Provider Manual

Last Updated: June 2022

Great Plains
Medicare Advantage

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Plan Overview

Introduction

Great Plains Medicare Advantage (HMO SNP) ("health plan" or "Plan") is a Medicare Advantage Institutional Special Needs Plan designed to improve the care for the residents of Skilled Nursing, Assisted Living or Basic Care Facilities in Nebraska, North Dakota and South Dakota. The Plan's target population is a Medicare beneficiary who resides or is expected to reside in a contracted facility for 90 days or longer.

Model of Care

The Plan's Model of Care provides residents with a patient-centered, primary care-driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the Model of Care is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits offer additional services and support for the Plan's specialized population.

Goals of the Great Plains Medicare Advantage's Institutional Special Needs Plan (I-SNP) Model of Care:

- Improve coordination of care through an identified point of contact;
- Improve transitions of care across health care settings and providers;
- Improve access to preventive health services;
- Improve member health outcomes.

Participating providers should know:

1) All members are required to select a Primary Care Physician (PCP) at enrollment. The Plan refers to PCPs providing regular services for residents at long-term care facilities as "NFists." A NFist is a physician who is (1) contracted with Great Plains Medicare Advantage, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine and (3) is responsible for providing primary care services for members in the Facility, including coordination and management of the delivery of all covered services. Members can choose their PCP from the list of contracted providers maintained and published by Great Plains Medicare Advantage. Members can change their PCP/NFist at any time.

2) All members are assigned a Nurse Practitioner or a Physician Assistant (an "Advanced Practice Provider"). Contracted Plan Advanced Practice Providers are involved in direct primary care services in collaboration with Plan PCPs and coordinate services and care for members. Advanced Practice Providers develop member care plans, participate in Interdisciplinary Care Team meetings and provide routine preventive services and comprehensive health risk assessments for members.

3) The Plan has received permission from CMS to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from the member's Advanced Practice Providers and PCP, to treat members in the nursing home when appropriate and reserves acute hospital stays for members requiring more intensive services.

4) Great Plains Medicare Advantage uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Advanced Practice Provider. This approach aids in care coordination as well as the pre-authorization of services.

5) The Plan is "provider friendly" and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, pre-authorization and referral processes outlined in this manual.

Working with the Plan

Key Contacts

Customer Service (844) 637-4760

Utilization Management/Prior Authorizations (800) 805-7938

VSP Vision Care (844) 344-4768

Nations Hearing (877) 280-1649

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility during each visit, or before the appointment.

Great Plains Medicare Advantage has the most current eligibility information. You can verify member eligibility through the following ways:

1. Member ID Card: Note that changes do occur and the card alone does not guarantee member eligibility.
2. Verify eligibility online using our eHealthsuite provider portal at https://ehsprd-shp300hs.healthsuiteadvantage.com/
3. Call the Customer Service Department at (844) 637-4760

Please note membership data is subject to change. CMS may retroactively terminate members for various reasons and recoup payments it made to the plan. When this occurs, the Plan's claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question and resubmit the claims to the CMS if appropriate. Typically,

the beneficiary is disenrolled from the Great Plains Medicare Advantage plan and enrolled in Traditional Medicare fee-for-service. If the Medicare timely filing period for claims submission has passed, Federal law gives providers an extra six months after the plan's recoupment to file a claim.

Benefits and Services

All Great Plains Medicare Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers may contact Customer Service for information on covered services and verification of applicable member copayments and/or cost-sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost-sharing as permitted under the Plan or by law. Participating providers of Great Plains Medicare Advantage are, however, prohibited from balance-billing members' copayments and/or cost-sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, click here **http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.**

Emergent and Urgent Services

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

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

4. 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;
5. Serious impairment to bodily functions; or
6. Serious dysfunction of any bodily organ or part."

Emergency services: "Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

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

7. Are medically necessary and immediately required as a result of an unforeseen illness, injury or condition;
8. Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
9. It was not reasonable given the circumstances to wait to obtain the services through the Plan network."

The Plan's provider network includes multiple hospitals, emergency rooms and providers able to treat the emergent conditions of our members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues occurring onsite in the member's nursing home or in the service area, the PCP/NFist is generally responsible for providing, directing or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCP/NFist or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCP/NFist, working with the Plan Advanced Practice Provider, is generally responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members may have a copayment responsibility for outpatient emergency visits unless it results in an admission.

While most members remain in the service area, members may at times receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside Great Plains Medicare Advantage authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved for only continuity of care.

Great Plains Medicare Advantage network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost-sharing.

Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by Great Plains Medicare Advantage:

10. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan
11. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
12. Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
13. Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).

14. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services unless otherwise specified in the EOC.
15. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hypogamy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
16. Reversal of sterilization measures and non-prescription contraceptive supplies.
17. Naturopathic services.
18. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost-sharing amount.

Continuity of Care

Great Plains Medicare Advantage's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient and coordination between medical and behavioral health services. When a practitioner leaves Great Plains Medicare Advantage's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, we will work to transition a member into care with a participating physician or other provider within Great Plains Medicare Advantage's network. The Plan is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Great Plains Medicare Advantage also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Great Plains Medicare Advantage's provider network. Under these circumstances, the Plan will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Great Plains Medicare Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at (800) 805-7938 (TTY: (888) 279-1549).

Referrals

Great Plains Medicare Advantage uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Plan Advanced Practice Provider to help in care coordination.

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

Whether the referral originates with the PCP, Plan Advanced Practice Provider or specialists, referrals should be made to Great Plains Medicare Advantage participating physicians/facilities. The PCP or Plan Advanced Practice Provider must approve the referral.

Referrals to "out of network" physicians or facilities require prior authorization from the Plan's Utilization Management team. Out-of-network referrals may be allowed in certain circumstances where in-network providers or services are not reasonably available to the member, or there is a continuity of care concern (see section on Continuity of Care).

Notification of Inpatient Admissions

Great Plains Medicare Advantage requires providers to notify the plan of an inpatient admission. For notification, providers should call: (800) 805-7938.

Emergent admission notification must be received within one business day of admission. For observation stays, Great Plains Medicare Advantage expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Great Plains Medicare Advantage waives the three-day stay requirement.

Prior Authorization

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

Great Plains Medicare Advantage recommends calling at least fourteen (14) days in advance of an elective admission, procedure or service. For prior authorizations, providers can fax a Request Prior Authorization form to (605) 312-8219 or call our Utilization Management department at (800) 805-7938.

NOTE: *Oncology treatment and services must be entered and authorized through Eviti Connect online at eviti.com.*

Services Requiring Prior Authorization

Providers should refer to the provider section of the plan's website at **greatplainsmedicareadvantage.com** for the listing of services typically requiring authorization. The presence or absence of a service or procedure on the list does not determine coverage or benefit.

Documentation for Prior Authorizations

The Utilization Management department evaluates requests using CMS guidelines as well as nationally accepted criteria to process prior authorization requests and notifies the provider and member of the determination.

Decisions and Time Frames

Expedited: When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited requests will be determined within 72 hours or as soon as the member's health requires.

Routine: If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days.

Once the Utilization Management department receives the request for authorization, Great Plains Medicare Advantage will review the request using nationally coverage determinations (NCDs) or local coverage determinations (LCDs) or nationally recognized industry standard criteria. If the request for authorization is approved, Great Plains Medicare Advantage will assign an authorization number and enter the information in the Plan's medical management system.

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

Concurrent Review

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

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility contract

The Plan's Utilization Management department uses CMS guidelines and Milliman Care Guidelines (MCGs) to conduct a medical necessity review. Great Plains Medicare Advantage is responsible for final authorization.

Great Plains Medicare Advantage's preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility UM staff within one business day of notification or on the last covered day. If clinical

information is not received within 24 hours of admission or on the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria. Facilities must fax the member's clinical information within one business day of notification to (605) 312-8219.

Review is not required for readmission to the referring Facility (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be faxed to (605) 312-8219.

A Plan Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the Plan Medical Director determines that the inpatient or SNF confinement does not meet medical necessity criteria, the Plan will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), verbally and in writing and will notify the member as required by law. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact Customer Service at (844) 637-4760.

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Great Plains Medicare Advantage will approve the request or issue a denial if the request is not medically necessary. Great Plains Medicare Advantage will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of 1care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

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

Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility. Late authorization, or not providing clinical information as requested, will result in an administrative adverse determination and does not allow the provider to appeal.

Only a Great Plains Medicare Advantage Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/

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

Great Plains Medicare Advantage employees are not compensated for denial of services. The PCP/NFist or Attending Physician may request a peer-to-peer phone call with the Plan Medical Director to discuss adverse determinations by calling Utilization Management at (844) 637-4760.

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

Notification of Adverse Determinations (Denials)

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

- For non-urgent pre-service decisions-within 14 calendar days of the request.
- For urgent pre-service decisions–*within 72 hours of the request.
- For urgent concurrent decisions–*within 24 hours of the request.

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

Great Plains Medicare Advantage complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

Billing and Claims

Claims Submission

Claims should be submitted to Great Plains Medicare Advantage using Payor ID RP035. We encourage you to submit claims electronically for faster reimbursement and increased efficiency (Please see Provider EDI resources section below in this Provider Manual or greatplainsmedicareadvantage.com for more information). Accepted claim forms are the CMS professional 1500, UB-04 or ADA claim form. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted with current coding within 365 days or as defined in your contract even if the member has not exceeded their deductible or copay amounts.

