PROVIDER MANUAL

MASS ADVANTAGE

Plan to love your plan.

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INTRODUCTION

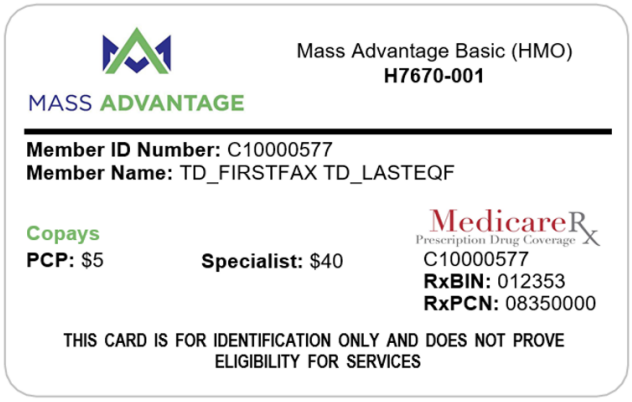
About This Manual

Mass Advantage was built by local providers for local people and the Mass Advantage philosophy is "Plan to Love Your Plan"; our provider network is an essential component of that promise. Mass Advantage is committed to partnering with our providers to remove the administrative burden so that you can spend more time caring for your patients in a way that best meets their needs. We've worked hard to develop our plan policies with our providers in mind and developed this manual as a reference and resource for Mass Advantage's provider network. The manual will be updated as needed and the most current version can be found online at www.massadvantage.com.

FAST FACTS

Sample ID Cards

Mass Advantage Basic (HMO)


MASS ADVANTAGE

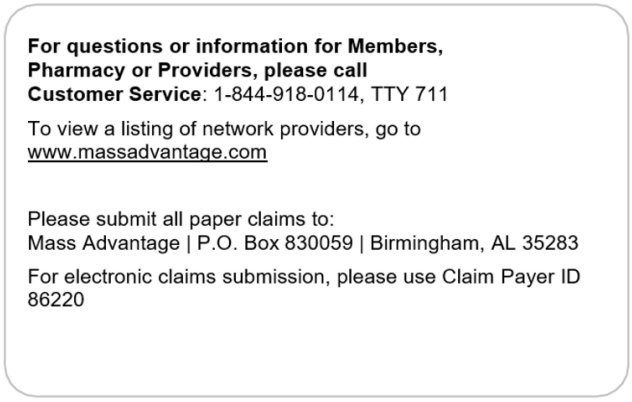
Mass Advantage Basic (HMO)
H7670-001

Member ID Number: C10000577
Member Name: TD_FIRSTFAX TD_LASTEQF

Copays
PCP: $5 **Specialist:** $40

MedicareRx
Prescription Drug Coverage
C10000577
RxBIN: 012353
RxPCN: 08350000

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICES

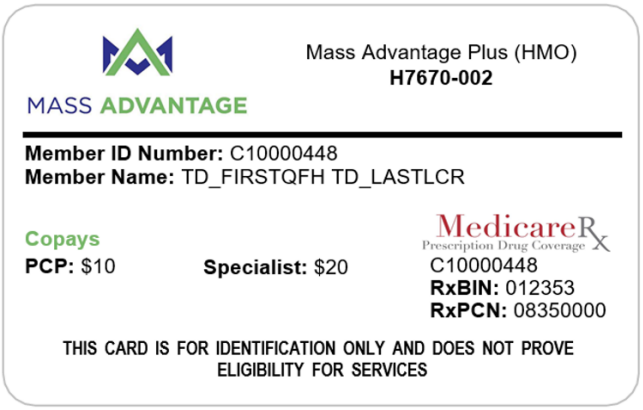

For questions or information for Members, Pharmacy or Providers, please call
Customer Service: 1-844-918-0114, TTY 711

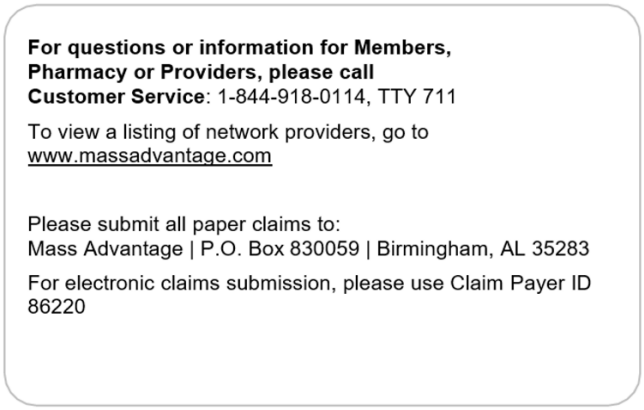
To view a listing of network providers, go to www.massadvantage.com

Please submit all paper claims to:
Mass Advantage | P.O. Box 830059 | Birmingham, AL 35283

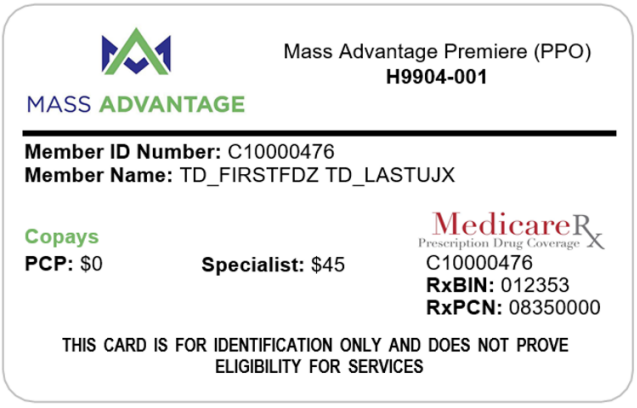
For electronic claims submission, please use Claim Payer ID 86220

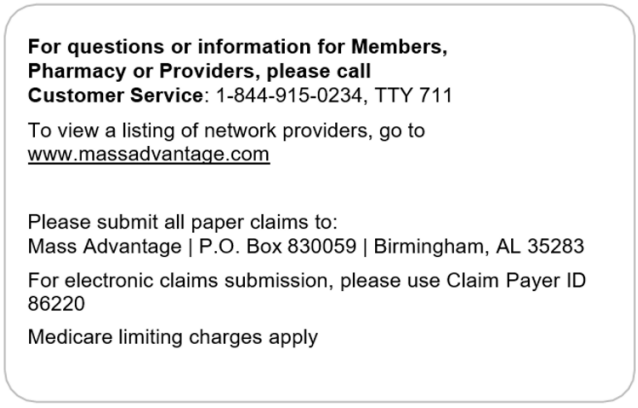
Mass Advantage Plus (HMO)





Mass Advantage Premiere (PPO)





Important Facts and Contact Info

Contact Information	
Member Services	• 844-918-0114 (HMO) • 844-915-0234 (PPO) • TTY: 711
Provider Services	• 844-918-0114 (HMO) • 844-915-0234 (PPO) • TTY: 711
Eligibility and Benefits	• 844-918-0114 (HMO) • 844-915-0234 (PPO) • TTY: 711

Contact Information	
Claims	• Electronically: Claim Payor ID 86220 • Paper: PO Box 830059 Birmingham AL 35283
Appeals	• For Claims: Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043 • For Medical Care: 1-888-656-7783 • For Part D Prescription Drugs: 1-888-904-1139
Authorizations	• For Medical and Behavioral Health: 1-888-656-7783 • For Part D Prescription Drugs: 1-888-904-1139
Website	• www.massadvantage.com

OUR PLANS

Mass Advantage offers three Medicare Advantage Part D (MAPD) plans serving those who have both Medicare Parts A and B and live in Worcester County, Massachusetts:

1. Medicare Advantage Basic (HMO)
2. Medicare Advantage Plus (HMO)
3. Medicare Advantage Premiere (PPO)

BENEFITS

Mass Advantage members are eligible for all benefits covered under the Original (Fee-for-service) Medicare Program. In addition, Mass Advantage offers benefits for pharmacy, dental, vision, hearing and health and wellness services. For a complete list of covered benefits, please refer to the Evidence of Coverage.

