Soundpath HEALTH

Medicare Advantage Provider Manual

Toll-free number:
866-789-7747 Option 3

2018/2019

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I. Introduction

A. Welcome to Soundpath Health

Soundpath Health is a Washington-based company focused on providing Medicare Advantage coverage. The "Plan", Soundpath Health, is an HMO plan with a Medicare contract. Enrollment in Soundpath Health depends on contract renewal. For additional information on Soundpath Health, visit our website, www.SoundpathHealth.com.

This Provider Manual is intended for providers who have contracted with Soundpath Health to deliver quality health care services to members enrolled in a Medicare Advantage (MA) Benefit Plan. It is designed to assist you and your staff and to provide information regarding Soundpath Health policies and procedures that encompass Member needs, provider standards, and Soundpath Health reporting. This makes it possible to deliver appropriate and cost-effective care using the full continuum of services.

The Provider Manual is an extension of the Provider Agreement ("Agreement") between Soundpath Health and all provider types including, but not limited to, physicians, hospitals and ancillary health care providers (hereinafter collectively and/or individually, as the context requires, referred to as "Provider(s)"). In accordance with the Agreement, participating Providers must abide by all applicable provisions of this Manual, as may be modified from time to time upon notice. Revisions to this Manual constitute revisions to Soundpath Health policies and procedures, and shall become binding ninety (90) days after the date indicated on any notice that is provided by mail or electronic means, or such other period of time as necessary for Soundpath Health to comply with any statutory, regulatory and/or accreditation requirements.

B. Plan Overview

"Member" is a person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

We feel the best healthcare is accomplished in partnership between the Member, Provider and health plan; because of this we are proud that our benefit designs are the result of input from our Providers and Members.

We provide a core plan that offers all of the benefits covered under Original Medicare and an array of benefits beyond what is offered under Original Medicare. Our core plan is designed to fit every budget, with NO premium, and has comprehensive medical and prescription drug coverage, predictable costs, and robust benefits. Find out more about this program in the Member's Evidence of Coverage (EOC) or on our website, www.SoundpathHealth.com.

C. Directory of Services/Contact Information

Provider Service (Claims, Eligibility Verification and Provider Information)	Phone: 866-789-7747 Fax: 253-779-8829
TTY	711
Electronic Claims - Emdeon (Preferred EDI Partner)	Payer ID – 42172
Paper Claims	Mail to: Soundpath Health Attn: Claims Department PO Box 853924 Richardson, TX 75085-3924
Compliance Hotline (EthicsPoint)	Phone: 800-261-5607 Online: www.ethicspoint.com Mail: PO Box 4537 Federal Way, WA 98063
Care Management (Including Prior Authorization Requests)	Phone: 866-352-7086 Fax: 866-362-0627
Provider Reconsiderations Department	Phone: 866-789-7747 Fax: 253-517-4365 (as of Jan 1, 2019) Address: Soundpath Health Attn: Provider Reconsiderations PO Box 27510 Federal Way, WA 98093
Website	www.SoundpathHealth.com
Pharmacy Coverage Determinations Phone (Urgent)	Phone: 800-711-4555 (OptumRx)
Pharmacy Coverage Determinations Fax	Fax: 800-527-0531
Pharmacy Coverage Determinations Electronic	https://professionals.optumrx.com/prior-authorization/medicare-part-d.html
Pharmacy Coverage Determinations (OptumRx)	Phone: 844-368-7174 Fax: 800-527-0531 Address: OptumRx Attn: Prior Authorization Dept. PO Box 25183 Santa Ana, CA 92799

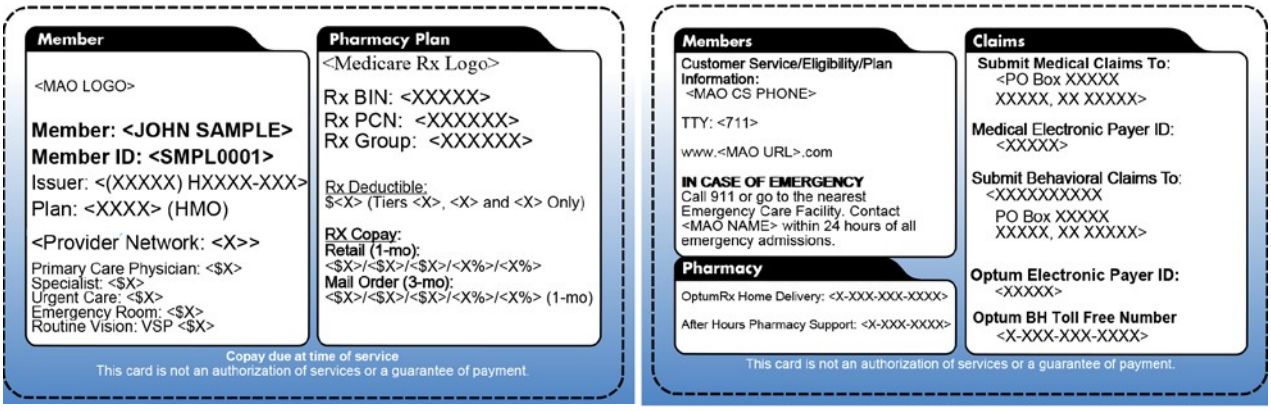
Medical Coverage Determinations	Phone: 866-789-7747 Fax: 253-779-8829
Vision Service Plan (VSP)	Phone: 800-877-7195
Hearing Care Solutions	Phone: 866-344-7756
Fitness	Phone: 877-427-4788
Behavioral Health - Optum	Payer ID – 87726 Claims Address: OptumHealth Behavioral Solutions PO Box 30760 Salt Lake City, UT 84130 Phone: 888-873-6769
Language Assistance	Soundpath Health provides Services with Cultural Competence which allows Members with access to interpretive services, if the Member does not speak English. In such cases, the provider may call Customer Service at 866-789-7747 on behalf of the Member.

II. General Information

A. Identifying a Health Plan Member

Member identification cards consistent with Centers for Medicare and Medicaid Services ("CMS") standards are issued to Members upon enrollment, and contain basic information you will need when providing covered services to our Members. Member identification cards are intended to identify Members, the type of plan they have, and facilitate their interactions with health care providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, copayment information, health plan contact information, and claims filing address. Possession of the Member identification card does not guarantee eligibility or coverage. Providers are responsible for determining the current eligibility of each Member.

Below is a sample of the Members' ID card:



Note: In order to avoid potential problems with identity theft or fraud, ask the Member for a separate form of identification along with the Member ID card, such as his/her driver's license.

B. Determining Eligibility and Benefits

Because of potential changes in a member's eligibility, each participating provider is responsible to verify a member's eligibility with Soundpath Health prior to providing services. Verifying a member's eligibility will ensure proper reimbursement for services. To verify a member's eligibility, the following methods are available to all practitioners:

- Ask to see the Member's Medicare ID card
- Verify eligibility and coverage by calling 866-789-7747
- Use our Provider Portal at www.SoundpathHealth.com

C. Covered Services

A service must be medically necessary and covered by the Member's contract to be paid by the Plan. The Plan determines whether services are medically necessary as defined by the Member's certificate of coverage and also in the Provider Agreement. To verify covered or excluded services, call Soundpath Health at the number listed on the back of the Member's ID card, or verify benefits on the Soundpath Health website.

Soundpath Health uses the current nationally approved criteria for any required medical necessity reviews. Soundpath Health makes coverage determinations, including medical necessity determinations, based upon its Members' certificates of coverage and applicable criteria and standards. However, Soundpath Health is not a provider of medical services. The Plan does not control the clinical judgment or treatment recommendations made by its network Providers. Providers make independent health care treatment decisions. All services may be subject to applicable copayments, deductibles, coinsurance and adequate and appropriate access to care.

D. Checking Claims Status

Soundpath Health Providers may contact Customer Service to check the status of a claim by calling 866-789-7747 or using the Provider Portal on our website. Providers must have the following information available:

A. Member Identification number
B. Member name
C. Date of service

E. Statement of Non-Discrimination

Soundpath Health does not discriminate against the delivery of health care and adheres to the principles of affirmative action and equal opportunity. Our organization will not discriminate on the basis of age, ethnicity, national origin, marital status, race, religion, sexual orientation, sex, mental or physical disability, genetic information, or source of payment in the enrollment of Members, the delivery of covered services or items, or the credentialing or contracting of providers. This organization follows CMS regulations prohibiting discrimination based on health status.

F. Designated Providers

In some cases, Soundpath Health offers benefits over and above what Medicare provides directly. Examples include routine vision care, preventive dental, hearing related services, discounted hardware (such as hearing devices and vision hardware), access to discounted health and wellness related items, and a fitness program. Members may use or access Providers contracted to provide these services without PCP referral. Please call Soundpath Health's Customer Service or consult our webpage for the most current PCP Panel established and maintained.

G. Accreditation

Accreditation requirements vary by state and accreditation organizations. Accrediting agencies generally measure Plan and Provider performance against accreditation standards.

- National Committee for Quality Assurance ("NCQA"): The NCQA review process examines the organization's quality improvement program structure, tests quality improvement processes, and looks for evidence that quality improvement activities have resulted in measurable improvement in the organization's performance in both clinical and service areas.

- Healthcare Effectiveness Data and Information Set ("HEDIS"): HEDIS is designed to measure Plan and Provider performance on a number of measures to produce a consumer report card. The information collected from managed care plans is published to assist consumers in choosing a health care plan, physicians and other health care providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts. Soundpath Health prepares information for NCQA based on data obtained from Providers in the form of claims or encounter records. For example, one HEDIS measure is to determine if Members with diabetes receive an annual dilated eye examination. The percent of diabetic Members who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the Member is identified as needing an examination. An annual reminder may be generated to Members who have not met the HEDIS criteria for certain measures.

- URAC (originally known as Utilization Review Accreditation Commission): A nonprofit organization founded in 1990 to establish standards for the health care industry by providing a method of evaluation and accreditation of organizations such as health plans and preferred provider organizations. Also known as the American Accreditation Healthcare Commission, URAC accredits many types of health care organizations. There are over 25 different accreditation and certification programs, some that review the entire organization, such as the

health plan standards, and some that focus on a single functional area in an organization, e.g., case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs, and provider groups can seek accreditation.

H. Non-Interference with Patient/Provider Relationship

The Plan encourages a strong Provider-Patient relationship, and therefore does not interfere, prohibit, or otherwise restrict Providers from freely communicating with or advising the Plan's Members concerning their health status, medical care or treatment options, including timely communication of clinical information. Therefore, we serve as an advocate on behalf of a Member regarding care and treatment options, regardless of benefit coverage limitations. The Plan provides all information to the Member concerning:

- Alternative treatments, medication options and any other medical care and treatment options;
- The opportunity to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment;
- The opportunity to refuse treatment and express preferences about future treatment decisions.

I. National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized National Provider Identifier (NPI) for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions. HIPAA defines a covered health care provider as any provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPI and use this number in all HIPAA transactions. To avoid payment delays or denials, Soundpath Health requires a valid billing NPI and Taxonomy Code(s) be submitted on each paper and electronic

claim. We require submission of your Tax Identification Number (TIN) with each claim as well.

J. Coordination of Benefits (COB)

Some Soundpath Health members have other insurance coverage. Soundpath Health adheres to CMS regulations to determine the primary insurance carrier and appropriate reimbursement process. The Provider is responsible for identifying all insurance coverage held by the Member at the time of admission or service initiation. Any excess coverage information obtained by Provider (in excess of Soundpath Health coverage) should be forwarded immediately by Provider to Soundpath Health. This information will help expedite payment. If the additional coverage is "primary," the claim must first be submitted by Provider to the primary carrier for payment.

Soundpath Health will use the following criteria to determine when it is not the primary insurance plan for Members. If a Member meets any criteria listed below, Soundpath Health will not be the primary insurance plan.

- 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 who is covered by an 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.

Soundpath Health will review the admission record or intake form to identify possible Coordination of Benefits (COB). If other coverage is determined by Plan to be primary, Soundpath Health will deny payment and return the claim to the Provider. If Soundpath Health is secondary, the Explanation of Benefit (EOB) from the primary insurer must accompany the claim for the Plan to process any secondary coverage payments.

