Banner Medicare Advantage

2024 Provider Manual

Effective 01/01/2024

Banner Medicare Advantage Plus PPO
Banner Medicare Advantage Prime HMO
Banner Medicare Advantage Dual HMO D-SNP

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Section 1 – Introduction

Banner Medicare Advantage would like to thank you for providing quality medical and behavioral health care to our members. We remain committed to developing a positive working relationship with all of our providers and welcome any comments or suggestions on how we can improve our operations and interactions with you, our customer.

Our Health Plans:

Banner Medicare Advantage HMO Prime

Banner Medicare Advantage PPO Plus

Banner Medicare Advantage Dual HMO D-SNP

Banner Medicare Advantage Dual HMO D-SNP is a Dual Eligible Special Needs Plan (D-SNP) members with both Medicare and Medicaid. Members must be entitled to Medicare Part A, enrolled in Medicare B and AHCCCS and reside in a contracted service area in order to be eligible.

Our Provider Manual is an extension of your Provider Agreement with Banner Medicare Advantage. We have designed the manual in an effort to supply you and your staff with pertinent operational protocols, policies, procedures, and regulatory expectations that will be critical to your success in working with Banner Medicare Advantage and administering the member benefit for each of the Banner Medicare Advantage product lines. We value your partnership and understand the fundamental role that you play in serving Banner Medicare Advantage members. Should you have any questions regarding the information conveyed in this manual, do not hesitate to contact your assigned Care Transformation Consultant.

Section 2 – Provider Responsibilities

Banner Medicare Advantage is proud to have a comprehensive network of valued providers to service our members. To ensure we maintain this valued provider network, our Providers are responsible to adhere to and comply with all terms of the Banner Medicare Advantage plans, provider contract and requirements in the Provider Manual. Responsibilities include but are not limited to:

- Must complete Credentialing requirements and be approved through Credentialing Committee
- Verify member eligibility
- Licensed Level I facilities and residential facilities must accept all referrals from Banner
- Provide preventive and appropriate routine services
- Meet Quality and Utilization Management standards
- Coordinate Care and refer when applicable for behavioral health and specialty
- Specialist providers to coordinate with the primary care provider
- Educate members on appropriate use of Urgent Care services
- Monitor Controlled and Non-Controlled Medication Utilization
- Maintain member medical records in a legible, detailed, and comprehensive manner, preferably an electronic health record, and be accessible to Banner Medicare Advantage, CMS or authorized Government entities.
- Comply with Member Rights, review the Member Handbook with all office staff and providers
- Provide healthcare services in a culturally competent manner
- Notify Banner Medicare Advantage of changes to providers, locations, key contacts, Tax Identification Numbers, or corporate structure within 30 days of change
- Provide a transition plan and 30-day notice when terminating a member from medical practice

Credentialing

Credentialing Application

A credentialing AzAHP application must be submitted for each participating professional practitioner and for each ancillary practitioner location. The credentialing application and supporting documents should be submitted as outlined in the application (AzAHP Form) cover letter.

Practitioners are not authorized to treat Banner Medicare Advantage members and must be contracted and credentialed by the Banner Credentialing Committee prior to rendering care to members.

The credentialing review process may take up to 60 days. The credentialing approval date is not necessarily your contract effective date, participation is based on the contract terms indicated in your service agreement. In compliance with credentialing accreditation requirements, re-credentialing occurs at least once every 36 months.

The AzAHP applications can be found on our website: https://www.banneruhp.com/join-us/join-ournetwork

Practitioner Types

Banner credentials practitioner types, including but not limited to:

- Medical Doctors (MDs)
- Doctors of Osteopathy (DOs)

- Oral and Maxillofacial Surgeons (DMDs)
- Doctors of Podiatric Medicine (DPMs)
- Chiropractors (DCs)
- Optometrists (ODs)
- Advanced Practice Providers (APPs)
- Independent Behavioral Health Professionals

Organization Types

Banner Medicare Advantage credentials practitioner types, including but not limited to:

- Hospitals
- Home Health Agencies
- Habilitation Providers
- Group Homes
- Skilled Nursing Facilities (SNF)
- Dialysis Centers
- Dental and Medical Schools
- Speech, Physical, and Occupational Therapy Centers
- Urgent Care Clinics
- Freestanding Surgical Centers
- Intermediate Care Facilities
- State or Local Public Health Clinics
- Community/Rural Health Clinics (or Centers) and Federally Qualified Health Centers (FQHC)
- Air Transportation
- Non-Emergency Transportation Vendor
- Transportation Companies
- Clinical Laboratories
- Pharmacies
- Respite Home/Providers
- Assisted Living Facilities
- Hospice
- Durable Medical Equipment (DME)
- Orthotic and Prosthetic Centers
- Radiology Centers
- Sleep Labs
- Mammography Centers

- Free Standing Emergency Centers
- Behavioral Health Facilities, including but not limited to:
    - Independent Clinics
    - Federally Qualified Health Centers (FQHC)
    - Community Mental Health Centers o Level 1 Sub-Acute Facility
    - Level 1 Sub-Acute Intermediate Care Facility
    - Level 1 Residential Treatment Center (secure and non-secure)
    - Community Service Agency (CSA) o Crisis Services Provider/Agency
    - Behavioral Health Residential Facility
    - Behavioral Health Outpatient Clinic
    - Integrated Health Clinic
    - Rural Substance Abuse Transitional Agency
    - Behavioral Health Foster Care Home
    - Behavioral Health Therapeutic Home o Respite Homes/Providers
    - Specialized Assisted Living Centers
    - Specialized Assisted Living Homes

Credentialing Process

Banner Medicare Advantage must complete a thorough review of documentation and qualifications for all practitioners/organizations requesting participation. This requires the ability to participate in Medicare, Medicaid, and other Federally funded healthcare programs, through the System for Award Management (SAM), Office of Inspector General (OIG) and Medicare Opt Out, Sanction Check and Medicare Preclusion.