Evidence of Coverage

Summary of Benefits

Members obtain most of their healthcare services directly from their primary care provider depending on plan type.

Summary of Benefits

The covered services listed in the Summary of Benefits are covered only when all requirements listed below are met:

- Services must be provided according to coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Medically necessary refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the member's doctor. Certain preventive care and screening tests are also covered.
- HMO covered services must be provided by plan providers.
- Certain services require prior authorization by Mass Advantage.
- For those temporarily out of the service area emergency and urgently needed services will be covered as provided in 42 CFR 422.113 and renal dialysis services will be provided in accordance with 42 CFR 422.100(b)(1)(iv).

Providers and members must comply with any administrative, billing or payment policies established under Medicare or by Mass Advantage. For example, some covered services require "prior authorization" by Mass Advantage to be covered.

Pharmacy Benefits

Prescription drug benefits are available to all Mass Advantage members. Prescriptions must be on-formulary (or subject to an exception), meet other coverage and administrative criteria, and be filled by a participating pharmacy to be covered. Mass Advantage contracts with a network of chain, independent, home infusion and long-term care pharmacies.

A list of participating pharmacies is available on our website at http://www.massadvantage.com or contacting the Mass Advantage Provider Services Department at:

844-918-0114 (HMO)

844-915-0234 (PPO)

TTY: 711

From October 1 to March 31, we're available 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we're available Monday through Friday from 8 a.m. to 8 p.m. EST.

When a member travels outside of the plan service area a national network of pharmacies is available. If a member must use an out-of- network pharmacy, they will generally have to pay the full cost of the prescription in some cases or a copay/coinsurance differential. The member may request to be reimbursed for the cost covered by Mass Advantage via Direct Member Reimbursement on our website at www.massadvantage.com or by contacting the Mass Advantage Member Services Department at:

844-918-0114 (HMO)

844-915-0234 (PPO)

TTY: 711

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Prescription coverage and cost varies by plan.

Formulary

Mass Advantage offers an extensive drug formulary. Generic prescriptions, when appropriate, are the most cost-effective alternatives. Mass Advantage's formulary includes a complete list of the drugs that we cover, generic and brand name and any requirements, limits and/or restrictions for each drug, if applicable. Visit http://www.massadvantage.com for the most recent version of the formulary.

Co-payments/Co-insurance

Member cost sharing for medications varies by plan, drug type and the amount of financial help, if any, that the member may receive. Members should contact Mass Advantage Member Services to learn more about their specific coverage.

Please Note: Mass Advantage may place limits on the amount of medication a member may receive. Members can receive up to a 30 or 90-day supply of medication for prescriptions filled at an in-network retail pharmacy. A 90-day mail order benefit is also available for all plans. Patients in Long Term Care settings are able to receive a 31-day supply.

Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include: prior authorization, quantity limits, or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Drug Exception Form for the non-formulary product. Please refer to our website at www.massadvantage.com for this form. Please refer to the Referral and Authorization Section of this manual for information regarding requesting non-formulary drugs.

Drug Exclusions

- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations - American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If one of these reference books, known as compendia, does not support the diagnosis indicated by the provider then the drug may not be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs."

Drugs Covered under Part B

Drugs covered under Part B are typically injectable or infusible and are not self- administered but are administered as part of a physician's service. Some examples include certain cancer drugs and blood clotting factors. Additional items that are covered under Part B include insulin when administered via pump, medications used via nebulizers, and diabetes test strips. These medications are typically available to members at their pharmacy, via a DME supplier, or an outpatient infusion site.

Drugs Covered under Part B or Part D

Some drugs can fall under either Part B or Part D. The determination of coverage as to whether the drug is covered under Part B or Part D is based on several factors such as diagnosis, route of administration and method of administration. For a list of medications in this category, refer to the CMS website at www.cms.gov; choose Medicare -> Prescription Drug Coverage-General Information -> Downloads, and select the appropriate document. Alternatively, you may contact the Mass Advantage Provider Services department at:

844-918-0114 (HMO)

844-915-0234 (PPO)

TTY: 711

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Home Infusion

Mass Advantage will cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. For information on home infusion therapy, contact the Mass Advantage Provider Services Department at:

- 844-918-0114 (HMO)
- 844-915-0234 (PPO)
- TTY: 711

Vaccines

Part D covers most preventive vaccines. Examples of Part D vaccines include the shingles and TDAP vaccines; Part B covers vaccines that are directly related to the exposure to a disease or condition. Examples of Part B vaccines include flu, pneumococcal, hepatitis B, COVID, and some other vaccines (i.e., Hepatitis B) for intermediate or high-risk individuals. Detail vaccine coverage information is outlined in Appendix I.

General Exclusions and Limitations

Exclusions and limitations are described in the Evidence of Coverage (EOC) booklet. The Evidence of Coverage booklet can be found on Mass Advantage's website at www.massadvantage.com.

At any time during the year, there can be changes in Medicare laws and regulations as well as local coverage determinations and national coverage determinations applicable to the Original Medicare program. Since Mass Advantage covers what Original Medicare covers, such changes would affect coverage under Mass Advantage as well.

MEMBER ENROLLMENT

The Centers for Medicare and Medicaid Services (CMS) has periods when beneficiaries can enroll or disenroll with/from Medicare. These times are known as election periods. Members can enroll into our plan by using any of these methods:

- Mailing in a paper enrollment form
- Enrolling on-line through Medicare's website
- Enrolling online: www.massadvantage.com
- By calling Mass Advantage at:

  844-918-0114 (HMO)

  844-915-0234 (PPO)

  TTY: 711

From October 1 to March 31, we're available 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we're available Monday through Friday from 8 a.m. to 8 p.m. EST.

Each Mass Advantage member will receive an ID card, which is issued once, unless cards are requested or reissued due to a demographic or plan change. ID Cards are valid for as long as the person is a member of Mass Advantage.

MEMBER DISENROLLMENT

A voluntary disenrollment may occur as a result of a written request by the member.

An involuntary disenrollment may occur as a result of, including but not limited to, one of the following:

- If the member does not stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If the member gives false or deliberately misleading information on the enrollment application having an impact on whether they qualify.
- Disenrollment for individuals who are not lawfully present in the United States.
- Disenrollment for individuals who are incarcerated in the United States.
- If member behaves in a way that is unruly, uncooperative, disruptive or abusive and his/her behavior seriously affects your ability to arrange or provide medical services, you must notify Mass Advantage. Before making a determination to disenroll the member for this reason, Mass Advantage must obtain permission from the Center for Medicare and Medicaid Services (CMS).
- If the member allows someone else to use his/her member ID card in order to obtain medical care. Before disenrolling the member, Mass Advantage must refer the case to the Office of the Inspector General and this may result in criminal prosecution of the member and the person(s) seeking care.

PROVIDER CREDENTIALING

Purpose of Credentialing

Credentialing is the process of validating a provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of malpractice histories, quality of care concerns and licensure status. Mass Advantage prides itself on the integrity and quality of the composition of the provider and provider networks.

Credentialing Standards

Mass Advantage has established credentialing and recredentialing policies and procedures that meet CMS and NCQA standards.

In order to initiate the credentialing process, providers are required to submit all applications and attachments in a timely manner with the most current information available.

For more information on Mass Advantage's credentialing and recredentialing policies and procedures, refer to Appendix II.

PROVIDER RESPONSIBILITIES

Mass Advantage Provider Network

Mass Advantage contracts with primary and specialty care providers, hospitals, and ancillary providers to care for our members. Mass Advantage also has an extensive network of pharmacies to service members across our service area. Participation in Mass Advantage in no way precludes participation in any other program with which the provider may be affiliated. To find a provider, go to www.massadvantage.com and access Mass Advantage's On-Line Provider Directory.

The following sections outline the basic guidelines for our network providers. These requirements are organized into responsibilities for all providers, for primary care physicians, for specialists, and for physician extenders. This section will be updated, as necessary, with any regulatory changes that require revisions to standard responsibilities.

TITLE VI of the Civil Rights Act of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of interpreter or translator services as necessary for these members.