K. Retroactive Disenrollment

Soundpath Health verifies Member eligibility and benefit availability at the time services are requested, at the time the claims are adjudicated, and again when notified by CMS of a retroactive disenrollment. Payments will be made only when the Member is eligible for coverage on the dates the service is provided by Provider. Occasionally, Soundpath Health is notified of a retroactive disenrollment by CMS after a claim has been paid. In this event, Soundpath Health will notify the Provider of the overpayment and will request an immediate refund. If such monies are not received, the overpayment will be deducted from the Provider's next remittance. Soundpath Health will assist the Provider in identifying the Member's other coverage if any are known to the Plan. Please contact customer service if you have questions.

L. Significant Health Risk Assessment Findings

Members who self-report depression and indicate they are in need of help on their Health Risk Assessment survey will be sent a letter from Soundpath Health's Chief Medical Officer encouraging them to schedule a follow-up appointment with their Primary Care Provider (PCP) at their earliest convenience. The Health Risk Assessment information and copy of the Member letter will be faxed to the PCP within 1 business day of receipt by Plan of the Health Risk Assessment survey.

Soundpath Health will forward the Health Risk Assessment Survey information to the PCP as requested by the Member. Soundpath Health may intervene on behalf of the Member to facilitate appointments, education, and assistance with resources available through the Plan and/or the continuity of care through community arrangement.

M. Member Transfer Between Contracted PCPs

The following guidelines apply to the transfer of a Soundpath Health Member, upon his/her request, from one PCP to another:

- The Member's decision to transfer should be strictly voluntary;
- The Member must not have been directly recruited by phone or in person by anyone involved with either primary care office;
- The Member must not have been influenced to transfer to the new PCP due to improper or incorrect information, or for medical reasons;
- Upon a Member's request, the primary care office must send his/her medical records to the newly selected primary care office without charge to the Member.

Any Provider who violates these guidelines is subject to corrective action by the Plan.

N. Involuntary Member Disenrollment

A Member may be involuntarily disenrolled from a Medicare Advantage Plan under the following circumstances:

- Change in residence outside the Plan's service area or temporary absence for more than six (6) consecutive months;
- Loss of entitlement to Medicare Part A or loss of enrollment in Part B;
- Member is deceased;
- Fraud and abuse;
- Contract termination.

O. Member Appeal & Grievance Process

The Plan's appeal and grievance process conforms to CMS guidelines, and applies to Soundpath Health Members who are dissatisfied with the health care services received, or any aspect of the Plan. An appeal/grievance may be filed by a Member or his/her authorized representative.

Soundpath Health will accept Member, Contracted Provider and/or Non-contracted Provider requests for standard and expedited/urgent appeals and grievances. Our Medicare Advantage Members can have a representative submit an appeal on their behalf if their Member Representative completes and provides an Appointment of Representative (AOR) form that can be found on our website. (Note: treating and prescribing physicians have the right to file a standard pre-service appeal request on behalf of the member without an AOR as long as the member is made aware.) Also, certain states and federal programs may have specific processes for physician appeal/grievance requests. The appeal/grievance process for Members is an internal process designed to resolve complaints or disputes regarding adverse determinations. If the initial appeal/grievance is upheld, the resolution letter sent by Plan will provide next level rights as applicable.

III. Billing and Claims Payment

A. Copayment and Coinsurance

Providers are responsible for collection of all Member copayments and coinsurance amounts. Such copayments and coinsurance are generally reflected on the Member's Soundpath Health identification card. To obtain or verify the information, please contact Soundpath Health Customer Service.

Additional fees

You may not charge Members fees for covered services beyond copayments, coinsurance or deductibles as described in the Member's benefit plans. You may not charge Members retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies or methodologies. Please note that CMS does not allow a provider to charge for "missed appointments" unless the provider has previously disclosed that policy, in writing, to the Member.

Charges for non-covered services

"Non-covered services" means services not covered by a Member's Subscriber Agreement, and for which Soundpath Health does not provide benefits. Non-covered services are identified as such on your payment voucher or other transmittal from Soundpath Health to you and in the Member's explanation of coverage and notice of denial for non-covered benefits. You may charge and collect from Members for non-covered services if in each instance, and prior to rendered services: (a) Member is advised in writing that the specific services are non-covered services; and (b) the Member affirmatively agrees in writing to assume financial responsibility for payment of such specific services after being so advised. If you are uncertain whether a service is a covered service, you must obtain a coverage determination from Soundpath Health before advising the Member as to coverage and liability for payment and rendering services.

Medicare Advantage risk adjustment data

The risk adjustment data you submit to Soundpath Health must be accurate and complete. Note that: (1) risk adjustment is based on diagnosis codes, not CPT codes. Thus it is critical for your office to refer to a diagnosis coding manual and code accurately, specifically and completely when submitting claims to Soundpath Health. (2) Diagnosis codes must be supported by the medical record. If it is not documented in the medical record, then Soundpath Health will not recognize it as occurring. Medical records must be clear and complete. (3) Be sure to distinguish between acute vs. chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the Member's condition and pertinent history at the time of the visit. (4) Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5 or even 7 character code more accurately describes the Member's condition. (5) Be sure that the diagnosis code is appropriate for the Member's gender.

You shall cooperate with any Soundpath Health audits and/or external audits mandated by federal or state law or regulations, and shall make all records available to appropriate federal and state authorities, subject to applicable federal and state laws and regulations relating to the privacy of an individual's health care information. You will allow and fully cooperate with inspection, audit and duplication by Soundpath Health of any and all

data and other records pertaining to Members and related to the Agreement, to the extent necessary to perform the audit or inspection. Such data and other records include, but are not limited to, billing, payment, assignment, utilization review, medical and medical abstract records maintained on Members pursuant to the Agreement, and charge and reimbursement data maintained by you related to charges made and payments received by you from other insurance carriers. Such inspection, audit verification and duplication shall be allowed upon reasonable notice during regular business hours.

In addition, you shall make such data and other records available to appropriate state and federal authorities involved in assessing the quality of care or investigating any grievances or complaints of Members, subject to applicable state and federal laws related to the confidentiality of medical records. Plan, the Secretary of Health and Human Services (the "Secretary"), the Comptroller General or their designees shall have the right to audit, evaluate, inspect and copy any books, contracts, medical records, Member care documentation and other records that pertain to: (1) the services performed under the Agreement; (2) reconciliation of benefit liabilities (3) determination of amounts payable; or (4) other relevant matters as such person or entity conducting the audit, evaluation or inspection deems necessary.

The right described above shall extend through 10 years from the final date of the applicable Plan Contract period or completion of audit, whichever is later; provided, however, that such access may be required for a longer time period if: (1) CMS determines that there is a special need to retain a particular record or group of records for a longer period and CMS provides notice at least 30 days before the normal disposition date; (2) CMS determines that there has been a termination, dispute, fraud or similar fault, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the matter; or (3) CMS determines that there is a reasonable possibility of fraud, in which case it may perform the inspection, evaluation or audit at any time.

For the purpose of conducting the above activities, you shall make available Providers' premises, physical facilities and equipment, records relating to Members, and any additional relevant information CMS may require.

B. Claims Submission

The Provider is encouraged to bill electronically. Providers using electronic submission must submit all claims to Soundpath Health or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. Soundpath Health uses Emdeon as the primary clearinghouse for claims. The clearinghouse's use of specific system edits ensures the accuracy of all claims forwarded. If you are a physician, other health care professional or facility you may use electronic transactions. Please use the Emdeon Claims Submission **payer ID # 42172.**

If you are not currently set up to bill Soundpath Health electronically, paper claims must be submitted on the appropriate claim form (CMS-1500 for professional claims and the UB-04 for facility claims). Please send claims to:

Soundpath Health
Attn: Claims Department
PO Box 853924
Richardson, TX 75085-3924
Fax to: 253-779-8829

All claims and encounter data will be used in accordance with guidelines established by HIPAA and the Genetic Information Nondiscrimination Act ("GINA"). This data allows Soundpath Health to comply with accreditation and regulatory requirements established by CMS, NCQA, URAC and/or other regulatory agencies, to calculate HEDIS qualitative scores, and to in connection with other Member-related initiatives.

C. Clean Claims

A clean claim is an uncontested, complete, accurate, and valid claim, submitted on a CMS 1500 or UB04 (or their successor forms), which has all mandatory entries and truthfully represents medically necessary services provided to a Member as documented in the Member's medical record and which complies with standards established by Soundpath Health. It is also defined as a claim that has no defect or impropriety, including lack of required substantiating documentation for non-contracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment for being made on the claim. 95% of claims submitted by Providers will be paid within sixty (60) days of receipt by Plan or as required by the Participant Agreement.

In a clean claim, the "UNIT" submitted will vary according to the type of service authorized. All "UNITS" must be submitted as whole numbers. Decimal numbers are not acceptable. The following are examples of UNITS:

- A day
- A visit
- An hour
- A dose of medication

D. Timely Filing and Prompt Payment

Soundpath Health strives to process and adjudicate claims for covered services in a timely and efficient manner consistent with the terms and conditions of the Agreement, and in accordance with all legal and regulatory requirements.

Timely Filing

Providers must submit any and all claims for reimbursement in accordance with the terms set forth in the Agreement, any Participation Attachment(s) to the Agreement, the Plan Compensation Schedule, this Provider Manual and Regulatory Requirements.

Prompt Payment

A claim is processed promptly if it is approved or denied within the time required by the Agreement or the applicable regulation of the state in which Soundpath Health is operating. For claims to be paid promptly:

- A properly completed claim must be submitted electronically or by paper and the claim must not involve an investigation for coordination of benefits (COB), pre-existing condition investigation, Member eligibility, or subrogation.

- A Member's original signature or a "Signature on File" or "Assignment on File" stamp is required for payments made directly to the Provider.

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

Note: The Provider must maintain a valid written assignment of benefits from the Member on file. This will serve as evidence that the Provider is entitled to all payments for service. Soundpath Health reserves the right to review this original signed assignment document at any time.

E. Reimbursement

Payment terms are defined in the Provider Agreement, but may also be affected by the following:

- Member's eligibility at the time of service;
- Whether services provided are covered services under the Member's Plan;
- Whether services provided are medically necessary as required by the Member's Plan;
- Whether services were without the prior approval of Plan, if prior approval is required;
- The amount of the Provider's billed charges;

- Member copayments, coinsurance, deductibles, and other cost-share amounts due from the Member and coordination of benefits with third-party insurance carriers as applicable;
- Adjustments of payments based on coding edits described in Section E above.

A Provider who receives reimbursement for services rendered to Members must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and the Rehabilitation Act of 1973. Nothing contained in the Agreement or this Manual is intended by Soundpath Health to be a financial incentive or payment which directly or indirectly acts as an inducement for Providers to limit medically necessary services.

Soundpath Health applies the CMS site-of-service payment differentials in its fee schedules for CPT® codes based on the place of treatment (physician office services versus other places of treatment).

F. Provider Remittance (Explanation of Payment)

All claim payments are sent with a provider remittance which includes the claims payment calculations and benefit codes explaining why a service reimbursement was paid, modified, or denied.

G. Claims Reconsideration and Dispute Process

If, upon receipt of an initial claim determination from Plan, a Provider disagrees with the determination made by the Plan and would like to request a reconsideration/ of the issue, the Provider may do so by contacting Soundpath Health in accordance with the procedure below:

1st Level: Provider Reconsideration

If you believe an item or service was denied in error by Soundpath Health, the first step in addressing your concern is to request a Claim Reconsideration. You may submit a Claim Reconsideration request via fax or mail.

Mail to:
Soundpath Health
Attn: Provider Reconsiderations
PO Box 27510
Federal Way, WA 98093
Fax to: 1-253-517-4365

Your reconsideration request must be submitted to us within twelve (12) months from the date of the Plan determination on the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA),

In addition, please identify the specific claim(s) in "paid" or "denied" status which you believe should be adjusted, and include all necessary supporting documentation.

If you are submitting a Claim Reconsideration Request for a claim which was denied due to untimely filing:

- *Electronic claims* – include confirmation that Soundpath Health received and accepted your claim.

- *Paper claims* – include a copy of a screen print from your accounting software to show the date you submitted the claim to Soundpath Health.

Note: All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.

2nd Level: Provider Claim Dispute

If you do not agree with the outcome of the Claim Reconsideration decision made at the 1st level review, you may submit a formal dispute.

