

2020
MEDICARE ADVANTAGE
PROVIDER MANUAL

Contents

Quick Reference	5
Welcome to Troy Medicare	6
Purpose of This Manual	6
Corporate Overview	6
Our Plan.....	6
Benefits.....	6
Benefits to the Healthcare Provider	6
Medical Benefits	7
Summary of Benefit Requirements	7
Pharmacy Benefits.....	7
General Exclusions	8
Formulary	8
Drug Exclusions	8
Enrollment	9
Eligibility Criteria	9
Disenrollment	9
Member ID Cards	10
Members' Rights and Responsibilities.....	10
Provider Responsibilities	11
TITLE VI of the Civil Rights Act of 1964	11
Coverage Arrangements:	12
Appointment Standards	12
Missed Appointments	12
Office Hours	13
Provider Information Changes	13
Patient Safety	13
Closing Your Practice/Panel	13
Member Confidentiality	13
Verifying Member Eligibility	14
Advance Directives	14
Transfer of Non-Compliant Members	15
Fraud, Waste and Abuse	15
Access and Interpreters for Members with Disabilities	16

Encounters	17
Accurate Submission of Encounter Data	17
Contracts/No Gag Clause	17
Beneficiary Financial Protections	17
Health Care Disparities	18
Quality Improvement	18
Purpose: Quality Improvement Program	18
Goal: Quality Improvement Program	18
Objectives: Quality Improvement Program	19
Scope: Quality Improvement	19
Utilization Management	20
Utilization Management Program	20
Goals and Objectives: Utilization Management Program	20
Medical Records	21
Medical Records Standards	21
Medical Records Reviews	23
Transfer of Medical Records	23
Facility Site Reviews	24
Provider Performance Measures	24
Preventable Serious Adverse Events/Hospital Acquired Conditions (HACs) and Never Events	24
Member Satisfaction Survey	24
Provider Satisfaction Survey	25
Health Effectiveness Data and Information Set (HEDIS)	25
Coordination of Care	26
Member Outreach	26
Health Risk Assessment	26
Concurrent Review	26
Discharge Planning	27
Health Services	27
Service Authorization Requests (Pre-Certifications)	27
Expedited Reviews:	28
Standard Reviews:	28
Medicare Outpatient Observation Notice (MOON)	28
Penalties for Not Obtaining Approval for Requested Services	29

Second Opinions	29
Emergency Care and Services (ER)	29
Service Denials	30
Self-Referrals	30
New Technology	30
Medicare Diabetes Prevention Program (MDPP)	31
Network Management	31
Adherence with Federal and State Laws	31
Provider Monitoring	32
CMS Guidance on Medicare Marketing Activities	32
Provider-initiated activities	32
Permissible contracted provider-initiated activities include:	32
Plan-Initiated Provider Activities in the Healthcare Setting	32
Contracted Providers Are NOT Allowed to:	33
Contracted Provider Are Allowed to:	33
Contracted Provider Marketing Requirements:	33
Claims and Billing	34
Claims General Information	34
Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process	34
Timely Filing	35
Electronic Claims Submission	35
Paper Claims Submission	35
Requirements for Submitting Claims to Troy Medicare through PeakTPA	36
HIPAA 5010	36
Electronic Remittance Advice/Electronic Funds Transfer	36
Claims Review Process	36
Administrative Claims Review	36
Coordination of Benefits	37
Billing	38
Billing Procedures	38
Appeals and Grievances	39
Appeals	39
Provider Retrospective Appeals Overview	39
Provider Retrospective Appeals Decisions	40

Member Reconsideration Process	40
Standard Pre-Service and Retrospective Reconsiderations	42
Expedited Reconsiderations	42
Member Reconsideration Decisions	43
Member Grievances	44
Provider	44
Member Grievance Overview	44
Grievance Resolution	45
Introduction to Credentialing.....	46
Who Is Credentialed?	46
Purpose of Credentialing	46
Credentialing Standards	46
Ongoing and Performance Monitoring	47
Practitioner Absences	48
Denial and Termination	48
Delegated Credentialing	49

Quick Reference

Important Phone Numbers

Reasons for Call	Telephone Number
Provider Services (Benefit & Claim Inquiries, Eligibility Verification)	888-494-8769
Vision	866-344-7756
Dental	800-700-1246
Member Services	888-494-8769
Pharmacy	888-494-8769
Care Management	888-494-8769
TTY/TDD	711
Over the Counter Program (OTC)	877-228-4603

Payer ID	27034
----------	-------

Reasons for Mailing	Address
Claims	Troy Medicare, ATTN: Claims P.O. Box 21631, Eagon, MN 55121
Member Appeals	Troy Medicare P.O. Box 30516, Charlotte, NC 28230
Provider Appeals	Troy Medicare P.O. Box 30516, Charlotte, NC 28230
Initial Applications for Credentialing	Troy Medicare P.O. Box 30516, Charlotte, NC 28230
Re-credentialing Applications	Troy Medicare P.O. Box 30516, Charlotte, NC 28230
Practice Change Information	Troy Medicare P.O. Box 30516, Charlotte, NC 28230
DME Claims	Troy Medicare, ATTN: Claims P.O. Box 21631, Eagon, MN 55121

WELCOME TO TROY MEDICARE



Purpose of This Manual

This Manual is intended for Providers who have contracted to participate in Troy Medicare's network to deliver quality health care services to Members enrolled in a Medicare Advantage (MA) Benefit Plan.

This Manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of Troy Medicare's Medicare Advantage Benefit Plans and is an extension of, and supplements, the contract under which Provider participates in Troy Medicare's network for Medicare Advantage Benefit Plans (the Agreement). This Manual replaces and supersedes any previous versions dated prior to 02/03/2020.

This Manual is available on our website at www.troymedicare.com. A paper copy of this Manual is available at no charge to Providers, upon request.



Corporate Overview

Troy Medicare is a new, Charlotte, North Carolina-based health insurance company. Our company is locally focused and has deep roots in the Provider community. Troy is transparent and Provider-friendly.

We also seek to improve chronic care management through the untapped clinical potential of pharmacists. Pharmacists are a central focus for data. They have information from every provider associated with a chronic patient. That enhanced access coupled with the increased likelihood of in-person, face-to-face interaction in the pharmacy setting give our pharmacists an opportunity to provide an enhanced level of care management, improving health outcomes and patient satisfaction.

We are choosing to build a network of high-quality, patient-focused providers. We want to empower these providers to offer the best care possible to our patients. Providers will be supported by local, dedicated Troy Medicare staff available to collaborate in any way needed.

OUR PLAN

Troy Medicare (HMO), which is a Medicare Advantage Part D Health Plan. PCP-\$0 co-pay, SPC-\$35 co-pay, ER-\$90 co-pay

**This list does not represent every service covered or every applicable co-pay and/or coinsurance.*

BENEFITS

Benefits to the Healthcare Provider

- No referrals for in-network providers
- Timely claims payment
- Dedicated Provider Relations representative

Medical Benefits

Troy Medicare members are eligible for all the benefits covered under the Original (Fee-for-service) Medicare Program. In addition, Troy Medicare offers extra benefits for dental, vision, Over-the-Counter, and Hearing services. For a complete list of covered benefits, please refer to the Evidence of Coverage. A complete copy of the Evidence of Coverage booklet is located on our website at www.troymedicare.com.