Coverage Arrangements

All participating providers must ensure 24-hour, 7 days-a-week coverage for members. Coverage arrangements should be made with another Mass Advantage participating provider. All encounters must be billed under the name of the rendering provider, not the member's assigned primary care provider. Reimbursement will be paid directly to the participating covering provider.

Covering providers, whether participating or not, must adhere to all of Mass Advantage's administrative requirements. Additionally, covering providers must agree not to bill the member for any covered services. The covering provider should report all calls and services provided to the member's primary care provider. Participating providers will be held responsible for the actions of their non-participating coverage providers. Participating providers will not use a provider who is excluded for the Medicare program for coverage in their absence.

Primary care providers agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Access Standards

Primary care providers agree to meet Mass Advantage's access standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately upon presentation, instructed to call 911, or directed to the nearest emergency room
Wait time for Urgent Care Appointment	Within 48 hours
Wait time for Persistent Symptoms	No later than the end of the following business day after their initial contact with the PCP site
Wait time for Routine Care Needs/Wellness Appointment	Within 30 calendar days
After Hours Care	Access to a provider 24 hours/7 days a week, 365 days a year
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour following appointment time when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a complex need

Specialty Care Providers agree to meet Mass Advantage's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Symptoms	Immediately upon presentation, instructed to call 911, or directed to the nearest emergency room
Wait time for Persistent Symptoms	No later than 30 calendar days after the initial contact with the specialist site
Wait time for Routine Care Needs	Within 12 weeks

Behavioral Health Providers agree to meet Mass Advantage's appointment standards, as follows:

REQUIREMENT	STANDARD
Care for non-life-threatening emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial visit for routine care	Within 10 business days

A member should be seen by a provider as expeditiously as the member's condition warrants, based on the severity of symptoms. If a provider is unable to see the member within the appropriate timeframe, Mass Advantage will facilitate an appointment with a participating or non-participating provider, if necessary.

Office Hours

Office hours for all physicians should be posted and must be convenient and not discriminate against Mass Advantage members relative to:

- Other, non-Medicare members
- Members who require access to care after normal business hours (5:00 p.m. – 9:00 a.m.) for urgent medical events that require attention after hours.
- Members who are not able to take time off from work to receive their care (Medicare Working-Aged).

Provider Information Changes

Providers are required to submit sixty (60) calendar day advance written notice of any demographic or panel status changes. All changes must be submitted in writing to Mass Advantage on provider letterhead.

Patient Safety

Patient safety is the responsibility of every healthcare professional.

Providers are required to meet safety standards in accordance with the Occupational Safety and Health Administration (OSHA), Americans with Disabilities Act (ADA), Rehabilitation Act, and other federal/state regulatory requirements. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and table, examination room, and medical equipment are in good working order.

Providers will establish a plan in compliance with OSHA standards regarding blood borne pathogens. In addition, provider will make the necessary provisions to minimize sources and transmission of infection in the office.

Member Confidentiality

All providers participating with Mass Advantage have agreed to abide by all policies and procedures regarding member confidentiality. Under these policies, the provider must meet the following:

Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including, but not limited to the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
- The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations
- The HIPAA Omnibus Rule, effective 3-26-2013 with a compliance date of 9-23-2013

Mass Advantage follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatment, or operational function.

Verifying Member Eligibility

A member ID card alone does not verify a member's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Providers are required to take the following steps prior to administering services:

1. Verify member's eligibility with Mass Advantage. Members are eligible if:
    a. currently enrolled
    b. eligible for the requested services
    c. not exhausted his or her benefits
2. Check the authenticity of the member's ID card to avoid problems with identity theft or fraud. Be sure to ask the member for an additional form of identification such as a driver's license.
3. Make a copy of the member's ID card and make it part of the member's medical record.

All providers are responsible for the verification of member eligibility prior to rendering services to ensure reimbursement. Providers can verify eligibility through the provider eligibility verification line at 844-918-0114 (HMO), 844-915-0234 (PPO) or TTY: 711, from October 1 – March 31, seven days a week, from 8:00 a.m. – 8:00 p.m. and from April 1 – September 30, Monday through Friday, 8:00 a.m. – 8:00 p.m.

Advance Directives

As a participating provider within the Mass Advantage network, you are responsible for determining whether any member you provide services to has executed an advance directive and for providing education about advance directives when it is requested. A copy of the "Living Will" form should be maintained in the member's medical record. Providers should ask members age 21 and older whether they have executed an advance directive and document the member's response in their medical records. If a member has executed an advanced directive, it will be placed in the medical record in an area that is clearly marked "Advanced Directives". Providers requiring additional information and guidance on Advance Directives are encouraged to visit Massachusetts Medical Society: Health Care Proxies and End of Life Care (massmed.org).

Transfer of Non-Compliant Members

Primary care providers agree (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Mass Advantage members on the basis of race, sex, age, religion, place of residence, health status or source of payment; and (b) to observe, protect and promote the rights of members as patients. Primary care providers shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the provider's panel. Mass Advantage's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given provider.

Should an incidence of inappropriate behavior occur, and transfer of the member is desired, the provider must send a letter requesting that the member be removed from his/her panel including the member's name, Mass Advantage ID Number, and details of the non-compliant behavior to the Mass Advantage Enrollment Department at:

Mass Advantage, PO Box 830059, Birmingham, AL 35283

The Enrollment Department notifies the requesting provider in writing when the transfer has been completed. If the member requests not to be transferred, the primary care provider is responsible for continuation of care for a minimum of 30 days until the member is assigned to a new primary care physician.

Primary care providers are required to provide emergency care for any Mass Advantage member dismissed from their practice until the member transfer has been completed.

Fraud, Waste and Abuse

Mass Advantage has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. Mass Advantage's policy to investigate any actions by members, employees or providers affects the integrity of Mass Advantage and or the Medicare Program.

Being a participating provider with Mass Advantage requires compliance with Mass Advantage policies and procedures for the detection and prevention of fraud and abuse. Such compliance may include referral of information regarding suspected or confirmed fraud or abuse to Mass Advantage and submission of statistical and narrative reports regarding fraud and abuse detection activities.

If fraud or abuse is suspected, whether it is by a member, employee or provider, it is the provider's responsibility to immediately notify Mass Advantage at 844-569-1389 or http://massadvantage.ethicspoint.com.

All providers participating providers agree to abide Mass Advantage's Fraud, Waste, and Abuse and Reporting policy. Providers can request the Fraud, Waste and Abuse policy, which includes legal requirements stipulated in the following:

- 31 U.S.C. § 3729 (Federal False Claims Act)
- 42 U.S.C. § 1320a-7a (Civil Money Penalties Act)
- 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute)

Providers can request the Fraud, Waste and Abuse policy.

It is Mass Advantage's policy to discharge any employee, terminate any provider or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified or has been involved in fraudulent or abusive activities. Some common examples of fraud, waste and abuse are:

- Billing for services not rendered
- Billing for supplies not being purchased or used
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

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. Advantage will assist providers in locating resources upon request.

Provider offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Providers may obtain copies of documents that explain legal requirements for translation services by contacting the Mass Advantage Provider Services Department at the following numbers. For interpreter services, please contact the Mass Advantage Member Services at the following numbers to arrange and coordinate interpreter services.

- 844-918-0114 (HMO)
- 844-915-0234 (PPO)
- TTY: 711

From October 1 to March 31, we're available 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we're available Monday through Friday from 8 a.m. to 8 p.m. EST.

Encounters

Providers are required to report to Mass Advantage all services they provide for Mass Advantage members by submitting complete and accurate claims. All Mass Advantage providers are contractually required to submit encounters for all member visits and all charted diagnoses for each member. Billing and claims requirements are outlined in detail in the Billing and Claim sections of this manual.

Contracts/No Gag Clause

Mass Advantage supports open provider-patient communication regarding appropriate treatment alternatives without penalizing providers for discussing medically necessary or appropriate care for the patient. All Mass Advantage providers can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Beneficiary Financial Protections

Mass Advantage follows all necessary requirements to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the Mass Advantage. To meet this requirement, Mass Advantage provider agreements include the following:

- Prohibit the organization's providers from holding any enrollee liable for payment of any such fees.
- Indemnify the enrollee for payment of any fees that are the legal obligation of Mass Advantage.
- Providers will accept Mass Advantage's payment as payment in full.