Mail to:

Soundpath Health
Attn: Provider Reconsiderations
PO Box 27510
Federal Way, WA 98093
Fax to: 1-253-517-4365

Your formal dispute request must be submitted to us within sixty (60) days from the date of the reconsideration decision shown on the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Member specific treatment plans or clinical records with the formal dispute letter. Include information which supplements your previous reconsideration submission that you wish to have included in the dispute review. Our decision will be rendered based on the materials submitted to the Plan with the formal dispute letter.

Soundpath Health will provide a written response to your formal dispute within thirty (30) calendar days for pre-service disputes and sixty (60) calendar days for post-service disputes from receipt of the complaint by the Plan.

Note: The second level dispute decision rendered is final and not subject to further appeal. The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in the Agreement.

If you are disputing a refund request, please send your letter of appeal to the address noted on the refund request letter. Your appeal must be received within thirty (30) calendar days of the date of the refund request letter, or as required by law or your Agreement, whichever date is later, in order to allow sufficient time for processing the appeal, and to avoid possible offset of the overpayment against future claim payments to you. When submitting this type of appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe we have made the refund request in error.

H. Expedited Appeals/Fast-Track Appeals

Providers can request and receive expedited decisions for their patients whose medical treatment is affected by "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize:

- the patient's life or health, or
- the patient's ability to regain maximum function

The following are examples of potential reasons for an expedited appeal request:

- Member is being discharged from a Hospital early and the Provider has missed the deadline for a Peer Review Organization (PRO) review.
- Member is being discharged from a Skilled Nursing Facility early.
- Member's Home Health care is being discontinued early.

How to request an expedited seventy-two (72) hour appeal
The Provider should call, write, or fax Soundpath Health, specifying that this is an expedited appeal or urgent appeal, at the following:

Mail to:
Soundpath Health
Attn: Appeals Dept.
PO Box 27510
Federal Way, WA 98093
Fax to: 1-253-517-4365

The following are possible dispositions of an expedited determination/appeal:

- The request to expedite our determination/appeal decision is approved, Soundpath Health will make a decision in seventy-two (72) hours and notify the Provider that Plan will provide or continue the service.
- The request to expedite our determination/appeal decision is not approved, and Soundpath Health informs the Provider that the request will be handled under the standard fourteen (14) day determination/appeal process.

- If the Provider does not hear back from Soundpath Health within seventy-two (72) hours of the request, they will receive a letter indicating the request was de-expedited for not meeting applicable criteria.

IV. Rights and Responsibilities

A. Participating Provider Rights and Responsibilities

As a Provider, you have agreed to provide care to Members of Soundpath Health. We look forward to supporting you in providing accessible, quality health care that meets the needs of our Members. Providers are also responsible for the education and training of all individuals working within their medical practice to ensure that procedures outlined in this Provider Manual are followed correctly. Below are Provider rights and responsibilities in accordance with CMS requirements:

- To maintain current licensure in the state in which services are provided.
- To be credentialed by Soundpath Health and meet all credentialing and re-credentialing criteria as required by the terms of the Agreement and this Manual.
- To maintain participation in Medicare under Sections 1128 or 1128A of the Social Security Act.
- To provide services in a manner consistent with professionally recognized standards of care.
- To comply with any and all state statutes regarding maintaining malpractice insurance in amounts deemed sufficient by Plan.
- To maintain the requirements for Continuing Medical Education (CME).
- To provide Plan notification if there are any changes to your licensure status, sanctions or business information (Tax ID number, address, etc.).
- To maintain confidentiality with the Members' records, correspondence, and discussions in accordance with state and federal laws and regulations.
- To maintain Members' medical records in a form that is consistent with the requirements of state and federal laws and regulations.
- To maintain procedures to inform Members of follow-up care or provide training in self-care as necessary.

- To provide coverage by a contracted Soundpath Health physician and/or mid-level provider twenty-four (24) hours a day, seven (7) days a week.
- To ensure all services are provided in a culturally competent manner.
- Applicable to PCPs, to provide, coordinate, monitor, and supervise the delivery of health care services for assigned-Members and to provide appropriate referrals to participating specialists.
- Applicable to specialists, to provide the Member's PCP with a written report no later than five (5) business days from the date of service regarding the proposed plan of treatment, including any proposed hospitalization or surgery. This report should also be provided to a Member's PCP for self-referred services such as women's health care services. Failure to provide the PCP with this report may result in nonpayment by Plan for services for which the provider cannot then bill the Member. With the exception of Urgent or Emergent Care, specialists should see Members only upon a referral from the PCP (for services not on the current Prior Authorization list). For services on the current Prior Authorization list, specialists should only see Members upon approval by Plan or its delegate.
- Applicable to acute facilities, to provide notification of all inpatient admissions as described in this Manual and have inpatient and emergency services available 24 hours a day, 7 days a week.
- To maintain active admitting privileges at an in-network hospital or designate coverage such as an associate or hospitalist.
- To collect the appropriate copayment, co-insurance or deductible in accordance with the Member's benefit plan.
- To provide copies of medical records to the Member upon request at no cost.
- To provide services in a manner consistent with standards of care.
- To encourage a Member to participate in his or her treatment planning and course of care.
- To provide clear and understandable information to the Member regarding treatment options, including interpretive services for Members who are hearing impaired or whose primary language is not English.
- To provide Members with written information about advance directives and the right to make anatomical gifts.
- To maintain an environmentally safe practice facility.

- To meet safety standards in accordance with the Occupational Safety Health Administration, ADA, and any other regulatory requirements.
- To comply with Plan's utilization management/quality improvement activities including, but not limited to, HEDIS, medical record reviews, audits and corrective action plans including participating provider access standards.
- To comply with Plan's audits including, but not limited to, retrospective Hierarchical Condition Category audits at no cost to Plan.
- To ensure that Members are not discriminated against based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disability, or source of payment.
- To ensure that the hours of operation are convenient for Members so services may be provided with reasonable promptness.
- To make an exception, as per written authorization from the Member, to allow their medical records or medical condition(s) to be disclosed to others.
- To maintain safe storage of inactive medical records for a minimum of ten years (or the extent required by applicable state and federal regulations) and have them easily retrievable when needed.
- To allow Members to directly access all services as required by CMS, state, and federal law, including, but not limited to, screening mammography and influenza vaccination services.
- To provide female Members with direct access to a women's health specialist for routine and preventive health care services.
- To refrain from distributing marketing materials or forms to Members without CMS and Plan prior approval.
- To ensure that any payment and incentive arrangements with subcontractors are specified in writing, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- To follow Plan processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist Members in making an informed choice about Medicare coverage.
- To follow Plan processes for notifying Members of any partial or full Agreement terminations.

- To cooperate with and assist Plan in fulfilling its responsibility to disclose to CMS quality, performance and other indicators, as specified by CMS.
- To follow Plan procedures for handling grievances, appeals, and expedited appeals.
- To provide full disclosure to Members before providing a health service if you believe there is a substantial likelihood that a specific service will not be covered. This notice may be either verbal or in writing; the Provider is encouraged to document the discussion and bill using the appropriate modifier. The Member may assume additional financial responsibility in accordance with the Member's benefit plan and the Evidence of Coverage language. A document similar to the Medicare Advanced Beneficiary Notice (ABN) must be signed by the Member before liability for payment can be passed to the Member. If a non-covered service is performed and there is no signed advance notice on record, the claim will be denied and you may not bill the Member.
- To abide by all state and federal rules, regulations, and statutes.
- To comply with all provisions of your Agreement with Plan.
- To refer all services to a participating provider in Plan's network, except as otherwise authorized by Plan.

Note: To the extent allowed by state law, mid-level providers are state licensed professionals who may be employed or contracted by Providers to examine and treat Members. Mid-level providers are Advanced Registered Nurse Practitioners (ARNPs) or Physician Assistants (PAs). The Member must be notified of their credentials and the possibility of not being seen by a Medical Doctor when utilizing a mid-level provider. The Provider must sign all progress notes made by PAs. Soundpath Health allows ARNPs and PAs the ability to have Members assigned as his or her PCP.

Changes in Provider Status

All Soundpath Health participating providers are responsible for giving written notice at least 30 days in advance of provider changes such as Tax ID, billing address, and practice locations. This ensures time for Soundpath Health to update its systems, notify Members, and prevent payment delay. Provider demographic change forms may be found on Soundpath Health's website.

PCPs are also responsible for notifying Soundpath Health when their practice reaches capacity and they can no longer accept new Members. This notice should be in writing and will be effective the first day of the month following 30 days from receipt of PCP panel report.

Discharging a Member From Your Practice

If you need to discharge a Member from your practice, there are very specific guidelines to follow. Reasons for ending the physician-patient relationship may include chronic non-compliance, rudeness to office staff, or non-payment of bills.

- You may not terminate your professional relationship for any discriminatory purpose.
- You may not terminate your professional relationship in violation of any CMS, State, or Federal laws or rules prohibiting discrimination such as the Americans with Disabilities Act.
- You may not terminate your professional relationship where you know, or reasonably should know, that no other healthcare provider is currently able to provide the Member the type of care or services that you are providing to them.

Reduce the Risk of Abandonment for the Member

Abandonment occurs when a physician suddenly terminates a patient relationship without giving the patient sufficient time to locate another provider. A Member, however, may withdraw from a physician's care at any time without notifying the physician.

- To reduce the risk of allegations of abandonment, it is recommended that you discuss with the Member, in-person, the difficulties in the physician-patient relationship and your intention to discharge the Member from the practice.
- Be sure to document the discussion fully in the Member's medical record, also noting the presence of any witnesses such as a Member's family or your office staff.

Formal Discharge Letter to the Member

You are required to notify the Member and Soundpath Health, in writing, of the termination. The letter must state that you will no longer provide care to the Member as

of a date certain. The termination date must be at least 30 days from the date of the letter. You must also state in the letter that you will be available to provide emergency care or services, including provision of necessary prescriptions, during the 30-day notice period. The discharge letter should also include:

- A description of any urgent medical problems the Member may have.
- An offer to forward copies of the Member's medical records to the subsequent treating physician.
- Soundpath Health's customer service contact information to assist the Member in locating a physician who is accepting new patients.

Participating Provider Access Standards

New & Established Patients (not seeking Behavioral Health Care)	
Routine, Wellness & Physical	Appointment within 30 days of request
Routine, Primary Care	Appointment within 7 days of request
Urgent Care	Same day appointment or within 24 hours
Emergency Care	24 hour availability of appropriate triage
Waiting time for scheduled appointment	Should not exceed 30 minutes
Patients Seeking Behavioral Health (BH) Care	
Care for non-life threatening emergency	Appointment with BH provider within 6 hours
Urgent	Appointment with BH provider within 48 hours
Emergency	24 hour availability of appropriate triage
Routine Office Visit	Appointment with BH provider within 10 business days
Waiting time for scheduled appointment	Should not exceed 30 minutes
Behavioral Health Telephone Access Standards	
Triage calls	Answered by a live voice within 30 seconds
Triage abandonment rate	Within 5%

- **Preventative Care:** No symptomatic clinical concerns, complete physicals or other preventative services, i.e. flu inoculations.
- **Routine Primary Care:** Stable conditions that require a visit but are not considered urgent.
- **After-Hours Care:** Care required after the provider's scheduled closing time and before their scheduled opening time or on a day the clinic is closed.

- **Office Waiting Time:** Amount of time between the time a Member checks in and the time they see a provider, starting no earlier than their scheduled appointment time.

B. Member Rights and Responsibilities

Soundpath Health Members have certain rights and responsibilities when being treated by Plan Providers. The rights and responsibilities statement below, though not intended to be exhaustive, reminds Members and Providers of their complimentary roles in maintaining a productive relationship.

Below are Member rights and responsibilities in accordance with CMS requirements. This information is taken directly from Chapter 8 of the Evidence of Coverage and is included in the Member Handbook (Your Rights and Responsibilities):

- We must provide information in a way that works for you.
- We must treat you with fairness and respect at all times.
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- We must give you information about the plan, its network of providers and your covered services.
- We must support your right to make decisions about your care.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- What can you do if you believe you are being treated unfairly or your rights are not being respected?
- We must assist you in obtaining additional information about your rights.

Soundpath Health Members are expected to be active participants in their own healthcare decisions. Below are the responsibilities of our Members:

- Become familiar with covered services and the rules to follow to get these covered services.