Members obtain most of their healthcare services either directly from their primary care practitioner or in-network specialist. Troy Medicare does not require a referral for a Member to see a specialist. A member's primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Summary of Benefit Requirements

The covered services listed in the Evidence of Coverage are covered only when all requirements listed below are met:

- Services must be provided according to the Original Medicare 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.
- In addition, some covered services require "prior authorization" by the Plan in order to be covered. Covered services that may need prior authorization (approval ahead of time) are marked in the Evidence of Coverage with an asterisk (*). The Evidence of Coverage can be found on Troy Medicare's website, www.troymedicare.com.

PHARMACY BENEFITS

Prescription drug benefits are available to all Troy Medicare members. Prescriptions must be filled by a participating pharmacy in order to be covered by Troy Medicare. When a member travels outside of the service area, a national network of pharmacies is available via the PerformRx network. Troy Medicare contracts with PerformRx to develop a network of chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to members. A list of participating pharmacies can be obtained by looking on our website, www.troymedicare.com.

General Exclusions

Exclusions or limitations are described in the Evidence of Coverage (EOC) booklet. The Evidence of Coverage booklet can be found on Troy Medicare's website at www.troymedicare.com.

Formulary

Troy Medicare offers an extensive drug Formulary. Generic prescriptions, when appropriate, are the most cost-effective alternatives. Troy Medicare'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 www.troymedicare.com for the most recent version of the Formulary.

Pharmacy cost information is also noted in the Formulary. A copy of the Formulary can be found on our website, www.troymedicare.com.

Drug Exclusions

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- 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. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If one of these reference books, known as compendia, does not support the use, then the drug is considered a non-Part D drug and cannot 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." These drugs include:

- **Drugs Covered Under Part B:** Drugs covered under Part B are typically administered and obtained at the provider's office. Some examples are certain cancer drugs administered by a provider in his/her office; insulin when administered via pump and diabetes test strips.
- **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 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 our Pharmacy department.

- **Home Infusion:** Troy Medicare will cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. However, Medicare Part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department.
- **Vaccines:** Most vaccines and the administration fees are covered under Part D. Troy Medicare provides coverage of a number of vaccines, some of which are considered to be medical benefits (Part B medications) and others which are considered to be Part D drugs. If you are unsure of how a vaccine will be covered by Troy Medicare, refer to the Formulary which is available on our website, www.troymedicare.com.

ENROLLMENT

The Centers for Medicare & Medicaid Services (CMS) has periods when members may enroll or disenroll in/from a Medicare Advantage plan. 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
- Complete an enrollment form with their sales agent, and agent submits form on their behalf.

Eligibility Criteria

A member is eligible to enroll in a Medicare Advantage Part D plan if they are entitled to Medicare Part A and are enrolled in Medicare Part B. Medicare eligibility may be due to either disability or age.

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 or not.
- If a 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 Troy Medicare. Before Troy Medicare makes a determination to disenroll the member for this reason, Troy Medicare 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 for this reason, Troy Medicare 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.

MEMBER ID CARDS

Each Troy Medicare member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic or plan change. ID cards are good for as long as the person is a member of Troy Medicare.

(Sample Member ID Cards)



MEMBERS' RIGHTS AND RESPONSIBILITIES

Please take a moment to familiarize yourself with member rights and responsibilities. As a Medicare member, Troy Medicare members have the right to:

- Be treated with respect and not be discriminated against based on race, ethnicity, national origin, disability, religion, gender or age.
- Be provided information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- Receive timely access to network providers and prescription drugs, including emergency care services, 24 hours a day, seven days a week.
- Protect the privacy of your personal health information.
- Get information about the plan, its network of providers and your covered services.
- Know all your treatment options and participate fully in discussions and decisions about your health care.
- Refuse any treatment recommended to you by any provider.
- File a complaint, ask for a coverage decision, or ask us to reconsider decisions we have made.

- Get help if you believe you are being treated unfairly or your rights have not been respected.

As a Medicare member, Troy Medicare members have the responsibility to:

- Tell your doctor and other health care providers that you are enrolled in our plan.
- Get familiar with your covered services and the rules you must follow to get these covered services.
- Tell us if you have any other insurance coverage or prescription drug coverage in addition to our plan.
- Be considerate. We expect all our members to respect the rights of other patients.
- Pay what you owe. Pay what you are responsible for paying, your co-pays, co-insurance, and premiums.
- Tell us if you move. If you move outside the plan's service area, you cannot remain a member of our plan.
- Help your doctors and other providers help you by giving them the necessary information, asking questions and following through on your care.
- Practice preventive care by having the appropriate tests and immunizations and engaging in healthy lifestyle choices (e.g., exercise, diet).

PROVIDER RESPONSIBILITIES

Troy Medicare contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Troy Medicare also has an extensive network of pharmacies. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained.

Participation in Troy Medicare in no way precludes participation in any other program with which you may be affiliated. You may review our complete provider directory at www.troymedicare.com.

The following requirements are the basic guidelines to which you, as a provider, have agreed in your Provider Agreement with Troy Medicare. You 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 VI 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 translator services as necessary for these members.

Coverage Arrangements

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

Appointment Standards

A member should be seen by a practitioner as expeditiously as the member's condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate time frame, Troy Medicare will facilitate an appointment with a participating or nonparticipating practitioner, if necessary.

Primary care practitioners agree to meet Troy Medicare's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately seen or instructed to call 911 or go directly to the nearest emergency room
Wait time for Urgent Care Appointment	Within 24 hours
Wait time for Non-Urgent Sick Visit	Within 1 week
Wait time for Routine Wellness Appointment	Within 30 days
After-Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
Waiting time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult need.

Missed Appointments

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

Office Hours

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

Provider Information Changes

Please provide written notice to Troy Medicare on provider letterhead of practice changes including, but not limited to, acceptance of new patients, change of location or termination of your provider agreement.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Healthcare errors can occur at any point in the healthcare delivery system and can be costly in terms of human life, function, and healthcare dollars. There is also a price in terms of lost trust and dissatisfaction experienced by both patients and healthcare practitioners.

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 equipment are in good working order as well as maintaining CLIA lab requirements, if applicable.

Closing Your Practice/Panel

As a Troy Medicare participating provider, you are required to provide prior written notice of no less than 60 calendar days if you are closing your practice. Please note that a panel must be closed to all new patients and not only to Troy Medicare members.

Member Confidentiality

Through contractual agreements, all practitioners and providers participating with Troy Medicare have agreed to abide by all policies and procedures regarding member confidentiality. Under these policies, the practitioner or provider must meet the following:

1. 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:
 - a. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
 - b. 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.
 - i. 111-5 (Feb 17, 2009) and related regulations
 - ii. The HIPAA Omnibus Rule, effective 3-26-2013 with a compliance date of 9-23-2013.

2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.
3. Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment or healthcare operations (TPO) is released to Troy Medicare without seeking the consent of a member. This information includes PHI used for claims payment, continuity and coordination of care, medical record audits, treatment, health assessments, performance measures (i.e. HEDIS), quality of care issues, and care and/or disease management.
4. All staff discussions related to confidential member information should be conducted in a private area, away from treatment or waiting areas.
5. Employees should have instructions on confidentiality policy and awareness training on their legal obligations regarding confidentiality.
6. Members must be informed of your confidentiality policy and privacy practices and may sign a document to that effect. Troy Medicare 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 functions.