The Plan also offers the ability to submit professional 1500 claims through our eHealthsuite Provider Portal at https://ehsprd-shp300hs.healthsuiteadvantage.com/. Instructions on how to gain access to the portal can be found on the plan website: **greatplainsmedicareadvantage.com**.

If you do not wish to file claims electronically, paper claims can be mailed to:

Great Plains Medicare Advantage
PO Box 981813
El Paso, TX 79998-1813

Timely Filing

As a Great Plains Medicare Advantage participating provider, you have agreed to submit all claims within 365 days or the timeframe outlined in your provider agreement.

Critical Access Hospital Claims

Providers should submit Critical Access Hospital (CAH) claims using Method 1. The Plan does not have current capability to process Method II for CAH claims. This is targeted as a future enhancement to our claims processing systems.

Critical Access Hospital and Rural Health Clinic Rates

Providers should submit their updated CMS rates received from their Medicare Administrative Contractor (Noridian, WPS, NGS) by email to **providerrelations@sanfordhealth.org** or by Fax to (605) 312-8237.

Hospital Part A to Part B Rebilling

When an inpatient admission is found to be not reasonable and necessary, payment is allowed for all hospital services furnished that would have been reasonable and necessary in an outpatient setting.

Hospitals may also be paid for Part B inpatient services if it's determined that a beneficiary should have received hospital outpatient services rather than inpatient services and the patient has already been discharged from the hospital.

Submit Part A to Part B Rebilling claims the same as you submit to traditional Medicare.

Supplemental Vision

Great Plains Medicare Advantage members have access to supplemental vision benefits such as routine eye exams, glasses and contacts in accordance with their evidence of coverage (EOC). The benefits for these services are processed through VSP Vision. For additional information, you may contact VSP at (844) 344-4768 or review their website at vsp.com.

Supplemental Hearing

Great Plains Medicare Advantage members have access to supplemental hearing benefits such as hearing exams and hearing aids in accordance with their evidence of coverage (EOC). The benefits for these services are processed through NationsHearing. For additional information, you may contact NationsHearing at (877) 212-0858 or review their website at nationsbenefit.com/GPMA.

Supplemental Dental

Great Plains Medicare Advantage members have access to supplemental dental benefits such as routine exams, fillings and dentures in accordance with their evidence of coverage (EOC). Claims can be submitted on either the Dental ADA claim form or the professional 1500. Submit electronically to the Plan using Payor ID RP035 or on paper to:

Great Plains Medicare Advantage
PO Box 981813
El Paso, TX 79998-1813

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: **cms.gov/manuals/downloads/clm104c12.pdf**

Great Plains Medicare Advantage can only pay claims which are submitted accurately. The provider is at all times responsible for accurate claims submission. While the Plan will make its best effort to inform the provider of claims errors, ultimately claim accuracy rests solely with the provider.

Claim Payment

Great Plains Medicare Advantage pays clean claims according to contractual requirements. A clean claim is a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by Great Plains Medicare Advantage, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim.

Claims must be submitted within the filing period of 365 days from date of service or as defined in your contract. For inpatient services, timely filing begins from the date of discharge. Claims submitted outside of the filing period will be denied due to untimely filing. Charges denied for untimely filing are not to be billed to the member, but must be written off. If it was not reasonably possible to send a claim

within the filing period, you must follow up with appropriate documentation within 60 days from the date of the denial shown on the Explanation of Payment. We strive to reimburse providers for "clean" claims within 30 days of the receipt of the claim. Clean claims are those claims not requiring additional information before processing.

Process for Refunds or Returned Checks

Great Plains Medicare Advantage processes overpayments by taking deductions on future claims. You may return the overpayment directly to the Plan, but it will only be accepted if the overpayment has not already been offset by other claims. If the overpayment remains outstanding for more than 90 days, our Finance Department will send you a letter requesting payment. If the Plan has paid a claim in error, you may return the check or write a separate check for the full amount paid in error. A copy of the remittance advice, supporting documentation noting reason for the refund should be included with the refund.

Refunds should be sent directly to the Finance Department at this address:

Great Plains Medicare Advantage
Finance Department
PO Box 91110
Sioux Falls, SD 57109-1110

Pricing

Original Medicare typically has market-adjusted prices by code (i.e., CPT or HCPCS) for the services traditional Medicare covers. However, there are occasions where Great Plains Medicare Advantage offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, the Plan will arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state-published schedules for Medicaid. Great Plains Medicare Advantage requests you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement is incorrect.