- If there is any other health insurance coverage or prescription drug coverage in addition to our Plan, there is a requirement to tell us.
- Tell doctors and other health care providers they are enrolled in our Plan.
- Help doctors and other providers help the Member by giving them information, asking questions, and following through on the Members' care.
- Be considerate.
- Pay what is owed.
- Inform the Plan if the Member moved their permanent residence.
- Call Customer Service for help if there are questions or concerns.

Members are directed to call the Plan's customer service department with questions regarding any of above.

Advance Directives

Soundpath Health is required to provide Members with information regarding their health care rights under current state law. State law recognizes a Member's right to accept or refuse health care by using documents called Advance Directives. If a Member is no longer able to make medical decisions, the Advance Directive takes effect when the Provider determines the Member's medical condition is terminal. The Advance Directive may also go into effect if the Member's Provider and another provider agree that the Member is in a permanently unconscious state.

Health Care Directives (also known as Living Wills) and Durable Power of Attorney for Health Care are the two types of Advance Directives that can be used to set forth in writing one's wishes regarding medical treatment in the event of the inability to clearly communicate due to incapacitating injury or illness. If a Member has signed either of these forms, copies should be included in his or her medical record. For all Medicare Advantage Members, documentation should include discussions of a Member's right to predetermine future health care and specific treatment preferences if expressed. Providers and staff members who make entries on Member charts regarding this subject should identify themselves by signing or initialing each entry.

Federal law requires hospitals to ask a Member if they have Advance Directives when he or she is admitted. Other health care Providers should document Advance Directives in

the Member's medical record. Hospitals and Providers must also inform Members of their own policies regarding Advance Directives and end-of-life treatment, as well as any conflict between the Member's Directive and their own policies. If there is a conflict, a written plan of action must be agreed upon and included in the Member's medical record.

To ensure our Members' wishes are met concerning the provision of health care if the Member becomes incapacitated and is unable to make those wishes known, physicians, other health care professionals and facilities should comply with the following:

- The office or facility should either have forms of Advance Directives available for the Members to complete, or advise them how to obtain one from a hospital or their attorney.
- If the office has received a signed Advance Directive, a copy of the document must be prominently displayed in the Member's chart so that it is easy to see.
- The physician or other health care professional must document in a prominent location within the Member's medical record whether or not the Member has executed an Advance Directive.

All hospitals and PCPs are required to provide Members with written information about Advance Directives and the right to make anatomical gifts. Specialists must inform Members of these rights when deemed appropriate based on the treatment or care they are providing. In addition, a Member has the right to be informed and educated about the opportunity to express his/her wishes concerning future care, including choosing a person to make medical decisions on the Member's behalf if the Member is unable to do so.

C. Soundpath Health Rights and Responsibilities

Below are rights and responsibilities of Soundpath Health:

- To offer a provider network that provides adequate access to and availability of covered services to Members.

- To provide for continuation of Member health care benefits for the duration of the contract period for which CMS payments have been made by the Member.
- To supply the Provider and Provider's office staff with any revisions to Plan Policies and/or procedures in accordance with regulatory and applicable accreditation agencies.
- To offer training and support to the Provider, Provider's staff, employees and entities contracting or partnering with Provider for the provision of benefits or services, in accordance with CMS requirements, on general compliance and fraud, waste and abuse.
- To ensure that Member health risk assessments received by the Plan will be forwarded to the Member's PCP.
- To offer support in the provision of language services to Members.
- To ensure that the provider relations staff will be adequately available for the Providers.
- To conduct oversight reviews in compliance with state and federal regulatory requirements.
- To conduct reviews to assess content, legibility, organization and completeness of the Members' records as well as assess compliance concerning confidentiality of medical and health information.
- To ensure the compliance of Providers with Plan and/or CMS requirements by conducting site audits, medical record reviews, access audits, QI reviews, and other requirements as determined by Soundpath Health or required by CMS or State insurance agencies.
- To maintain and provide access to accurate Provider directory information on the Plan's website.
- To maintain current Membership records for Providers.
- To ensure non-discriminatory practices for prospective enrollees and current Members, including those with physical or mental disabilities, or chronic illnesses.
- To conduct Member satisfaction surveys regarding the Provider's services and share the survey results with the Provider.
- To refrain from using providers or provider groups to distribute printed information comparing the benefits of different health plans unless the providers, provider groups, or pharmacies accept and display materials from all health plans with which the providers, provider groups, or pharmacies contract.

- Soundpath Health will send each new Member a health risk assessment within the first 30 days after the Member's selection of a PCP. The objectives of this assessment tools is:
    - To proactively identify conditions that require attention by a health care provider
    - To promote continuity and coordination of care
    - To identify conditions that may qualify for disease management programs or case management
    - To provide Members with appropriate educational materials

V. Medical Management

Medical management is designed to assure and deliver consistent, high quality, cost-effective, medically necessary care and services for all Members. All care and services delivered to the Members will be compliant with CMS regulatory requirements and evidence-based criteria. The Plan's medical management division provides:

- Care Management
- Utilization Management
- Case Management
- Pharmacy Services
- Quality Improvement Program

A. Care Management

Care management is the set of processes that manages utilization of medical services, promotes equal access for Members to their Plan benefits, and promotes cost effective, high quality care across the continuum. The Plan's care management (CM) program is designed to coordinate resources for Members to ensure the delivery of high quality, cost efficient health care for Members with the intent of optimizing health outcomes. This includes a team approach to manage patient care across the healthcare continuum. This broad-based program uses a multifaceted approach in providing various services

intended to promote Member satisfaction and responsibility while protecting the patient's rights and confidentiality.

The Care Management Program has two key areas:

- Utilization Management
- Population Health/Case Management

The Plan's CM team will provide services uniformly to all Members. These services are designated to include:

- Monitoring access, timeliness, and the quality of medical services provided to all Members.
- Identifying and promoting of health care benefits and community resources in order to advance efficiency, optimize Member health, and ensure appropriate utilization of health care services by Members.
- Coordinating and collaborating with the Plan's quality improvement, pharmacy services, grievances & appeals, claims and Compliance departments to monitor Members requiring increased healthcare coordination and/or services.

Key functions of care management include, but are not limited to:

- Pre-service authorization and management for services on the Plan's prior authorization list and for all services provided by a non-contracted provider. The prior authorization list is available in the Member's EOC document and on the Plan's website.
- Concurrent review
- Retrospective or post-service review
- Home health/ambulatory review
- Out of area review and management
- Discharge planning
- Coordination and oversight of delegated care management/utilization management entities
- Case management

- Population health/chronic disease management
- Transplant coordination
- Behavioral health coordination

In addition, key responsibilities include:

- Assisting Member transition to other care, if necessary, when benefits have ended or are not part of the Member's benefit package.
- Working with appropriate members of the health care team to facilitate Member care at the appropriate level, meet service needs, ensure continuity of services and decrease overall costs.
- Consulting with physicians and subcontracted groups to coordinate care within the network to maximize available resources for Member.
- Working closely with the Member population, the Providers and medical staff, hospital patient care staff, and hospital departments (social services, discharge planning, quality improvement, home health/hospice)
- Coordinating all services for Member discharge in a timely manner and with contracted Providers.
- Monitoring utilization, cost, and other quality performance indicators.
- Following and facilitating care coordination and population health management activities.
- Evaluating each case based on the Member's needs and local delivery system, considering age, co-morbidity, complications, progress of treatment, home environment and availability of facilities.
- Ensuring determinations are made in a timely, efficient manner within regulatory standards.
- Communicating the determinations of requests to the PCP and specialty providers within regulatory required timeframes for final status determination.
- Ensuring compliance with the appeals and grievance process.
- Ensuring confidentiality of clinical and proprietary information.

B. Prior Authorization Process

Prior authorization is required or notification is requested for certain medications and medical services. Plan's care management division is responsible for managing services on the prior authorizations list. The prior authorization list is available in the Member's EOC document and on the Soundpath Health website.

The PCP is responsible for initiating and submitting requests for authorization to the Plan's care management department. Services performed without authorization are subject to review and denial of payment. Member eligibility and benefits must be checked prior to authorizing services.

Coverage for medical services is subject to the limits and conditions of the Member benefit plan. Members and their Providers should consult the Member's summary of benefits and/or EOC or contact a customer service representative to determine whether there are any applicable benefit limitations.

The current prior authorization list can be located at www.SoundpathHealth.com. **The prior authorization list is also subject to change.** New-to-market drugs may be added monthly to the list of medications which require review. Changes to the preauthorization list outside of new-to-market drugs are communicated through notices to Providers in accordance with the Provider Agreement.

When a plan referral or authorization request is received, Soundpath Health determines the level of urgency and follows Medicare Part C turnaround time requirements, as follows. These are the Plan's minimum standards:

Service Type	Turn Around Time (TAT)	Notification Timeframes (Approvals & Denials)	Extensions Allowed (Pending status)
Pre-Service Urgent (Expedited)	72 hours	VERBAL Notification within 72 HOURS FROM receipt of request. WRITTEN notification required within 3 days of verbal notification	Extension up to 14 days allowed using Notice of Expedited Grievance Rights to Member
Pre-Service Non Urgent (Standard)	14 calendar days	14 calendar days from date of receipt – WRITTEN notification must follow within 3 days of verbal notification	
Post-Service (Retrospective – prior to claim being submitted)	30 calendar days	30 calendar days from date of receipt	

- Request for a prior authorization must be submitted on the Plan's prior authorization request form or over the phone.
- Providers must provide clinical notes and supporting documentation in order for Plan to make a determination of medical necessity.
- All decisions to deny a requested service are made by a Plan medical director.

The Plan's care management division uses the following industry and nationally-recognized criteria in assisting decision-making. The following is the hierarchy used in making utilization management clinical decisions:

- Regulatory requirements supersede EOC;
- EOC supersedes medical necessity criteria (i.e. if no benefit exists for a particular service, or if there is a specific coverage exclusion/ limitation);
- **Durable medical equipment**: Local Coverage Determinations (LCDs) → National Coverage Determinations (NCDs) OR CMS Manuals;

- **Pharmacy**: LCD → NCD → CMS-approved compendia;
- **Medical** (Authorization requests, concurrent review, etc): CMO-approved pass-through lists → LCD → NCD → Milliman → community standard ONLY per medical director review.

C. Facility Admissions

All Members' acute hospital and skilled nursing facility (SNF) admissions must be approved through the prior authorization request process. Pertinent medical records and supporting documentation will be required on a periodic basis and may involve on-site review at the hospital or SNF. Emergency admissions or admissions after an ER Visit require notification to Soundpath Health within 24 hours of initiation of the service. Providers are subject to the following requirements:

- Pre-scheduled acute and SNF admissions must be pre-certified and approved.
- Concurrent review is performed by the Plan's utilization management nurse who will monitor the necessary services in Member cases as well as any discharge planning services.

D. Out of Area (OOA)

Soundpath Health provides coverage for emergent services for Members worldwide. For purposes of CMS compliance, Soundpath Health defines OOA services as being those services received by a Member outside the Plan's approved service area. In accordance with federal regulations, Soundpath Health may offer a continuation of enrollment option to Members when they no longer reside in the Plan's service area and permanently move into the geographic area designated by Soundpath Health as a continuation area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as a driver's license or voter registration card.

OOA services (except urgent/emergent) require a prior authorization. These requests are reviewed on a case by case basis and determinations are made based on the Member's medical needs and the availability of services within the Provider network to meet these needs.

Plan requires its care management division receive notification of all out-of-area inpatient admissions if PCP is made aware of such admission. The Plan's care management staff will conduct a concurrent review and assist in discharge planning. Soundpath Health staff will assist in coordination of the Member discharge/transfer with the appropriate delegated group when necessary.

E. Urgent or Emergent Services

Prior authorization is NOT required for treatment of an urgent or emergent medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention:

- Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or
- In the opinion of the practitioner with knowledge of Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. However, the Plan's care management department requests notification within 48 hours of a Member receiving urgent or emergent services in order to assist with any medical management needs.

F. Notice of Medicare Non Coverage (NOMNC)

The NOMNC is issued to inform Members, in writing that the Member's Medicare health plan and/or provider have decided to terminate their covered SNF, HHA, or CORF care.

Delegation of Care Management Services (if applicable)

Delegation occurs when Soundpath Health gives to another organization the decision making authority to perform a function that Plan would otherwise do itself. Any delegation is done through a formal process, is contractual, and is consistent with industry standards. Soundpath Health does not delegate management of Members' complaints, appeals and grievances or quality improvement.