Verifying Member Eligibility

The presentation of a member's ID card neither creates nor serves to verify a member's status or eligibility to receive benefits. Providers are required to take the following steps prior to administering services:

- Currently enrolled
- Eligible for the requested services
- Has not exhausted his or her benefits
- Did not disenroll after receiving the membership card
- Check the authenticity of the member's ID card in order 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.
- 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 portal, which may be accessed through Troy Medicare's website at www.troymedicare.com, or the eligibility verification line can be reached at 1-888-494-TROY (8769), from October 1 – March 31, seven days a week, from 8:00 am – 8:00 pm EST and from April 1 – September 30, Monday through Friday, 8:00 am – 8:00 pm

Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the Patient Self-Determination Act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Patient Self-Determination Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the Troy Medicare network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested. A copy of the completed advance directive 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.

A copy of the North Carolina advance directive form is available on our website at www.troymedicare.com. You may request educational materials regarding a member's right to advance directives by calling Troy Medicare Member Services at 1-888-494-TROY (8769).

Transfer of Non-Compliant or Unruly Members

Primary care practitioners agree (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Troy Medicare 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 practitioners 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 practitioner's panel. Troy Medicare's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner. Should an incidence of inappropriate behavior occur and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member's name, Troy Medicare ID Number, and details of the non-compliant behavior to the Medicare Enrollment Department at:

Troy Medicare
Attn: Enrollment
P.O. Box 30516 Charlotte, NC 28230

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner 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 practitioners are required to provide emergency care for any Troy Medicare member dismissed from their practice until the member transfer has been completed.

Fraud, Waste and Abuse

Troy Medicare has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. Troy Medicare's policy to investigate any actions by members, employees or

practitioners affects the integrity of Troy Medicare and/or the Medicare Program.

As a participating practitioner, Troy Medicare requires compliance with 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 Troy Medicare 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 practitioner, it is your responsibility to immediately notify Troy Medicare at 1-888-494-TROY (8769).

All practitioners and providers participating with Troy Medicare agree to abide by Troy Medicare's Fraud, Waste, and Abuse Program, which can be accessed on Troy Medicare's website, www.troymedicare.com. This policy and procedure include legal requirements determined by the state as determined by the plan's coverage area:

- 31 U.S.C. §3729 of the Federal False Claims Act
- SEC. 1128. [42 U.S.C. 1320a-7]
- 31 U.S.C. 3729 False Claims Act Sanctions
- TITLE 18--CRIMES AND CRIMINAL PROCEDURE

Providers are requested to review the Fraud, Waste, and Abuse Program on Troy Medicare's website periodically to determine if any changes have occurred.

It is Troy Medicare'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 being 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. Troy Medicare will assist providers in locating resources upon request. Troy Medicare offers the Evidence of Coverage and other Troy Medicare information in large print, Braille and other forms required by a member at no cost to the member. If required, please instruct members to call Member Services at 1-888-494-TROY (8769), TTY 711.

Practitioner 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. Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Troy Medicare's Provider Services Department at 1-888-494-TROY (8769). For interpreter services, please contact Troy Medicare's Member Services at 1-888-494-TROY (8769) to arrange and coordinate interpreter services.

Encounters

Primary care practitioners are required to report to Troy Medicare all services they provide for Troy Medicare members by submitting complete and accurate claims. All Troy Medicare providers are contractually required to submit encounters for all member visits and all charted diagnoses that the member may suffer from.

Accurate Submission of Encounter Data

Encounter data provides the basis for many key medical management and financial activities at Troy Medicare. In order to effectively and efficiently manage members' health services, encounter submissions must be comprehensive and accurately coded. All Troy Medicare providers are contractually required to submit encounters for all member visits.

For primary care practitioners, encounter data is essential as many of Troy Medicare's quality indicators are based on this information. It is important that all diagnosis codes that are applicable to the member be submitted on every claim, especially chronic conditions. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

Contracts/No Gag Clause

Troy Medicare allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. Practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options available to them, regardless of benefit coverage limitations. There is no language in Troy Medicare's contracts that prohibits open clinical dialogue between practitioner and patients.

Beneficiary Financial Protections

Troy Medicare agrees to comply with the following requirements:

- Troy Medicare will adopt and maintain arrangements satisfactory to CMS to protect its members from incurring liability for payment of any fees that are the legal obligation of Troy Medicare (for example, as a result of an organization's insolvency or other financial difficulties). To meet this requirement, Troy Medicare:

- o Ensures that all contractual or other written arrangements with providers prohibit the organization's providers from holding any member liable for payment of any such fees;
- o Indemnifies the member for payment of any fees that are the legal obligation of Troy Medicare or the state Medicaid Program (dual eligible members). Provider may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will accept Troy Medicare's payment as payment in full or bill the appropriate State source.

Health Care Disparities

Troy Medicare understands that in order to help improve our members' quality of life, we must take into account their cultural uniqueness. We believe a strong patient-provider relationship is the key to reducing the gap in health care access and health care outcomes due to cultural and language barriers. Troy Medicare is continuously working to close the gap in health outcomes by focusing on education and prevention.

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.

QUALITY IMPROVEMENT

Purpose: Quality Improvement Program

The purpose of the Quality Improvement Program is to provide a formal process by which the quality, appropriateness, efficiency, safety and effectiveness of care and services are objectively and systematically monitored and evaluated. This process allows the Plan to identify operational areas for improvement, effectiveness of care and services in relation to member health outcomes, as well as member and provider satisfaction. The Quality Improvement Program promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to members.

As a participating provider, Troy Medicare asks that you cooperate with Quality Improvement activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various Quality Improvement initiatives and programs and participation in relevant member education initiatives.

Goal: Quality Improvement Program

The overarching goal of the Quality Improvement Program is to ensure the provision and delivery of high-quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality services. The Quality Improvement Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality

improvement concepts and appropriately recognized quality measurement tools and reports — such as qualitative, quantitative and root/cause barrier analyses — Troy Medicare focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving positive member health outcomes.

Objectives: Quality Improvement Program

The overarching objective of the Quality Improvement Program is to effectively use healthcare resources to achieve program goals for continuous quality improvement. The Quality Improvement Program is evaluated on an annual basis to determine the status of all activities and identify opportunities that meet the Quality Improvement Program objectives. Objectives are as follows:

- Improvement of the member's health status and outcomes by incorporating health promotion programs and preventive medicine;
- Evaluate the standards and appropriateness of clinical care and performance to promote the most effective use of resources;
- Evaluation of access and availability of care and services;
- Oversight and improvement of member and provider satisfaction;
- Monitor over utilization and under utilization of services.

Scope: Quality Improvement Program

The Quality Improvement Program monitors and evaluates the use of healthcare services. The Quality Improvement Program follows the "Plan, Do, Study, Act" methodology to ensure implementation of care intervention strategies. The Quality Improvement Program is reviewed annually with involvement of key stakeholders including Plan Medical Director and provider network representatives. The scope of the Program includes:

- Members' Rights and Responsibilities
- Network Accessibility and Availability
- Healthcare Disparities
- Network Credentialing/Re-credentialing
- Medical Record Standards
- Member and Provider Services
- Preventive Health
- Clinical Outcomes
- Oversight of Delegated Activities
- Member Safety
- Quality of Care

- Model of Care
- Continuous Quality Improvement

For more information on the Quality Improvement Program, please contact Troy Medicare's Member or Provider Relations department at 1-888-494-TROY (8769).

