stay including, but not limited to, acute care hospital for medical/surgical, behavioral, drug, or alcohol use, a skilled nursing facility (SNF), long-term acute care hospital (LTACH) and inpatient rehabilitation. Concurrent review is necessary when the inpatient stay will exceed the previously approved length of stay. Concurrent review may also occur in situations where prior authorization was not obtained prior to the hospitalization. Providers should contact Medical Management to obtain certification for additional days. Contact information is available on General Information page of this Provider Manual.

Concurrent review also determines coverage for continuing medical necessity and appropriateness of continued treatment or services. Reviews of ongoing care are conducted for outpatient procedures and ongoing outpatient care that require prior authorization.

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 care 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 Member Services 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.

Memorial Hermann Medicare Advantage HMO

Memorial Hermann Medicare Advantage Overview

MHHP has contracted with the Centers for Medicare and Medicaid Services (CMS) to provide physical, behavioral health and prescription drugs coverage to Medicare enrollees within the MHHP Medicare Advantage service area.

Beginning in 2022, MHHP will offer 4 Medicare Advantage benefit plans:

- Memorial Hermann Medicare *Advantage* HMO
- Memorial Hermann Medicare *Advantage* Plus HMO
- Memorial Hermann Medicare *Advantage* Jefferson HMO
- Memorial Hermann Medicare *Dual Advantage* HMO D-SNP

Member Services

October 1 – March 31
Member Services is available from 8 a.m. to 8 p.m., 7 days a week (closed Thanksgiving Day and Christmas Day; open New Year's Day, Martin Luther King Jr. Day and President's Day) to assist members and providers with benefits and claim information. See "General Information" for contact information.

April 1 – September 30
Member Services is available from 8 a.m. to 8 p.m., Monday through Friday (closed weekends and federal holidays) to assist members and providers with benefits and claim information. See "General Information" for contact information.

For more information about our Memorial Herman Medicare *Advantage* plans, visit the "Our Plans" section at the MHHP Medicare *Advantage* webpage.

Accessing Services

Medicare Advantage ("MA") members are encouraged to choose a Primary Care Provider (PCP) 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 healthcare).

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.

Contact the Member Services number listed on the back of the member's MHHP ID card or use our online Medicare Advantage Provider Directory search to find a participating provider.

Part D (Pharmacy) benefits are covered for MA members 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 the Formulary Information and Search Tools webpage.

Benefits and Coverage

In addition to covering all traditional Medicare benefits Memorial Hermann Medicare *Advantage* includes 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
- Dental (Limitations may apply)

For complete details please see the Evidence of Coverage or Summary of Benefits document at: http://healthplan.memorialhermann.org/medicare

Pharmacy Benefit Management (PBM)

MHHP utilizes the PBM, Navitus Health Solutions, to manage member pharmacy benefits. As the PBM, Navitus provides MHHP members with an extensive pharmacy network, pharmacy claims services, and a complete drug formulary. For additional information regarding MHHP's pharmacy program refer to MHHP Pharmacy Information on page 11 of this Provider Manual.

Medication Therapy Management (MTM) Information

MHHP offers a Medication Therapy Management (MTM) program administered by MedWiseRx (formerly known as SinfoniaRx) 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 additional information regarding MHHP's MTM program contact MedWiseRx Customer Service at (844) 866-3735, TTY Users (800) 367-8939.

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

Fax:
MA HMO: (713) 338-5811

Write: Memorial Hermann Health Plan
Medical Management
929 Gessner Road, Suite 1500
Houston, TX 77024

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 limit Non-contract Unclean Claim 60 day limit

Pharmacy Part D Coverage Determination

Coverage Determination is when the health plan makes a determination regarding a Part D drug request. Contact Navitus Health Solutions for a list of drugs that require pre-authorization prior to dispensing. To request a coverage determination for Part D drugs, submit a Request for Medicare Prescription Drug Coverage Determination form online. The completed Request for Medicare Prescription Drug Coverage Determination form can also be mailed or faxed to:

Memorial Hermann Health Plan
c/o Navitus Health Solutions, LLC
Attn: Prior Authorization
P.O. Box 1039
Appleton, WI 54912-1039
Fax: (855) 668-8552

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 Member Services phone number listed on the back of the member's card.