Soundpath Health may delegate in part or in whole care management, which may include utilization management and/or case management, to an entity Plan determines demonstrate compliance with Plan's established standards. Soundpath Health will perform an initial pre-delegation audit to ensure the medical group/IPA complies with Soundpath Health standards for delegation of care management. On an annual basis thereafter, or more frequently as indicated, Soundpath Health will audit the entity to ensure continued compliance. Delegated groups that are accredited through national bodies such as NCQA or URAC, may be exempt from annual onsite delegated audits.

Plan monitors all delegated operations through mutually defined reporting and formal goal-based evaluations. An agreement specific to the function(s) delegated is mutually agreed upon and defines the parameters, responsibilities and expectations, including consequences of failure and/or inability of the delegated entity to carry out these functions.

Any care management delegated service agreement with the Plan lists the specific services delegated to the entity. Annual delegation oversight audits include evaluation, guidance, and counsel on, among other things,

- CMS regulatory compliance
- Plan Policy and Procedure compliance, including with any changes or amendments
- Individual criteria deemed appropriate for a specific delegation
- A corrective action plan if needed

The Plan oversees all activities delegated to a delegated entity The Plan may revoke such delegation under the terms of the delegation contract, consistent with any required notices of such action.

G. Pharmacy

The Plan's pharmacy services support clinical, operational, and quality components of the Medicare Part D benefit. In partnership with the Pharmacy Benefits Manager (PBM), pharmacy services initiatives include:

- Formulary Development
- Pharmacy Network maintenance
- Utilization management (prior authorization, step therapy, quantity limits)
- Coverage determination/exception process (prior authorization, step therapy, quantity limits)
- Transition fill oversight
- Denied claims monitoring and interventions with provider offices
- Part D quality improvement: Medication Therapy Management (MTM) programs, drug use evaluation (DUE), opiate Overutilization Management Service (OMS)
- Pharmacy network development

Medicare Requirement for Provider Enrollment For Part-D Covered Drugs
Effective in 2019 (delayed from 2016), if a provider writes prescriptions for Part D covered drugs and they are not enrolled in Medicare in an approved status or have a valid record of opting out, they will need to submit an enrollment application or an opt out affidavit to their Medicare Administrative Contractor (MAC). They may submit the enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at **https://pecos.cms.hhs.gov/pecos/login.do** or by completing the paper CMS-855I or CMS-855O application, which is available at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html** on the CMS website.

Note that an application fee is not required as part of the application submission.

Beginning in 2019, Part D plans will no longer be permitted to cover drugs prescribed by prescribers who are not enrolled in Medicare, except in very limited circumstances.

To ensure that providers are properly enrolled in Medicare, plan providers are encouraged to use PECOS to submit their enrollment application online. All prescribers should enroll before 2019 to allow for the processing of applications and to ensure enrollees get their prescriptions.

For more information about Part D Prescriber Enrollment or to sign up for the listserv to receive updates and important information, visit the CMS Part D Prescriber Enrollment website at go.cms.gov/PrescriberEnrollment.

The Plan Formulary

- Part D formularies are updated **monthly** and available on the Plan website
- Members receive a copy of an **abridged** formulary once per year which only lists ~70% of covered drugs and does not reflect all subsequent monthly updates
- Brand name drugs are capitalized (e.g., COUMADIN and generic drugs are listed in lower-case italics (e.g., warfarin sodium).
- Covers at least two drugs in every therapeutic class used to treat the same medical condition.
- Covers all, or substantially all drugs used in the following six classes of medication:
    - Antidepressants
    - Antipsychotics
    - Anticonvulsants (epilepsy, etc.)
    - Antiretrovirals (for HIV/AIDS)
    - Immunosuppressant (for transplant)
    - Anticancer drugs

- Covers several generic **Over-The-Counter (OTC)** anti-allergy medications at no-cost to our Members when submitted at the pharmacy **with a valid prescription** written by a prescriber. For example:

DRUG		Dosage Form
Generic Name	(Reference Brand Name)	
cetirizine hydrochloride	(ZYRTEC)	Chewable Tablets, Solution, Tablets
cetirizine hydrochloride/ pseudoephedrine hydrochloride	(ZYRTEC -D)	12 Hour Tablets
loratadine	(CLARITIN)	Tablets, Solution
loratadine/ pseudoephedrine sulfate	(CLARITIN -D)	12 Hour Tablets 24 Hour Tablets
ketotifen fumarate	(ZADITOR)	Drops

Part D Covered Day Supply

The Plan covers up to a 31-day supply per month of most Part D covered medications. All prescription plans include retail and mail-order benefits which also allow up to a 93-day supply per fill. Members are not required to use mail-order to obtain an extended day supply of medications. Tier-5 Specialty Drugs are limited to a 31-day supply per fill.

Prior Authorization Guidelines

The Plan requires Members or their prescribers get prior authorization (PA) for certain drugs. To determine if a drug has PA requirements, you can refer to the online formulary, or search the 'Prior Authorization Guidelines' available on our plan website.

If a Part D covered drug requires prior authorization, 'PA' will be listed to the right of the drug name on the formulary.

Part B vs. D Coverage

As a Part D plan, the Plan is responsible for making the Part B and D coverage determinations. To make this determination, drugs on our formulary require PA and we require the prescriber to provide information that will assist us with making this determination. Some drugs are automatically determined to be either Part B or D depending on how the claim is submitted or the Member's demographic information.

If a Part D drug is also covered under Part B, and requires a Part B versus Part D determination, 'B/D' will be listed to the right of the drug name on the formulary.

Step Therapy Guidelines

The Plan requires Members try alternative drugs before other drugs will be covered. These drugs require Step Therapy (ST). To determine if a drug has ST requirements, you can refer to the online formulary, or search the 'Step Therapy Guidelines' available on our Plan website.

If a Part D covered drug requires ST, 'ST' will be listed to the right of the drug name on the formulary.

Quantity Limit

For certain drugs, The Plan limits the amount of drugs that will be covered in a certain time period. These drugs have quantity limits (QL). To determine if a drug has QL requirements, you can refer to the online formulary.

If a Part D covered drug has a QL, 'QL' will be listed next to the drug name on the form

Exception Requests

An exception means that The Plan may pay for a non-formulary drug or will make an exception to the PA restrictions, ST restrictions or QL. Making an exception to these restrictions or limits means allowing coverage for drugs even though the guidelines are not met.

Other types of exceptions include tiering or copay exceptions. These exceptions mean that Plan may place a drug on a lower tier or approve a lower copay. We cannot approve tier exceptions from a brand tier to a generic tier or for drugs in the specialty tier. Only those non-preferred drugs or non-preferred generic drugs that have a formulary preferred alternative that does not work in a lower tier are allowed to be moved the preferred brand or preferred generic tier.

Exception requests require a supporting statement from prescriber. The period for coverage determinations begins with the receipt of physician statement. Drugs excluded from Part D cannot be covered, even by exception.

To Request a Part D Prior Authorization, Step Therapy, Quantity Limit, Exception, or Override:

Prescribers and Members can request PA, or exceptions to non-formulary status, PA restrictions, ST restrictions, and QL by:

- Completing an online coverage determination request through OptumRx: https://professionals.optumrx.com/prior-authorization/medicare-part-d.html
- Calling or faxing a completed Medicare Request Form to our PBM:

  OptumRx: 800-711-4555 **(Urgent)** (fax: 1-800-527-0531)

Medication Request Forms can be found on the Plan's website by going to:

- Click on 'Providers' link at the top of the website
- Go to 'Forms & Tools for Providers' link on the left-hand side of the page
- Scroll to 'Pharmacy Authorization Tools'
- Access the 'Pharmacy Part D Coverage Determinations' links and forms

Transition Supplies of Medication and Communication to Providers

The Plan Members whose drugs are non-formulary, require a PA or have a ST or QL requirement may be eligible for a temporary supply of medication in certain circumstances. This temporary supply of medication enables Members and Providers to find an alternative medication that is covered without restriction, or to submit documentation in support of the drug that has PA, ST, QL, or is non-formulary for The Plan.

When a temporary supply of medication is provided, both The Plan Members and their prescribing Provider will receive a letter notification in the U.S. Mail to meet Medicare requirements.

Medicare Required Part D Quality Improvement Programs

Medication Therapy Management (MTM)

As part of its mandated Quality Improvement Program, Medicare requires plans to administer a Medication Therapy Management Program (MTMP). Medicare requires plans to target enrollees who meet certain criteria. The MTM program includes a suite of services intended to help patients improve their medication use. For the Plan, the MTM services offered to our members by community and consultant pharmacists include:

- Comprehensive Medication Reviews (CMR)
- Medication-Adherence Check-In for patients late to fill
- 90-Day Fill Check-Ins for patients who may be candidates
- Gaps-in-Care check-ins for patients who may be candidates
- Medication Reconciliation for patients who experience a transition in care setting

Certain Members are eligible to receive a Comprehensive Medication Review (CMR), patient consultation and/or monitoring/education services. These services are FREE to the Member. Members who qualify for a CMR must be taking at least six chronic drugs and have at least two chronic diseases (specific diseases apply), as well as expected to reach the annual CMS-defined drug costs (for 2018, the amount is $3,967).

Certain members may qualify for the additional MTM services outside of a CMR based on patient-specific conditions such as patterns of medication non-adherence, or recent hospital discharge.

Certain Members may be contacted by a consultant pharmacist and invited to receive these MTM services. Members can also call the Plan if they want to receive these services. If Members do not want to participate, they can opt out.

Drug Use Evaluation (DUE)

The Plan performs quarterly Provider mailings focused on Part D Quality Improvement clinical areas. These clinical areas may identify your patients who are Members of the Plan and identified as:

- Taking medications that cumulatively exceed 120 Morphine-Equivalent Doses (MED) per day
- Taking medications that cumulatively exceed 4,000mg acetaminophen (APAP, Tylenol™) per day
- Taking medications classified as 'High Risk' for patients 65 and older
- Not taking some of their medications at least 80% of the time they should be based on claims data

The goal of our DUE programs are to support quality improvement in the overall clinical management of your The Plan members. The plan employs clinical staff to ensure these programs meet the needs of our providers to engage their patients.

Pharmacy Network Development

The Plan delegates pharmacy network development to their Pharmacy Benefits Manager (PBM). In an effort to improve quality and affordability of our plans, The Plan has

selected a narrow pharmacy network for the 2018 plan year. If a retail pharmacy is contracted within the OptumRx Medicare Part D Limited pharmacy network, the Plan Members are able to fill their prescriptions at the retail pharmacy location. The OptumRx Medicare Part D Limited pharmacy network meets all Medicare required adequacy standards, so your patients are able to have a pharmacy location in urban areas, within 2 miles of 90% of all plan members; in suburban areas, within 5 miles of 90% of all plan members; and in rural areas, within 15 miles of 70% of all plan members.

The Plan does not require Members to fill their prescriptions through mail-order pharmacies. Both Retail-93 and Mail-93 day supplies are offered to members at a cost of 2.5 times their monthly cost-share rather than 3 times the cost-share for a 3-month supply. If a mail-order pharmacy is contracted in the OptumRx Medicare Part D pharmacy network, plan Members are able to fill their prescriptions at these mail-order pharmacy locations.

Specialty Pharmacy

New for 2018! The Plan does not require members to utilize a single specialty pharmacy location, however OptumRx provides access to its specialty pharmacy, BriovaRx. Providers are able to submit specialty prescriptions to BriovaRx.

To learn more about BriovaRx

Please call 1-855-Briova (1-855-427-4682) or visit BriovaRx.com.

H. Quality Improvement (QI)

The primary purpose of Soundpath Health's Quality Improvement (QI) Program is to continuously improve the quality of care and appropriateness of services provided to Members with the intent of optimizing their health outcomes. This includes offering programs to Members that will help them stay as healthy as possible and facilitate their increased participation in improving their health outcomes.

The QI Program is designed to comply with all applicable state laws and regulations and with CMS requirements. Measurement and reporting of performance includes using the measurement tools required by CMS to report performance. Information on quality and

outcomes measures that will enable beneficiaries to compare health coverage options and select among them is made available to CMS.

The scope of the Plan's QI department is integrated within clinical and non-clinical services provided for Members. This includes initiatives within quality improvement, pharmacy services and care management, including those that extend to and/or impact the overall enterprise. QI extends to all areas and across all levels of the Plan's organization, in acknowledgment that teamwork and collaboration are fundamental to QI. The full participation and cooperation of physicians, hospitals and other health care providers is essential to the success of the QI Program.