Primary Source Verification (PSV) is also conducted for the following elements, to include but not limited to:

- Education
- Training
- Accreditation
- Certifications
- Licensure status
- Hospital privileges
- Professional liability insurance
- Malpractice history

Collection of Required Documentation and Application Data

Banner Medicare Advantage partners with CAQH® to collect and store credentialing information including application data and supporting documents. The Universal Provider DataSource (UPD) is the database operated by CAQH that stores provider credentialing information.

You will receive correspondence from Aperture™ on behalf of Banner Medicare Advantage requesting you complete or update a credentialing application and/or provide additional documentation to complete your application process. Likewise, if your application process includes CAQH, it will be imperative that you continue to update and re-attest to your information on a regular and timely basis.

Any requests from Aperture™ are legitimate and vital to the timely completion of your initial credentialing or recredentialing event.

Practitioners/organizations must respond to any and all reasonable requests for additional information from Aperture CVO, Banner Credentialing or Credentialing staff which supports the Credentialing Committee to prevent the withdrawal or delay in your credentialing.

To inquire about the status of your credentialing, please contact BUHPProviderInquiries@bannerhealth.com.

Re-credentialing

The Banner Medicare Advantage Credentialing Department will initiate a re-credentialing process for each practitioner approximately six (6) months prior to expiration of the credentialing cycle. Practitioners must maintain an active updated CAQH account. Failure to update CAQH information during this period, after appropriate notification, email, or fax, shall be deemed a voluntary termination of participation with Banner Medicare Advantage.

For Organizations requiring re-credentialing an application will be sent to the credentialing contact on file approximately six (6) months prior to expiration of the credentialing cycle. Failure to return a completed application within 60 days after appropriate notification, email, or fax, shall be deemed a voluntary termination of participation in the health plan.

Credentialing Criteria

Practitioners seeking credentialing/re-credentialing must demonstrate the following minimum qualifications:

Licensure

Practitioners must show proof of a current valid, unrestricted license issued by the appropriate state to practice medicine. APPs are required to provide evidence of a current valid, unrestricted license, certification and/or registration by the state in which they practice.

Professional Education and Training

For purposes of this section, an "approved" or "accredited" school or university is one that is fully accredited at the time of the practitioner's attendance, by one of the agencies, its successor and/or the accrediting agency on file with the U.S. Secretary of Education.

Graduation Requirements

Practitioners must show proof of graduation from an approved medical, osteopathic, dental or podiatric school; satisfactory completion of an approved post-graduate training program; attainment of a PhD degree in a recognized scientific field from an accredited university; certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences.

APPs must show proof of graduation from an approved training program appropriate for the area of practice.

Board Certification

Physicians may be required to maintain board certification. Failure to abide by any certification requirements may result in the voluntary, automatic termination of participation with the health plan. The Banner Medicare Advantage Credentialing Committee may make exceptions to board certification requirements.

Hospital Privileges

Practitioners must have clinical privileges in good standing at a network hospital/facility, unless the applicant is:

- A primary care or specialty practitioner that does not routinely practice at hospitals (e.g., dermatology), and does not have active privileges at an out of network hospital/facility;
- Serving in a coverage area where there is not a contracted network hospital/facility;
- A specialist practicing primarily at ambulatory surgery centers (not hospitals); and does not have active

privileges at an out of network hospital/facility; or

- In good standing with clinical privileges at a contracted ambulatory surgery center.

Practitioners who are required, but do not have privileges at a network hospital/facility must apply for and be granted privileges prior to seeing health plan patients or must request and be granted an exemption. Exemption requests must be made in writing at the time of application.

Drug Enforcement Agency (DEA)

Evidence of a current valid, unrestricted DEA registration or pending registration with an agreement by a practitioner in the same specialty to write all prescriptions until the DEA certificate is received. For APPs, evidence of a valid DEA registration is required, if applicable to area of practice.

Professional Liability Insurance

Evidence of professional liability insurance in a type and amount to meet regulatory requirements.

Right to Review

Practitioners have the right to review any information submitted and gathered in support of the credentialing application. Practitioners have the right to review this information and to correct any erroneous information on the credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards, etc.), but does not extend to the review of information, references or recommendations protected by law from disclosure.

If information obtained by Banner Credentialing varies substantially from information submitted by the practitioner, credentialing staff shall notify the practitioner of the discrepancy in writing. The practitioner is then afforded the opportunity to submit a written or telephonic response to correct any erroneous information and, as applicable, explain why the information supplied was not accurate and/or complete. The practitioner will be asked to provide written or telephonic response within 10 business days of receipt of credentialing staff's notification. Failure to respond will be deemed a voluntary resignation and withdrawal of the credentialing application.

Practitioners have the right to be informed of their status in the credentialing or re-credentialing process. Practitioners may request such information at any time.

Appeal Process

The appeal process is not available to applicants whose initial application for participation is denied by the Credentials Committee.

To appeal an adverse action, or if denied during a re-credentialing process, the practitioner must submit a written request to the Banner Health Insurance Division, President within 30 calendar days of receipt of a notice of adverse action. The failure of a practitioner to request an appeal within the required time and in the manner specified shall constitute a waiver of the practitioner's right to appeal.

Credentialing Site Audit

Pre-contractual on-site visits to each PCP office, Pediatric PCP office as well as OB/GYN and behavioral health offices, are conducted. A structural review of the site appearance, adequacy, accessibility, safety, and medical record keeping practices shall be conducted for initial applications.

Ongoing Monitoring

Banner Credentialing monitors monthly reports from:

- Appropriate state licensing agencies
- Office of the Inspector General (OIG)
- Medicare/Medicaid sanction lists or reports
- Medical staff disciplinary actions

- Member/customer complaints
- Medicare/Medicaid participation

Practitioners/Organizations are required to notify Banner Credentialing of any licensure changes/loss, privileges changes/loss and changes in Medicare/Medicaid participation.

The Credentialing Committee will be advised of any findings, including disciplinary, possible disciplinary and non-disciplinary action(s) taken against the practitioner/organization.

