LIBERTY MEDICARE ADVANTAGE

Planning your advantage

2022 +

Provider Manual

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CHAPTER ONE: ABOUT LIBERTY MEDICARE ADVANTAGE

WELCOME TO LIBERTY MEDICARE ADVANTAGE

We are excited you have chosen to be a participating provider with Liberty Medicare Advantage. We view you as an integral partner in providing the highest quality of health to our unique Special Needs population.

ABOUT LIBERTY MEDICARE ADVANTAGE

Liberty Medicare Advantage Plan (LMA), is offered by Liberty Advantage, LLC dba Liberty Medicare Advantage. Our mission is to improve the health and well-being of our members within our community by offering a complete and cost-effective senior care continuum, close to home and family. We believe by combining our Customized Care team and community resources we enhance the health and well-being of our members and enforce the core values of our company's founders of quality, honesty, and integrity that guide us to this day.

Liberty Healthcare Insurance, LMA's parent company, is an experienced family-owned company that has been helping people manage their healthcare and residential needs for more than 145 years. The company founders, who opened their first pharmacy in 1875, established Liberty's core values of quality, honesty, and integrity that guide us to this day.

Liberty Healthcare Insurance oversees the development, operation of independent living, assisted living, memory-care communities, and continuing care retirement communities ("CCRCs"). Through our affiliated companies, we also offer a range of home health, hospice, in-patient short-term rehabilitation, long-term care, and outpatient services to residents of many of our communities and to seniors living outside of our communities. The continuum extends beyond the walls of our communities and to the affiliated company's home health, pharmacy and medical equipment branches to meet the needs of patients following discharge.

For the most vulnerable population, it is particularly essential the Plan delivers services in a manner that will be consistent with the members' capacity and abilities. For example, if a member is visually impaired, any instructions will need to be in Braille, large print or recorded based on members' preference. In addition, it may be important for the Plan to provide services in the member's facility/home, maximizing member access to covered benefits and minimizing the disruptions associated with seeking services outside the home environment.

Products Offered

	Description	Designed For
C-SNP	Chronic Condition Special Needs Plan	Qualify for one of the following Chronic Conditions: • Diabetes • Congestive Heart Failure • Cardiovascular Disorders • And Must have Medicare Parts A & B Our goal is to keep our members healthy and independent.
D-SNP	Dual Eligible Special Needs Plan	Members with both Medicare and Medicaid
I-SNP	Institutional Special Needs Plan	Members who are expected to be in a Nursing Facility for 90 days or longer must have Medicare Parts A and B.

Key Contacts at LMA

The following table includes several important telephone and fax numbers available to Providers and their office staff.

Topic	Link/Address	Phone Number
Member Services	LibertyMemberIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Provider Services	LibertyProviderIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Prescribers Part D - Navitus	www.navitus.com	1-866-270-3877 (TYY 711)
Pharmacies Part D - Navitus	www.navitus.com	1-866-270-3877 (TYY 711)
Home Office	2334 41st Street Wilmington, NC 28403	1-910-815-3122
Claims Processing	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 LibertyProviderIVR@mirrahealthcare.com	1-844-854-6884 (TTY771)
Concurrent Review/Clinical Information	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 UM@LibertyMedicare Advantage.com	1-844-854-6884 Fax: 1-877-760-3560
Appeals and Grievances	Liberty Medicare Advantage – Appeals and Grievances PO Box 3325 Spring Hill, FL 34611 Email: LibertyMemberIVR@mirrahealthcare.com	Fax: 1-877-760-3620
Care Management	Liberty Medicare Advantage PO Box 3325 Spring Hill, FL 34611 UM@LibertyMedicareAdvantage.com	1-844-854-6884
Network Operations	LibertyProviderIVR@mirrahealthcare.com	1-844-854-6884 (TTY711)
Prior Authorization	UM@LibertyMedicareAdvantage.com	1-844-854-6884
Contracting	Contracting@LibertyMedicareAdvantage.com	
Compliance	Compliance1@libertyadvantageplan.com	1-844-854-6884

CHAPTER TWO: PROVIDER MANUAL

Medicare Regulatory Requirements

As a Medicare contracted Provider, you are required to follow all Medicare regulations and CMS requirements. Some of these requirements are found in your Provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare Members in any way based on the health status of the Member.
- Providers may not discriminate against Medicare Members in any way based on race, color, national origin, sex, age, or disability in accordance with subsection 92.8 of Section 1557 of the Patient Protection and Affordable Care Act.
- Providers must ensure that Members have adequate access to covered health services.
- Providers may not impose cost sharing on Members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow Members to directly access screening mammography and influenza vaccinations.
- Providers must provide Members with direct access to health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- LMA will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 days. Providers agree to notify LMA according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operation are convenient to the Member and do not discriminate against the Member for any reason. Providers will ensure necessary services are available to Members 24 hours a day, 7 days a week.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to LMA Members without CMS and/or LMA approvals of the materials and forms.
- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, Members who are deaf or hard of hearing or are blind or have low vision and diverse cultural and ethnic backgrounds.
- Providers will work with LMA procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the Member’s medical record whether the Member has executed an advance directive.

- Providers must provide services in a manner consistent with professionally recognized standards of care. Providers must cooperate with LMA to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit Members to make an informed choice about their Medicare Advantage coverage.
- Providers must cooperate with LMA in notifying Members of Provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any LMA medical policies, QI programs, Utilization Management policies and medical management procedures.
- Providers must cooperate with LMA procedures for handling grievances, appeals, and expedited appeals.
- Providers must request prior authorization from the Plan if the Provider believes an item or service may not be covered for a member or could only be covered under specific conditions. If the Provider does not request prior authorization, the claim may be denied, and the Provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the Member's Evidence of Coverage, no prior notice of denial is required, and the Member may be held responsible for the full cost of the item or service.
- Providers must allow CMS or its designee access to records related to LMA services for a period of at least ten (10) years following the final date of service or termination of this agreement unless a longer period is required by applicable state or federal law.
- Providers must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with LMA policy for all Members, for the duration of the LMA contract period with CMS.
- The provider shall disclose to LMA all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS

THE PROVIDER MANUAL

This manual applies to any health care provider, including physicians, health care professionals, hospitals, facilities and ancillary providers, except when indicated otherwise. It includes LMA policies and procedures. LMA may add, delete or change policies and procedures, including those described in this manual, at any time. Please read this manual carefully. Your agreement requires you to comply with LMA policies and procedures including those contained in this manual.

Please visit www.libertymedicareadvantage.com to find programs we offer that could benefit your LMA patients. You will also find contact information, so you can reach us whenever you need to.

You will find information on how to get your claims paid faster, your pre-authorization requests processed promptly, and your administrative burdens lessened. We want you to find what you need quickly and efficiently.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for LMA. LMA also has a portal where you can look up Eligibility and Claims status 24 hours a day 7 days a week. Access to this website can be found under member responsibility verifying eligibility.