QI Department Performance Indicators

Soundpath Health is rated by the government and by certain accrediting agencies on multiple measures on an annual basis, including (but not limited to) the following:

- Medicare Star Ratings
- NCQA Medicare HEDIS® Measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- Health Risk Assessment (HRA)

Quality Improvement Initiatives/Activities

Providers agree to allow and assist Soundpath Health with its performance of the following quality management activities:

- Medicare Star Rating Improvement
- Healthcare Effectiveness and Data Information Set (HEDIS) reporting
- HEDIS Compliance Audits
- Consumer Assessment of Healthcare Providers and Systems
- Health Outcomes Survey
- Health Risk Assessments
- Chronic Care Improvement Program (CCIP)
- Quality Improvement Project (QIP)
- Potential Quality of Care Concerns

- Data Analytics
- Annual Wellness Visits - Closing Gaps in Care
- Prospective In-home Assessments
- Physician Engagement – Actionable Reports
- Disease Management – in partnership with Care Management
- Pharmacy Quality Improvement - in partnership with Pharmacy Services

The Plan's QI department, on an ongoing basis, investigates potential quality of care (PQOC) issues including but not limited to Member complaints, grievances and unexpected adverse outcomes. As applicable, findings from each investigation are forwarded to the Plan's re-credentialing department to be included for consideration in the credentialing and re-credentialing processes.

I. Provider Cooperation

In support of Plan's care management program and QI initiatives, including but not limited to, HEDIS, quality improvement projects, prior-authorization requirements, and concurrent review activities, Providers, subcontracted groups, and facilities are required to give access to: (1) facilities, including the emergency room; (2) our Members' medical records; and (3) hospital and medical staff for purposes of obtaining necessary clinical information regarding our Members' conditions or treatment plans. Each Provider office will maintain complete and accurate medical records for all Members receiving medical services, in a format and for time periods as required by the following:

- Applicable state and federal laws;
- Licensing, accreditation, and reimbursement rules and regulations to which Soundpath Health is subject;
- Accepted medical practices and standards;
- The Agreement.

In addition, Providers and facilities are expected to participate in discharge planning activities for Plan Members. This also applies when providing continued care to our Members following termination of the Agreement.

J. Adverse Incident Reporting

Serious Reportable Adverse Events (SRAEs)

Soundpath Health adopts the most current version of the Serious Reportable Adverse Events (SRAE), as published by the National Quality Forum ("NQF") (www.qualityforum.org). SRAEs are serious patient safety incidents that, by definition, should never happen and include events such as surgery on the wrong part of the body or surgical instruments left in the body after an operation.

The SRAE system is one of the components of Soundpath Health's risk management program. All Plan Providers, employees, and agents are required to report to Soundpath Health's director of QI any "adverse" or "sentinel" incident involving a Member. An "adverse" or "sentinel" incident means any incident that:

- Is associated, in whole or in part, with any action of any health care facility or personnel in the provision of health care to a Member (referred to as a "medical intervention") rather than the condition for which such intervention occurred.
- Is not consistent with or expected to be a consequence of such medical intervention.
- Occurs as a result of medical intervention to which the Member has not given his or her informed consent.
- Occurs as a result of any other action or lack thereof on the part of the facility or personnel of the facility.
- Results in a surgical procedure being performed on the wrong Member.
- Results in a surgical procedure unrelated to the Member's diagnosis or medical needs being performed on any Member (including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries and procedures to remove foreign objects remaining from surgical procedures), which causes injury to a Member.
- If a SRAE occurs to a Soundpath Health Member, the Provider, hospital or healthcare facility must immediately report it to Plan.

VI. Credentialing

Our goal is to demonstrate to the community that we maintain high standards for provider credentialing based upon national criteria. All Providers are initially credentialed and then re-credentialed at least every three years based upon CMS guidelines.

A. Locum Tenens

A locum tenens provider is a provider who is sponsored by or otherwise retained by a Provider on a temporary basis, not to exceed 60 days per 12-month period, to provide services to the Provider's patients. Soundpath Health does not credential, contract with or make any representation with regard to a locum tenens provider's qualification or competency. All liability for the acts or omissions of a locum tenens provider rests with the Provider or organization retaining the services of the locum tenens. Locum tenens providers must bill for their services under the name and tax identification numbers of the Provider(s) they are replacing.

Locum tenens must be licensed in the state in which they are practicing and must only perform services within the scope of their professional license and certification.

Locum tenens must be the same type of provider as the authorizing Provider (e.g., an MD can only authorize another MD as a locum tenens, a DC can only authorize another DC, an NP can only authorize another NP, etc.) To be considered for locum tenens status the temporary provider must be one of the following provider types:

- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Doctor of Naturopathy (ND)
- Doctor of Podiatry (DPM)
- Doctor of Chiropractic Medicine (DC)
- Doctor of Optometry (OD)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Physical Therapist (PT)

B. Hospital Based or Ambulatory Surgery Center Based Providers

Standard credentialing requirements are waived for hospital based and/or ambulatory surgery center (ASC) based Providers who perform medical services at a contracted and credentialed hospital and/or ASC.

Hospital-based and/or ASC- based Providers are defined as providers who practice within the hospital or ASC setting and are contracted by the hospital and/or the ASC or practice exclusively in the hospital or ASC setting.

Providers identified as hospital-based and/or ASC based may include, but are not limited to the following specialties:

- Anesthesiologists
- Certified Registered Nurse Anesthetists
- Emergency Room Physicians
- Hospitalists
- Neonatologists
- Pathologists

C. Provider Right to Review Submitted Credentialing Information

- The Provider has the right to review information obtained during the credentialing process to evaluate his/her application.
- The Provider must schedule such a review through the Plan's credentialing department in advance. If, during the review process, the Provider identifies information that is no longer applicable or is incorrect, a written addendum may be attached to the application. Only responses to the Provider application may be modified.
- The addendum will become a part of the credentialing file. The Provider must sign and date the addendum to certify the accuracy of the information provided.

D. Right to be Informed of Application Status

- An applicant may request the status of their credentialing application by contacting the Plan's credentialing department. The request may be forwarded via telephone or written correspondence (email, facsimile and/or US mail).

- Within two (2) business day, a representative from the credentialing department will respond to the request for information (via telephone, email, facsimile and/or US mail).
- There is no requirment to reveal the source of the information if the disclosure is prohibited by state law and/or peer review protected information.
- Prior to Plan's credentialing committee review, the Plan's credentialing department will accept additional information from applicants to correct incomplete, inaccurate or conflicting information.
- Prior to making a decision, the Plan's credentialing committee may request and accept additional information from applicants requesting network participation.

E. Rights to Notification and Correction of Erroneous Information

If information provided on the provider application is found to have substantial discrepancies from information obtained by the Plan's credentialing department during the credentialing or re-credentialing process, the Plan's credentialing department will notify the provider (in writing) of such discrepancies.

Providers have the right to correct erroneous information submitted by another party (i.e., actions on a license, malpractice claims history, suspension or termination of hospital privileges or board certification status).

F. Credentialing Requirements for Participation

Established credentialing criteria, which will be developed by the Plan and reviewed by clinical peers through the establishment of a credentialing committee or similar mechanism, will be maintained for Providers and facilities as applicable. Satisfaction of these criteria is required in order to participate in the Soundpath Health Provider network. Any exceptions are at the discretion of the Plan and its credentialing committee.

- The health care provider must possess a current, valid, and unrestricted license to practice in the state where he or she provides services to Members.

- The health care provider must have clinical privileges and be in good standing at a hospital participating in the network. If the health care provider is a PCP, he or she must have admitting privileges and be in good standing at a hospital participating in the network or use contracted hospitalists that admit at a participating hospital.
- Exceptions may be granted if:
    - The health care provider's practice does not require admitting or clinical privileges at a hospital participating in the network. This type of practice may include, but is not limited to: anesthesiology, dentistry, chiropractic, pathology, occupational medicine, optometry, physical therapy, and podiatry.
    - The health care provider's practice is exclusively office-based and the health care provider provides documentation that another provider or hospitalist will provide inpatient services for the health care provider's patients at a hospital participating in the network.
- The health care provider must provide all information regarding any current or past limitations, restrictions, terminations or other disciplinary actions taken with respect to his or her medical staff appointment or clinical or admitting privileges.
- The health care provider must never have had his or her medical staff appointment or clinical or admitting privileges denied, revoked or terminated by any hospital or other health care facility. Exceptions may be granted if Soundpath Health has identified an access, adequacy or other need in the practice area in which the health care provider practices, and the health care provider's history and present circumstances do not indicate a probable future substandard provider performance or competency concerns.
- The health care provider must never have been convicted of, pled guilty to or no contest to, or have been sanctioned for, any offense or action involving Medicare, Medicaid or other governmental or private third party Payer fraud or program abuse, and must not be listed on the Office of Inspector General (OIG) "Sanction List".
- The health care provider must never have been sanctioned, debarred, excluded or precluded from participation in Medicare or Medicaid programs.

- The health care provider must possess and maintain, in the proposed practicing contracted specialty, Board Certification; completion of an approved and accredited residency-training program, awaiting certification results; or equivalent of acceptable training and/or experience.
- The health care provider must provide a minimum of five (5) years of malpractice history. If the health care provider has a history of liability suits, claims, arbitration or settlements, this history must not demonstrate probable future substandard provider performance.
- The health care provider must provide evidence of and maintain provider liability insurance coverage in such minimum amounts as are required by Soundpath Health. The provider must maintain liability insurance coverage in the amount of at least $1,000,000 million dollars per occurrence and $3,000,000 million dollars in the aggregate.
- The health care provider must never have been indicted or convicted of, pled guilty to or no contest to, a felony, any offense involving moral turpitude or fraud, or any offense related to the practice of healing arts, other health care related matters, third-party reimbursement, controlled substances violations, child or adult abuse, or any other matter that would adversely affect the ability of the applicant to participate. Exceptions may be granted if Soundpath Health has identified an access, adequacy or other need in the practice area in which the health care provider practices and the health care provider's history and present circumstances do not indicate a probable future substandard provider performance.
- The health care provider must possess a valid, current and unrestricted state and federal Drug Enforcement Agency Certificate (DEA number) applicable to his or her specialty. Exceptions may be granted if the health care provider does not need to prescribe narcotics or other controlled substances in his or her practice (e.g., pathologist or non-invasive radiologist).
- The health care provider must permit plan representatives to conduct on-site office reviews and the results of such review must not demonstrate a probable substandard provider performance.
- The health care provider must have no current abuse of illegal substances or chemical dependency.

- The health care provider must not be experiencing physical or mental health problem(s), which impair the health care provider's ability to practice within the scope of his or her license. Proof of ability will be based upon the nature of the impairment and other information obtained.
- The health care provider's financial and legal status history must not demonstrate probable future substandard provider performance or lack of financial capability and must demonstrate that the provider has authority to provide health care services to Members.
- The health care provider must not be restricted from participating in the provider network of Soundpath Health by an exclusive or other arrangement with any person or entity other than Soundpath Health.
- In certain geographic areas, the health care provider must participate in the provider network of Soundpath Health through an intermediary with whom Soundpath Health has an exclusive or other restrictive arrangement.
- The health care provider must execute, and enter into with Soundpath Health (or any required intermediary), the then current template of Soundpath Health's written Provider Agreement, and must abide by and comply with all terms and conditions of the Provider Agreement and fulfill all obligations imposed on the health care provider under such Provider Agreement.

G. Re-Credentialing Process

Providers, and facilities as applicable, are re-credentialed at a minimum every three (3) years. The process for re-credentialing will be developed by the Plan and reviewed by clinical peers. Approximately 120 days before the re-credentialing date, Soundpath Health will review the Provider's CAQH or state credentialing record. The record must be up-to-date and include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage

- Correctness and completeness of the application

If the record is not up-to-date, the Provider will be notified in writing and requested to update his or her information. Three (3) attempts will be made to obtain up-to-date information. If the Provider is unresponsive it may be cause for suspension or termination of Plan participation. Incomplete re-credentialing may also result in suspension or termination in accordance with the Agreement. Plan may also elect to itself to obtain updated copies of those Provider documents that expire. This includes but is not limited to the state license, business license, professional liability coverage, DEA certificate if applicable, board certification and accreditation of a Provider.