Great Plains Medicare Advantage will apply correct coding edits and Multiple Procedure Payment Reductions (MPPRs) as outlined by CMS. Great Plains Medicare Advantage will also follow guidelines put forth by the AMA CPT and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by Great Plains Medicare Advantage is subject to appeals/payment dispute and clinical review policies and procedures outlined in this manual.

New or Non-Listed Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when codes are developed by CMS for newly approved services or if existing codes are changed. Great Plains Medicare Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, the Plan will make every effort to load the new code as quickly as possible.

In the event a provider submits a code that the Plan does not recognize as a payable code or the code does not have a contracted allowance, the following process will occur:

- Great Plains Medicare Advantage maintains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis and to make coverage determinations. Examples include but are not limited to, new CPT/HCPC codes, not otherwise classified codes and codes designated as Carrier Defined by CMS;
- The provider may then appeal the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and

Claims Encounter Data

Providers who are paid under capitation must submit claims to capture encounter data within 365 days or the same timely filing limit required in their provider agreement with Great Plains Medicare Advantage.

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

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

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Great Plains Medicare Advantage are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your Provider Agreement, the member may not be billed for non-covered services unless the member is notified in writing **before** the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed Great Plains Medicare Advantage's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this.

Obtaining pre-services review will reduce denials.

Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow this process. Payment dispute procedures are separate and distinct from appeal procedures.

A formal payment dispute request is required from the provider to contest a paid amount on a claim which does not include a medical necessity or administrative denial. All Payment Disputes must be:

- Submitted in writing within 60 days from the original payment
- Include a cover letter with:
  - Claim Identifiable information
  - The specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
  - Copy of the original remittance advice (RA)
  - All applicable medical records or other attachments supporting additional payment

Providing the above information enables the Payment Dispute Unit to properly and promptly review the request. Requests that do not follow all of the above may delay resolution. Great Plains Medicare Advantage will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Mail or Fax provider claims payment disputes to:

Great Plains Medicare Advantage
Appeals & Grievance Department
PO BOX 91110
Sioux Falls, SD 57109
Fax (605) 312-8217

Participating Provider Administrative Plea/Appeals Responsibility

A provider may submit a formal request to review a previous decision where a determination was made stating the participating provider failed to follow administrative rules, assigning liability to the provider (see original decision letter) where the services were rendered.

All requests must be:

- Submitted in writing
- Submitted within 60 days from the decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - The specific rationale as to why the administrative rules were not followed, requiring an exception to be made or extenuating circumstance warranting a re-review of the request for provision of payment.
- Include necessary attachments:
  - Copy of the original decision
  - All applicable medical records

Mail or Fax Provider Administrative Plea/Appeal to:

Great Plains Medicare Advantage
Appeals & Grievance Department
PO BOX 91110
Sioux Falls, SD 57109
Fax (605) 312-8217

In the event Great Plains Medicare Advantage waives the administrative requirement and the request requires a medical review, Great Plains Medicare Advantage will not request additional records to support the provider's argument. The provider is expected to submit the necessary information to substantiate the request for payment.

Providing the above information enables the appeals team to properly and promptly review requests within 60 business days. In the event Great Plains Medicare Advantage waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable timeframes. Requests that do not follow the above requirements may be delayed.

Non-Participating Provider Appeals Rights

In accordance with CMS regulations, providers who are not contracted with Great Plains Medicare Advantage may file a standard appeal for a claim that has been denied but only if they submit a completed Waiver of Liability. If you complete a Waiver of Liability, you waive the right to collect payment from the member, with the exception of any applicable cost-sharing, regardless of the determination made on the appeal.

When submitting the reconsideration, a signed Waiver of Liability form must be included. A waiver of liability form can be obtained on the Plan's website, greatplainsmedicareadvantage.com in the provider section. The provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. The provider should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement.

The appeal must be in writing and can be Faxed or mailed:

Great Plains Medicare Advantage
Appeals & Grievance Department
PO BOX 91110
Sioux Falls, SD 57109
Fax (605) 312-8217

Processing of Hospice Claims

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

The only services Great Plains Medicare Advantage is financially responsible for during this time include any supplemental benefits (e.g., hearing, dental, vision) that the plan offers in addition to Original Medicare benefits.

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

When a member elects hospice, bill the claims as instructed below:

- Hospice-related services to CMS
- Services covered under Medicare Part A and B (unrelated to the terminal illness) to the Medicare administrative contractor
- Supplemental vision to VSP
- Supplemental hearing exams, fittings and hearing aids to Nations Hearing
- Supplemental dental benefits to Great Plains Medicare Advantage

Subrogation and Coordination of Benefits

Great Plains Medicare Advantage plans are subject to subrogation and coordination of benefits rules.