Changes and Updates

When things change, we will let you know. You are required to provide us with your email or practice address so we can contact you with important information, such as updates about our members and group health plans. Likewise, we update this manual periodically and certain changes can affect you, such as clinical policies, procedures, plan names or ID cards.

CHAPTER THREE: MEMBERS' RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

- ***The Right to Be Treated with Dignity and Respect***

  Members have the right to be treated with dignity, respect and fairness at all times. LMA and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say LMA and its' contracted providers cannot discriminate against members for any of the following reasons:

  - Race
  - Disability
  - Religion
  - Gender
  - Sexual orientation
  - Health
  - Ethnicity
  - Creed
  - Age
  - National origin

  Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. If a member needs help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access facilities (such as wheelchair access).

  Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

- ***The Right to see Participating providers, get covered services and get prescriptions filled promptly***
  - Members will get most or all their healthcare from participating providers – the doctors and other health providers who are part of LMA.
  - Members have the right to choose a participating provider. LMA will work with members to ensure they find physicians who are accepting new patients.
  - Members have the right to go to a woman's health specialist (such as a gynecologist) without a referral.
  - Members have the right to timely access to their providers and to see specialists when care from a specialist is needed.
  - Members also have the right to access their prescription benefit promptly.
  - Timely access means members can get appointments and services within a reasonable amount of time.

The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

- ***The right to know about treatment choices and to participate in decisions about their healthcare***
  - Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their healthcare.
  - LMA providers must explain things in a way that members can understand.
  - Members have the right to know all their treatment choices that have been recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether LMA covers them.
  - This includes the right to know about the different Medication Management Treatment Programs LMA offers and those in which members may participate.
  - Members have the right to be told about any risks involved in their care.
  - Members have the right to receive a detailed explanation from LMA if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.
  - Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave.
  - Members have the right to stop taking their medication.
  - If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.
- ***Members have the right to make complaints***
  - Members have the right to file a complaint if they have concerns or problems related to their care or coverage.
  - Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations.
  - If members make a complaint or file an appeal determination, LMA must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination.

Member Enrollment Card

Privacy Regulations – Health Insurance Portability and Accountability Act (HIPAA)

HIPAA privacy regulations offer full federal protection for member's health care information. These regulations control the internal and external uses and disclosures of member data. They also create member rights.

- Access to protected health information
  - Members may access their medical records or billing information either through you or LMA. If their information is electronic, they may ask that you or LMA send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.
  - Amendment of PHI – our members have the right to ask that you or LMA change information they believe to be inaccurate or incomplete. The member request may be in writing and explain why they want the change. You or LMA must act on the request within 60 days, or may extend another 30 days with written notice. If you deny the request, provide certain information to the member explaining the denial reason and actions the member must take.
- Accounting of Disclosures
  - Our members have the right to request an accounting of certain disclosures of their PHI, made by you or LMA, six years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:
    - For treatment, payment and health care operations purposes
    - To members or pursuant to member's authorization
    - To correctional institutions or law enforcement officials
    - For which federal law does not require us to give an accounting
- Right to request restriction

- Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Through guidelines established by the CMS, HEDIS requirements, and the Plan's policy and procedures, LMA requires all participating providers to have a process in place under the intent of the Patient Self-Determination Act.

There are three types of Advance Directive:

- A Durable Power of Attorney for healthcare (POA) allows the member to name a patient advocate to act on their behalf.
- A Living Will allows the member to state his or her wishes in writing, but does not name a patient advocate.
- A Declaration for Mental Health Treatment gives instructions regarding a member's future mental health treatment if the member becomes unable to make personal decisions. The instructions state whether the member agrees or refuses to have the treatment described in the declaration, with or without conditions and limitations.

All providers contracted directly or indirectly with LMA may be informed by the member that the members have executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and LMA.

LMA and PCP/NFist and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives. LMA conducts periodic patient medical record reviews to confirm the required documentation exists.

Member Eligibility

For an individual to enroll with LMA plans, the individual must be entitled to Medicare Parts A and B in addition to living within the service area the plan is offered. Refer to the LMA website for a list of areas we do business in. Medicare Advantage eligible beneficiaries who request enrollment with LMA will be effective the first day of the month following the changes are completed and enrollment application is accepted by CMS.

See products offered for additional eligibility requirements based on the plan LMA offers.

Verifying Eligibility

The most efficient way to verify eligibility is to request portal access. This will allow you to check Member Eligibility as well as claims. By going to our website and clicking on Provider – go to bottom of page and download request to access our portal. See below for details.

Re: Provider Portal Access

Dear Participating Provider,

Liberty Medicare Advantage appreciates your participation in our network and the valuable care you provide to our members.

A provider portal is now available for you to access and obtain fast resolution of routine needs such as:

- Member Eligibility Check
- Member Search
- Member Details
- Claims Search & Listing
- Authorization Look-Up

To request access to the provider portal please send an email request to

Enhancedbenefits@libertyhcare.com and include the following information:

- Provider/Facility Address
- NPI (group or individual)
- Tax ID (group or individual)
- User First, Middle and Last Name
- Gender
- DOB
- Contact Number
- Fax Number
- Email Address

Once the request has been made, the requester will be set up and instructions will be sent to the requester regarding how to access the portal. Please reach out to our customer service number of 910-685-8133 with questions or registration requests.

We remain committed to providing you with the best tools possible to support your administrative needs.

Liberty Medicare Advantage

CHAPTER FOUR: COVERED SERVICES

COVERED SERVICES

All LMA members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers should go to www.libertymedicareadvantage.com then choose the members' plan for breakdown of coverage.

Benefits and Services

All participating providers are obligated to bill and collect applicable member copayments and/or cost sharing as permitted under the LMA or by law. Participating providers of LMA are however, prohibited from balance-billing members copayments and /or cost sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, go to CMS.gov.

Emergent and Urgent Services

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

- Emergency Department (ED) Utilization: The PCP collaborates with the Care Manager for enrollment in Care Management and Disease Management Programs where opportunities are identified;

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

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

Emergency services: a provider qualified to furnish emergency services and needed to evaluate or treat an emergency medical condition performs covered inpatient and outpatient services.

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

- Are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;

- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the plan network.

The LMA network includes multiple hospitals, emergency rooms, and providers able to treat the emergent conditions of LMA members 24 hours a day 7 days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals.

Benefits Over and Above Original Medicare – 2023 Benefits

Benefit	***I-SNP***	***C-SNP***
Customized Care Team	X	X
Hearing	Routine exam, hearing aid fittings, and $2,800 toward hearing aids every two years.	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $2,000 annually for either Vision, Dental or Hearing in any combination, no rollover
Vision	Routine eye exam and up to $350 annual limit on eyewear.	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $2,000 annually for either Vision, Dental or Hearing in any combination, no rollover
Podiatry	4 routine foot care visits every year.	4 routine foot care visits every year.
Non-Emergency Transportation	20 one-way trips for non-emergency medical services not to exceed 25 miles.	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $20 per month for either transportation and/or fitness
Fitness	N/A	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $2,000 annually for either Vision, Dental or Hearing in any combination, no rollover
Prescription Drugs	Prescription Drug coverage, plus pharmacy coordination and monitoring	Prescription Drug coverage, plus pharmacy coordination and monitoring
Skilled Nursing	No prior hospital stay required.	No prior hospital stay required.