Reporting

The Credentialing Committee shall comply with reporting requirements of the Boards of

Medical/Osteopathic Examiners and other state agencies and the Federal Healthcare Quality Improvement Act as required by law. All reporting will be done by the assigned Chief Medical Officer or appointed designee. The practitioner/organization will be notified of the report and its contents.

Medicare Opt Out

In order to identify Practitioners/Organizations who have opted out of the Medicare program, BANNER Credentialing staff will review monthly updates from the Medicare website. The Credentialing Committee will be notified of any practitioners listed as not participating in Medicare programs and will be removed from participation with the health plan.

Appointment Availability

Banner Medicare Advantage has made a commitment to meet appointment availability standards as set forth by Medicare and community standards. In accordance with Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members timely access to care. Should providers be non-compliant with appointment or wait time standards, a CAP is required.

Note: All Providers are to become familiar with and adhere to the following appointment availability standards.

Access to Primary Care - PCP
Urgently needed services or emergency – immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention – within 7 business days
Routine and preventative care – within 30 business days
Access to Behavioral Health Providers
Urgently needed services or emergency – immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention – within 7 business days
Routine and preventative care – within 30 business days

Cultural Competency

Banner Medicare Advantage promotes Cultural Competency for its staff, provider network and members. Cultural Competency is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment, and interaction with members. We have a Cultural Competency Committee and Program as well as a Cultural Competency Liaison who creates education programs for the specific audiences of staff, providers, and members. This education comes in the form of provider education sessions and in- services; member and provider newsletter articles, staff in- services and many other forms of communication forums.

The goal of the Cultural Competency Committee is to ensure that members are provided with culturally competent care and services by the health plan staff and the provider network. The purpose is to increase awareness of how our cultural assumptions and language affect interactions with others, including but not limited

to, patient care. This does not mean each person will be competent in all cultures, but that each person should be aware that people may have different perceptions of health care based on their respective cultures. The Cultural Competency Plan follows the guidelines set forth by Section 1557 of the Patient Protection and Affordable Care Act, which is the nondiscrimination provision. This law prohibits discrimination based on race, color, national origin, sex, age or disability in certain health program or actives. Section 1557 builds on standing Federal Civil Rights laws.

Additionally, the Cultural Competency Plan ensures that services are provided in a culturally competent manner and to promote equitable access to all enrollees, including the following:

- People with limited English proficiency or reading skills.
- People of ethnic, cultural, racial, or religious minorities.
- People with disabilities.
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- People living in rural areas and other areas with high levels of deprivation.
- People otherwise adversely affected by persistent poverty or inequality.

Banner Medicare Advantage will provide member education related to available services offered e.g., translation and interpretation which assist the member with their Banner Medicare Advantage and provider experiences and the results on their health outcome. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency requirements.

Civil Rights Act of 1964, Title VI

The Civil Rights act of 1964, Title VI, prohibits discrimination based on race, color, or national origin. Banner Medicare Advantage providers will mainstream all Plan members so that they are provided covered services without regard to payer source, evidence of insurability, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, medical condition, physical or intellectual disability. Restriction of appointment availability standards may not occur. Members must be treated with dignity and respect and have equal access and appointment time availability as other patients in the providers' office. Banner Medicare Advantage will promptly intervene if it is identified that discrimination was involved with a member and will require a corrective action plan from the provider. If you have any questions or are interested in receiving additional information, please contact your Provider Relations Representative.

Interpretation and Translation Services

Banner Medicare Advantage provides interpretive and translation services for its members. If you have a member who is in need of these services, please contact the Customer Care Center. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the interpretation service.

If you have questions or are interested in receiving additional information, please contact your Provider Relations Representative.

- An interpreter renders SPOKEN word from one language to another.
- A translator renders WRITTEN word from one language to another.

Interpretation Services for Banner Medicare Advantage

1. Call Banner Medicare Advantage's – Customer Care Center
2. Provide the representative with member's Medicare ID number and the nature of the interpretation services required.

3. You will be placed on hold while the representative connects you with the interpretation services.

Important Tips

Working with an Interpreter – Give the interpreter specific questions to relay. Group your thoughts or questions to help conversation flow quickly.

Length of call – Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning-for-meaning, not word-for-word. Concepts familiar to English speakers often require explanation or elaboration in other languages and cultures.

Interpreter identification – Interpreters identify themselves by first name only. For reasons of confidentiality, they do not divulge either their full names or phone numbers.

Document translation – Banner Medicare Advantage is responsible for translating written documents for our members. If you have a written document that needs to be translated for a member, call the Customer Care Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

Culturally Competent Care:

1. Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Language Access Services:
5. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
6. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
7. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
8. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports:

1. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
2. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence- related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
3. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's

management information systems, and periodically updated.

4. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
5. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
6. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross- cultural conflicts or complaints by patients/consumers.
7. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Office of Minority Health, U.S. Department of Health and Human Services. (March 2001) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879. http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Provider Policies

Provider Location and Accessibility Policy

Banner Medicare Advantage has established the highest standards for the delivery of health care for all members. To that end, we require the following commitments from our health care providers:

- Ensure members are treated without discrimination.
- Make provider materials, services and information available in an accessible format as required by Section 504 of the Rehabilitation Act of 1973. Providers are encouraged to utilize the Section 504 best practices outlined in the April 26, 2019 HPMS memo Communications Accessibility for Individuals with Disabilities Best Practices for Medicare Health and Part D Prescription Drug Programs.
- Meet standards for member care.
- Meet Quality and Utilization Management standards.
- Comply with reporting requirements.
- Meet credentialing standards.
- Notify plan with changes to providers, locations, key contacts, telephone numbers, Tax Identification Numbers, or corporate structure, etc. This notification should occur within 30 days of the above noted changes.
- Provide care for members via in-network facilities to ensure the most cost effective and quality care.
- Provide transition plan and 30-day notice when terminating a member from medical practice.

Banner Medicare Advantage will ensure that providers are aware that providers have mechanisms to advise or advocate on behalf of the member regarding: the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or nontreatment; and, the members right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

Provider directories contain provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities.