Health Care Disparities

Mass Advantage understands that to help improve our members' quality of life, we must consider their cultural uniqueness. For this reason, addressing disparities in health care is of high importance. We believe a strong patient-provider relationship is the key to reducing the gap in disparate health care access and health care outcomes due to cultural and language barriers.

Providers must deliver services and information regarding treatment options in a language the member understands, and in a culturally competent manner, accommodating the special needs of ethnic, cultural and the social circumstances of the patient.

UTILIZATION MANAGEMENT

Utilization Management Program

The Utilization Management (UM) Program is a component of the Clinical Operations Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care across the Medicare lines of business. 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 the Mass Advantage Utilization Management Committee (UMC) and annually approved by the Quality Improvement Committee (QIC). Information below outlines the obligations of providers for collaboration with the UM program including complying with coverage guidelines, providing information in a timely manner, completing necessary documentation, and responding to questions.

Coverage Requests (Prior Authorization)

The prior authorization process includes steps confirming the eligibility of the member, verifying coverage of services, assessing the medical necessity and appropriateness of care, and establishing the appropriate level of care.

Only a limited number of services, items, or Part B drugs require prior authorization, and a complete list can be found on our website at www.massadvantage.com. It is the responsibility of the ordering or admitting provider to obtain prior authorization before services are rendered. The Clinical Operations Department accepts coverage requests via phone or fax, by completing a Prior Authorization Request Form and submitting it to Mass Advantage's Clinical Operations Department. A copy of the Prior Authorization Request Form can be found on our website. All requests are assessed based on medical necessity and appropriateness of services using a hierarchy of medical evidence that includes nationally recognized criteria, such as MCG® Guidelines, the Centers for Medicare and Medicaid Services' (CMS) definition of medical necessity and CMS National and Local Coverage Determinations, and Magellan coverage guidelines, when authorizing the delivery of healthcare services to members. MCG® Guidelines are used in conjunction with the member's benefit plan and the provider's recommendation to approve, append and/or deny services.

Providers must submit the appropriate supporting clinical documentation for review with the authorization request to avoid an adverse determination by the plan. Documentation should include:

- Medical records that describe the planned treatment, including the medical rationale for the services being requested, lab reports, radiology reports, consultants' notes, etc.
- All pertinent medical information supporting the requested treatment and/or procedure.

The Clinical Operations Department is committed to assuring prompt, efficient delivery of healthcare services. The Utilization Management Department can be contacted between the hours of 8:00 a.m. and 6:00 p.m. EST, Monday through Friday at 866-312-8467 or by fax at 888-656-7783. Providers calling before or after operating hours or on holidays are asked to leave a voicemail message and a Clinical Operations Representative will return the call the next business day. Providers with urgent requests or questions are directed to call 866-312-8467.

Expedited Reviews

The Utilization Management Department will process an expedited review for a member with a life-threatening condition, or for a member who is currently hospitalized and needs specialized services not covered under the hospitalization, or to authorize a treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

For expedited requests for services or items, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request and written notification to the member and provider will be provided. The time frame to deciding for a Part B drug requested as expedited is 24 hours.

Standard Reviews

For standard prior authorization requests, the Utilization Management Department will decide to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires. Notification will be sent to the requesting provider and member in writing on all standard prior authorization determinations no later than 14 calendar days from the receipt of the request. The time frame to deciding for a Part B drug requested as standard is 72 hours. A 14-day extension may be granted to an expedited or standard coverage request if the member requests it or if we have a need for additional information and the extension of time benefits the member (for example, if additional medical records are needed in order to change a potential denial decision).

Inpatient Hospital Services Authorizations (Inpatient Prior Authorization)

All request for inpatient hospital services and/or admissions must include appropriate supporting medical documentation, such as treatment plans, test results, medical history, needed to determine medical necessity to issue the authorization. The supporting medical information will help the Utilization Management Department facilitate the authorization process.

Elective Hospital Admission – the primary care provider or specialist may request the admission. Prior authorization requests for a selected list of procedures must be submitted to Mass Advantage's Clinical Operations Department at a minimum of 14 days prior to the admission or service. A list of the selected procedures can be found on our website at www.massadvantage.com.

Emergency Admissions are reviewed retrospectively.

The following are examples of services requiring prior authorization before providing the following non-urgent or urgent care services. For a complete list of services/items/Part B drugs requiring prior authorization please our website at www.massadvantage.com for the Prior Authorization List or call the Mass Advantage Provider Services Department at: 844-918-0114 (HMO), 844-915-0234 (PPO) or TTY: 711.

- Certain elective Inpatient admissions
- Inpatient mental health services
- Skilled Nursing Facility (SNF) admissions
- Home health care services
- Prosthetics
- Wheelchairs and Scooters
- Out of Network Services
- Transplant evaluation and services
- Outpatient IV infusion or injectable medications
- Requests for non- covered services under traditional Medicare program

Medicare Outpatient Observation Notice (MOON)

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 18669(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and critical access hospital (CAHs) to provide written notification and oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospital or CAHS.

- The MOON is a form that must be delivered before the member received 24 hours of 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 psychiatric hospital patients.

Further information about the MOON can be found at the CMS site:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html

Instructions on how to complete the MOON can be found at:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

Penalties for Not Obtaining Approval for Requested Services

Mass Advantage will not be responsible for paying a provider for a service if the provider has not complied with administrative requirements such as prior authorization and other UM policies. Under such a situation, the provider is also prohibited from charging the member for the service. If there are extenuating circumstances that delayed the authorization process, the provider should advise the Clinical Authorization Department when requesting an authorization.

Out of Network Authorization Requests (Out of Network Pre-Certifications)

Members of HMO plans may need to see a healthcare professional outside of Mass Advantage's provider network. When the need for out-of-plan services arises, the provider contact Mass Advantage's Clinical Operations Department to obtain an authorization. The Clinical Operations Department will review the request and arranges for the member to receive the necessary medical services with a specialty care provider in collaboration with the recommendations of the primary care provider. Best effort will be made to locate a healthcare professional within an accessible distance to the member.

Second Opinions

A member has the right to a second surgical/medical opinion in any instance when the member disagrees with his or her provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness.

The second surgical/medical opinion, if requested, is to come from a provider chosen by the Member who may select:

- A provider who is participating with Mass Advantage and not in practice with first opinion provider, or
- If a network provider is not available, a non-participating provider located in the same geographical service area of Mass Advantage, who has a Medicare ID.

If a non-participating provider is required, the referring provider must contact Mass Advantage for authorization. Any tests that are deemed necessary as part of the second surgical/medical opinion will be conducted by participating Mass Advantage providers.

Emergency Care and Services (ER)

Federal and state regulations prevent a plan from requiring members to contact a primary care provider, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. 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 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.
- 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.

Physicians, specialist and covering physician 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 Clinical Operations of known emergency inpatient admissions.
- Providers directing members to an emergency room for treatment are encouraged to notify the emergency room of the pending member arrival.

Prior Authorization is NOT REQUIRED for emergency room visits and coverage CANNOT be denied retrospectively for emergency services satisfying CMS and Mass Advantage criteria for such covered services.

The facility providing emergency inpatient admissions must notify Mass Advantage of a member's emergency admission within 24 hours, or as soon as the member's condition has stabilized. The Clinical Operations department can receive fax admission notifications 24 hours/day, seven days/week by fax at 888-656-7783.

Service Denials

Mass Advantage may deny a prior authorization request for several reasons:

- Member is not eligible
- Service is not a covered benefit
- Member has exhausted his or her benefits
- Service is not deemed medically necessary based on medical necessity guidelines

Mass Advantage notifies both the provider and member in writing of any adverse decision (partial or complete) within required time frames. The notice will state the reasons for the decision and inform of the right to file an appeal.