Primary Care Physician	$0 copay for Primary Care Physician visits.	$0 copay for Primary Care Physician visits. Also includes no copay for endocrinologist and cardiologist
Meal Preparation	N/A	Eligible to receive 2 meals per day for up to 7 days following an acute inpatient stay. Inpatient stay for chronic illness plan will pay for 3 meals per day up to 28 meals per month for 2 months.
At Home Monitoring	N/A	Remote monitoring of vital signs with referral from RN case manager.
Insulin Coverage	N/A	$0 co-pay for insulins covered on our formulary.
Dental	N/A	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $2,000 annually for either Vision, Dental or Hearing in any combination, no rollover
OTC and Grocery	N/A	Liberty Medicare Advantage Freedom Flex care allows you to choose where to spend $55 per month on groceries and/or OTC items, no rollover

Excluded Services

In addition to any exclusions or limitations described in the members EOC, the following items and services are not covered under the Original Medicare Plan or by LMA:

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

Continuity of Care

Continuity of Care is essential to maintain member stability. As a part of the care transition process, the Nurse Practitioner (or Care Manager) will be the primary advocate in ensuring the member's well- being across multiple care settings and across the health spectrum.

The Nurse Practitioner or Care Manager will work with the PCP to ensure that the highest quality of health care will be delivered to the member in each of the health care settings. LMA nurses understand how coordinated health care improves the care of this vulnerable membership, and will work to ensure coordinated care by:

- Providing members and caregivers/families one accountable point of contact – the assigned Nurse Practitioner or Care Manager.

- Following members across care settings during transitions (i.e., admission to a hospital)
- Educating members and caregivers/families on member diagnoses
- Setting goals that promote coordinated care
- Making and keeping specific tasks/appointments, follow up items with members
- Coordinating care within and across treatment settings between external and internal stakeholders
- Creating a process through which health care providers can communicate with one another about the member's care
- Making member preferences known and accessible to all health care providers

LMA's policy is to provide continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a medical practitioner leaves LMA network and a member is in an active course of treatment, LMA will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. If the Plan terminates a participating provider, LMA will work to transition a member into care with a Participating Physician or other provider within LMA network.

LMA is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances. LMA also recognizes that new members join the health plan and may have already begun treatment with a provider who is not in our network. Under these circumstances, we will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

LMA will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the PCP evaluates the member and establishes medical necessity.

CHAPTER FIVE: CLAIMS

CLAIMS

Claim Submission

While LMA prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact LMA Provider Services Department at 1-844-854-6884 (TTY 711).

As an LMA provider, you have agreed to submit all claims within the timeframes outlined in your provider agreement. Forward all completed paper claim forms to the address below:

Liberty Medicare Advantage, PO Box 3325, Spring Hill, FL 34611

Timely Filing

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

If your agreement does not specify a filing guideline, please use the following:

- Submit claim within 180 calendar days after the date of service.
- Initial bills submitted after 180 days will be denied as untimely.

Corrected claims or requests for review are considered if information is received within 180-days from the date on the remittance advice.

Providers must bill within 180 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when LMA is secondary. An original bill along with a copy of the EOB is required to process the claim. Requests for reviews/corrections of processed claims must be submitted within 180 calendar days from the date of the corresponding remittance advice. All claims submitted after the 180-day period following receipt of the EOB or after the 180-day follow-up period from the date on the remittance will be denied.

Any claim that has been submitted to LMA but does not appear on the remittance advice within 60 days the following submission should be researched by calling LMA Provider Services Department to inquire whether the claim was received and/or processed.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim. Standards are in the CMS Claims Processing Manual. The link to the CMS Claims Processing manual is cms.gov Claim Manual Chapter 3.

LMA can only pay claims which are correctly submitted. The provider is always responsible for accurate claims submission. LMA will make its best efforts to inform the provider of claim errors, ultimately claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and receive payment as though they are a single physician. If the same physician or more than one physician in the same specialty group provides more than one service on the same day to the same patient, they must bill and receive payment as though they were a single physician.

- Example: Only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

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

Claim Payment

LMA pays clean claims according to contractual requirements. A clean claim is a claim for a covered service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by LMA, or a particular circumstance requiring special handling or treatment, which prevents timely claim payment.

The standard CMS required forms and data elements are in the CMS claims processing manual located at cms.gov, claim manual Chapter 3. Appropriate forms and data elements must be present for a claim to be a clean claim.

Offsetting Claims

Contracted providers are informed of any overpayments or other payments you may owe LMA. You will have 30 days from receipt of our repayment demand to refund such amounts to LMA. If you have not refunded the amount within a 30-day recovery period, LMA will offset the recovery amounts identified in the initial repayment demand, or in accordance with the terms of your agreement.

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

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

Non-Payment/Claim Denial

- Any denials of coverage or non-payment for services by LMA are addressed on the EOP or RA. An adjustment/denial code will be listed for each billed line if applicable.
- An explanation of all applicable adjustment codes per claim is listed below the claim on the EOP/RA.
- Per your contract, the member may not be billed for services denied by LMA unless the member received the denial before the service was provided and the member indicated they wanted to receive the services regardless of coverage.
- The member may not be billed for a covered service when the provider has not followed LMA procedures.
- In some instances, providing the needed information may reverse the denial.
- When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this.
- Obtaining pre-services review will reduce denials.

Provider Claim Payment Disputes

If your claim was paid and you dispute the payment amount, please follow the process below.

- Payment dispute procedures are separate and distinct from the appeal process.
- A formal payment dispute request is required from the provider to contest a paid amount on a claim, which does not include a medical necessity or administrative denial. All payment disputes must be:
    - Submitted in writing within 60 days of the original payment
    - Include a cover letter with:
        - Claim identifiable information
        - The specific rationale as to why the payment made is not appropriate or needs adjustment
    - Include necessary attachments:
        - Copy of the original RA
        - All applicable medical records or other attachments supporting additional payment.

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

- **Mail provider claim payment disputes to:**
    - Liberty Medicare Advantage, PO Box 3325, Spring Hill, FL 34611

Seeking Payment from Members

The Medicare plan members cannot be billed for covered services. The Health Plan members may receive services from providers that are not covered by Medicare. Providers must have the member sign a release form stating that he/she understands the service is not a covered benefit and he/she is responsible for payment of the charges.

Coordination of Benefits (COB) and Third-Party Recoveries

Some LMA members have other insurance coverage. LMA follows Medicare coordination of benefits rules.

For LMA to be responsible as either the primary or the secondary carrier, the member must follow all HMO rules (i.e., pay copays and follow appropriate referral process as applicable).