1. Subrogation: the Plan may recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan

2. Medicare Coordination of Benefits: If the provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when Great Plains Medicare Advantage pays secondary. We accept secondary claims electronically.

3. Other coverage is primary over a Medicare plan in the following instances:
   a. Aged employees: For members who are entitled to Medicare due to age, a commercial plan is primary over the Medicare plan if the employer group has 20 or more employees.
   b. Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, a commercial plan is primary to the Medicare plan if the employer group has 100 or more employees

Member Grievances and Appeals

Appeals

Members of Great Plains Medicare Advantage have the right to appeal any decision about Great Plains Medicare Advantage's failure to provide or pay for what they believe are covered services.

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for or reimbursed by Great Plains Medicare Advantage
- Services they have not received, but believe are the responsibility of Great Plains Medicare Advantage to pay; and/or
- A reduction in or termination of service a member feels is medically necessary.

Also, a member may appeal any decision if they feel they are being discharged from the hospital too soon. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to Great Plains Medicare Advantage Evidence of Coverage (EOC) for additional information.

For pre-service determinations, the enrollee's treating physician acting on behalf of the enrollee may submit an appeal. An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may still be to uphold the original decision.

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

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an appeal orally, please call (844) 637-4760. An enrollee or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers contracted with Great Plains Medicare Advantage may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the process outlined in the "Billing and Claims" section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances the Plan should consider.

Part C Appeals Phone and Fax Number

- Phone: (844) 637-4760 (TTY 711)
- Fax: (800) 541-9048

Grievances

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

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

Complaints may be received by Advanced Practice Providers, Nursing Facilities, Plan Customer Service representatives and through Member Services. All complaints are logged, categorized and worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with Great Plains Medicare Advantage in investigating grievances related to the provider or provider's services.

Provider Information

Provider Credentialing and Re-credentialing

Credentialing is the process of verifying that an applicant meets the established standards and qualifications for consideration in the Great Plains Medicare Advantage network. Initial credentialing is performed when an application is received. Re-credentialing is performed every three years. In general, the credentialing and re-credentialing process applies to:

- Practitioners who have an independent relationship with the organization.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities.
- Practitioners who are hospital-based, but who see the organization's members as a result of their independent relationship with the organization.
- Non-physician practitioners who have an independent relationship with the organization and can provide care under the organization's medical benefits.

During the initial credentialing period, providers should submit claims to Great Plains Medicare Advantage. However, all claims for the provider will be pended until the credentialing process is complete. Once the provider is approved by the credentialing committee, the pended claims will release for processing.

Locum Tenens Providers

Locum tenens arrangement is when a physician is retained to assist the regular physician's practice for reason such as illnesses, pregnancy, vacation, staffing shortages or continuing medical education. Locum tenens generally have no practice of their own and travel from area to area as needed. Locum tenens who are providing coverage for a physician for 60 consecutive days or less do not need to be fully credentialed. However, if the locum tenens cover for periods longer than 60 consecutive days, the Plan will require the provider to complete the credentialing process and they will no longer be allowed to bill with the absent provider's NPI.

- The locum tenens provider must submit claims using the provider NPI and tax ID of the physician for whom the locum tenens provider is substituting or temporarily assisting.
- Bill with modifier Q6 in box 24d of the CMS-1500 form for each line item service on the claim
- The code(s) being billed must qualify for the Q6 modifier for payment

Supervising Physician

A Supervising Physician is a licensed physician in good standing who, pursuant to U.S. State regulations, engages in the direct supervision of a practitioner with limited licensure. Claims using the supervising physician's name and provider number can be used where the practitioner is still working towards licensure, or has limited licensure.

Supervising physicians may not bill separately for services already billed under these circumstances, unless there are personal and identifiable services provided by the teaching physician to the patient they performed in management of the patient. Great Plains Medicare Advantage does not require PAs or APRNs to bill with the name of their supervising physician on the claim form.

Credentialed Providers

The following types of practitioners are eligible for Participating Provider status provided that they possess and provide satisfactory evidence as required through the Plan's credentialing process. The types of practitioners requiring credentialing by the Plan include, but are not limited to:

- Doctors of Allopathy
- Doctors of Osteopathy
- Physician Assistants *
- Nurse Practitioners *
- Podiatrists
- Chiropractors
- Optometrists
- Audiologists (master's level or higher)
- Speech Pathologists
- Physical Therapists