CHRONIC CARE IMPROVEMENT PROGRAM (CCIP)

A CCIP is a clinically focused initiative designed to improve the health of a specific group of members with chronic conditions. CMS requires that each MA plan conduct, over a 5-year period. Mass Advantage will select a condition for its the Chronic Care Improvement Program for 2022.

CDC Guideline for Prescribing Opioids for Chronic Pain

The CDC developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

In order to be compliant with 42 CFR §423.153(b)(2), Mass Advantage, in partnership with its Pharmacy Benefit Manager SS&C, are taking steps to ensure prescribers understand the criteria used to identify potentially at-risk Medicare beneficiaries, specifically point-of-sale edits. The PBM clinical team will provide information to ensure prescribers understand the reason for implementing edits. The point-of-sale edits will be administered by the PBM:

- Seven-day supply limit for initial fills (opioid naïve) edit
  - Edit logic: Members considered to be opioid naïve (no history of opioid use in the past 120 days) will be limited to a seven-day supply or less of opioids for their initial fill.
  - Resolution for reject: Reduce day supply to seven days or less, pharmacy enter continuation of therapy override, member requests a coverage determination exception.
- Care coordination edit (90 Milligrams of Morphine Equivalents (MME))
  - Edit logic: Members meeting or exceeding 90 MME will be required to have an additional check to ensure safety of utilizing >90 MME per day.
  - Resolution for reject: Dispensing overrides reject with codes once they have contacted the prescriber to validate safety or member requests a coverage determination exception if pharmacy is unable to resolve the edit at the point–of-sale.
- Duplicative long-acting (LA) opioid therapy edit
  - Edit logic: Members utilizing more than one extended release opioid concomitantly will require the dispensing pharmacy to ensure safety of the member's opioid regimen.
  - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate for the member to utilize >1 extended release opioid.

- Concurrent opioid and benzodiazepine use edit
  - Edit logic: Members utilizing an opioid analgesic and benzodiazepine concomitantly will require the dispensing pharmacy to ensure safety of the member's regimen.
  - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate for the member to utilize an opioid analgesic and benzodiazepine together.
- Concurrent opioid and buprenorphine use edit
  - Edit logic: Members utilizing opioid analgesics and buprenorphine medications only indicated for the treatment of opioid dependence concomitantly require an additional safety check to ensure it is appropriate to fill an opioid medication while a buprenorphine medication indicated only for the treatment of opioid dependence is still active.
  - Resolution for reject: Dispensing pharmacy overrides reject with codes only if they have verified it is safe and appropriate to utilize an opioid analgesic in conjunction with a buprenorphine medication that is only indicated for the treatment of opioid dependence.

Transfer of Medical Records

Primary care providers are required to transfer member medical records or copies of records within seven (7) days of request, at no charge to the member, to:

- Newly designated primary care providers
- Newly designated Managed Care Organization
- Centers for Medicare and Medicaid Services and/or any governmental or accrediting agency

COORDINATION OF CARE

If a primary care provider or specialty care provider directs a member to an emergency room for treatment, it is considered best practice for the provider to notify the hospital emergency room of the pending arrival of the patient for emergency services. Members should be directed to the closest appropriate emergency provider.

Member Outreach

Mass Advantage representatives may call members to verify or coordinate services, to facilitate physician appointments or obtain information for authorizations coming into the Clinical Operations Department and to encourage member compliance with appointments. Another important component of member outreach, which is conducted by the Clinical Operations Department in some cases, is post discharge follow-up calls. These activities ensure that the member receives quality care and services and achieve positive health care outcomes.

Concurrent Review

Concurrent review is a targeted review that is performed during an acute hospital and post-acute facility stay. The review is performed to confirm the appropriateness of the setting in meeting the medical needs of the member and to initiate the member's discharge planning process. In general, the concurrent review process examines the length of stay and medical necessity and appropriateness of the admission and/or continued hospital stay.

Discharge Planning

The discharge planning process is a collaborative effort between Mass Advantage's Concurrent Reviewers, the hospital/facility care manager, the member, and the admitting provider. The main goal of discharge planning is to ensure the coordination and quality of medical services through the post-discharge levels of care.

Providers and facilities are required to provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. The extension must be requested prior to the expiration of the approved days.
- The member's discharge plan, which indicates that transfer to an alternative level of care, is appropriate.
- The member is in need of a complex plan of treatment, which includes home health services, home infusion therapy, total parental nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

The Clinical Operations Nurse will at Mass Advantage's discretion, conduct telephonic reviews to support the discharge planning efforts to coordinate health services prior to the discharge.

Mass Advantage may assist, but is not required to, help identify health care community resources following an inpatient stay.

Members who are discharged from the hospital receive a written notice called "Important Message from Medicare" (IM). When discharge from a facility such as a Skilled Nursing Facility (SNF) or when home health services or comprehensive outpatient rehabilitation services are to be discontinued, members receive a notice called "Notice of Medicare Non-Coverage" (NOMNC). These notices provide information and instructions to members regarding their right to appeal the decision to the Quality Improvement Organization (QIO). All members receive these documents, not only those who may disagree with a non-coverage determination.

POLICIES AND PROCEDURES

Mass Advantage has developed policies and procedures to provide guidelines for identifying and resolving issues with providers who fail to comply with the terms and conditions of the applicable Provider Agreement and Mass Advantage policies and procedures.

Policy Changes

In order for Mass Advantage to be in compliance with Federal and State Laws, Regulations and Regulatory Bulletins governing the Medicare and Medicaid Program in the course of providing services,

Providers and their staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs.

Provider Education and Sanctioning

Mass Advantage providers will be monitored for compliance with administrative procedures, trends of inappropriate resource utilization, potential quality of care concerns and compliance with medical record review standards. Provider education is provided through Quality Improvement Nurses, Provider Relations Representatives and Mass Advantage Medical Directors. Network providers who do not improve through the provider education process will be referred to the Mass Advantage Quality Improvement/Utilization Management Committee for evaluation and recommendations.

CMS GUIDANCE ON MEDICARE MARKETING ACTIVITIES

Below is the CMS guidance on provider marketing activities as detailed in the Medicare Marketing Guidelines Provider-Based Activities.

Although providers may not be fully aware of all plan benefits and costs and may face conflicting incentives when acting as a Plan/Part D Sponsor representative, Plans/Part D Sponsors may not prohibit contracted providers from engaging in discussions about Medicare Advantage plan options with beneficiaries should a beneficiary seek advice. Mass Advantage providers must remain neutral when engaging in any discussions with patients about Medicare Advantage plan options.

Mass Advantage providers are not allowed to:

- Offer scope of appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Plans/Part D Sponsors.

- Offer anything of value to induce enrollees to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for enrollment activities.
- Distribute materials/applications in an exam room.

Mass Advantage providers are allowed to:

- Provide the names of Plans/Part D Sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the LIS.
- Make available and/or distribute plan marketing materials in common areas.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or 1-800-MEDICARE.
- Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS.

APPEALS AND GRIEVANCES

Introduction

Mass Advantage members have the right to communicate dissatisfaction with the quality of care that they receive, the timeliness of services, or decisions made by Mass Advantage or its providers. CMS separates these into two categories: grievances and appeals.

A "grievance" is any expression of dissatisfaction by a member made verbally or in writing related to any aspect of the operations, activities or behavior of Mass Advantage or its delegated entities in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care. Examples of grievances include complaints about:

- Timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Any matter pertaining to the contractual relationship between the member and Mass Advantage.
- Availability, coverage, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to our utilization review programs.
- Claims payment, handling, or reimbursement for health care services.
- Adequacy of facilities, providers, or other similar issues.
- If the member disagrees with our decision to process your appeal request for a service or to continue a service under the standard 30 calendar day time frame rather than the expedited 72-hour time frame.

A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Providers must direct Mass Advantage members with complaints to Mass Advantage Member Services. to see the *How to File a Grievance* section below for specific instructions. Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

How to File a Grievance

Generally, grievances should be filed directly with Mass Advantage, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO).

Members are encouraged to contact Mass Advantage Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is required or requested, one will be provided. Mass Advantage employs a formal, multi-disciplinary process to review member grievances.