Medicare Advantage 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 one 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 electronic claims to:

Clearinghouse	Payer ID
Availity/THIN	MHHNP
WebMD/Emdeon	TN092

Submit paper claims to:

All Products
Memorial Hermann Health Plan
Attn: Claims Department
929 Gessner Rd Ste 1500
Houston, TX 77024-2317

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, on the CMS Preclusion list, 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 one 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

MHHP will process all clean claims as defined in this manual within 30 days of receipt of electronic claims and within 45 days of receipt of paper claims. 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 healthcare 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 and Information Set)	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 (Heath 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 year 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.
-
- 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@apex4health.org.

HEDIS Reference Guide

How can I use CPT 2 Codes to Close Gaps?
CPT Category II codes are a set of supplemental tracking codes that can be used for performance measurement. Submitting CPT Category II codes in addition to CPT or other codes used for billing will decrease the need for record abstraction and chart review, thereby minimizing your administrative burden for a number of quality-based initiatives including HEDIS.
CPT Category II codes are billed in the procedure code field, just as CPT Category I codes are billed.

Please review the following CPT Category II codes. Although this is not a complete list, it includes the most common used for HEDIS.

MEASURE	CRITERIA	CODES TO IDENTIFY SCREENING
Breast Cancer Screening (BCS) Women who had a mammogram to screen for breast cancer between 10/01/2020 - 12/31/2022	Age: 50-74 ♀ Document date of mammogram ***Exclusion:* History of bilateral mastectomy or two unilateral mastectomies**	**Mammogram:** CPT: 77061-77067 HCPCS: G0202, G0204, G0206
Colorectal Cancer Screening (COL) Patients who received appropriate screening for colorectal cancer by one of the following methods: - Colonoscopy: between 2013 - 2022 - Flex Sigmoidoscopy: between 2018 - 2022 - CT Colonography: between 2018-2022 - FIT DNA: between 2020 - 2022 - FOBT: 2022	Age: 50-75 Document date and type of colorectal cancer screeing. ***Exclusion:* History of colorectal cancer or total colectomy** *Note: screening date and results should be documented in the medical record*	**FOBT:** CPT: 82270, 82274 HCPCS: G0328 **Flex-Sigmoidoscopy:** CPT: 45330-45335, 45337-45338, 45340-45342, 45346-45347, 45349-45350, HCPCS: G0104 **CT Colonography:** CPT: 74261 - 74263 **FIT-DNA:** CPT: 81528 HCPCS: G0464 **Colonoscopy:** CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121
Hemoglobic A1c Control for Patients with Diabetes (HBD) Patients with type I or II diabetes whose hemoglobin A1c (HbA1c) was at the following levels during 2022: -HbA1c control (<8.0%) -HbA1c poor control (>9.0)	Age: 18-75 **Test Needed:** - HgbA1c Test Document date and result/value in the medical record. Most recent lab value during 2022 will be the represented value used.	**HbA1c Test:** CPT: 83036, 83037 CPT II: 3044F, 3046F, 3051F, 3052F
Eye Exam for Patients with Diabetes (EED) Patients with diabetes (type 1 and 2) who had a retinal eye exam	Age: 18-75 **Test Needed:** Retinal Eye Exam, by an eye care professional (optometrist or ophthalmologist), during 2022 or a negative eye exam during 2021	**Retinal Eye Exam:** **CPT: 92229** **CPT II**: 2022F-2026F, 2033F,3072F