Provider directories can be found here:
https://www.bannerhealth.com/medicare/advantage/find-provider-or-rx

Member Rights

Banner Medicare Advantage is committed to treating members with dignity and respect at all times. Member rights and responsibilities are shared with staff, providers and members and are included in our Evidence of Coverage. A list of member's rights under 42 CFR 438.100 is include below:

- Provide information in a way that works for member (in languages other than English, in braille, in large print, or other alternate formats, etc.)
- Ensure member's get timely access to covered services and drugs
- Protect the privacy of member's personal health information
- Give member's information about the plan, its network of providers, and covered services
- Support member's right to make decisions about their care
- Give the right to make complaints and to ask Banner Medicare Advantage to reconsider decisions made

Primary Care

Primary Care Providers (PCP's) perform a critical function for Banner Medicare Advantage members. Each PCP is responsible and accountable for the coordination, supervision, delivery, and documentation of health care services to any Banner Medicare Advantage member. PCP's are responsible for maintaining a complete medical record of all services delivered by all providers involved in the members care, including vision, behavioral health, rehabilitative therapy, and medical specialty services, as applicable. The use of the PCP in this model provides for less fragmentation and ensures continuity of care for our members. This model helps to attain effective control over utilization of medical services while maintaining the highest level of care.

The appropriate education of members regarding disease management is not only expected and encouraged, but also required. Providers may discuss medically necessary or appropriate treatment options with members – even if the options are not covered services. Health maintenance education is not only expected and encouraged; it is required for all providers participating with Banner Medicare Advantage. Banner Medicare Advantage develops and implements procedures to ensure that our providers have information required for effective and continuous care and quality review. This includes the provider's good faith effort to conduct an initial Health Risk Assessment of all new members within 90 days of the effective date of enrollment and follow up on unsuccessful attempts to contact a member. Members should receive counseling regarding disease management, prevention, and the importance of regular health maintenance visits. Banner Medicare Advantage has no policies preventing our providers from advocating on behalf of a member and encourages this dual approach of care and disease management. PCP's are expected to advise the members of their ability to treat behavioral health conditions within the scope of their practice.

Members must be included in the planning and implementation of their care. Providers must recognize that it is the patient's right to choose their final course of action among clinically acceptable choices.

Services must be provided in a culturally competent manner to all members, including those with limited English proficiency or limited reading skills. Providers should always consider the ethnic and religious beliefs of their members and their impact on members' participation in care. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency (LEP requirements).

PCP's are expected to educate members on the differences between urgent and emergent conditions and instruct members to contact their PCP before visiting an emergency room or calling an ambulance unless a life-threatening emergency exists.

At a minimum, PCPs are responsible for the following activities:

- Supervision, coordination, and provision of care to each assigned member.

- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

Covering Providers

All primary care physicians and office-based specialists contracted with Banner Medicare Advantage must provide or arrange for medical care for their patients 24 hours a day, seven days a week, including phone accessibility. The provider or the designated covering physician or health care professional must be available to provide care personally or direct the member to the most appropriate treatment setting

Release and Confidentiality of Medical Information

It is the policy of Banner Medicare Advantage to ensure the appropriate and confidential exchange of member information among providers to ensure continuity of care. All contracted providers who house medical records shall appoint a "custodian of medical records". Such person shall be responsible for the safe storage and handling provider of the medical record as well as procedures to maintain confidentiality and integrity of each record.

Note: Subject to change per State and Federal requirements. Please contact Banner Medicare Advantage to verify the most current policy.

HIPAA (Health Insurance Portability and Accountability Act) requires covered entities, including, but not limited to, health plans and providers, to safeguard protected health information (PHI) and use or disclose it only as permitted under Federal and State law. The confidentiality of member PHI must be protected by policy and/or procedure as required by Federal and State law, (Health Plan Policy #CP 6007). Documentation must also exist that both the Banner Medicare Advantage and provider office staff are informed of, understand, and agree to required confidentiality standards.

Certain PHI may be disclosed without member authorization as outlined in HIPAA 45 CFR164.512, including but not limited to the following reasons:

- Requirement by law
- Regarding victims of abuse, neglect, or domestic violence
- Health oversight
- Judicial and Administrative proceedings

When a member chooses a new PCP, medical records must be transferred to the new provider within 10 days of the request in order to assure and promote continuity of care. Any provider sending member records, upon member written request to a new or referring provider must ensure the medical records are forwarded in such a way that unauthorized individuals are not able to access or alter PHI.

HIPAA also provides the member the right to obtain a copy of their records. Any Banner Medicare Advantage member is entitled to receive one copy of his/her medical records from the provider office at no cost, annually as specified in Title 45 of the Code of Federal Regulations CFR 164.524. The records maintained in the designated record set must be provided within 30 days unless the provider requests a 30-day extension from the member and the member agrees. The records much be provided in the form and format requested by the member if it is readily producible in such form and format, or if not in a readable hard copy form or a form agreed upon by both parties. If a member requests an amendment of their medical record, you must review the request including the reason that supports the request and inform the member of the decision regarding their request. You may require members to make this request in writing. You must act on the member's request no later than 60 days of the receipt of such request. You may deny the request for an amendment if the information was not created by you, is not part of the record used to make decisions about the member, is not part of the information that the member is permitted to inspect or copy or if the information is accurate and complete. If the request is denied, you must provide a written denial with the basis for the denial and information on the member's right to submit a written statement

disagreeing with denial and how to file the statement. You must, as appropriate, identify the record or protected health information in the designated record set that is the subject of the request for amendment and either amend or attach the statement of disagreement to the designated record set. Additional information on the amendment of protected health information can be located at Title 45 of the Code of Federal Regulations CFR 164.526.

Additional HIPAA requirements and information is available via the government website: www.hhs.gov/ocr/privacy/hipaa/understanding/summary

Advanced Directives

Banner Medicare Advantage members have the right to make decisions about their health care, including the right to accept or refuse medical care and the right to execute an advanced directive. Members can exercise his or her rights, and the exercising those rights shall not have an adverse effect on service delivery to the member.