- Occupational Therapists
- Dentists
- Oral/Maxillofacial Surgeons
- Nurse Anesthetists (nonhospital based or independent relationship)
- Other practitioners with master's level training or higher who have an independent relationship with Great Plains Medicare Advantage
- Locum tenens providers who have practiced in the same location or on a contracted period of more than 60 consecutive days
- Behavioral Health Practitioners
  - Psychiatrists
  - Psychologists (doctoral or master's level who are state certified or licensed)
  - Social Workers (master's level or higher who are state certified or licensed)
  - Addiction medicine specialists
  - Clinical nurse specialists or psychiatric nurse practitioners (master level or higher who are nationally or state certified or licensed)
  - Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- Residents in his/her third or fourth year of residence training. Credentialing cycle will end 60 days after estimated residency completion date. A re-credentialing cycle will be completed to include residency verification.
- Anesthesiologist with pain management practices
- Clinical nurse specialists (master level or higher who are nationally or state certified or licensed.)*
- Advanced Practice Registered Nurses (master level or higher who are nationally or state certified or licensed.)
- Telemedicine practitioners who have an independent relationship with the organization and who provide treatment services under the organizations medical benefit. Practitioners providing medical care to patients located in another state are subject to the licensing and disciplinary laws of that state and must possess an active license in that state for their professions.

Nurse-Midwives, Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists must have an agreement with a licensed physician or physician group unless the state law allows the practitioner to practice independently. This is in reference to H.R. 3590 – Patient Protection and Adorable Care Act C. 2706, non-discrimination in health care and 42 U.S.C. 300gg-5. Non-discrimination in health care. State laws requiring collaborative agreements will be required by Great Plains Medicare Advantage Plan.

Practitioners Who Do Not Need to be Credentialed/Recredentialed

Inpatient Setting

Practitioners who practice exclusively within the inpatient setting and who provide care for members only as a result of an inpatient stay do not need to be credentialed. Examples include:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency room physicians
- Hospitalists
- Board-certified consultants
- Locum tenens physicians who have not practiced at the same facility for 60 or more consecutive calendar days and do not have an independent relationship with Great Plains Medicare Advantage
- Nurse anesthetists (hospital-based)

Freestanding Facilities

Practitioners who practice exclusively within freestanding facilities and who provide care for members only as a result of members being directed to the facility do not need to be credentialed. Examples include:

- Mammography centers
- Urgent care centers
- Surgical-centers
- Ambulatory behavioral health care facilities(i.e., psychiatric and addiction disorder clinics) Practitioners who are not accepted by Great Plains Medicare Advantage

Practitioners who are not accepted by Great Plains Medicare Advantage

The following listing of practitioner types will not be credentialed:

- Registered Nurses
- Licensed Practical Nurses
- Practitioners not providing all required documentation in addition to a completed and attested to credentialing application
- Practitioners who have not yet received their required license by their state
- Practitioners who are currently on a leave of absence. In the event that the practitioners credentialing cycle expired during the leave of absence, the practitioner must reapply within 30 days of returning to practice.
- Providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Balanced Budget Act of 1997 or any provider excluded by Medicare, Children's Health Insurance Program or Medicaid

Ongoing Monitoring Policy

Great Plains Medicare Advantage identifies and takes appropriate action when practitioner quality and safety issues are identified. The Plan monitors ongoing practitioner sanctions or complaints between re-credentialing cycles. Great Plains Medicare Advantage, and its delegates, will monitor on an ongoing basis:

- Medicare and Medicaid sanctions
- State sanctions or limitations on licensure
- Complaints against practitioners
- Adverse events

The Plan will delegate this responsibility to its contracted delegates as long as the processes in those policies meet the intent of NCQA and Great Plains Medicare Advantage standards. A practitioner in good standing means that no sanctions can be identified through the Office of Inspector General (OIG), state sanctions or complaints to that specific practitioner. When sanctions are identified between re-credentialing cycles or the number of Quality Risk Issues exceeds the Plan's threshold of five within two years, then the practitioner will be presented to the Plan's Credentialing Committee through formal re-credentialing so the sanctions and/or complaints can be peer-reviewed.

The Credentialing Committee reviews all sanctions, limitations of licensure and complaints. The Committee determines the appropriate interventions when instances of poor quality are identified. Recommendations to approve the practitioner with additional education or required supervision, or may require the practitioner a one-year re-credentialing cycle. The Committee may also decide on other courses of improvement based on the evidence provided.

In the event that the Committee determines that the practitioner possesses serious quality issues and is no longer fit to participate in the network, the practitioner will be sent formal appeal rights. If the final result is termination of that practitioner from the Plan's provider network, the appropriate agencies will be contacted. All decisions made by the Plan's Credentialing Committee are reviewed and approved by the Board of Directors.