UTILIZATION MANAGEMENT

Utilization Management Program

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

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

Goals and Objectives: Utilization Management Program

The UM program is designed to accomplish the following objectives:

- Demonstrate flexibility in the application of members' benefits to ensure that all medically necessary services are available to members;
- Collaborate with and provide necessary oversight to delegated entities to ensure a high quality of care for members;
- Develop, implement and maintain an ongoing process aimed at assuring proper utilization of health care resources within the established benefit plan;
- Educate clinical and support staff on the purpose and philosophy of the UM program;
- Assure that members receive the highest quality of medically necessary care delivered in the most appropriate setting;
- Provide individualized and integrated care to each member;
- Maintain the rights and responsibilities of the member during all aspects of review;
- Review and analyze UM data and statistics to identify trends and opportunities for improvement;
- Review, update as necessary, approve and implement the UM program and all related processes, policies, and procedures at least annually;

- Comply with professional standards, guidelines and criteria set by governmental and other regulatory agencies;
- Improve coordination of care between Primary, Specialty and Behavioral Health disciplines;
- Maintain and monitor the provider network in order to provide adequate access to covered services and to meet the needs of the member population served;
- Monitor overutilization, underutilization and inappropriate use of services through regular care plan and service utilization reviews.

MEDICAL RECORDS

Medical record documentation should facilitate communication, coordination and continuity of care and services, as well as promote efficiency and effectiveness of treatment. Participating providers are required to keep accurate and complete medical records of Troy Medicare members for a minimum of 10 years, or as required by state or federal law.

Medical Records Standards

Providers must ensure that their medical records meet Troy Medicare's record standards. Medical record standards incorporate criteria from applicable federal, state and regulatory requirements.

Complete medical records include, but are not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other health care professionals' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided
- Medical records must be signed and dated.

All medical records, including all entries in the medical record, at a minimum must:

- Be neat, complete, clear, and timely and include all recommendations and essential findings in accordance with accepted professional practice.
- Be signed and include the name and profession of the Provider.
- Be legible to readers and reviewing parties.
- Be dated and recorded in a timely manner.
- Include the Member's name (first and last name or identifier) on each page.

- Include the following personal and biographical data in the record:
 - Name
 - Member identifier
 - Date of birth
 - Gender
 - Address
 - Home/work telephone numbers
 - Emergency contact name and telephone numbers. This may include next of kin or name of spouse.
 - Legal guardianship, if applicable
 - Marital status
- If not English, the primary language spoken by the Member and, if applicable, any translation or communication needs are addressed.
- Include allergies and adverse reactions to medication.
- Include a HIPAA protected health information release.
- Include a current medication list.
- Include a current diagnoses/problem list.
- Include a summary of surgical procedures, if applicable.
- Include age-appropriate lifestyle and risk counseling.
- Include screening for tobacco, alcohol or drug abuse with appropriate counseling and referrals, if needed.
- Include screening for domestic violence with appropriate counseling and referrals, if needed.
- Include the provision of written information regarding advance directives to adults (18 years and older).
- Include an assessment of present health history and past medical history.
- Include education and instructions, verbal, written, or by telephone.
- Include, if surgery is proposed, a discussion with the Member of the medical necessity of the procedure, the risks, and alternative treatment options available.
- Include evidence that results of ordered studies and tests have been reviewed.
- Include consultant notes and referral reports.
- Include evidence of follow-up visits, if applicable.
- Include appropriate medically indicated follow-up after hospital discharge and emergency department visits.

A medical record of a clinical encounter/office visit must minimally include:

- Chief complaint
- History and physical examination for presenting complaint
- Treatment plan consistent with findings
- Disposition, recommendations and/or instructions provided

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Troy Medicare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to Troy Medicare upon request.

Medical Records Reviews

Troy Medicare's Quality Improvement Department reviews providers' medical records as part of Troy Medicare's re-credentialing process.

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

Medical record reviews will be conducted every three (3) years for re-credentialing purposes. All primary care providers and high-volume specialists are subject to medical record reviews. At the conclusion of the review, the reviewer will notify the provider of any deficiencies. If applicable, Troy Medicare will issue a Corrective Action Plan (CAP) or provide guidance and other tools to assist the provider in improving documentation. If a provider fails to comply with a Corrective Action Plan, the provider will be reported to the Credentialing Committee for further action.

Transfer of Medical Records

Primary care practitioners 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 practitioners
- Newly designated Managed Care Organization
- Centers for Medicare & Medicaid Services and/or any governmental or accrediting agency.

FACILITY SITE REVIEWS

A site review may be required as part of the initial credentialing process for new providers if the site:

- Was not reviewed and accepted as part of our credentialing process;
- Is not accredited and;
- Is not licensed.

Should an initial site review be required, it will be conducted by the Provider Relations Department. Consequently, upon re-credentialing, a member of our Quality Improvement department will call the provider's office to schedule an appointment date and time before the facility site review due date. The department will fax or mail a confirmation letter with an explanation of the audit process and required documentation.

After the facility site review is completed, the QI Coordinator will meet with the provider or office manager and review and discuss the results of the facility site review and explain any required corrective actions, if applicable. The results of the site review and any corrective action plans issued will be provided to the Credentialing Committee.

PROVIDER PERFORMANCE MEASURES

Preventable Serious Adverse Events/Hospital Acquired Conditions (HACs) and Never Events

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

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

Once a potential event has been identified, an extensive review is conducted by the Quality Improvement Department. The process includes a medical record review and possible telephonic or mail communication with the practitioner/provider. Upon final determination of an actual event occurring, Troy Medicare will notify the practitioner/provider by mail that payment denial or retraction will occur. Should you have any questions, please contact Troy Medicare's Provider Services Department at 1-888-494-TROY (8769).

Member Satisfaction Survey

The Quality Improvement department monitors providers' compliance with Troy Medicare's standards through periodic data collected from the CAHPS survey. The Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) is administered to our members by CMS each year

between January and April. The survey's goal is to evaluate the experience Medicare members have had with the Troy Medicare services and our participating providers.

Quality Improvement reviews survey data to obtain a general indication of how well Troy Medicare meets member expectations and to identify areas where improvement is needed. All areas surveyed are used to facilitate comparisons among all Medicare health plans.

Provider Satisfaction Survey

A provider satisfaction survey may be conducted not more frequently than annually by the Provider Relations Department in order to obtain the providers' perspective on and satisfaction with Troy Medicare's services and programs. Provider participation in the survey is highly encouraged and your feedback is very important to us.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Healthcare Effectiveness Data and Information Set (HEDIS) is the set of annual performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). It is used to establish accountability with the goal of improving the quality of health care. HEDIS is one of the most widely used health care performance measures in the United States, and allows consumers to compare health plan performance to other plans and to national or regional benchmarks.

HEDIS includes a number of measures across several domains of care. However, the number of measures each health plan reports may vary according to contractual or federal standards. HEDIS results are accessible to the public.

Although many of the measures are obtained through claims/encounter data, there may be additional information that may be missing or can only be found in the member's medical record. The QI department performs medical record abstraction to close any information gap and consequently supplement data to improve the measurement rates. The process of medical record data abstraction is in compliance with, and permitted by, the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, 45 CFR 164.506, and does not require consent or authorization from the member.

The HEDIS medical record abstraction process usually begins in March. Prior to requesting medical records, or on-site visit, your office will be contacted. Based on the number of medical records to be abstracted. The QI department will send information about the visit and explain its data collection process. Chart abstractions may also involve the mailing, faxing or emailing of certain chart components for off-site review. The number of medical records to be reviewed will be based on the number of members meeting HEDIS criteria and receiving care at the provider office.