H. Criteria for Credentialing Provider Denial or Termination

Credentialing refers to a process performed by Soundpath Health to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration for participation in a Soundpath Health provider network. Providers will be notified in writing of the reason for denial, suspension or termination by Soundpath Health. The following may subject a applicant or Provider to denial, suspension or termination by the Plan:

- Submission of inaccurate or misleading information on the application, or failure to disclose relevant information.
- Inability to complete the timely credentialing/re-credentialing process due to the failure to provide relevant information or the necessary release.
- Failure to notify Plan of any changes in clinical privileges, any changes in hospital staff privileges, any changes in practice scope; any sanctions or restrictions or any medical or mental health problems that could affect the provision of care or services to Members.
- Any current or previous loss of, or revocation, or restrictions to, or limitations, or sanctions, or actions to professional license, certification/registration or authorization to practice, including but not limited to, probationary status, monitoring requirements, chaperone requirements or related requirements (i.e.,

monitoring, open doors, etc), prescribing limitations, required supervison, or restricted hospital privileges.

- History of practicing without valid license, registration/certification or authorization.
- Current or previous loss of, or revocation, or restrictions to, DEA certificate.
- Current or previous loss of or restrictions to hospital, clinic, facility, surgical center, network or other healthcare privileges or scope of practice.
- Refusal, revocation, suspension or restrictions of hospital staff privileges at any hospital.
- Lack of local hospital admitting privileges or inpatient coverage plan (if applicable).
- Loss of local hospital admitting privileges or inadequate inpatient coverage plan (if applicable).
- Criminal record affecting professional practice.
- Current or history of a felony conviction.
- Currently or previously censured or excluded or sanctioned by Medicare.
- Current or history of chemical dependency or substance abuse.
- Notification from a confidential program for chemically impaired Providers documenting that they can no longer provide advocacy for the Provider because of instability in his/her recovery and/or for non-compliance with the program/contract.
- Current physical or mental health condition that may significantly impair the Provider's ability to practice within the full scope of licensure and qualifications or may impose a risk of harm to Members.
- Loss of, or insufficient, or inadequate malpractice insurance coverage.
- History of malpractice claims judged excessive by the Plan's credentialing committee. Professional liability claims history is defined as cases that are settled or have resulted in an adverse judgement against the Provider.
- Renders or has rendered any services outside the scope of license, registration/certificate, or other authorization.
- History of practice trends that raise concerns regarding Provider's ethics, quality of care and/or practice standards.
- Practice inconsistent with professional standards of care.
- History of significant Member complaints documented by licensing authority, healthcare facility, Planlan, or network administrator.
- Failure to become board-certified in practice specialty within five years of completion of residency (if applicable).

- Failure to maintain board certification in practice specialty for specialties that require periodic recertification (if applicable).
- Quality issues as reported by National Practitioner Data Bank (NPDB)/Healthcare Intregrity Data Bank (HIPDB), licensing boards or prior work/training sites.
- Failure to comply with procedures implemented in connection with the administration of utilization review or failure to cooperate with quality management activities.
- Voluntary relinquishment, withdrawal or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct.
- Voluntary relinquishment or withdrawal of clinical privileges in order to avoid an adverse action, or to preclude an investigation, or while under investigation relating to professional competence or conduct.
- Unethical conduct in violation of laws or standards governing the practice of healthcare.
- History of unethical conduct in violation of laws or standards governing the practice of healthcare.
- Acts of fraud, deceit, dishonesty or moral turpitude.
- History of acts of fraud, deceit, dishonesty or moral turpitude.
- Evidence of compromised quality of care.
- Submission of erroneous, improper, or incomplete claims for payment.
- Inadequate medical record practices or inappropriate billing practices (i.e., upcoding, failure of adequate chart documentation to support submitted claims, etc).
- History of or current non-compliance with Agreement.
- Lack of Plan and/or Membership needs.

I. Credentialing Appeal Process

As required by CMS, Soundpath Health maintains a process for appealing adverse credentialing or re-credentialing decisions, including the right of physicians to present information and their views on the decision.

If a Provider is denied re-credentialing approval, placed on suspension or a corrective plan, or terminated for failure to meet participation criteria, the Provider, has the right to appeal the Plan's decision in accordance with Medicare regulations.

Note: The appeal process is to be considered in conjunction with the termination rights set forth in Agreement and, where applicable, state and federal law and regulations. If there is any conflict between the provisions of the Agreement and this Provider Manual, the Agreement shall control.

J. Office Site Visits

It shall be the policy to conduct onsite visits of PCPs practicing in a solo practice or in a group setting with five (5) or less providers. An on-site visit must occur within six (6) months of Agreement effective date.

Thereafter, an onsite visit is conducted as Plan determines is appropriate, and such visit may be based on Member complaints, practice specific Member surveys, reports from Plan representatives, Department of Health investigations/actions, application concerns and/or requests by the Plan's credentialing committee.

K. State Specific Requirements

Washington:

- As of January 2011, Washington State now requires a centralized collection of provider credentialing data to simplify the provider's experience. OneHealthPort (OHP) hosts the ProviderSource application as a single source to enter provider credentialing data. This service is free to Providers.

VII. Quality Improvement Organization (QIO)

The Quality Improvement Organization (QIO) program is an integral part of the U.S. Department of Health and Human Services' national quality strategy for providing better care, better health at lower costs, and providing "boots on the ground" technical assistance through a national network of independent organizations working to improve care delivery at the community level.

The Centers for Medicare and Medicaid Services restructured the QIO Program effective August 1, 2014, to improve Member care, health outcomes, and save taxpayer resources.

There are two Beneficiary and Family-Centered Care (BFCC) QIO contractors to support the program's case review and monitoring activities separate from the traditional quality improvement activities of the QIOs. They will be responsible for ensuring consistency in the review process with consideration of local factors important to beneficiaries.

For more information, contact the QIO in your area:

Livanta contact information			
CMS Area	Address	Toll-free Phone Number	Fax Numbers
Area 1: CT, ME, MA, NH, NJ, NY, PA, PR, RI, VT, Virgin Islands	BFCC-QIO Program 9090 Junction Dr., Suite 10 Annapolis Junction, MD 20701	877-588-1123	For appeals: 855-694-2929 For all other reviews: 844-420-6672
Area 5: AK, AZ, CA, HI, ID, NV, OR, WA	BFCC-QIO Program 9090 Junction Dr., Suite 10 Annapolis Junction, MD 20701	877-588-1123	For appeals: 855-694-2929 For all other reviews: 844-420-6672

KePRO contact information			
CMS Area	Address	Toll-free Phone Number	Fax Numbers
Area 2: DC, DE, FL, GA, MD, NC, SC, VA, WV	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	844-455-8708	844-834-7129
Area 3: AL, AR, CO, KY, LA, MS, MT, NM, ND, OK, SD, TN, TX, UT, WY	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	844-430-9504	844-878-7921
Area 4: IA, IL, IN, KS, MI, MN, MO, NE, OH, WI	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	855-408-8557	844-834-7130

VIII. Compliance & Ethics

Soundpath Health is committed to compliance with all applicable laws contract provisions and regulations. The following is meant to be representative of compliance and ethical issues Providers should be familiar with, and is not intended to be an exhaustive list. For additional information regarding compliance and ethical responsibilities, please refer to the Provider Agreement.

A. Definitions

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program *(18 U.S.C. § 1347)*.

- **Waste** is over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

- **Abuse** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. (Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors).

B. General Requirements

Providers are responsible for complying with all applicable laws, regulations and Plan policies and procedures. These documents incorporate requirements outlined by CMS for all sponsors of Medicare Advantage and any individuals and entities that provide administrative support, related materials/supplies and/or render services for sponsors' Plans, as detailed in Chapter 21 of the Medicare Managed Care Manual.

C. Reporting Fraud, Waste, & Abuse

Providers, their employees, and related entities are required to notify Soundpath Health of suspected or detected Fraud, Waste and Abuse ("FWA").

Information on how Providers, their employees, and downstream entities may report concerns and information related to FWA and noncompliance can be found on our website at www.SoundpathHealth.com, in the provider section "Annual FWA, HIPAA Training". You may also contact the Plan's Compliance department:

1. Call our EthicsPoint Compliance hotline at 1-800-261-5607 (you may choose to remain anonymous)
2. File a report online at www.ethicspoint.com (reference Catholic Health Initiatives)
3. Write to Compliance at PO Box 4537, Federal Way, WA 98063

Individuals and entities that report suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Soundpath Health has a policy of non-retaliation against those who in good faith report suspected or detected violations of Plan policies, and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct.

D. Laws and Regulations

False Claims Act

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have enacted false claims laws as well.

- A "claim" is broadly defined to include any submissions that results, or could result, in payment.
- Under the False Claims Act, 'knowing' or 'known' means that a person:
    - Has actual knowledge
    - Acts in deliberate ignorance of truth or falsity or Acts in reckless disregard of truth or falsity (Proof of specific intent to defraud is not required to fall within the definition of "knowing" or "known").
- Claims submitted to the government include claims submitted to intermediaries such as state agencies, managed care organizations and other subcontractors under contract with the government to administer health care benefits. Liability can also be created by improper retention of an overpayment.
- The Affordable Care Act of 2010 (ACA) expanded a provision of the False Claims Act referred to as a reverse false claim.
- Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to must be reported and returned within sixty (60) days of identification.

Whistleblower and Whistleblower Protections

- The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. or state governments to file suit on behalf of the government against the person or business that committed the fraud.
- Individuals who file such suits are known as 'whistleblowers'. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing or participating in a whistleblower action.
- Soundpath Health expressly prohibits retaliation against employees – including employees of first tier, downstream and related entities– who, in good faith, report or participate in the investigation of compliance concerns.
- Examples of FWA include:
    - A physician who submits a bill to Medicare for medical services not provided.
    - A government contractor who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
    - An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit or receive something of value to induce or reward business referrals under federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for health care services are based on medical need and not financial or other types of incentives to individuals or groups.

The Affordable Care Act (sometimes referred to as the Health Care Reform law) has added a provision to the Anti-Kickback statute where "knowingly and willfully" does not mean the individual had the intent to specifically violate the statute. In addition, violations of the Anti-Kickback statute can now be considered a false and fraudulent claim under the False Claims Act.

Examples include:

- A frequent flyer campaign in which a physician may be given airline frequent flier mileage rewards for questionnaires completed for new Members put on a drug company's product.
- Free laboratory testing offered to health care providers, their families and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback statute could result in civil monetary penalties and exclusion from federal health care programs, including the Medicare and Medicaid programs.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to prevention of health care fraud and abuse.

- HIPAA Privacy - The Privacy Rule outlines specific protections for use and disclosure of PHI. It also grants rights to Members.

- HIPAA Security - The Security Rule outlines specific protections and safeguards for electronic PHI. If you become aware of a potential breach or inappropriate disclosure of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any Business Associate Agreement.

  Examples of HIPAA provisions related to the prevention of health care fraud and abuse:

- Creation of the Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.
- Expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.

- Creation of a new series of federal crimes, together referred to as "health care fraud," which make it a federal crime to defraud health care benefit programs – any benefit program, not just Medicare or Medicaid.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:

- To defraud any health care benefit program; or
- To obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program in connection with the delivery of or payment for health care benefits, items or services.

Proof of actual knowledge or specific intent to violate the law is **not** required. Penalties for violating the Criminal Health Care Fraud statute may include fines, imprisonment, or both.

Examples of Member FWA:

- **Doctor Shopping –** Consumer or other individual consults with a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale.
- **Prescription Diversion and Inappropriate Use –** Consumers obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and give or sell this medication to someone else. Also can include the inappropriate consumption or distribution of a consumer's medications by a caregiver or anyone else.
- **Identity Theft or Medical Identity Theft –** A person uses another person's Medicare card to obtain services or prescriptions – OR – another person's information is used to bill for procedures never done or for supplies never received.

Examples of Pharmacy FWA:

- **Prescription Drug Switching –** The pharmacy or pharmacy benefit manager (PBM) receives a payment to switch a consumer from one drug to another or influences the prescriber to switch the Member to a different drug.
- **Prescription Drug Shorting or Splitting –** A pharmacy or PBM's mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the Member or make arrangements to provide the balance, but bills for the fully-prescribed amount. The pharmacy splits the original prescription to receive additional dispensing fees.
- **Inappropriate billing practices such as:**
    - Billing for brand when generics are dispensed.
    - Billing for non-covered prescriptions as covered items.
    - Billing for prescriptions that are never picked up.