PCP's are required to:

- Provide written information to adult members regarding their rights under state law to make decisions regarding their medical care and the provider's policies concerning advanced directives, including conscientious objections, if applicable.
- Document in the member's medical record whether or not the adult member has been provided with the above information and whether or not an advanced directive has been executed.
- Not discriminate against a member because of his or her decision to execute or not execute an advanced directive and not make it a condition of or the provision of health care.
- Provide education to staff on issues concerning advanced directives, including notification of direct care providers of services, such as home health care and personal care providers, of any advanced directives executed by the member to whom they are assigned to provide services.

PCP's are encouraged to obtain a copy of the member's executed advanced directive from a hospital, nursing facility, home health agency, hospice, or any organization responsible for providing personal care for inclusion in their medical record.

Information concerning advanced directives may be obtained from your Provider Relations Representative or at https://www.azag.gov/seniors/life-care-planning

Medical Record Transfer During Member Transition

If a member is under active treatment for an acute or chronic condition and transitioning out of the Banner Medicare Advantage plan the Primary Care Physician is responsible for providing a copy of the medical record upon request from the member

Medical records must include records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.

Confidentiality must be maintained by all staff, provider and/or vendors according to medical record policy and procedure.

Member Care Requirements

Immunizations

Formulary

The plan specific Drug Formularies can be found on Banner Medicare Advantage website at https://www.bannerhealth.com/medicare/advantage/find-provider-or-rx/rx

Hospital Admissions

PCPs are expected to admit members to Banner Medicare Advantage contracted facilities and follow his/her own

patients in the hospital. If the PCP is unable to admit and or follow the patient, it remains his/her responsibility to arrange for an admitting/attending provider. The selected provider must be contracted and must have privileges at the admitting facility.

Referrals/Prior Authorizations

The PCP is responsible for initiating and coordinating referrals to specialists within the contracted network when necessary and obtaining prior authorization for services listed on the Prior Authorization Grid. Please refer to the Prior Authorization Grid and Referral Guidelines at www.bannerhealth.com/medicare -

Banner Medicare Advantage encourages contracted specialists to secure needed authorizations, but it is the responsibility of the PCP to ensure the authorization is requested. It is critical that the PCP maintains a strong communication link with specialists who are treating their members.

Caring for Members with Special Needs

Banner Medicare Advantage considers our contracted providers partners in caring for our members. As health care reform becomes a reality, it is a critical time for health plans and providers to align their efforts in providing care for members and patients with special needs.

The methods in which plans, and providers will be reimbursed are rapidly moving toward payment for quality and improved health outcomes. Banner Medicare Advantage would like to share some of the specific areas where you can impact the outcomes of your patients and assist the plan in achieving high quality ratings.

Why is Member Experience Important?

Most of us have high expectations for service and experience across industries, and healthcare consumers are no different. Our members are the reason we exist and every interaction we have matters. Each of us is responsible for providing a great care experience, whether you are providing care at the bedside or supporting those who do. Ultimately, you are the member experience. Everything you do impacts members' perceptions of the care they receive and whether they will choose Banner Medicare Advantage providers to care for them, or their family and friends, in the future.

Capturing the Member Experience

Member experience is an important part of the member's healthcare journey. As result, Banner Medicare Advantage uses internal and external processes to gather member satisfaction.

Banner Medicare Advantage contracts with a vendor to obtain near real-time Member feedback for participating providers. Shortly after a visit, members are given the option to share feedback via text, email, or phone (Interactive Voice Response). In addition to sharing comments about their experience, members are asked to rate the following on a 0-10 scale with 0 being "Not at all likely" and 10 being "Extremely likely" (N/A is also a response option):

- How likely are you to recommend this Banner Health clinic to friends or family?
- It was easy to get an appointment in a timely manner.
- I clearly understood the cost of my visit before my appointment.
- My interaction with the provider was excellent.
- The reason for my visit/interaction was addressed.
- I would recommend the provider (e.g., doctor, physician assistant, nurse practitioner) to my family and friends.
- The provider showed respect for my time.
- The provider genuinely cared about helping me.
- It was easy to receive care from the provider over the phone or by videoconference.

- The provider helped manage my care among different providers and services.

The Centers for Medicare and Medicaid Services (CMS) uses approved vendors who field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is a federally required, standardized, publicly reported survey. The CAHPS survey covers a range of topics that are important to healthcare consumers and are used to assess various aspects of healthcare quality such as a provider's communication skills and ease of accessing healthcare services.

CAHPS survey results are used by healthcare consumers, regulators and organizations that monitor quality of care, provider organizations, health plans, community collaboratives, and public and private healthcare purchasers. These individuals and organizations use the survey results to make informed decisions about their care and to improve the overall quality of care.

CAHPS surveys are specific to the type of insurance coverage a Member has. Each type of CAHPS survey is fielded once annually during a specific timeframe. For Medicare Advantage the CAHPS survey is conducted annually between March-May.

Here are some of the CAHPS questions specifically tied to a member's experience with their care provider:

Annual Flu Vaccine Have you had a flu shot?	Care Coordination Has your personal doctor or doctor's office... • ...managed your care among different providers and services to your satisfaction? • ...followed up promptly on test results? • ...talked to you about all the medications you take?
Getting Appointments and Care Quickly How often have you ... • ...gotten urgent care as soon as needed? • ...gotten appointments at your doctor's office? • ...been seen within 15 minutes of your appointment time?	Overall Ratings On a scale from 0 to 10, how would you rate your... • ...overall health care? • ...personal doctor? • ...specialist seen most often?