When can a Grievance be filed?

Members may file the grievance within 60 calendar days after they had the experience for which they are submitting the grievance.

Filing a grievance with Mass Advantage

The process for filing a grievance is different from the process for coverage decisions and appeals. Members are encouraged to contact Mass Advantage promptly either by phone or in writing if they would like to file a grievance at the following numbers:

- HMO: 1-844-918-0114
- PPO: 1-844-915-0234
- TTY: 711

Mass Advantage may be able to provide an immediate response to complaints submitted by phone.

Member Services also has free language interpreter services available for non-English speakers.

Complaints can also be submitted in writing to:

Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043.

OR

By e-mail for grievances related to Part D Prescription Drugs to: MedDResponseTeam@magellanhealth.com.

OR

By fax at 1-888-904-1139

Expedited Grievance

Members have the right to request an expedited grievance if they disagree with Mass Advantage's decision to take an extension or decision to process an expedited level 1 appeal as a standard level 1 appeal.

Mass Advantage will process this grievance as an expedited grievance and will respond within twenty-four (24) hours of receipt.

Standard Grievances

If possible, Mass Advantage will respond immediately on grievances filed verbally. Also, if the Member's health condition requires us to answer quickly, we will do that.

Most complaints are answered within 30 calendar days. If we need more information and the delay is in the Member's best interest or if the Member requests additional time, Mass Advantage can take up to 14 more calendar days (44 calendar days total) to answer a complaint. If we need additional days for review, Mass Advantage will inform the Member writing.

If the Member requests a written response, they are required to file a written grievance. If the complaint is regarding a quality of care, Mass Advantage will respond in writing. Otherwise, we may provide a verbal response.

Filing a Grievance with Medicare

Members can submit a complaint about Mass Advantage Basic (HMO) directly to Medicare online at www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes all complaints seriously and will use this information to help improve the quality of the Medicare program.

Filing a grievance about quality of care to the Quality Improvement Organization

When a complaint is about the quality of care a Member has received, they have two extra options:

1. Members can make their complaint to the Quality Improvement Organization. Members can make a complaint about the quality of care directly to this organization (without making the complaint to Mass Advantage).

a. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

b. These complaints can be submitted to Kepro:

   i. Call: 1-888-319-8452
   Monday - Friday: 9:00 a.m. - 5:00 p.m.,
   Weekends-Holidays: 11 a.m.-3 p.m.
   Please note, representatives are not available on weekends and holidays to assist with quality of care concerns.

   ii. TTY: 1-855-843-4776

   iii. Send written grievance:
   Kepro, 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131

   If a Member makes a complaint to the Quality Improvement Organization, Mass Advantage will work with them to resolve the grievance.

2. Members can also make complaints to Mass Advantage and also to the Quality Improvement Organization, at the same time.

Who May File a Grievance

A grievance may be filed by any of the following:

- The Member
- Someone else may file a grievance on behalf of the Member. A Member can name another person to act for them or as their "representative" to file a grievance on their behalf.
  - There may be someone who is already legally authorized to act as the Member's representative under State law.
  - If the Member would like a friend, relative, doctor or other provider, or other person to be their representative, they need to complete the "Appointment of Representative" form, available on our website at Appointment of Representative (massadvantage.com). The form must be completed and signed by the Member and by the person who will act on their behalf. A copy must also be filed with Mass Advantage.

- Members may submit an equivalent written notice in place of the Appointment of Representative form, but it must include the following:
  - Member's name, address, and telephone number along with the individual being appointed
  - Member's Medicare Beneficiary Identifier or member number from the identification (ID) card, or plan ID number
  - The appointed representative's professional status or relationship to the Member
  - A written explanation of the purpose and scope of the representation (e.g. authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with claims, appeals, grievances.)
  - A statement that the Member is authorizing the representative to act on their behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative
  - A statement by the individual being appointed that he or she accepts the appointment; and
  - Is signed and dated by the Member and the individual being appointed.

Appeals

An appeal is a request to review and change a coverage decision (initial determination) Mass Advantage has made regarding adverse benefit determination (a decision unfavorable to the Member), or the amount of cost share assigned to the patient for a specific service. If a Member receives a denial letter informing or other adverse benefit determination and they are not satisfied with this decision, they may file an appeal.

Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or physician.

For standard prior authorization appeals, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form.

You may contact Mass Advantage for additional information as to when standard prior authorization reconsiderations can be filed without a completed representative form.

Mass Advantage providers are not eligible to submit payment appeals (e.g., after the service has been rendered) in accordance with this section but must proceed through the claim dispute process described in the *Claims and Billing* section below.

Who can file an Appeal?

An appeal may be filed by any of the following:

- Member
- Member's Provider
- Another health care provider or prescriber.
- Member representative: Members can name another person to act as their "representative" to file an appeal on their behalf.
  - A member representative may be someone who is already legally authorized to act as the Member's representative under State law.
  - If the Member would like a friend, relative, doctor or other provider, or other person to be their representative, they need to complete the "Appointment of Representative" form, available on our website at Appointment of Representative (massadvantage.com). The form must be completed and signed by the Member and by the person who will act on their behalf. A copy must also be filed with Mass Advantage.
  - Members may submit an equivalent written notice in place of the Appointment of Representative form, but it must include the following:
    - Member's name, address, and telephone number along with the individual being appointed.
    - Member's Medicare Beneficiary Identifier or member number from the identification (ID) card, or plan ID number.
    - The appointed representative's professional status or relationship to the Member.

- A written explanation of the purpose and scope of the representation. (e.g., authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with claims, appeals, grievances).
- A statement that the Member is authorizing the representative to act on their behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative.
- A statement by the individual being appointed that he or she accepts the appointment.
- Is signed and dated by the Member and the individual being appointed.

When can an Appeal be filed?

Appeal requests must be made within 60 calendar days from the date of the denial letter or other adverse benefit determination. If a Member misses this deadline and have good cause, Mass Advantage may allow addition time to appeal. The Member will need to provide a written explanation why the appeal was not filed timely so Mass Advantage can determine if there is good cause to process the untimely appeal. Examples of good cause for missing the deadline may include a serious illness that prevented the Member from contacting us or if we provided incorrect or incomplete information about the deadline for requesting an appeal.

Where can an Appeal be filed?

To initiate an expedited or standard appeal the patient (or representative or doctor or other provider/prescriber) must contact Mass Advantage as follows:

- By Mail: Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043
- By e-mail for Part D Prescription Drugs: MedDResponseTeam@magellanhealth.com
- By fax:
  - Appeals For Medical Care: 1-888-656-7783
  - Appeals for Part D Prescription Drugs: 1-888-904-1139
- By Phone for expedited appeals only:
  - H7670 Plan 001 and 002 (HMO): 1-844-918-0114, TTY: 711
  - H9904 Plan 001 (PPO): 1-844-915-0234, TTY: 711

How to file an Appeal?

A written request should include:

- Member's name, Member ID Number (found on the insurance card) address and phone number. Mass Advantage may contact the member for additional information.
- The items or services for which a Member is requesting an appeal, the dates of service, and the reason(s) why the Member is appealing.
- If a Member has appointed a representative, they are required to include the name of the authorized representative and proof of representation.

Fast Decisions/Expedited Appeals

Members have the right to request a quick response and receive expedited decisions affecting their medical treatment in cases where applying the standard timeline for a decision to be made could seriously jeopardize:

- The Member's life or health
- The Member's ability to function

Requests for Expedited Appeals can be made in writing or by phone.

If a health plan or a doctor makes a request or supports a Member's request that their health requires an expedited appeal, Mass Advantage will automatically agree to provide an expedited decision. Mass Advantage will issue a decision as fast as possible, but no later than seventy-two (72) hours for a medical item or service plus 14 calendar days, if an extension is taken, after receiving the request.

If an appeal request is for a Medicare Part D or Medicare Part B prescription drug, Mass Advantage will answer within seventy-two (72) hours.

If a Member requests an expedited appeal without their doctor's support, Mass Advantage will decide whether the Member's health requires an expedited decision.