We expect chart abstractors and reviewers to be given full access to medical records and to be allowed to copy or scan appropriate supporting documentation. Providers can request consultation and training in the following areas:

- Information about the year's selected HEDIS studies

- How data for those measures will be collected
- Codes associated with each measure
- Tips for improvement of HEDIS rates

Troy Medicare utilizes a NCQA-certified software system for HEDIS data reporting that allows information to be entered electronically and extracted on a monthly, quarterly, and annual basis. This software allows Troy Medicare to utilize the data for other quality studies as needed.

COORDINATION OF CARE

If a primary care practitioner or specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the primary care practitioner of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider.

Member Outreach

Utilization Management representatives may call members to verify or coordinate services, to facilitate referrals coming into the Utilization Management Department and to encourage member compliance with appointments. Utilization Management representatives may also call members post-discharge to coordinate the care transition, to ensure a follow-up visit with primary care physicians and/or to answer member questions. These activities ensure that the member receives quality care and services and achieves positive outcomes.

Health Risk Assessment

Troy Medicare will conduct a comprehensive Health Risk Assessment (HRA) of all members within 90 days of members' enrollment and will be reassessed on an annual basis. The assessment will identify the members' medical, physical, cognitive, psychological, functional and social service needs. The HRA will be performed by a license professional in accordance to with state, federal and accreditation standards. A copy of the HRA may be requested by contacting Provider Services at 1-888-494-TROY (8769).

Concurrent Review

Concurrent review is a targeted review that is performed during a hospital and skilled nursing facility stay. The review is performed to confirm the appropriateness of the setting in meeting the medical needs of the member, grant an extension to an approval, and/or 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.

A Nurse Care Manager performs the concurrent review activities, under the oversight of the Troy

Medicare Medical Director. The reviews are conducted either on-site and/or telephonically. On occasions, a provider or facility will be notified of cases that do not meet coverage criteria for continuation of services. The provider or facility is responsible for providing clinical documentation to support coverage decisions.

Upon receiving the supporting documentation, Troy Medicare may consider such factors as the number or length of services, the location of services, and/or the member's severity of illness and intensity of service to determine whether the services meet the definition of medical necessity for coverage purposes only. If coverage criteria is NOT met, the Care Manager will provide notification to the provider, facility and in some situations, the member.

Discharge Planning

The discharge planning process is a collaborative effort between Troy Medicare'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 phase of care. Providers and facilities are required to provide clinical information to support discharge decisions under the following circumstances:

- 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 parenteral nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

The Nurse Care Managers can conduct on-site and/or telephonic reviews to support the discharge planning efforts in order to coordinate health services prior to the discharge.

HEALTH SERVICES

Service Authorization Requests (Pre-Certifications)

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who may benefit from case management or disease management.

Authorization is the responsibility of the ordering or admitting provider and can be obtained by completing a Prior Authorization Request Form and faxing it to Troy Medicare's Utilization Management Department at 910-239-8293.

The Utilization Management Department assesses the medical necessity and appropriateness of services using the Centers for Medicare & Medicaid Services' (CMS's) definition of medical necessity and CMS National and Local Coverage Determinations criterion.

In certain cases, Providers may need to submit appropriate clinical supporting documentation for review with the authorization request for the authorization to be processed. Required documentation may include:

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

Non-participating providers, please contact Provider Services at 1-888-494-TROY (8769) to coordinate a member's care and to commence the completion of the out-of-network agreement.

Expedited Reviews:

The Utilization Management Department will process an expedited review for a member whose health requires expedition.

For expedited requests, the Utilization Management Department will make a decision as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request. Written notification to the member and provider will be provided.

Standard Reviews:

For standard pre-certification requests, the Utilization Management Department will make a decision as expeditiously as the member's health condition requires, but no later than 14 calendar days from the receipt of the request. A 14-day extension may be granted 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).

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services. The Utilization Management Department can be contacted at 1-888-494-TROY (8769). The Utilization Management Department is available from 8:00 am to 8:00 pm, Monday through Friday. When calling before or after operating hours, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day.

Urgent requests or questions are directed to call 1-888-494-TROY (8769).

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 hospitals (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 CAH.

- The MOON is a form that must be delivered before the member receives 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 a psychiatric hospital.

Further information about the MOON can be found at the CMS site: <https://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/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf>.

Penalties for Not Obtaining Approval for Requested Services

Depending on the member's benefit plan, payment may be delayed, reduced or — in some circumstances — withheld or denied if approval is not obtained when required. If there are extenuating circumstances that delayed the authorization process, the provider should advise the Utilization Management Department when requesting an authorization.

Second Opinions

A member may request second opinions from a qualified health care professional. When requesting a second opinion consultation, Troy Medicare recommends that the practitioner refer the member to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact Troy Medicare's Utilization Management Department to assist in arranging the second opinion of an out-of-network provider at no additional cost to the member.

Emergency Care and Services (ER)

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; or
- Serious dysfunction of any bodily organ or part.

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

All Troy Medicare members or responsible parties are informed that they should contact their primary care practitioner prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Troy Medicare realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition. In these cases, the member may contact the specialist for instructions. Troy Medicare requests that the member and their primary care physician connect within 48 hours of the ER visit to schedule and track follow-up care.

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

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

Emergency services are NOT REQUIRED to have prior authorization and CANNOT be denied retrospectively for eligible members.

Service Denials

Troy Medicare may deny a pre-certification 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.

Troy Medicare will notify you in writing of any adverse decision (partial or complete) within standard referral time frames. The notice will state the reasons for the decision and also inform of the right to file an appeal.

Self-Referrals

Troy Medicare members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services, but self-referral is acceptable.

New Technology

All new medical technology or experimental and investigational procedures will require review by the Medical Director prior to approval in order to establish guidelines where applicable.

MEDICARE DIABETES PREVENTION PROGRAM (MDPP)

The MDPP is an expansion of CMS's Diabetes Prevention Program under the authority of Section 11154(b) of the Social Security Act.

The MDPP aims to prevent the onset of type 2 diabetes among eligible Medicare members with an indication of pre-diabetes. The goal of the intervention is lowering the progression to type two (2) diabetes, measured using a proxy of at least 5% average weight loss. The program includes 16 core group-based, classroom-style sessions over a period of 6 months, which provide training in dietary changes, physical activity and weight control. After the core sessions, monthly follow-up meetings are available to members in order to maintain healthy behavior.

The Program began April 1, 2018, and there's no cost for eligible members. Eligible members may participate in the core sessions as a one-time benefit. If the members do not meet the program goals, they are not eligible to take part in the follow-up meetings and can't start over, even if they change insurance carriers.

Providers wanting to offer the MDPP services must be reviewed and certified by the Centers for Medicare & Medicaid Services (CMS). This network of providers is still being developed and some areas may not have a certified provider.

For more information, visit CMS's Medicare Diabetes Prevention Program (MDPP) Expanded Model website: [Go.CMS.gov/MDPP](https://www.cms.gov/MDPP).

NETWORK MANAGEMENT

Troy Medicare has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the applicable Practitioner Agreement.

Adherence with Federal and State Laws

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. No regulatory order or requirement of the Centers for Medicare & Medicaid, Departments of Insurance or any other state or federal agencies shall be subject to arbitration with Troy Medicare.

Preclusion

If you receive a letter notifying you that you have been precluded from the Medicare program, your patients will be notified and we will stop paying claims within 90 days and terminate you from our network.

Provider Monitoring

Troy Medicare practitioners 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. Practitioner education is available through Quality Improvement Nurses, Provider Relations Representatives and the Medical Directors. Network practitioners who do not improve through the provider education process will be referred to the Quality Improvement/Utilization Management Committee for evaluation and recommendations, as appropriate and required.