Right to Review and Correct Credentialing Information

Practitioners have the right to review information submitted in support of their credentialing applications, however, the Plan respects the right of the Peer Review aspects that are integral in the credentialing process. Therefore, practitioners will not be allowed to review references or recommendations or any other information that is peer review protected. All other information obtained from an outside source is allowed for review.

If, during the review process, a practitioner discovers an error in the credentialing file, the practitioner has the right to correct erroneous information. The practitioner will be allowed 10 days to provide corrected information. Great Plains Medicare Advantage will accept corrected information over the phone, in person or via voice mail. Corrected information must be submitted to the appropriate Credentialing Specialist who is processing the file.

Finally, each contracted practitioner retains the right to inquire about their credentialing application status. Contact a representative of the Provider Relations Team.

If there are new practitioners added to existing participating facility/groups, the Plan requires the new practitioner complete a Provider Credentialing Application. Our Credentialing Application can be found at https://www.sanfordhealthplan.com/providers/contracting-and-credentialing. Contact the Provider Relations Team at (800) 601-5086 if you have questions.

Providers must be contracted with and credentialed by Great Plains Medicare Advantage or the entity under contract to perform credentialing services. Great Plains Medicare Advantage may agree to delegate credentialing to a provider organization so long as a) a Delegation Agreement is signed by both parties, and b) a delegation audit is conducted and found to be satisfactory.

Provider Directory

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

Plan Notification Requirements for Providers

The following list of changes must be reported to Great Plains Medicare Advantage

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

By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory. You can update your information online at https://www.sanfordhealthplan.com/providers/contracting-and-credentialing.

Closing Patient Panels

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

Access and Availability Standards for Providers

Great Plains Medicare Advantage has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards and to take corrective action as needed. Great Plains Medicare Advantage also requires all providers to offer standard hours of operation that (1) do not discriminate against Medicare enrollees and

(2) are convenient for Great Plains Medicare Advantage members, the facilities where members reside and facility staff who aid in member care. PCPs are NOT to provide routine visits at times that coincide with regular facility meal times or interfere with expected member sleep patterns by occurring before 8 am or after 8 pm or occur during nursing staff shift changes.

Provider Responsibility

- Great Plains Medicare Advantage members have access to care 24 hours a day, 7 days a week as medically necessary. Great Plains Medicare Advantage has the additional policies in place to make sure members have timely access to routine, preventive and urgent care services. PCPs—referred to by Great Plains Medicare Advantage as NFists—are required to provide routine, preventive care and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as a moderate or high risk.
- Routine visits for non-urgent new-onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner.
- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.

- Specialists are required to be available for a consult or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Great Plains Medicare Advantage Advanced Practice Providers, Great Plains Medicare Advantage Medical Director and Utilization Management staff and nursing home facility staff):
  - Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately. Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
  - Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.
- A provider may not balance bill a member for providing services that are covered by Great Plains Medicare Advantage. This excludes the collection of standard co-pays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.

Network Access Monitoring and Compliance

Using valid methodology, Great Plains Medicare Advantage will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- **NFist visit frequency report:** Utilizes claims data to monitor the frequency of NFist routine visits for members.
- **Medical specialty appointment access**: Utilizes the third next available appointment methodology to survey selected high-volume specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology and urology for availability of consult or new patient appointment within 21 calendar days.
- **After-hours care telephone survey:** Annual survey of nursing facility staff and Nurse Practitioners about the after-hours availability and responsiveness of NFists to routine and urgent calls.
- **Member satisfaction survey:** Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, Great Plains Medicare Advantage will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access to care (provider or after hours) are collected through Great Plains Medicare Advantage Member Services Department line or submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Provider Marketing Guidelines

The below is a general guideline to assist Great Plains Medicare Advantage providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to a number of plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions.

Providers Can:

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

Providers Cannot:

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

Member Assignment to New PCP/NFist

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

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

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to Great Plains Medicare Advantage. Great Plains Medicare Advantage will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment. If so, Great Plains Medicare Advantage will document all actions taken by the provider and Great Plains Medicare Advantage to cure the situation, including member education and counseling. A Great Plains Medicare Advantage PCP/NFist cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

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

Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues identified by the Utilization Management staff and referred to the Quality Improvement Department staff. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families or providers indicating a potential problem in the provision of quality care and services.

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

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-op complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome)

Quality complaints are categorized as:

- Access to care
- Availability of services
- Clinical quality concerns
- Provider/staff concerns

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

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at Great Plains Medicare Advantage is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners and other stakeholders so the Plan may fully realize its vision, mission and commitment to member care. In the implementation of the QI Program, Great Plains Medicare Advantage will be an agent of change, promoting innovations throughout its health plan organization, sites of care and in the utilization of resources, including technology, to deliver health care services to meet the health needs of its target population. The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to Great Plains Medicare Advantage's members. Also, to provide mechanisms for continuous improvement and problem resolution.