Ratings are based on the frequency at which an experience occurred or a scale of 0 to 10. The percent of the best possible response ("Top Box") receives a higher weighting than the other responses. For the CAHPS questions, the possible responses are:

- Never
- Sometimes
- Usually
- Always
- OR 0-10 (9 or 10)

Health Outcomes Survey

The Health Outcomes Survey (HOS) is specific to the Medicare Advantage population and captures patient-reported outcomes. The ultimate goal of the HOS is to gather valid and reliable clinically meaningful data that can be used to target quality improvement activities and help Medicare Advantage beneficiaries make informed health care choices. The HOS involves comparing the results from a baseline survey (occurs April-June) with a follow-up survey (occurs 2 years later from May-July) and focuses on the following areas:

Improving or Maintaining Physical Health

Improving or Maintaining Mental Health

Monitoring Physical Activity

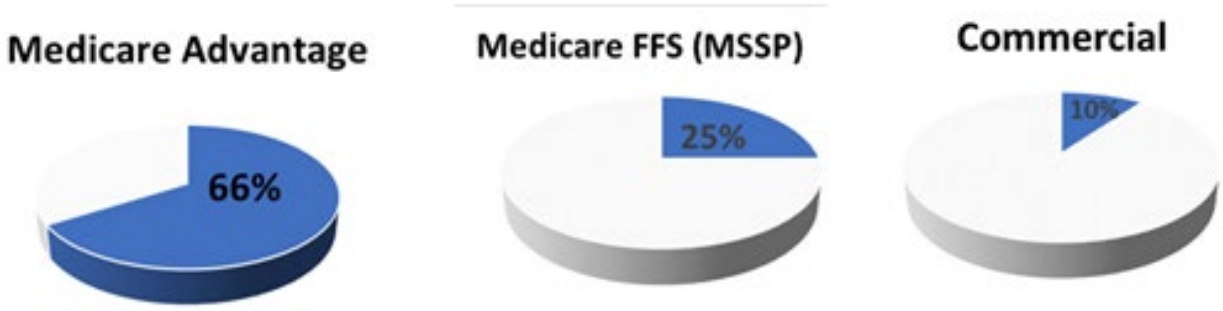
Improving Bladder Control

Reducing the Risk of Falling

A copy of the HOS can be accessed here.

How Does Performance Impact Your Practice?

The value-based arrangements Banner Medicare Advantage has with various payors include performance on the patient experience. The pie charts below show the approximate percent patient experience accounts for in the overall performance of the various types of plans:



The Centers for Medicare and Medicaid Services (CMS) also uses a Star Rating System to measure how well Medicare Advantage plans perform in several categories, including the patient experience.

Ratings range from 1 to 5 stars, with five being the highest and one being the lowest. While plans receive an individual rating in each evaluation category, Medicare assigns one rating to summarize a plan's overall performance.

The Medicare Star Rating System helps members measure the quality of a plan while giving them confidence in knowing that their Medicare Advantage provider is committed to delivering an exceptional member experience.

Members with a Medicare Advantage plan may switch to another Medicare Advantage plan with a 5-star rating one time outside of the open enrollment period (typically mid-October through early December). This means the number of Medicare Advantage members you care for could increase.

What are Some Ways to Improve Performance?

Below are some tips for improving the overall experience. More detailed tips can be accessed on the provider portal located at https://eservices.uph.org.

- Greet Members warmly.
    - Example: "Good morning/afternoon! How may I help you today?"
- Give opportunities to ask questions.
    - Example: "I want to make sure we cover everything you wanted to talk about today. Was there anything else you wanted to discuss or had questions about?"
- Explain the "why" behind a diagnosis, treatment, etc.
- Use common language that Members can understand. Try to stay away from technical medical terminology.
- Provide thorough instructions for what the Member needs to do next, such as setting follow-up

appointments, taking medications, etc. Give the Member a printed copy of instructions to take home, if possible.

- Avoid interrupting or rushing a Member.
- Identify Members who have had a fall or problems with balance or walking and talk with them about how to address these issues.
- Identify Members who experience urinary incontinence and talk with them about how to address the issues.
- Discuss the importance of physical activity with Members and encourage them to maintain or increase physical activity as appropriate
- Offer ideas to improve mental health, such as taking daily walks, staying involved with family, doing crossword puzzles, or meditating.
- Consider a hearing test when appropriate as loss of hearing can feel isolating.

Provider as Member's Advocate

Banner Medicare Advantage does not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health care, medical needs, or treatment options, including alternative treatment that may be self-administered, even if needed services are not covered by the Health Plan.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. (42 CFR 438.102)

Providers must provide information regarding treatment options in a culturally competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options.

Americans with Disabilities Act (ADA) and Title VI Requirements

Banner Medicare Advantage providers must adhere to the Americans with Disabilities Act (ADA). The Act of 1990 gives civil rights protections to individuals with disabilities similar to those provided to individuals based on race, color, sex, national origin, age and religion. While the ADA is a Federal law, Arizona does have a mirror statute regarding disabilities, giving the Attorney General the authority to enforce this law.

In accordance with the Act, a member will not be discriminated against based on his/her disability. Contracted providers will make reasonable accommodations, without undue hardship, in order to provide quality care for a member with a disability.

PCP Policies

Provider Assignment

Selecting and Changing Primary Care Providers

Members have the right to select their own PCP using the print and/or online directory of participating and available providers. Members also have the right to change a PCP at any time.

1. Changes become effective the first of the month following the day of their request. Please refer members to our Customer Care Center for further assistance.
2. When a member changes PCPs, his or her original or copied medical records MUST be forwarded to the new PCP within 10 business days from receipt of the request for the transfer of medical records.

Primary Care Provider Initiated Changes

A PCP may request member reassignment for a variety of reasons. The PCP must send a written request to the Customer Care Department. The request should include the reason and a copy of the medical record/office notes or other supporting documentation. All requests to reassign members must be reviewed and approved by the Banner Medicare Advantage Medical Director.

PCPs must allow 30 days for a member reassignment and are obligated to continue to treat the member as necessary during this change. Members are offered freedom of choice within our PCP Network.

However, we may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. We hope all our members and providers have satisfactory, productive relationships. If provider staff are having difficulties with a member (not keeping appointments or not complying with their care regime, etc.), please notify our Case Management Department.

PLEASE NOTE: PCPs rendering services for the Banner Medicare Advantage should not advise a member that they have been discharged until the request has been approved and communicated by the Banner Medicare Advantage Chief Medical Officer. Upon final decision by the Banner Medicare Advantage Chief Medical Officer the Administrative Assistant will notify the member of the outcome in writing.