MEASURE	CRITERIA	CODES TO IDENTIFY SCREENING
Kidney Health Evaluation for Patients with Diabetes (KED) Patients who received a kidney health evaluation during 2022	Age: 18-75 **Tests Needed**: **Both an Estimated Glomerular Filtration Rate (eGFR) *AND* a Urine Albumin-Creatinine Ratio (uACR) during 2022 on the same or different dates of service:** *At least one eGFR; *At least one uACR identified by either of the following: BOTH a quantitative urine albumin test AND a urine creatininte test with service dates four days or less aprt. -A uACR ***Exclusion:*** ESRD or Dialysis anytime during the member's history on or prior to December 31, 2022	**Kidney Health Evaluation:** **CPT eGFR:** 80047-80048, 80050,80053, 80069, 82565 **CPT uACR:** identified by either of the following: Both 82043, 82570 with service dates 4 days or less apart. **LOINC uACR**: 13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7
Blood Pressure Control for Patients with Diabetes (BPD) Members with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during 2022	Age: 18-75 **Test Needed**: Blood Pressure Document date and BP in the medical record. Most recent BP during 2022 will be the represented value used.	**Blood Pressure Reading:** CPT: 3074F - 3080F
Controlling Blood Pressure (CBP) Patients who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during 2022	Age: 18-85 Blood Pressure goal should be <140/90	CPT: 3074F - 3080F **Note:** the last blood pressure taken during 2022 will be the representative blood pressure reading used.
Osteporosis Fracture Management (OMW) Women who suffered a fracture and had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis (bisphosphonate) within 6 months after the fracture	Age: 67-85 ♀ BMD test or prescription to treat osteoporosis within 6 months after a fracture. Document date of BMD or date prescription was dispensed	**To Identify BMD Test:** CPT: 76977, 77078, 77080, 77081, 77085, 77086 Medications: J0897, J1740, J3110, J3111, J 3489

MEASURE	CRITERIA	CODES TO IDENTIFY SCREENING
Statin Therapy for Patients with Cardiovascular Disease (SPC) Patients who are identified as having clincal atherosclerosis cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin during 2022	Age: 21-75 ♂ ; 40-75 ♀ ***Exclusion:*** Intolerance to Statins (myalgia,etc.); must be coded and documented in the medical record	***No applicable codes to identify screening*** ***Action:*** *Member should be prescribed a high-intensity or moderate-intensilty statin during 2022, unless clinically contra-indicated. In which case the appropriate diagnosis code should be submitted via claims and documenetd in the medical record for the member to be excluded from the measure*
Statin Use in Persons with Diabetes (SUPD) Patients who are identified as having Diabetes and who do not have clinical atherosclerosis cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year	Age: 40-75***Note:*** *Supplemental and medical record data may* not *be used for exclusions*	***No applicable codes to identify screeningAction:*** *Member should be prescribed and dispensed atleast one statin medication of any intensity during the measurement year*
Transitions of Care (TRC) Patients who were discharged from an acute or non-acute inpatient stay and had each of the following: - Notification of Admisssion - Receipt of Discharge Information - Patient Engagement After Discharge - Medication Reconciliation Post Discharge	Age: 18+ **Notification of Admission:** Medical record documentation must include evidence of receipt of notification on the day of admission through 2 days after admission **Receipt of Discharge Information:** Medical record documentation of receipt of discharge information on the day of discharge through 2 days after discharge **Patient Engagement**: Medical record documentation of patient engagement (office visit, home visit or telehealth) completed within 30 days after discharge **Medication Reconciliation**: Medical record documentation of evidence of medication reconciliation on the date of discharge through 30 days after discharge (31 days total) **Note: Medical record documentation must reside in the outpatient chart.**	**Patient Engagement:** CPT: 98966-98972, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99421-99423, 99429, 99441-99444, 99455-99457, 99483, 99495-99496, HCPCS: G0402, G0438, G0439, G0463, G0071, G2010, G2012, G2061-G2063, T1015 **Medication Reconciliation:** CPT: 99483, 99495, 99496 CPTII: 1111F

Please note: members using hospice or palliative services anytime in 2022 are a required exclusion

*References: American Medical Association; American Academy of Professional Coders; 2022 HEDIS Specs

Provider Responsibilities

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 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 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.

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 fora 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 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.

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

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.

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 Related and 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: https://healthplan.memorialhermann.org/about-us/legal-notices/compliance .

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

You may contact us in writing at:

Memorial Hermann Health Plan
Attn: Compliance/Fraud Department
929 Gessner Road
Suite 1500
Houston, TX 77024

For additional information, please email the Compliance-FWA department at MHHealth-PlanFWA@memorialhermann.org

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

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
Attn: 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 (availableathttp://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), 31U.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.

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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