Quality improvement activities include the following:

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

Utilization Reporting and Monitoring

Risk-based compensation methods may create an incentive for Great Plains Medicare Advantage providers and practitioners to limit approval of needed care. Over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines and the system as a whole, Great Plains Medicare Advantage monitors for under- and over-utilization, analyzes data to identify the causes and takes action to correct any issues identified. Great Plains Medicare Advantage then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions. Great Plains Medicare Advantage also carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. Great Plains Medicare Advantage unequivocally promises members, providers and employees that it does not employ incentives to encourage barriers to care and service.

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment. Through guidelines established by the CMS, HEDIS requirements and the Plan's policies and procedures, Great Plains Medicare Advantage requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted directly or indirectly with Great Plains Medicare Advantage may be informed by the member that the member has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and Great Plains Medicare Advantage. Great Plains Medicare Advantage and the PCP/NFist and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, Great Plains Medicare Advantage conducts periodic patient medical record reviews to confirm the required documentation exists.

Additional Rights

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect and fairness at all times. Great Plains Medicare Advantage and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say Great Plains Medicare Advantage and its' providers cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697, or the Office for Civil Rights in their area for assistance.

The right to see participating providers, get covered services and get prescriptions filled promptly

Members will get most or all of their health care from participating providers—the doctors and other health providers who are part of Great Plains Medicare Advantage. Members have the right to choose a participating provider. Great Plains Medicare Advantage will work with members to ensure they find physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know about treatment choices and to participate in decisions about their health care

Members have the right to get full information from their providers when they receive medical care and the right to participate fully in treatment planning and decisions about their health care. Great Plains Medicare Advantage's providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether Great Plains Medicare Advantage covers them. This includes the right to know about the different Medication Management Treatment Programs Great Plains Medicare Advantage offers and those in which members may participate. Members have the right to be told about any risks involved in their care.

Members have the right to receive a detailed explanation from Great Plains Medicare Advantage if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave, and the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to make complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Great Plains Medicare Advantage must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances or concerns and/or coverage determinations.

Corporate Compliance Program

Overview

The purpose of Great Plains Medicare Advantage's Corporate Compliance Program is to articulate Great Plains Medicare Advantage's commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Great Plains Medicare Advantage's operations. Further, Great Plains Medicare Advantage's Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations.

Great Plains Medicare Advantage and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Great Plains Medicare Advantage's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers and most importantly, its members. Great Plains Medicare Advantage and its employees are also committed to meeting all contractual obligations outlined in Great Plains Medicare Advantage's contracts with the CMS. These contracts allow Great Plains Medicare Advantage to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing Great Plains Medicare Advantage's lines of business, including but not limited to, health care fraud, waste and abuse laws. In the event such

violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution and when necessary, disclosure to the appropriate governmental authorities.

Great Plains Medicare Advantage has in place, policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices and law enforcement. Great Plains Medicare Advantage also has policies ensuring the Plan will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designees.

If you have compliance concerns or questions, call Great Plains Medicare Advantage Compliance Hotline toll-free at (844) 317-9059 (TTY: 711).

Fraud, Waste and Abuse

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

The evaluation and detection of fraudulent and abusive practices by Great Plains Medicare Advantage encompasses all aspects of Great Plains Medicare Advantage business and its business relationship with third parties, including health care providers and members. All employees, contractors and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at (844) 317-9059 (TTY: 711). The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members or other parties to voice concerns about any issue potentially affecting Great Plains Medicare Advantage's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at **compliance@greatplainsmedicareadvantage.com**
- By mail at: Corporate Compliance Officer, Great Plains Medicare Advantage, PO Box 91110, Sioux Falls, SD 57109
- Directly by phone at (844) 317-9059 (TTY: 711)

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor or another party that reports compliance concerns in good faith can do so without fear of retaliation.

Also, as part of an ongoing effort to improve the delivery and affordability of health care to our members, Great Plains Medicare Advantage conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows Great Plains Medicare Advantage to comply with its regulatory requirements for the prevention of fraud, waste and abuse (FWA) and to supply our providers with useful information to meet their own compliance needs in this area. Great Plains Medicare Advantage will review your coding and may review medical records of providers who continue to show significant variance from their peers. Great Plains Medicare Advantage endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Great Plains Medicare Advantage's medical management efforts and our provider community.

To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

You may request a copy of Great Plains Medicare Advantage Compliance Program document by contacting Great Plains Medicare Advantage Provider Services at (844) 637-4760 (TTY: 711), or via email at **compliance@greatplainsmedicareadvantage.com**.