CMS GUIDANCE ON MEDICARE MARKETING ACTIVITIES

To maintain appropriate beneficiary safeguards while not impeding the provider/patient relationship, CMS distinguishes between provider-initiated activities and plan-initiated activities in a healthcare setting.

Provider-initiated activities

Provider-initiated activities are those conducted by a healthcare professional, including pharmacists, at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship between healthcare provider and patient. Provider-initiated activities do not include those conducted at the request of the Plan/Part D sponsor or pursuant to the network participation agreement between the Plan/Part D sponsor and the provider. Provider-initiated activities fall outside of the definition of marketing as outlined in §§422.2260 and 423.2260.

Permissible contracted provider-initiated activities include:

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>) including in areas where care is delivered;
- Providing the names of Plans/Part D sponsors with which they contract and/or participate;
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered);
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Office, CMS’s website at <https://www.medicare.gov>, or 1-800-MEDICARE;
- Referring patients to Plan marketing materials available in common areas; and
- Providing information and assistance in applying for the LIS.

Plan-Initiated Provider Activities in the Healthcare Setting

CMS defines plan-initiated activities as those activities where either a Plan/Part D sponsor requests

contracted providers to perform a task or the provider is acting on behalf of the Plan/Part D sponsor. For the purpose of plan-initiated activities, the Plan/Part D sponsor must ensure compliance with requirements applicable to communication and marketing.

Plan/Part D sponsor requests for providers to discuss benefits and cost sharing would fall under the definition of marketing and are hence prohibited from taking place where care is being delivered.

Contracted Providers Are NOT Allowed to:

- Accept/collect scope of appointment forms;
- Accept Medicare enrollment applications;
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider;
- Mail marketing materials on behalf of Plans/Part D sponsors;
- Offer inducements to persuade their patients to enroll in a particular plan or organization;
- Conduct health screenings as a marketing activity;
- Distribute marketing materials/applications in areas where care is being delivered;
- Offer anything of value to induce enrollees to select them as their provider; or
- Accept compensation from the plan for any marketing or enrollment activities.

Contracted Providers Are Allowed to:

- Make available, distribute, and display communication materials, including in areas where care is being delivered, as long as the provider and/or facility distributes or makes available Plan/Part D sponsor marketing materials for all plans with which the provider participates, if requested by other Plan/Part D sponsors.
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).
- Plans/Part D sponsors and/or contracted providers (including pharmacies) may announce new or continuing affiliations with specific Plans/Part D sponsors once a contractual agreement between the Plan/Part D sponsor and provider has been agreed upon by both parties.

Contracted Provider Marketing Requirements:

- Providers to remain neutral when assisting beneficiaries with enrollment decisions.
- Providers should participate with Plan marketing activities in a manner consistent with Medicare regulations and guidelines.

CLAIMS AND BILLING

Claims General Information

The focus of Troy Medicare's Claims Department is to process claims in a timely manner. Troy Medicare has established a toll-free telephone number for Providers to access a representative in the Customer Service Department.

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

Troy Medicare has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once a Provider has registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Procedures for Troy Medicare are as follows:

- Payment for CPT and HCPCS codes are covered to the extent that they are HIPAA-compliant. Troy Medicare utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted.
- Hospitals should bill on an original UB-04 Form, and other providers, including ancillary providers, should bill using an original CMS-1500 (02-12) Form.
- Troy Medicare Health does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.
- 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. Paper claims will be handled just like rejected EDI claims and will not be loaded in the claims system.
- Correct/current member information, including Member ID Number, must be entered on all claims.
- Troy Medicare will process all claims as quickly and accurately as possible. However, please allow up to six weeks for a remittance advice. Providers may contact Provider Services if information is required timelier at 1-888-494-TROY (8769).
- Troy Medicare is secondary to any commercial plan.
- Inpatient hospital claims must be submitted with an MS-DRG Code.
- Inpatient skilled or sub-acute claims must be submitted with a HIPPS Code.
- Home care claims must be submitted with a HIPPS Code.

Timely Filing

Providers are encouraged to submit a complete original, initial CMS-1500 (02-12) or UB-04 Form within 180 calendar days after the date of service. Any initial claim not submitted within 180 days must be submitted within 365 days from the date of service. Initial bills submitted after 365 days will be denied as untimely.

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

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

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

Electronic Claims Submission

Troy Medicare can accept claims electronically through PeakTPA. PeakTPA has clearinghouse agreements with Trizetto, Change Healthcare, and Smart Data Solutions. If your clearinghouse is not on this list, please check for the option to submit claims electronically to PeakTPA through your clearinghouse. Troy Medicare encourages practitioners to take advantage of our 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 Troy Medicare, the Troy Medicare Payer ID is 27034.

Paper Claims Submission

If you bill on paper, Troy Medicare will only accept paper claims on a CMS-1500(02-12) or a UB-04 Form. No other billing forms will be accepted. Troy Medicare's claim address is: Troy Medicare, Attn: Claims, P.O. Box 21631, Eagan, MN 55121

Requirements for Submitting Claims to Troy Medicare Through PeakTPA

To submit claims to Troy Health, please note our Payer ID Number is 27034. A claim can be rejected if it does not include required NPI(s) and current procedure and diagnosis codes. To ensure that claims have been accepted via EDI, providers should receive and review claim status.

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically.

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required in order 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 for dates of service on or after 1/1/2017. Effective January 1, 2017, the billing provider address submitted on claims must be a physical address.

Electronic Remittance Advice/Electronic Funds Transfer

Providers may receive electronic claims remittance advice (ERA). Troy Medicare uses Emdeon to transfer the 835 Version 5010A Healthcare Claim Remittance Advice to claim submitters. Rules for format, content, and field values can be found in the Implementation Guides available on the Washington Publishing Company's website at: www.wpcedi.com.

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts and errors.

Providers may receive claims payments via electronic funds transfer (EFT).

Claims Review Process

Troy Medicare will review any claim that a provider feels was denied or paid incorrectly. The request may be conveyed in writing (per instructions below) or verbally through Troy Medicare's Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate 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 follow-up review requests must be received within 180 calendar days of the initial remittance advice.

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 Troy Medicare's service center. For inquiries requiring documentation or received in the mail, Claims Review Representatives evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. 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: Troy Medicare: Claims Review, P.O. Box 30516, Charlotte, NC 28230.

Coordination of Benefits

Some Troy Medicare members have other insurance coverage. Troy Medicare follows Medicare coordination of benefits rules. Troy Medicare does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third-party liability is identified in Troy Medicare's records for the member at the time the claims are submitted. Please note the following criteria applies and designates when Troy Medicare is not the primary plan for Medicare-covered members:

- Enrollee is 65+ years and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.
- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available. In order to receive payment for services provided to members with other insurance coverage, the practitioner 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 practitioner should submit a claim to Troy Medicare. The practitioner must:
 - o Follow all billing procedures.
 - o File all claims within timely filing limits as required by the primary insurance carrier.
 - o Submit a copy of the primary carrier's EOB with the claim within 180 days of the date of the primary carrier's EOB.
 - o The amount billed to Troy Medicare must match the amount billed to the primary carrier. Troy Medicare 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 practitioner and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

BILLING

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 and the following elements of information are furnished on a standard UB-04 or CMS-1500 (02-12) Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a Troy Medicare-contracted clearinghouse:

- Patient name;
- Patient medical plan identifier;
- Date of service for each covered service;
- Description of covered services rendered using valid coding and abbreviated description;
- ICD-10 surgical diagnosis code(s) (as applicable);
- Name of practitioners/providers and applicable/required NPI numbers;
- Provider tax identification number;
- Valid CMS place of service code(s);
- Billed charge amount for each covered service;
- Primary carrier EOB when patient has other insurance;
- 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 ICD-10-CM diagnosis code;
- MS-DRG code for inpatient hospital claims;
- HIPPS code for home care or sub-acute claims.