Provider Panel

A PCP who contracts with Banner Medicare Advantage is required to have a panel and accept a minimum of 100 members. If a PCP wishes to close a panel to new members after reaching this minimum, the PCP must send the Data Department written notification at least 60 days in advance. The Data Department will review the request and may agree to close the panel 60 days from the date the written notice is received. The PCP is obligated to accept assignment of any member assigned until the approved date of the panel closure. Members already assigned to a panel at the time of panel closure are considered to be established Members whether or not they have been seen in the office at the time of panel closure.

Provider Panel updates should be sent directly to the data department, providers need to email BUHPDataTeam@bannerhealth.com.

Member Roster Requests

Banner Medicare Advantage has a dedicated email address that primary care providers may use to obtain information regarding assigned membership. Please send inquiries related to obtaining information for the provider's assigned membership to our dedicated inbox at providerexperiencecenter@bannerhealth.com. Requests will be provided within ten (10) business days of the request. A Provider self-service option is also available. To access member enrollment information and obtain member rosters, please visit https://eservices.uph.org. For more information about eServices, contact your Provider Relations Representative.

Section 3 – Compliance Program

Banner Medicare Advantage's commitment to compliance includes ensuring that our providers are in compliance with applicable state and federal regulations. All contracted providers are responsible for complying with all federal laws, regulations including but not limited to, Banner Medicare Advantage policies and procedures, Compliance and Fraud Waste and Abuse Plan, Compliance guide for staff and business partners and the Code of Conduct. All of these documents are available on the www.BannerMA.com/For-Healthcare-Providers, eServices.uph.org, or upon request.

Banner Medicare Advantage has incorporated requirements outlined by Medicare in these documents. Providers must review the respective guidelines and ensure appropriate protocols are in place to demonstrate compliance.

CMS Requirements

To assist you in understanding the requirements please access the CMS website.

Banner Medicare Advantage Compliance Program Requirements

Requirements of all Banner Medicare Advantage contracted providers include, but are not limited to:

- Providers are expected to adhere to Banner Medicare Advantage's compliance requirements relating to FWA, which have been outlined in Banner Medicare Advantage's Compliance and FWA Plan, Compliance Guide for staff and business partners and CMS general compliance and FWA trainings.
- Ensure monitoring and oversight is in place for all employees.
- Implement monitoring and oversight of compliance requirements for all relationships with subcontractors.
- Maintain member medical records in a legible, detailed, and comprehensive manner, preferably an electronic health record. Progress notes must be signed after each appointment and/or procedure. Provider signature shall occur as close to the actual entry of treatment notes as possible but must be within 7 calendar days from the date of service. Documentation must contain enough information to determine the date when the service was performed or ordered. If the entries immediately above and below an undated entry are dated, medical review may assume the date of the entry in question.
- Comply with requirements to provide medical records to BMA Compliance within 10 business days of receipt of request.
- Complying with Offshore requirements.
- Report all suspected and/or detected FWA.
- Establish and maintain policies and procedures for preventing, detecting, correcting and reporting FWA, in addition to other requirements listed below.
- To ensure employees, managers, officers and directors responsible for the administration or delivery of Medicare benefits are free from any conflict of interest and provide Banner Medicare Advantage with full disclosure on any situation that may present a conflict of interest.
- Completion of the Banner Medicare Advantage Compliance Attestation is required upon contract and annually thereafter. Completion of the form will confirm that your internal processes are compliant with Medicare Compliance Program requirements.

Additional information about these requirements is discussed below and can also be found at www.BannerMA.com.

Written Policies and Procedures and Code of Conduct

Banner Medicare Advantage requires that all providers supporting the Medicare Advantage and Part D Prescription Drug Program adopt and abide by the Banner Medicare Advantage Code of Conduct and Policies and

Procedures. Providers may also implement a code of conduct and policies and procedures that incorporates requirements consistent with Banner Medicare Advantage's Code of Conduct and Policies and Procedures. The code of conduct states your organization's over-arching principles and values by which your Organization operates and defines the underlying framework for the compliance policies and procedures. The code of conduct must provide the standards by which providers and staff will conduct themselves, including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations and policies. Providers and staff are required to comply with all applicable laws, whether the laws are specifically addressed in the code of conduct or not.

As stipulated in the Banner Medicare Advantage Code of Conduct, Providers and staff are required to report issues of noncompliance and potential FWA through the appropriate mechanisms and ensure that all reported issues will be addressed and corrected. Your processes must include detailed and specific guidance for employees regarding how to report potential compliance issues. Anonymous reports can be made to Banner Medicare Advantage's toll-free alert line at (888) 747-7989 or through bannerhealthcomplylineethicspoint.com.

Policies and Procedures should include provisions and procedures that, at a minimum, outline the following:

- Require that all employees and downstream entities immediately report suspected and/or detected FWA.
- Ensure all Banner Medicare Advantage confidential and proprietary information is safeguarded.
- Screen all employees and downstream entities against federal government exclusion lists, upon hire or contract and monthly thereafter. These include the CMS Preclusion List and Office of Inspector General "OIG" list of excluded Individuals and Entities, and the General Services Administration's" Excluded Parties Lists System. Anyone listed on one or any of these lists is not eligible to support Banner Medicare Advantage's Medicare plans, must be removed immediately from providing services. Upon identification of an excluded individual or organization, Banner Medicare Advantage must be notified immediately.
- Cooperate fully with any investigation of alleged, suspected or detected violation of state or federal laws or regulations.
- Distribute compliance and FWA training to employees and downstream entities.
- Implement and publicize disciplinary standards and take action upon discovery of FWA or actions that could lead to FWA.

The code of conduct and policies and procedures should be distributed to employees within 90 days of hire, when there are updates to the policies, and annually thereafter. You should ensure that employees, as a condition of employment, read and agree to comply with all written compliance policies and procedures and code of conduct within 90 days of date of hire and annually thereafter. Employee statements or certifications should be retained and be available to Banner Medicare Advantage and CMS.

This information must be available upon request by Banner Medicare Advantage and CMS and records should be maintained for 10 years.