Under coordination of benefit rules, if another payer is the primary payer for Covered Services, the Provider must:

- First bill the primary payer; All LMA guidelines must be met in order to reimburse the provider (i.e., pre-certification, referral forms, etc.).
- Share with LMA the information regarding the primary payer; and
- Reports to LMA all third-party recoveries received by Provider as a result of providing Covered Services to the Member.

At LMA's request, Provider agrees to complete any and all necessary forms and consents to permit Banner to bill and process forms from other payers, if necessary, where the Plan is determined to be secondary. Provider further agrees that Plan will be billed on a secondary basis for Covered Services on the balance due, only after Provider has received reimbursement from the primary payer. However, in no event will payment be made if Provider receives combined payments in excess of the amount Provider would have received for services rendered to a Member solely under the applicable Plan coverage.

Provider further agrees to cooperate in Plan's subrogation, workers' compensation, and other third-party recovery programs to the extent permitted by applicable law. Be sure to have the member sign the "assignment of benefits" sections of the claim form. Once payment and/or EOB are received for the other carriers, submit another copy of the claim with the EOB of LMA for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When LMA is primary insurance carrier:

- Provider collects the copayment required under the LMA plan.

- Submit the claim to LMA first.
- Be sure to have the member sign the "assignment of benefits" sections of the claim form.
- Once payment and/or RA has been received from LMA, submit a copy of the claim with the RA to the secondary carrier for adjudication.

Subrogation

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

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

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

Processing Hospice Claims

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

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

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

Claim Correction

You may need to update information on a claim you have already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to Use:

- Submit a corrected claim to fix or void one that has already been processed.
- When submitting late charges on 837 institutional claims, use bill type xx7: Replacement: of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

- If a paper claim, it will need to be clearly marked as a corrected claim. For EDI, box 22 is where you indicate this is a corrected claim. Use code 6 for a corrected claim or a 7 which is a replacement of prior claim.

Resubmitting a Claim

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal of the claim it needs to be corrected through resubmission.

Prompt Pay

LMA will pay Participating Providers in accordance with applicable provisions of their agreement with LMA.

Request for Additional Information

If LMA determines that additional information is necessary to process the claim, the following steps may occur:

- The claim is pended and on the next business day, a notification letter requesting additional information is mailed to the provider.
- For all professional claims, if the requested information is not received within 45 days from the date the claim has been sent a second request will be made.
- If the requested information is not received within 60 days from the claim-receipt date of the claim, the claim will be denied.
- For all inpatient and ancillary claims, if the requested information is not received within 60 days from the claim receipt date, the claim will be denied.

If LMA obtains the requested additional information within 60 days from the receipt of the claim and the information support payment or a favorable reconsideration, the claim will be denied. Providers can access the appropriate dispute process.

Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once LMA receives the additional information requested, the original claim is processed.

CHAPTER SIX: APPEALS AND GRIEVANCES

Appeals and Grievances

Definitions

LMA classifies **appeals** that meet one of the criteria identified below:

- Full or partial denied claim
- Full or partially denied authorization request
- Denied reimbursement request
- Dispute of a copay amount or the calculation of the copay amount

A **grievance** is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested. Examples of grievances can include:

- A change in premiums or cost sharing arrangements from one contract year to the next;
- Lack of quality of the care received;
- Plan benefit design
- Difficulty contacting the plan via phone;
- General dissatisfaction about a co-payment amount, but not a dispute about the amount the enrollee paid or has been billed.

Grievances will be classified by type to facilitate prompt and effective responses.

PROVIDER APPEALS

As defined by CMS Managed Care Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance, CMS states that Contracted Providers do not have appeal rights. Contracted Providers are not permitted to file appeals on claims. Those must be handled through the Provider Dispute process. See the Claims section of this manual for information on our dispute process.

Contracted providers are only permitted to file appeals on behalf of a member (member must be aware) for pre-service denials and certain types of discontinuation service denials (SNF, HH, or CORF)

- Standard appeal – A standard pre-service appeal request is processed by LMA within a 30-calendar day time frame, from the date the Plan receives the request.
- Expedited appeal – An e within a 72-hour time frame, from the date and time the Plan receives the request. An expedited appeal request is a time sensitive service appeal request that is processed by LMA

How to request an appeal:

- All appeals must be requested within 60 calendar days of the denial.
- Standard and Expedited appeal request can be requested in writing via fax or postal mail.

Send requests to:

Liberty Medicare Advantage – Appeals & Grievances

PO Box 3325

Spring Hills, FL 34611

Member Appeals

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

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide,
- A denied claim for any other health service furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by LMA,
- A reduction in or termination of service a member feels is medically necessary

In addition, a member may appeal any decision to discharge from the hospital. In this case, a notice will be given to the member with information on how to appeal. The member will remain in the hospital while the member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to LMA Evidence of Coverage for additional information.

An appeal is a reconsideration of a previous decision not to approve or pay for a service. Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved or the claim paid.

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

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an appeal orally, please call 1-844-854-6884. A member or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the member or member's ability to regain maximum function.

Providers contracted with LMA may not use the member appeal process to file an appeal for post-service payment disputes.

Member Grievances

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

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

All complaints are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

CHAPTER SEVEN: MEDICAL POLICIES

Medical Policies

Model of Care

The Plan's Model of Care (MOC) provides members with a customer care team dedicated to their complete health. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the MOC is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits offer additional services and support for the member's individual needs.

Goals of LMA MOC:

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

The participating provider should know:

- All members are required to choose or designate a Primary Care Physician (PCP) at enrollment
- All members are assigned a Nurse Practitioner, Case Manager or an Advanced Practitioner (PA).
- On our **I-SNP** program, CMS has granted LMA permission to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from members PCP, to treat member in the nursing home when appropriate and reserves acute hospital stays for members requiring services that are more intensive.
- Our **C-SNP** Program focuses on three chronic conditions: Diabetes, Chronic Heart Failure and Cardiovascular Disorder.
- The plan is provider friendly and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, and preauthorization and referral process outlined in this manual.

Most importantly, the MOC focuses on the individual member who receives a comprehensive health risk assessment when becoming a member and annually thereafter. Based on the assessment, an individualized care plan is developed, based on evidenced-based clinical protocols. An Interdisciplinary Care Team (ICT), which includes a case manager, PCP and other key partners depending on our members' needs. This customized team is involved in all aspects of our members' wellbeing and care.

Medical Directors Responsibilities

Referrals

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

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

Referrals should be made to LMA at 1-844-6884.

Referrals to Out of Network physicians or facilities require prior authorization from the Plans Utilization Management Team. Out of network referrals may be allowed in certain circumstances where in-network providers or services are not reasonably available to the member, or there is a continuity of care concern.

CHAPTER EIGHT: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT

Utilization Management (UM) Program

The UM Program is a component of the Medical Management Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care. The UM program facilitates optimal settings for delivery of care and educates physicians and facilities on the advantages of managing care in a medically appropriate and cost-effective manner. The UM structure is routinely evaluated such that appropriate utilization is continuously monitored and corresponding interventions initiated to improve health outcomes. The UM program maintains regulatory compliance and is annually reviewed by LMA Quality and Medical Management Committee.