Troy Medicare processes medical expenses upon receipt of a correctly completed CMS-1500 (02-12) Form and hospital expenses upon receipt of a correctly completed UB-04. Paper claim forms must be submitted on original forms.

Troy Medicare 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 Troy Medicare. Below please find a few highlights of the ACA requirements and Troy Medicare policies and procedures to support these requirements.

- NPIs for billing providers are required to be reported on paper claims in addition to 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 claims 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 Troy Medicare's claims system. Providers will be held to Troy Medicare's timely filing policies in regards to submission of the initial and corrected claims.

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 practitioner 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 practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete. Troy Medicare's claim address is:

Troy Medicare
Attn: Claims
P.O. Box 21631 Eagan, MN 55121

Any questions concerning billing procedures or claim payments can be directed to Troy Medicare's Provider Services Department at 1-888-494-TROY (8769).

APPEALS AND GRIEVANCES

Appeals

Provider Retrospective Appeals Overview

A Provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing Troy Medicare a letter of appeal or an appeal form with supporting documentation such as medical records.

Providers have sixty (60) calendar days from Troy Medicare's original utilization management review decision or claim denial to file a Provider appeal. Appeals after that time will be denied for untimely filing. If the Provider feels that the appeal was filed within the appropriate time frame, the Provider may submit documentation showing proof of timely filing.

Upon receipt of all required documentation, Troy Medicare has up to 60 calendar days to review the

appeal for medical necessity and/or conformity to Troy Medicare guidelines and to render a decision to reverse or affirm. Required documentation includes the Member's name and/or identification number, date of services, and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. If the Provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the Provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by Troy Medicare due to lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of Troy Medicare or appropriate regulatory agencies when required for appeals. The Provider is not allowed to charge Troy Medicare or the Member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the Provider has complied with Troy Medicare protocols and that the appealed services were Medically Necessary, the initial denial will be reversed. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal, if one has not already been submitted. If the decision to reverse the denial is made, any claims previously denied as a result of the now-reversed denial will be adjusted for payment.

Affirmation of Initial Denial

If it is determined during the review that the Provider did not comply with Troy Medicare protocols and/or Medical Necessity was not established, the initial denial will be upheld. The Provider will be notified of this decision in writing.

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member Reconsideration Process

A Member reconsideration, also known as an appeal, is a formal request from a Member for a review of an action taken by Troy Medicare. With the Member's written consent, a reconsideration may also be filed on the Member's behalf by an authorized representative or by a physician who has or is currently treating the member.

To request an appeal of a decision made by Troy Medicare, a Member may file a reconsideration

request orally or in writing within 60 days from the date of the denial. If the Member's request is made orally, Troy Medicare will mail an acknowledgment letter to the Member to confirm the facts and basis of the appeal.

Troy Medicare gives Members reasonable assistance in completing forms and other procedural steps for a reconsideration, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

Troy Medicare will assign decision-makers who were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of Medical Necessity, a grievance regarding denial of expedited status of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be health care professionals with clinical expertise in treating the Member's condition/disease or will seek advice from professionals with expertise in the field of medicine related to the request.

Troy Medicare will not retaliate against any Provider acting on behalf of or in support of a Member requesting a reconsideration or an expedited reconsideration.

Appointment of Representative

If the Member wishes to use a representative, he or she must complete a Medicare Appointment of Representative (AOR) form. The Member and the person who will be representing the Member must sign the AOR form.

Types of Appeals

A Member may request a standard pre-service, retrospective, or an expedited appeal.

Standard pre-service appeals are requests for coverage of services that Troy Medicare has determined are not covered services, are not Medically Necessary, or are otherwise outside of the Member's Benefit Plan. A pre-service appeal must be filed before the Member has received the service.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the Provider on his or her own behalf.

Only pre-service appeals are eligible to be processed as expedited appeals and are required to meet the expedited criteria. The expedited request must be supported or made by a physician who indicates applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Appeal Decision Time Frames

Troy Medicare will issue a decision to the Member or the Member's representative within the following time frames:

- Standard Pre-Service Request: 30 calendar days (7 calendar days for Pharmacy Appeals)

- Retrospective Request: 60 calendar days (7 calendar days for Pharmacy Appeals)
- Expedited Request: 72 hours

Standard Pre-Service and Retrospective Reconsiderations

A Member may file a reconsideration request within 60 calendar days of the date of the adverse determination either in writing or verbally by contacting the Customer Service Department.

If the Member's request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for Troy Medicare to accept the late request. Examples of good cause include, but are not limited to:

- The Member did not personally receive the adverse organization determination notice or received it late.
- The Member was seriously ill, which prevented a timely appeal.
- There was a death or serious illness in the Member's immediate family.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The Member had incorrect or incomplete information concerning the reconsideration process.

Expedited Reconsiderations

To request an expedited reconsideration, a Member or a Provider (regardless of whether the provider participates in Troy Medicare's network) must submit a verbal or written request directly to Troy Medicare. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life, health or ability to regain maximum function, including cases in which Troy Medicare makes a less than fully favorable decision to the Member.

A request for payment of a service already provided to a Member is not eligible to be reviewed as an expedited reconsideration.

If a reconsideration is expedited, Troy Medicare will complete the expedited reconsideration and give the Member (and the provider involved, as appropriate) notice of the decision as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Troy Medicare denies the request to expedite a reconsideration, Troy Medicare will provide the Member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Troy Medicare will mail a letter to the Member explaining:

- That Troy Medicare will automatically process the request using the 30-calendar-day time frame for standard reconsiderations;
- the Member's right to file an expedited grievance if he or she disagrees with Troy Medicare's

decision not to expedite the reconsideration, and providing instructions about the expedited grievance process and its time frames; and

- the Member's right to resubmit a request for an expedited reconsideration, and that if the Member gets any provider's support indicating that applying the standard time frame for making a determination could seriously jeopardize the Member's life, health or ability to regain maximum function, the request will be expedited automatically.

Member Reconsideration Decisions

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Troy Medicare
2. Reconsideration of adverse organization determination by the independent review entity (IRE)
3. Hearing by an administrative law judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met
4. Medicare appeals council (MAC) review
5. Judicial review, if the appropriate threshold requirements have been met

Standard Pre-Service or Retrospective Reconsideration Decisions

If Troy Medicare reverses its initial decision, Troy Medicare will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If Troy Medicare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, it will:

- submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard appeals, the IRE has 30 days from receipt of the appeal to issue a final determination.

Once a final determination has been made, the IRE will notify the Member and Troy Medicare. In the event the IRE agrees with Troy Medicare, the IRE will provide the Member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the Member or representative in writing of the decision. Troy Medicare will also notify the Member or Member's representative in writing that the services are approved along with an authorization number.

Expedited Reconsideration Decisions

If Troy Medicare reverses its initial action and/or the denial, it will notify the Member verbally within 72

hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Troy Medicare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), it will:

- submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination.
- notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the Member and Troy Medicare. In the event the IRE agrees with Troy Medicare, the IRE will provide the Member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the Member or representative in writing of the decision.