- If Mass Advantage determines that the Member's medical condition does not meet the requirements for an expedited decision, we will send written confirmation of the decision says so (using standard deadlines).
- This letter will inform the Member that if their doctor requests an expedited appeal, Mass Advantage will automatically render an expedited response.

- The letter will inform the Member of their right to file an expedited complaint about our decision to render a standard decision instead of the expedited coverage decision requested.

Standard Appeals

A standard appeal must be submitted in writing.

Mass Advantage will issue a decision as fast as possible, but no later than 30 calendar days after receiving a request for a medical item or service.

If we need more information and the delay is in the Member's best interest or if the Member requests additional time, Mass Advantage can take up to 14 more calendar days (44 calendar days total) to make a decision. If we need additional time, we will inform the Member in writing to explain the reasons for the extension and outline their right to file an expedited grievance if they disagree with the decision to extend the timeframe.

If the Member's request is for a Medicare Part D or Medicare Part B prescription drug, Mass Advantage will respond within seven (7) calendar days after receiving the request.

If the Member's request is for a Part D prescription drug payment redetermination, Mass Advantage will respond within (14) calendar days after receiving the request.

If the Member's request is for a payment reconsideration, Mass Advantage will respond within sixty (60) calendar days after receiving the request.

Request Appeals and Grievance Data

You have a right to request Mass Advantage general data regarding the number and handling of appeals and grievances members have filed with the plan. Please contact Member Services at:

- H7670 Plan 001 and 002 (HMO): 1-844-918-0114 TTY 711
- H9904 Plan 001 (PPO): 1-844-915-0234, TTY: 711

Regarding Hospital Discharge

There is a certain type of appeal that applies only to hospital discharges. If a member feels that the Mass Advantage coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO).

Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS).

The QIO for Massachusetts is Kepro. The QIO is a group of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or member's authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

To request a QIO review regarding a hospital discharge, the member or member's authorized representative must contact the QIO no later than noon the day of discharge. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or member's authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Mass Advantage for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Mass Advantage and/or the care provider decides to end coverage for SNF, HHA or CORF a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. The member or member's authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Mass Advantage provides to the QIO. It is very important that the provider immediately faxes all of the member's medical records to the QIO for their review. Mass Advantage will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to decide. If the QIO decides in favor of the member, will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor Mass Advantage will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Mass Advantage staff decides upon expedited appeal review those services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

Independent Review Entity (IRE) Review

Mass Advantage will notify the member and provider in writing when an appeal has been forwarded to the IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and decide about whether Mass Advantage must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision.

For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to decide. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

The IRE will issue its decision in writing to the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge (ALJ) Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made can request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council (MAC)

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Acting as an Authorized Representative

Mass Advantage will accept requests made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non- participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found at Appointment of Representative (massadvantage.com).

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Mass Advantage will require submission of appropriate documentation, such as a durable power of attorney.

A physician who is providing treatment to a member (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review.

It is important to note that the appeals process will not commence until Mass Advantage receives a properly executed AOR.

CLAIMS AND BILLING

Claims General Information

Mass Advantage maintains billing and claims processing guidelines consistent with industry standards. This section contains billing and claims guidelines for claims filed with Mass Advantage. Providers must follow these guidelines to ensure accurate and timely payments.

Timely Filing

Providers are required to file claims with Mass Advantage within 90 calendar days of the date the services are rendered.

Providers must bill within 365 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Mass Advantage 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.

Mass Advantage processes the majority of claims within 30 days; however, providers are encouraged to call Mass Advantage's Provider Services Department to inquire on any claim not processed within 60 days.

Electronic Claims Submission

Mass Advantage accepts claims electronically through Change Healthcare and encourages providers to take advantage of the electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

For submission of professional or institutional electronic claims for Mass Advantage, the Payer ID is 86220.

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Only version 5010 transactions will be accepted. The billing provider address submitted on claims must be a physical address. Claims submitted via Change Healthcare or will be rejected if a P.O. Box number is submitted as the billing address. To prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Claims Dispute Process

Mass Advantage will review any claim that a provider feels was denied or paid incorrectly if the provider follows the process to dispute a claim. The provider can request a claims review in writing (per instructions below), or by phone call to the Provider Services Department if the inquiry relates to an administrative issue. Hard copies of the information should be mailed to the Claims Review Department along with all of the relevant supporting documentation, i.e., the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All review requests must be received within 180 calendar days of the initial remittance advice.

Mass Advantage cannot accept verbal requests to retract claim(s) overpayments. Providers are required to complete and submit a Refund Form or a letter that contains all of the information requested on this form located on the provider section of the massadvantage.com.

The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

Mass Advantage Care, PO Box 830059, Birmingham, AL 35283.

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Mass Advantage Plan. Reviews requiring additional documentation are evaluated to determine whether the documentation is sufficient to allow for reconsideration.

Claims that qualify for adjustments will be reprocessed and claim information will appear on subsequent remittance advices. Claims that do not qualify for reconsideration will be forwarded to the Appeals Department for review. All review requests must be received within 180 days of the initial remittance advice.

Please refer to the Appeals and Grievances Section of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to:

Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043.

Coordination of Benefits

Some Mass Advantage members may have other insurance coverage. Mass Advantage follows Medicare coordination of benefits rules. Mass Advantage does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third party liability is identified in Mass Advantage's records for the member at the time the claims are submitted.

To receive payment for services provided to members with other insurance coverage, the provider must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits, the provider should submit a claim to Mass Advantage. The provider must:

1. Follow all Mass Advantage authorization and billing procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.
3. Submit a copy of the primary carrier's EOB with the claim to Mass Advantage within 180 days of the date of the primary carrier's EOB.

The amount billed to Mass Advantage must match the amount billed to the primary carrier. Mass Advantage will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Members seeking care, regardless of primary insurer, are required to contact their primary care provider and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

Billing Procedures

A “clean claim” as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered “clean” if the appropriate authorization has been obtained in compliance with Mass Advantage’s Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS.

1500 (08-12) Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through clearinghouse:

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-10 surgical diagnosis code(s) (as applicable);
6. Name of providers/providers and applicable/required NPI numbers;
7. Provider tax identification number;
8. Valid CMS place of service code(s);
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;

11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD10-CM diagnosis code;
12. MS-DRG code for inpatient hospital claims.

Mass Advantage processes medical expenses upon receipt of a correctly completed CMS1500 (08-05) Form and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS-1500 (08-05) Form can be found in the Forms and Reference Material Section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

Mass Advantage requires all providers to submit claims according to the updated National Provider Identification (NPI) submission procedures. These changes went into effect January 1, 2013 as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010. The Final Rule, published in the April 27, 2012 Federal Register, is applicable to all claims submitted to Mass Advantage. Below please find a few highlights of the ACA requirements and Mass Advantage policies and procedures to support these requirements.

- NPIs for billing providers are required to be reported on paper and electronic claims.
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in Mass Advantage's claims system. Providers will be held to Mass Advantage's timely filing policies regarding submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

- CMS-1500: The following fields are to be reported as indicated:
    - Field 17b: NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health)
    - Field 24J (b): NPI of Rendering Provider (if applicable) Field 32a – NPI of Service Facility (if applicable)
    - Field 33a: NPI of Billing Provider (required)

- UB-04: The following fields are to be reported as indicated: Field 56 – NPI of Billing Provider (required)
    - Field 76: NPI of Attending Physician (required)
    - Field 77: NPI of Operating Physician (if applicable)
    - Field 78 & 79: NPI of Other Physician (if applicable)

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires but does not include the fourth or fifth digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the provider certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the provider or an employee under the provider's direction. The provider certifies that the information contained in the claim is true, accurate and complete.

Mass Advantage's claim office address is: Mass Advantage, PO Box 830059, Birmingham, AL 35283.