The UM Program and Quality and Medical Management Committee work together to evaluate the care and service provided to members, identify opportunities for improvement, prioritize the improvement opportunities and interventions, and assist in the re-measurement process to determine the effectiveness of the interventions provided.

Goals of UM Program

The UM program is designed to accomplish the following objectives:

- Ensure all medically necessary services are available to our members,
- Partner with and provide necessary oversight to delegated entities to ensure high quality of care for our members,
- Assuring proper utilization of health care resources within the members benefit plan,
- Educate clinical and support staff on the purpose and philosophy of the UM program,
- Members receive the highest quality care delivered in the most appropriate setting,
- Provide individualized and integrated care to each member,
- Maintain the dignity, rights and responsibilities of our members during all aspects of review,
- Review and analyze UM data and statistics to identify trends and opportunities for improvement,
- Comply with professional standards, guidelines and criteria set by governmental and other regulatory agencies,
- Work closely with our customized care team to improve health outcomes for our members,
- Maintain and monitor the provider network in order to provide adequate access to covered services to meet the needs of the member population LMA serves,
- Monitor over/under utilization and inappropriate use of services through regular care plan and service utilization reviews.

UM Functions

- Prior Authorization
- Concurrent Review
- Discharge Planning along with Case Manager
- Continuity of Care

Prior Authorization

Prior Authorization is a process whereby approval must be obtained from LMA before certain services will be covered in accordance with the member's EOC.

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

When possible prior authorizations should be requested at least 3 business days prior to the date of service/admission to allow LMA time to determine eligibility, level of benefits and medical necessity. Requests for prior authorization will be prioritized according to the level of medical necessity. For prior authorizations, providers should call 1-844-854-6884, Fax 1-877-760-3560 or email UM@LibertyMedicareAdvantage.com.

LMA will allow providers to submit post service (retrospective) authorizations 7 calendar days after the date of service. Failure to comply with LMA's authorization requirements will result in an administrative denial of the claim payment with the provider held liable for any denied claim.

> Members cannot be held liable for claims denied because a contracted provider did not obtain prior authorization.

Referring/ordering providers are responsible for obtaining prior authorization from LMA for all non-emergent referrals.

Services Requiring Prior Auth:

Please refer to our website: libertymedicareadvantage.com

- Click on the provider page and at the bottom click on Authorization Chart for the services requiring authorization.

Notification

The provider (usually the hospital/facility) is responsible for notifying LMA within 24 hours:

- When a member is admitted to the hospital on an emergency basis, including observation and inpatient admission from the emergency room.
- When a member in observation status changes to inpatient admission.
- When a facility receives a post-emergency room transfer.
- When surgical day care results in an observation stay or inpatient admission.
- When any change (e.g., diagnosis, procedure, date of service, etc.) related to a previous notification is made.

Notification does not guarantee payment by LMA. Only claims for services that are covered under eligible members' benefit plans are reimbursed.

The Utilization Management Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes and authorization determination, and notifies the provider and member of the determination. Below is an example of LMA authorization form and the information required for us to make a decision.

Decision and Time Frames

Type of Authorization	When to Use	Time Frame
Expedited	If a provider believes waiting for a decision under the routine time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you may request the authorization to be expedited	72 Hours
Routine Authorization	If not an urgent matter	14 Calendar Days
Concurrent Review	Medical necessity for continued inpatient stay	24 hours or the next business day following
Retrospective Review	Occurs after services have been rendered and must be sent in 7 calendar days or UM will issue a dismissal notification.	Within 30 calendar days of receiving all pertinent clinical information

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

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

Concurrent Review

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

- Covered services are provided at the appropriate level of care, and
- Services are administered according to the member's policy.

LMA utilizes CMS guidelines and InterQual to review criteria, LMA Utilization Management department and the Plan's Medical Directors will conduct a medical necessity review. LMA is responsible for final authorization.

LMA preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility Utilization Management staff within 1 business day of notification or on the last covered day. If clinical information is not received within 24 hours of admission or on the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria.

Specific to our I-SNP – Review is not required for readmission to the referring nursing facility (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be faxed to 1-877-760-3560.

A LMA Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the LMA Medical Director deems the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The UM nurse or designee will notify the provider(s), e.g., facility, attending/ordering provider verbally and in writing and will notify the member as required by law. The criteria used for the determination are available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact 1-844-854-6884 (TTY 711).

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

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

Rendering of Adverse Determinations (Denials)

In some instances, the UM staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility. Late

authorization, or not providing clinical information as requested, will result in an administrative adverse determination, and does not allow the provider to appeal. UM will not review retro requests that are submitted 7 calendar days or more after the date of service.

Only a LMA Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, LMA notifies the facility or provider's office of the denial of service. Notices are issued to the provider, the member, or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal.

The PCP or Attending Physician may contact the Medical Director by phone to discuss decisions only before an adverse determination is rendered.

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

Notification of Adverse Determinations (Denials)

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

Type	Number of Days
Non-Urgent pre-service decisions	14 Calendar Days of the request
Urgent pre-service decisions	Within 72 hours of the request*
Urgent concurrent decisions	Within 24 hours of the request*

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

Retrospective Review

Retrospective review is the process of determining coverage after treatment has been given. LMA policy is to allow 7 calendar days for the review to be considered. The retrospective service request will be reviewed by the Utilization Management Team. If the request is received after 7 calendar days, LMA's Utilization Management Team will issue a notification of dismissal.

These evaluations occur by:

- Confirming member eligibility and availability of benefits

- Analyzing patient care data to support the coverage determination process
- Receiving supporting clinical documentation from providers with payment request

Retrospective review is available when:

- Precertification/notification requirements were met at the time service was provided, but the dates of service do not match the submitted claim.
- LMA converts from secondary payer to primary payer at the time of inpatient claims adjudication.

Retrospective review is not available when claims are for:

- Elective ambulatory or inpatient services on the LMA precertification list for which precertification did not occur before providing the service.
- Emergency inpatient services on the previously mentioned precertification lists did not meet notification requirements (notification of inpatient admissions is required within one business day of the admission date).
- Services not included on the precertification list.
- Services that do not require pre-certification under the terms of a member's plan.

Retrospective reviews shall be completed within 20 business days from receipt of the request.

Request for Medical Records and Review

The purpose of medical record reviews is to determine compliance with LMA standards for documentation, coordination of care and outcome of services; to evaluate the quality and appropriateness of treatment and to promote continuous improvement. These reviews are performed to evaluate compliance with requirements and do not define standards of care or replace a practitioner's judgement.

On an ad hoc basis, we conduct a review of our members' medical records. The request may be to assist in rendering a decision or periodic audit of member records. The medical records you maintain should include the following:

Problem list with:

- Biographical data with family history
- Past and present medical and surgical intervention
- Significant medical conditions with date of onset and resolution
- Documentation of education/counseling pre and posttests, including results
- Entries dated and signed
- Legible entries
- Medication for allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times).