MEMBER GRIEVANCES

Provider

Per CMS guidance, providers acting on their own behalf are not entitled to file a grievance.

Member Grievance Overview

The Member may file a grievance. With the Member's written consent, a grievance may also be filed on the Member's behalf by an authorized representative (which may include a Provider). All grievance rights described in this section apply to Members and will also apply to the Member's authorized representative (including a Provider acting on behalf of the Member with the Member's consent). If the Member wishes to use a representative, then she or he must complete a Medicare Appointment of Representative (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement.

Examples of issues that may result in a grievance include, but are not limited to:

- Provider Service including, but not limited to:
 - o Rudeness by Provider or office staff
 - o Refusal to see Member (other than in the case of patient discharge from office)
 - o Office conditions
- Services provided by Troy Medicare including, but not limited to:
 - o Hold time on telephone
 - o Rudeness of staff
 - o Involuntary disenrollment from Troy Medicare
 - o Unfulfilled requests

- Access availability including, but not limited to:
 - o Difficulty getting an appointment
 - o Wait time in excess of one hour
 - o Handicap accessibility

A Member or a Member's representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the Member was made aware of the incident.

Grievance Resolution

Standard

A Member or Member's representative shall be notified of the decision as expeditiously as the case requires, based on the Member's health status, but no later than 30 calendar days after the date Troy Medicare receives the verbal or written grievance, consistent with applicable federal law. Unless an extension is elected, Troy Medicare will send a closure letter upon completion of the Member's grievance.

An extension of up to 14 calendar days may be requested by the Member or the Member's representative. Troy Medicare may also initiate an extension if the need for additional information can be justified and the extension is in the Member's best interest. In all cases, extensions must be well-documented. Troy Medicare will provide the Member or the Member's representative prompt written notification regarding Troy Medicare's intention to extend the grievance decision.

Troy Medicare's Grievance Department will inform the Member of the determination of the grievance as follows:

- All grievances submitted verbally will be responded to verbally, unless the Member requests a written response. All grievances submitted in writing will be responded to in writing; and
- All grievances related to quality of care will include a description of the Member's right to file a written complaint with the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). For any complaint submitted to a BFCC-QIO, Troy Medicare will cooperate with the BFCC-QIO in resolving the complaint.

Troy Medicare provides all Members with written information about the grievance procedures/process available to them, as well as the complaint processes. Troy Medicare also provides written information to Members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by Troy Medicare, upon the denial of a Member's request for an expedited review of a determination or appeal, upon the Member's request, and annually thereafter. Troy Medicare will provide written information to Members and/or their appointed representatives about the BFCC-QIO process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

Expedited Grievance Rights

A Member may request an expedited grievance if Troy Medicare makes the decision not to expedite a plan determination, expedite an appeal, or invoke an extension to a review. Troy Medicare will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review time frame or extend a review time frame does not jeopardize the Member's health.

Troy Medicare will contact the Member or the Member's representative via telephone with the determination and will mail the resolution letter to the Member or the Member's representative within three business days after the determination is made. The resolution will also be documented in the Member's record.

INTRODUCTION TO CREDENTIALING

Who Is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Master's level and Doctorate of Psychology (Ph.D), Doctorate of Philosophy (Ph.D) and Clinical Social Workers. (This listing is subject to change.)

Extenders: Physician Assistant (PA), a Certified Nurse Midwife (CNM), a Certified Registered Nurse Practitioner (CRNP), Master level Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, and facilities providing mental health and substance abuse services. (This listing is subject to change.)

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and re-credentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns and licensure status.

Credentialing Standards

Troy Medicare's credentialing and re-credentialing practices are designed to meet CMS, DOH, DPW, and NCQA standards.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is

important to provide Troy Medicare with either your CAQH ID on the CAQH Provider Data Form or submit all applications and attachments in a timely manner with the most current information available.

The credentialing/re-credentialing process involves primary sourced verification of practitioner credentials. Troy Medicare's Credentialing Department will notify practitioners in writing of any information obtained during the credentialing or re-credentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly.

Practitioners, upon request, have the right to be informed of the status of their credentialing or re-credentialing application. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information.

All practitioners must be re-credentialed at least every three (3) years in order to continue participation with Troy Medicare. This helps to ensure Troy Medicare's continued compliance with Centers for Medicare & Medicaid Services (CMS), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted. Troy Medicare is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department.

Ongoing and Performance Monitoring

Troy Medicare'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's) report, the Medicare Opt Out Listing (CMS), and applicable state disciplinary action report. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB)/Healthcare Integrity Practitioner Data Bank (HIPDB), as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Troy Medicare participating practitioner is found on the OIG, Medicare Opt Out Listing, or applicable state disciplinary action report, the practitioner's file is immediately pulled for further investigation. Depending on severity level, the practitioner may be flagged for review by the Medical Director and the Health Care Quality and Access Committee. The Medical Director and the Health Care Quality and Access Committee will determine appropriate next-steps up to and including provider termination. In all instances, the information is reported to the Executive Steering Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Troy Medicare Credentialing Department reviews all complaints filed against practitioners. 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

practitioner may be flagged for review by the Medical Director and Health Care Quality and Access Committee. The Medical Director and the Health Care Quality and Access Committee will determine appropriate next-steps up to and including provider termination. In all instances, the information is reported to the Executive Steering Committee. Troy Medicare's re-credentialing process includes a comprehensive review of a practitioner'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.

Practitioner Absences

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

Denial and Termination

In accordance with Troy Medicare's business practices, the inclusion of a practitioner in the Troy Medicare Practitioner/Provider Network is within the sole discretion of Troy Medicare.

Troy Medicare 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 practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Troy Medicare 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 practitioner does not meet Troy Medicare's baseline credentialing criteria, the Health Care Quality and Access Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner 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 Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care

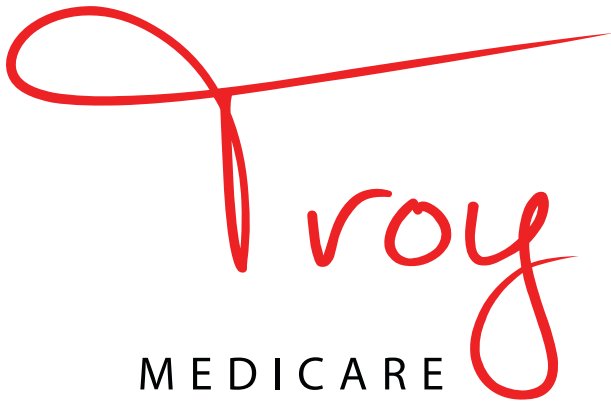
Quality Improvement Act, as well as state licensing boards.

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

Practitioners 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 Troy Medicare within thirty (30) calendar days of the date of the notification.

Delegated Credentialing

Delegation is the formal process by which Troy Medicare has given other entities the authority to perform credentialing functions on the behalf of Troy Medicare. Troy Medicare may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association (IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Troy Medicare's program requirements. The delegated entity has authority to conduct specific activities on behalf of Troy Medicare. Troy Medicare has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub-delegation shall occur only with the approval of Troy Medicare and shall be monitored and reported back to Troy Medicare.



Troy Medicare, P.O. Box 30516, Charlotte, NC 28230

1-888-494-TROY (8769)

(TTY/TDD users, please call 711)

www.troymedicare.com

We're here for you from:

October – March: 8:00 am – 8:00 pm seven days a week

April – September: 8:00 am – 8:00 pm Monday through Friday