Any questions concerning billing procedures or claim payments can be directed to Mass Advantage's Provider Services Department at:

- HMO: 1-844-918-0114
- PPO: 1-844-915-0234
- TTY: 711

APPENDICES

APPENDIX I: Vaccine Coverage

Immunizations

- Covered Medicare Part B services include:
  - Pneumonia vaccine
  - Flu shots, each flu season in the Fall and Winter, with additional flu shots if medically necessary
  - Hepatitis B vaccine for high or intermediate risk members
  - COVID-19 vaccine
  - Other vaccines for high-risk members and they meet Medicare Part B coverage rules
- Part B drugs require prior authorization to be covered.
- No prior authorization is required for Pneumonia, Influenza, Hepatitis B, and COVID-19 vaccines.
- We also cover some vaccines under our Part D prescription drug benefit.
- There is no co-insurance, co-payment, or deductible for the Pneumonia, Influenza, Hepatitis B, and COVID-19 vaccines.

APPENDIX II: Credentialing and Recredentialing Policies and Procedures

Credentialing Standards

Mass Advantage has established credentialing and recredentialing policies and procedures that meet CMS, and NCQA standards.

All information must be current to begin the credentialing process. Submit all applications and attachments in a timely manner with the most current information available.

- Applicant has successfully graduated from an accredited school of medicine, osteopathy, podiatry, dentistry, or other professional school (as applicable).
- Applicant has successfully completed an internship and residency program (as applicable).
- Applicant has an unrestricted current license to practice in State(s) where contracted to practice, and where applicable, has a current, unrestricted DEA registration and state-controlled substance license.
- Applicant has signed and dated a properly completed Medicaid Disclosure Statement.
- A completed provider credentialing application with a signed attestation that has not been flagged for an adverse action.
- Applicant must attest to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application constitutes grounds for a discovery that the provider did not meet criteria for participation in the network, agrees to abide by the policies and procedures.
- There are no substantive discrepancies in information received from the applicant or references.
- Applicant has valid, professional liability insurance coverage satisfactory to Mass Advantage with limits of dollar amounts, name of company and expiration date.
- Board certification, eligibility, or equivalent experience in the specialty/ies in which they practice medicine.
- Other items as deemed appropriate.

The credentialing/re-credentialing process involves primary sourced verification of provider credentials.

Upon completion of the credentialing application, source verification and credentialing process the application is forwarded to the CMO or designee for review. The CMO or Designee physician will review the file and determine if the file meets credentialing criteria and is considered a “clean file”. A “clean file” is a file with no deficiencies or issues identified. If clean the CMO or designee physician will recommend approving the file and provider for contract.

If the file is “unclean” by which contains issues such as lawsuit, criminal history, negative educational/affiliation verifications etc., that file will then be presented to the Credentialing Committee for discussion of next steps at the next scheduled committee meeting.

The Credentialing Committee reviews a summary of all applicants. The Credentialing Committee may accept, reject, or pend the recommendations of the CMO or designee. The final decision to approve or reject an applicant is with the Credentialing Committee and must be documented in the file.

The decision to accept or reject a provider is based on the information provided and available. This is including but is not limited to the information gathered through the completed application process and the verification of all collected information. Credentialing criteria has been set to establish consistent, clear objectives for the credentialing for prospective providers.

If the applicant is rejected for any reasons related to quality of care, competence or professional conduct, the Credentialing Department will inform applicant of his/her right to an appeal/additional review. The Credentialing Department will notify the applicant of the decision by formal letter within 30 calendar days of the Credentialing Committees decision.

The denial of a provider’s initial application to become the provider/provider shall not be grounds for a fair hearing and review under this policy. Providers who are denied initial credentialing may, within thirty (30) calendar days of receiving notice of such denial, file a written request for reconsideration containing their views on the decision, and attaching any additional information they would like the to consider. Such requests for reconsideration will be reviewed by the CMO or Designee physician and Credentialing Committee and the provider will be notified of the final decision of the within 30 calendar days after the Credentialing Committee Meeting. Further, it shall not be grounds for a fair hearing review if a provider’s participation as the Provider and/or Provider Agreement is terminated or not renewed for reasons other than the provider’s quality of care, competence, or professional conduct. When any provider receives a notice of an adverse decision by the Credentialing Committee that would invoke the fair hearing process as described above, he/she may request a fair hearing before a Hearing Committee.

All providers must be re-credentialed at least every 36 months in order to continue participation within Mass Advantage. This helps to ensure Mass Advantage's continued compliance with Center for Medicare and Medicaid Services (CMS) and), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

Ongoing and Performance Monitoring

Mass Advantage's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt Out Listing (CMS), and applicable state disciplinary report. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Mass Advantage participating provider is found on the OIG, Medicare Opt Out List, or applicable state disciplinary action report, the provider's file is immediately pulled for further investigation. Depending on severity level of the sanction, the provider may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Mass Advantage Credentialing Department reviews complaint reports, outlining member complaints filed against providers. The Credentialing Department will review and investigate all complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented. Depending upon the severity level of the complaint(s), the provider may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Mass Advantage's re-credentialing process includes a comprehensive review of a provider's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Provider Absences

Mass Advantage continues to follow NCQA guidelines for providers called to active military service, on maternity leave or an approved sabbatical. However, it is the provider's or his/her office's responsibility to notify Mass Advantage in writing that the provider is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the provider who will be covering during his or her leave. The Mass Advantage Credentialing Department will not terminate the provider in these cases if appropriate coverage is in place. Provider/provider's office should notify Mass Advantage of providers return, as soon as possible, but not exceeding ten (10) business days from their return. The Mass Advantage Credentialing Department will determine, based upon the length of time, if the provider will have to complete a recredentialing application. If the provider requires recredentialing, it must be completed within sixty (60) calendar days of the provider resuming practice.

Denial and Termination

In accordance with Mass Advantage's business practices, the inclusion of a provider in the Mass Advantage Provider Network is within the sole discretion of Mass Advantage Plan.

Mass Advantage conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a provider's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Mass Advantage understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation. If a provider does not meet Mass Advantage's baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a provider fails to submit information and/or documentation within requested time frames, processing of the provider application may be discontinued or terminated. All requests for re-credentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation. Denial and termination decisions that are made based on quality concerns can be appealed. If necessary, the information is reported to the National Provider Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Mass Advantage will notify providers in writing of any decisions to deny, suspend or terminate their privileges to participate in the network.

Providers who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Mass Advantage within thirty (30) calendar days of the date of the certified notification.

APPENDIX III: Claim Form Requirements

Hospital Services

Hospital claims are submitted to Mass Advantage on a UB-04. To assure that claims are processed for the correct member, the member's ten-digit Mass Advantage identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the provider are indicated in the Patient ID field on the Mass Advantage remittance advice. Please review field numbers below carefully as many of them differ from the former UB-92 format.

FIELD	DESCRIPTION	REQUIREMENTS
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birthdate	Required
11	Patient Sex	Required

FIELD	DESCRIPTION	REQUIREMENTS
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

FIELD	DESCRIPTION	REQUIREMENTS
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name Address	Not Required
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required

FIELD	DESCRIPTION	REQUIREMENTS
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Mass Advantage Provider Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Mass Advantage Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required

FIELD	DESCRIPTION	REQUIREMENTS
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required
71	Prospective Payment System (PPS)	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send

FIELD	DESCRIPTION	REQUIREMENTS
78-79	Other Provider Name Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

FIELD #	DESCRIPTION	REQUIREMENTS
1	Insurance Type	Required
1a	Insured Identification Number	Required
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program	Required, If Applicable
10	Is Patient Condition Related to: 1. Employment 2. Auto accident 3. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required

FIELD #	DESCRIPTION	REQUIREMENTS
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Provider or Other Source	Required, If Applicable
17a, b	Identification Number of Referring	
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Required

FIELD #	DESCRIPTION	REQUIREMENTS
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	Type of Service	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Not Required
24i	ID Qualifier	Required, if applicable
24j	Rendering Provider ID	Not Required
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Provider or Supplier including degrees or credentials	Mass Advantage Individual Provider Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required

FIELD #	DESCRIPTION	REQUIREMENTS
33	Billing Provider Info and Phone #	Mass Advantage Vendor (Payee) Name, Address, and Phone Number Required. NPI and Mass Advantage Legacy Number should be Entered.