- Medication record, including names of medication, dosage, amount dispenses and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consist with findings
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or another follow-up
- Consultations, labs, imaging and other special studies initiated by primary care provider to indicate review
- Consultation and abnormal studies including follow-up plans
- Hospitalization Record Requirements:
- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventative screening and services
- Documentation of behavioral health assessment

Hospital Observation

LMA requires notification for a Hospital Observation by furnishing the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though LMA waives the 3 days stay requirement for our I-SNP program.

- The MOON is a form that must be delivered before the member receives 24-hour observation as an outpatient.
- If the member is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of Medicare observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- The MOON notice is required to be delivered to a psychiatric hospital.

Further information can be found at the CMS site: cr9935-moon-instructions.pdf.

Emergency Admissions

Per CMS guidelines: An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson,

with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention in:

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

Members are instructed to call 911 and/or go to the nearest emergency room for treatment if they believe that they are having a medical emergency. Medical emergencies include but are not limited to: severe chest pain, shortness of breath, uncontrolled bleeding, broken bones, sprains, burns, poisoning, convulsions and extended fever.

All LMA members or responsible parties are informed that they should contact their PCP prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, LMA realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition. In these cases, the member may contact the specialist for instructions. LMA requests that the member and their PCP connect within 24 hours of the ER to schedule and track follow-up care.

Physicians, specialists and covering physicians must provide advice, consultation, and access to care appropriate for each member's medical condition.

- All Life-threatening conditions must be referred to the nearest emergency room.
- All providers must notify LMA of known emergency room visits and emergency room admissions within 1 business day.
- Providers directing members to an emergency room for treatment are required to notify the emergency room of the pending member arrival.
- Specialty care providers referring members to the ER are required to notify the primary care provider of member's emergency service visit. If the ER visit occurs during a weekend, the specialist must provide notification within 1 business day of referral.

ER services do not require prior authorization but notification of an inpatient admission needs to go to UM at LMA.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. UM will review emergency admissions within one business day of notification. The hospital shall not be entitled to compensation from LMA for provider services rendered if the hospital fails to notify LMA of admission within the agreed upon time period.

LMA makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. LMA.

If a member meets an acute inpatient level of stay, admission starts at the time you write your order.

Inpatient Admissions

All non-emergency hospital admissions require pre-certification by contacting LMA UM department at UM@LibertyMedicareAdvantage.com or fax 1-877-760-3560.

CHAPTER NINE: CARE MANAGEMENT

CARE MANAGEMENT

Case Management Overview

The Care Manager is the primary point of contact who facilitates communication between the PCP, the member and/or member's family, nursing facility and any required specialty care or other social or other services. The Care Manager engages other core ICT participants including the PCP and the member/caregiver in order to develop trust, strengthen communication, and coordinate individual member's ICPs. This relationship enhances understanding and coordination of services, improving members' care.

Our care model utilizes Care Management Team with the Care Manager as the hub of the members Interdisciplinary Care Team (ICT). ICT is assembled by the Care Manager and is intended to address the entire spectrum of care for the member based on HRAT results and ICP content such as prevalence of certain chronic diseases or conditions, cognitive and social needs. The ICT is primarily responsible for informing, maintaining and coordinating the member's care plan. The ICT includes and collaborates with the member's providers, specifically the member's PCP and appropriate chronic condition specialists, as determined by the Care Manager.

LMA has implemented the MOC in the nursing home, ALF and community settings where the appropriate person/role will provide care management, clinical care, and education to the member, as well as education to the staff or PCP. The Care Management Team facilitates early identification, intervention, communication, and coordination of the appropriate services in a quality cost effective manner.

LMA conducts an initial and annual health risk assessment for each member using the Health Risk Assessment Tool (HRAT) to determine individual health care needs. The HRAT is used for all members. The assessment covers multiple important domains to manage individuals with chronic conditions including medical history, functional status, psychosocial and cognitive status, and mental health history and well-being.

Some members' care may be coordinated by two or more Care Managers who share responsibility for care management, clinical documentation and ICT communications. Care Plans modified by LPNs must be reviewed and approved by an RN or APP.

Coordination of Care Includes:

- Facilitate the completion of the initial and annual HRAT's and review the HRAT schedule to ensure that all annual HRAT's are completed on a timely basis. The HRAT is completed upon enrollment into the plan, and annually before the anniversary of the member's last completed HRAT.
- Reviews and modifies the care plan

- Tracks care plan implementation
- Facilitate the care plan's communication to the ICT for discussion and customization to the member's specific care needs.
- Coordinates Behavioral Health consults based on member needs
- Ensures that Transitions of Care are properly coordinated with all members of the care team.
- Contact members telephonically or in-person and track progress against their care plans
- Promote member empowerment by facilitating resources and benefits to develop skills to remain safely in the most independent health care / residency location available.
- Maintain strong working knowledge of the healthcare community to advise for appropriate care setting in regards to network participation and other factors.
- Maintain strong working knowledge of community-based resources to aid members in their needs for non-healthcare related services such as custodial care, meals, or other traditional Medicaid benefits
- Arrange or coordinate pre- and post-acute care needs upon notification of a transition.

Provides education:

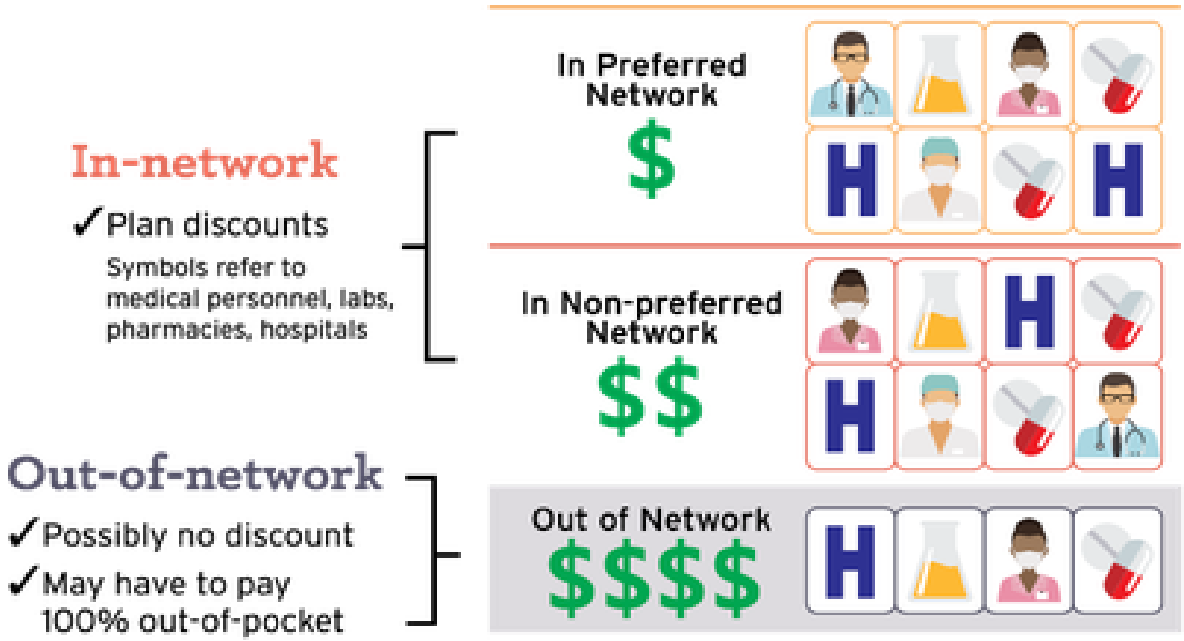
- Advocates, informs and educates members and family members through regular meetings and informal discussions as part of the care team. Provides self-management education to the member.
- Educates NF staff, with assistance from the facility account managers, through ICT meetings and regular communications when on site.