    - **Prescriber FWA:**
        - **Script Mills –** Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for Members that are not their patient. These scripts are usually written, but not always, for controlled drugs for sale and might include improper payments to the provider.
        - **Illegal Remuneration Schemes –** Prescriber is offered, paid, solicits or receives unlawful remuneration (payment or items of value) to induce or reward the prescriber to write prescriptions for drugs or products.
        - **Prescription Drug Switching –** Drug switching involves offers of cash payments or other benefits to a prescriber to induce them to prescribe certain medications rather than others.

Examples of Sales Agent FWA:

- **Marketing Schemes**
    - Enrollment of a consumer in a Medicare Plan without the consumer's knowledge or consent.

- Offering consumers a cash payment or other reward as encouragement to enroll in a Medicare, Medicaid, or health care benefit plan.
- Selling or marketing insurance without a license.
- Using consumer information supplied through a third-party (another agent, friend, etc.) to market Medicare plans.
- Agents splitting commissions or agent referral fees.
- Misrepresenting themselves as a representative of the government (Medicare/Social Security/Federal Government).

If you identify or are made aware of potential misconduct or a suspected FWA situation, it is your right and responsibility to report it. **Please call our Compliance/Fraud, Waste and Abuse EthicsPoint Hotline at 800-261-5607.**

State and the federal government regulations have very clear guidelines on the mandatory reporting of claims that are suspicious. In addition, Soundpath Health policy states that any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

As a result of our legal obligations, Soundpath Health has established an anti-fraud program. We routinely audit, and when necessary, investigate claims submitted to us for payment of services. Common errors in billing include:

- Billing for non-chargeable or non-covered services.
- Reciprocal billing – billing for services rendered for another provider.
- Submitting duplicate claims for services rendered.
- Any other unsound fiscal practices, i.e., up-coding, unbundling.

Upon investigation, it may be necessary to elicit your cooperation in an effort to resolve questions regarding suspicious claims. While it is important to follow policies and procedures and internal controls to prevent FWA, Soundpath Health is committed to balancing prompt claims processing adjudication with effective claims control at all times.

Healthcare FWA affects us all and causes an increase in health care costs. If you suspect any person, provider or company of defrauding or attempting to defraud Soundpath Health, please call our EthicsPoint hotline at 800-261-5607. All calls are confidential and you may report your suspicions anonymously, via our toll-free hotline. For more information about health care fraud, visit *https://www.stopmedicarefraud.gov/*.

Resources:

CMS' Prescription Drug Benefit Manual – Chapter 9
CMS' Medicare Managed Care Manual – Chapter 21
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf

CMS' Prescription Drug Benefit Manual https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

CMS' Medicare Managed Care Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

Code of Federal Regulations (see 42 CFR 422.503 and 42 CFR 423.504)
https://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

Office of the Inspector General – Fraud Information https://oig.hhs.gov/fraud/

Medicare Learning Network (MLN) Fraud & Abuse Job Aid
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf

IX. Adherence to Regulations

Soundpath Health and its Providers are committed to comply with the most current applicable CMS Regulations. The following is intended as a representative list, and is not exhaustive. Please refer to the Agreement for additional information regarding applicable state and federal laws and regulations, which are subject to change.

A. Medicare Marketing Activities

All Plan Providers will adhere to CMS regulations regarding marketing activities, including but not limited to all provisions of Chapter 3 of the Medicare Marketing Guidelines in the Medicare Managed Care Manual. CMS contractual obligations prohibit Providers from accepting enrollment applications or offering inducements to persuade beneficiaries to join Medicare Advantage plans. Providers cannot direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan. In addition, Providers cannot offer anything of value to induce a Soundpath Health Member to select him/her as the Member's provider.

CMS is concerned with provider marketing activities because Providers may not fully be aware of all plan benefits and costs and Providers may confuse the Member if the Provider is acting as an agent of the Plan versus acting as the Member's Provider.

For purposes of this Manual, the term "Medicare Marketing" incudes any information, whether oral or in writing, that is intended to promote or educate prospective or current Members about Soundpath Health or its Medicare Plans, products or services. This includes, but is not limited to, any and all promotional materials used at Provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of

promotional materials include letters, advertisements, invitations, and announcements which use the Soundpath Health name. Medicare Marketing must be approved by Soundpath Health prior to a Provider conducting any Medicare Marketing activity. The approval process includes review by Soundpath Health legal and regulatory compliance personnel and CMS (as applicable), in accordance with CMS guidelines. To obtain approved Medicare Marketing materials or to arrange for a Provider-sponsored activity, contact the Medicare sales director in the local Soundpath Health market office, marketing sales support specialist or the Plan's marketing director. Any misrepresentation of a Soundpath Health product or service, intentional or not, is a serious violation of Plan's agreements with CMS.

CMS is concerned with Plans/Part D sponsors engaging in provider-based marketing activities because:

- Providers may not be fully aware of all plan benefits and costs
- Providers may confuse the Member if the Provider is perceived as acting as an agent of the Plan versus acting as the Member's Provider
- Providers may face conflicting incentives when acting as a Plan/Part D Sponsor representative

Providers must remain neutral when assisting with enrollment decisions and may not engage in any of the following activities as detailed in the Medicare Marketing Guidelines, Section 70.11.1 – Provider Based Activities:

- Offer sales/appointment forms;
- Accept Medicare enrollment applications;
- Make phone calls or direct, urge or attempt to persuade Members to enroll in a specific Plan based on financial or any other interests of the Provider;
- Mail marketing materials on behalf of the Plan ;
- Offer anything of value to induce Plan Members to select them as their Provider;
- Offer inducements to persuade Members to enroll in a particular Plan or organization;
- Conduct health screening as a marketing activity;
- Accept compensation directly or indirectly from the Plan for Member enrollment activities; or

- Distribute materials/applications within an exam room setting.

Providers may, however:

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

B. Member & Provider Protections

§ 422.501(i)(3)(i) and 422.504 (g)(1)(i)

For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid. First Tier or Downstream Entities 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: (1) accept the Plan payment as payment in full, or (2) bill the appropriate state source.

§ 422.200 Basis and scope.

This subpart is based on sections 1852(a)(1), (a)(2), (b)(2), (c)(2)(D), (j), and (k) of the Act; section 1859(b)(2)(A) of the Act; and the general authority under 1856(b) of the Act requiring the establishment of standards. It sets forth the requirements and standards for the MA organization's relationships with providers including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under MA private fee-for-service plans. This subpart also contains some requirements that apply to non-contracting providers.

§ 422.202 Participation procedures.

(a) *Notice and appeal rights.* An MA organization that operates a coordinated care plan or network MSA plan must provide for the participation of individual physicians, and the management and Members of groups of physicians, through reasonable procedures that include the following:

(1) Written notice of rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions.

(2) Written notice of material changes in participation rules before the changes are put into effect.

(3) Written notice of participation decisions that are adverse to physicians.

(4) A process for appealing adverse participation procedures, including the right of physicians to present information and their views on the decision. In the case of termination or suspension of a provider contract by the MA organization, this process must conform to the rules in §422.202(d).

(b) *Consultation.* The MA organization must establish a formal mechanism to consult with the physicians who have agreed to provide services under the MA plan offered by the organization, regarding the organization's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met:

(1) Practice guidelines and utilization management guidelines—

(i) Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(ii) Consider the needs of the enrolled population;

(iii) Are developed in consultation with contracting physicians; and

(iv) Are reviewed and updated periodically.

(2) The guidelines are communicated to providers and, as appropriate, to enrollees.

(3) Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

(c) *Subcontracted groups.* An MA organization that operates an MA plan through subcontracted physician groups must provide that the participation procedures in this section apply equally to physicians within those subcontracted groups.

(d) *Suspension or termination of contract.* An MA organization that operates a coordinated care plan or network MSA plan providing benefits through contracting providers must meet the following requirements:
(1) *Notice to physician.* An MA organization that suspends or terminates an agreement under which the physician provides services to MA plan enrollees must give the affected individual written notice of the following:
(i) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.
(ii) The affected physician's right to appeal the action and the process and timing for requesting a hearing.
(2) *Composition of hearing panel.* The MA organization must ensure that the majority of the hearing panel Members are peers of the affected physician.
(3) *Notice to licensing or disciplinary bodies.* An MA organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.
(4) *Timeframes.* An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

§ 422.204 Provider selection and credentialing.

(a) *General rule.* An MA organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the credential and re-credentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in §422.205.
(b) *Basic requirements.* An MA organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—
(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider is—
(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and
(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including Members of physician groups, covers—
(i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;
(ii) Re-credentialing at least every 3 years that updates information obtained during initial credentialing, considers performance indicators such as those collected through quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and
(iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and re-credentialing.
(3) Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of "provider of services" in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with CMS permitting them to provide services under original Medicare.
(4) Ensures compliance with the requirements at §422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at §422.220 regarding physicians and providers who opt out of Medicare.
[65 FR 40324, June 29, 2000, as amended at 66 FR 47413, Sept. 12, 2001; 70 FR 4724, Jan. 28, 2005]

§ 422.205 Provider antidiscrimination rules.

(a) *General rule*. Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under §422.204, and with the requirement under §422.100(c) that all Medicare-covered services be available to MA plan enrollees, an MA organization may select the providers that participate in its plan provider networks. In selecting these providers, an MA organization may not discriminate, in terms of participation, reimbursement, or

indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision.

(b) *Construction*. The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).

(2) Use of different reimbursement amounts for different specialties or for different providers in the same specialty.

(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

[65 FR 40324, June 29, 2000]

X. Glossary of Standard Terms

A. Emergency Medical Condition

Soundpath Health utilizes the following definition for all Medicare products, as defined in the Medicare Managed Care Manual, Section 20.2:

> 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
>
> Emergency Medical Condition status is not affected if a later medical review found no actual emergency present.

For all non-Medicare lines of business, Soundpath Health utilizes the following Emergency Medical Treatment and Active Labor Act (EMTALA) definition:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> - placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> - serious impairment to bodily functions, or
> - serious dysfunction of any bodily organ or part, or
>
> With respect to a pregnant woman who is having contractions:
>
> - that there is inadequate time to effect a safe transfer to another hospital before delivery,
> - or that the transfer may pose a threat to the health or safety of the woman or her unborn child

Both definitions are subject to change by CMS and EMTALA, respectively. Any and all changes will take immediate affect for the purposes of the Plan's definitions.

B. Referral

A referral is defined as a physician-to-physician/Provider (specialist or vendor) request to a Provider for a service that is a covered benefit and does not require PA. Although the PCP is expected to direct the Members' care, referrals do not require submission to Soundpath Health but must be documented in both the PCP and specialist/vendor medical records.

C. Standard Care Management Coverage Decision

Occurs when the Member's medical condition is routine in nature and there is no urgent or emergent medical condition present.

D. "Expedited" or "Fast" Coverage Decision

Must meet the following two requirements:

- It must be for medical care the Member has not yet received (cannot be about payment for medical care already received), and
- Using standard deadlines could cause serious harm to the Member's health or hurt the Member's ability to function.

E. Advanced Coverage Decision

For procedures or services that are investigational, experimental or may have limited benefit coverage, or for any questions about whether Soundpath Health will pay for a service, the Provider may request an Advanced Coverage Decision on behalf of the Member prior to providing the service. Members may be contacted if additional

information is needed. An advanced coverage decision for Members may be initiated by submitting a written request to:

Soundpath Health
ATTN: Care Management
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

F. Urgently Needed Service

Soundpath Health complies with CMS regulations regarding emergency and urgently needed services. Soundpath Health has adopted the following definition for all Medicare products, as defined in the Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, Section 20.2. Urgently-needed services are covered services that:

- Are not emergency services as defined in Section 20.2, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when the Member is temporarily absent from the Plan's service (or, if applicable, continuation) area, or under unusual and extraordinary circumstances, when the enrollee is in the service or continuation area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan network.

G. Observation Services

Soundpath Health utilizes Medicare's definition of "observation" as follows:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether a Member will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation services are commonly ordered for Members who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit Members to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a Member from the hospital following resolution of the reason for the observation care or to admit the Member as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. This definition is subject to change.