Update of the Individualized Care Plan (ICP)

At a minimum, an ICP update is driven by an annual HRAT reassessment or a re-assessment due to a transition of care or change in health status. The goals and modified ICP are shared verbally with the member or caregiver to promote understanding of an agreement with what has been captured and the intended course of care management and coordination. The Plan also either mails, faxes, posts to the care management system/portal or makes the updated ICP available

upon request to the Interdisciplinary Care Team (including the PCP and other specialists, as needed) and contacts them for telephonic review as appropriate.

CHAPTER TEN: PROVIDER NETWORK INFORMATION



PROVIDER INFORMATION

Joining Our Network

To become part of our Network it starts with an application! First e-mail us at Contracting@LibertyMedicareAdvantage.com. You will be sent an application requesting the information below.

Dear Provider/s:

Thank you for considering becoming a participating provider with Liberty Advantage! Please complete the information below and a contracting representative will be in touch with you shortly.

Provider NPI	
Provider Last Name, First Name	
PCP Y/N	
Specialty	
Practice/Clinic Name	
Practice Address 1	
Practice Address 2	
Practice City, State, Zip	
Practice County	
Practice Phone	
Contact Name	
Provider e-mail address	

Please email to:
LibertyProviderIVR@mirrahealthcare.com
Thank you so much and we look forward to working with you.

Provider Credentialing Process

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to 60 days for completion from the date a complete application is received by LMA. LMA facilitates all credentialing activities, requiring all sections of the uniform application to be completed accurately, along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform Application to participate as a health care practitioner
- Drug Enforcement Administration (DEA)
- Sufficient comprehensive general liability and professional insurance coverage
- Medicare/Medicaid sanctions
- National Practitioner Databank (NPDB)
- Hospital Privileges or letter stating how patients are admitted
- Board certification*
- Other pertinent documentation
- In some instances, a letter of recommendation from the chief of staff or department chair may be required.

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Please send your completed documents to: Contracting@LibertyMedicareAdvantage.com.

Office Site Evaluations

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

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

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

Facility/Organizational Provider Selection Criteria

When assessing organizational providers, LMA utilizes the criteria below:

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

Facility/Organizational Provider Application Requirements

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
- If resp9onded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required
- Copies of all applicable state and federal licenses (i.e., facility license, DEA, Pharmacy License, etc.)
- Proof of current professional and general liability insurance as applicable.
- Proof of Medicare participation
- Copy of DEA Registration
- If accredited, proof of current accreditation
    - Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high-tech radiology providers who perform MRIs, CTs and /or Nuclear/PET studies.
- If accredited, a copy of any state or CMS site survey that has occurred within the last 3 years including evidence the organization successfully remediated any deficiencies identified during the survey.

Facility/Organizational Site Surveys

As part of the initial assessment, an on-site review will be required at all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted after the receipt of a complaint.

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

Pending Credentialing

The LMA credentialing department must deem a practitioner's credentialing complete and effective on or before providing services to a LMA member in order to receive the practioners contracted reimbursement for members covered services.

Claims for covered services provided to members by a non-participating practitioner in a participating provider group will be denied unless pre-approved. LMA member will be held harmless, including copayments, coinsurance and/or deductibles.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least 30 days in advance. The Plan will establish a time for provider to view the information at the LMA office.

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

Providers have the right to be informed of the status of their application and may request the status of the application either telephonically or in writing. LMA will respond within 2 business days and may provide information on any of the following: application receipt date, any anticipated committee review date, and approval status.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process before approval or re-approval as a participating provider. LMA Medical Director may approve providers who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration.

The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and re-credentialing process must be obtained and verified within 180 days before presentation to the Medical Director of the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discrimination in the Decision-Making Process

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

Provider Notification

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

Appeals Process and Notification of Authorities

In the event a provider's participation is limited, suspended or terminated, the provider is notified in writing within 60 days of the decision. Notification will include:

- The reason(s) for the action,
- Outlines the appeals, process or options available to the provider, and
- Provides the time limits for submitting an appeal.

A panel of peers review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the NPDB are notified of the action.

Confidentiality of Credentialing Information

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

Ongoing Monitoring

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

Provider Directory

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

Never Event Policy

The CMS Program established in August 2007 initiatives to track “serious preventable events” and “hospital acquired conditions” that occur in a hospital setting.

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events are identified by several internal and external mechanisms such as, but not limited to, claims payment, retrospective reviews, utilization management case review, complaint and grievance review, fraud and abuse investigations, through notification by practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the Quality Improvement Department. The process includes a medical record review and possible telephonic or mail communication with the practitioner/provider. Upon final determination of an actual event occurring, LMA will notify the practitioner/provider by mail that payment denial or retraction will occur.

Quarterly Attestation or Provider Changes

On a quarterly basis, we will require you to attest that all information in our provider directory is accurate and no changes are needed. If changes are made prior to quarterly attestation please notify LMA. Below is a list of categories we would need to be notified of if a change occurred:

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

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

Closing Patient Panel

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

CHAPTER ELEVEN: PROVIDER RESPONSIBILITIES

PROVIDER RESPONSIBILITIES

LMA contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide the best care for our members. Practitioners and other healthcare providers are valued partners in providing continuity and quality of care for our membership.

Role of Primary Care Physician (PCP)

PCPs will provide regular patient care services, and work directly with the LMA Nurse Practitioners (or Case manager) to provide and oversee all aspects of member care including evaluating, recommending, or providing treatments to optimize members' health status.

PCPs will be key participants in the member's interdisciplinary care team, directly supervise Plan midlevel care, and be accountable for all care decisions for members assigned to them.

The PCP is responsible for managing all the health care needs of a LMA member as follows:

- Manage the health care needs of LMA members who have chosen the physician as their PCP
- Ensure that members receive treatment as frequently as is necessary based on the member's condition
- Develop an individual treatment plan for each member along with LMA care team
- Submit accurate and timely claims and encounter information for clinical care coordination
- Comply with LMA prior authorization and referral procedures
- Refer members to appropriate LMA participating providers
- Comply with LMA Quality Management and Utilization Management programs
- Use appropriate designated ancillary services
- Comply with emergency care procedures
- Comply with LMA access and availability standards as outlined in this manual, including after-hours care
- Submit claims to LMA in accordance with our billing policies
- Ensure that, when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to LMA medical record standards as outlined in this manual

Access and Availability Standards

LMA has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance standards, and to take corrective action as needed. LMA also requires all providers to offer standard hours of operation, that:

- Do not discriminate against Medicare enrollees, and
- Are convenient for LMA members, the facilities where members reside, and facility staff who aid in our members' care.

Appointment Standards

LMA members should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate time frame, LMA will facilitate an appointment with another participating provider.

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately seen or instructed to call 911 or go directly to the nearest emergency room
Wait time for Urgent Care Appointments	Within 24 hours
Wait time for Non-Urgent Sick Visit	Within 1 week
Wait time for Routine Wellness Appointment	Within 30 days
After-Hours Care Accessibility	Access to a practitioner 24 hours a day/7 days per week (telephone is acceptable)
Waiting time in the Waiting Room	No more than 30 minutes or up to 1 hour when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult need.
Specialist Visit	21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding member.
Telephone Access includes members and LMA staff	• Emergency calls, both weekdays and after-hours calls, will be dealt with immediately. Returned within 30 minutes. • Routine care calls, both weekdays and after-hours calls will be returned promptly.

A provider may not balance bill a member for providing services that are covered by LMA. This excludes the collection of standard co-pays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.

Coverage Arrangements

All participating providers must ensure 24 hour 7 days a week coverage for members. All encounters must be billed under the name of the rendering practitioner, not the member's assigned PCP. Reimbursement will be paid directly to the participating covering practitioner. Covering practitioners, whether participating or not, must adhere to all of LMA administrative requirements. Additionally, covering practitioners must agree not to balance bill the member for any covered services. The covering practitioner should report all calls and services provided to the members PCP. Participating practitioners will be held responsible for the actions of the non-participating coverage practitioner. Participating practitioners will not sue any practitioner who is excluded from the Medicare program for coverage in their absence. PCP agree that, in their absence, timely scheduling fo appointments for members should be maintained.

Missed Appointments

A member who misses an appointment without notification is considered a "no-show". Providers should have a process in place to ensure that the "no-show" is documented within the member's medical record. Members with chronic failure to attend appointments should be brought to the attention of LMA Care Manager for follow-up.

Office Hours

Office hours for all physicians should be posted and should be reasonable. Hours of operations must be convenient and not discriminate against LMA members.

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each provider is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. LMA will assist providers in locating resources upon request.

Provider Marketing Guidelines

Below is a general guideline to assist LMA providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to a number of plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent.

Providers remain neutral parties to the extent they assist beneficiaries with enrollment decisions. ***LMA Providers Can:***

- Mail or provide a letter to patients notifying them of their affiliation with LMA

- Provide objective information to patients on specific plan attributes and formularies, based on a patient's medications and healthcare needs in the course of treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPS), LMA marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Provide beneficiaries with communication materials furnished by LMA in a treatment setting.
- Refer patients to the plan marketing materials available in common areas.
- Display and distribute in common areas LMA marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Display promotional items with LMA logo.
- Allow LMA to have a room/space in provider offices completely separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a LMA sales representative.

Providers Cannot:

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

Member Assignment to New PCP/NFist – I-SNP Program

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

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

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists. If the member's behavior cannot be remedied through reasonable efforts, and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to LMA. LMA will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment.

If so, LMA will document all actions taken by the provider and to cure the situation, including member education and counseling. A LMA PCP/NFist cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

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

Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues identified by the Utilization Management staff and referred to LMA Quality Improvement Department staff.

They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting indicative of potentially inappropriate or incomplete medical care. Complaints about

Quality of Care are those concerns reported by members, families, or providers indicating a potential problem in the provision of quality care and services.

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

Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-op complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome) Quality complaints are categorized as:
    - Access to care
    - Availability of services
    - Clinical quality concerns
    - Provider/staff concerns All Quality-of-Care issues are reviewed and investigated.

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

CHAPTER TWELVE: CORPORATE PROGRAMS

Corporate Programs

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at LMA is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so the Plan may fully realize its vision, mission, and commitment to member care.

In the implementation of the QI Program, LMA will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver healthcare services to meet the health needs of its target population.

The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness, and outcome of care/services delivered to Great Plains Medicare Advantage's members. Also, to provide mechanisms for continuous improvement and problem resolution. LMA Quality improvement activities include the following:

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

Corporate Compliance Program Overview

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

Further, LMA Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations. LMA and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines LMA's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, our members.

LMA and its employees are also committed to meeting all contractual obligations outlined in LMA contracts with the CMS. These contracts allow LMA to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries through the Special Needs Programs. The Corporate Compliance Program is designed to prevent violations of federal and state laws governing LMA lines of business, including but not limited to, healthcare fraud, waste and abuse laws.

In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities. LMA has in place policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement.

LMA also has policies ensuring the Plan will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designers. If you have compliance concerns or questions, call LMA Hotline toll-free at 1-866-380-0075.

Fraud, Waste, and Abuse

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

The evaluation and detection of fraudulent and abusive practices by LMA encompasses all aspects of LMA business and its business relationship with third parties, including healthcare providers and members.

All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at 1-866-380-0075. The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affect LMA ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at compliance1@libertyadvantageplan.com

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or another party that reports compliance concerns in good faith can do so without fear of retaliation. Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, LMA conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers.

The analysis allows LMA to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. LMA will review your coding and may review medical records of providers who continue to show significant variance from their peers.

LMA endeavors to ensure compliance and enhance the quality of claims data, a benefit to both LMA medical management efforts and our provider community. To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards. You may request a copy of the LMA Compliance Program document by contacting compliance1@libertyadvantageplan.com.

CHAPTER THIRTEEN: PHARMACY OPERATIONS

PHARMACY OPERATIONS

Liberty Medicare Advantage provides Medicare Part D prescription drug coverage through our partner Navitus Health Solutions.

Navitus Health Solutions is a full-service pharmacy benefit management company committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence.

For Prescribers:

Access Formulary and Prior Authorization Forms at www.navitus.com

- Select “Prescribers” and click on “Prior Authorization”
- Enter your NPI number and State to access the prescriber portal
- Navitus Health Solutions Pharmacy Helpdesk
- Phone number 1-866-270-3877
- TTY phone number: 711
- Refer to the Prescription Drug Benefit page for formulary, prior authorization criteria, and step therapy criteria

For Pharmacies:

Access payer sheets and other information at www.navitus.com

- Select “Pharmacies” and click “Pharmacies Login”
- Enter your NPI number and NCPDP number to access the pharmacy portal
- Navitus Health Solutions Pharmacy Helpdesk
- Phone number 1-866-270-3877
- TTY phone number: 711
- Refer to the Prescription Drug Benefit page for formulary, prior authorization criteria, and step therapy criteria