Your Organization may make Banner Medicare Advantage's Code of Conduct available to all employees. The Banner Medicare Advantage Code of Conduct is available online at www.BannerMA.com.

Providers are given access to applicable Banner Medicare Advantage Policies and Procedures via eServices or upon request by contacting the Banner Medicare Advantage Compliance Department at BHPCompliance@bannerhealth.com.

Conflicts of Interest

Your Organization's code of conduct should include provisions to ensure employees, managers, officers and directors responsible for the administration or delivery of the Medicare benefits are free from any conflict of interest in administering or delivering Medicare benefits. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

Federal Health Care Program Requirement

As a contracted provider, you are obligated under 42 C.F.R.100.1.1901, to screen all employees, contractors, temporary employees, volunteers, consultants, governing board members, and /or subcontractors, to determine whether any of them have been excluded from participation in Federal health care programs upon hire or contracting and monthly thereafter. The Organization is required to verify their employees (including temporary and volunteer) are not excluded by comparing them against the CMS Preclusion List, Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA) System of Award Management (SAM) formerly known as the Excluded Parties List (EPLS) and any other databases directed by CMS. Monthly screening is essential to prevent the Health Plan from making inappropriate payment to providers, pharmacies or other entities that have been added to the exclusions lists since the last time the list was checked. Upon discovery of an excluded individual or entity, the Organization must provide immediate disclosure to Banner Medicare Advantage. No payment will be made by Medicare or any other Federal or State of Arizona health care programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.

The Health Plan will, on a monthly basis, determine the exclusion status through routine checks of:

a. The List of Excluded Individuals (LEIE)

b. The System of Award Management (SAM) formerly known as The Excluded Parties List (EPLS)

c. Any other databases directed by CMS

For providers found on the CMS Preclusion List, as documented in the 2020 Final Rule CMS 4185-F, 42 CFR 422.504 and after the expiration of the 60-day period specified in § 422.222:

- The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per § 422.504(g)(1)(iv); and
- The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the beneficiary will have already received notification of the preclusion.

To assist you with implementation of your CMS/OIG/GSA Exclusion process, links to the exclusion websites are below.

- The List of Excluded Individuals (LEIE)
- The System of Award Management (SAM) - *formerly known as The Excluded Parties List (EPLS)*
- CMS Preclusion List
- Any other databases directed by CMS

Offshore Requirements

The term "Offshore" refers to any country that is not one of the 50 United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands). Subcontractors that are considered Offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Providers must ensure its employees and downstream and related entities have read and understand all requirements pertaining to the regulations for services that are performed by workers located in Offshore countries, regardless of whether the workers are employees of American or foreign companies. Consistent with CMS direction, this applies to entities the Organization may contract or sub-contract with to receive process,

transfer, handle, store, or access beneficiary protected health information (PHI) in oral, written, or electronic form. In the event the Organization sub-delegates any Banner Medicare Advantage Medicare activities to an offshore subcontractor, the Organization will be required to adhere to the approval process outlined for sub-delegation activities and complete an additional offshore attestation.

To ensure that Banner Medicare Advantage is compliant with CMS regulations for offshore subcontracting, Banner Medicare Advantage's contract with Organizations based in the United States and its territories and includes contract language that the Organization will inform Banner Medicare Advantage 90 days in advance from the date Organization plans to outsource part or all of its responsibilities that includes providing Health Plan member PHI to an Offshore company. Banner Medicare Advantage will evaluate the specific circumstances and may be required to terminate its contract with the Organization.

Fraud, Waste and Abuse Requirements

In support of the Banner Medicare Advantage Compliance Program, it is the policy of the Health Plan to detect, prevent and control member and provider related Fraud, Waste and Abuse within the Medicare system. The Health Plan is committed to comply with applicable statutory, regulatory, and other requirements, sub-regulatory guidance and contractual commitments related to the delivery of Medicare benefits. The Health Plan has a written Fraud, Waste and Abuse plan to employ controls to prevent, detect and control potential cases of Fraud, Waste and Abuse.

As a payer of Medicare claims, any BR code found, after pre-payment or retrospective review, to be excessive based on billed charges will be priced by another means than at the BR percentage in order to prevent waste. Banner Medicare Advantage has defined excessive to be any amount that is greater than invoice, greater than similar relative value units of listed codes or in excess of Average Wholesale Price (AWP) + 15% for those codes that have a NDC (National Drug Code). Banner Medicare Advantage will monitor provider billing patterns to avoid excessive reimbursements that contribute to potential fraud, waste and/or abuse.

Our Goal: Eliminating Fraud, Waste and Abuse

The Health Plan will strictly enforce fraud and abuse prevention policies. Specific controls are in place to prevent and/or detect potential cases of fraud and abuse.

It is our policy to educate providers and their staff on how to prevent, detect and report potential cases of fraud and abuse. To eliminate fraud and abuse successfully, everyone must work together to prevent, identify, and report inappropriate and potentially fraudulent practices. This can be accomplished by:

- Monitoring claims submitted for compliance with billing and coding guidelines
- Adherence by providers and facilities to Treatment Record Standards
- Education of all staff members who have any contact with PHI
- Referring cases of suspected fraud and abuse

What is a Fraud Violation?

- Fraud violations occur when a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he/she is not otherwise entitled.

What is an Abuse Violation?

- Abuse violations occur when provider practices are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the CMS Program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, non-compliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges.

What is Waste?

- Waste occurs when overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program.

Any employee, member, vendor, or provider has the right to make a Fraud, Waste or Abuse -related complaint to Banner Medicare Advantage if he/she feels that there have been suspicious activities.

Examples of Fraud include, but are not limited to:

- Billing for services that were not rendered;
- Misrepresenting as medically necessary non-covered or screening services by reporting them as covered procedure or revenue codes;
- Signing blank records or certification forms, or falsifying information on records or certification forms for the sole purpose of obtaining payment;
- Upcoding or consistently using procedure/revenue codes that describe more extensive services than those actually performed;
- Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement;
- Selling or sharing Medicare health insurance identification numbers so that false claims can be filed; and
- Falsifying information on applications, medical records, billing statements, cost reports or on any documents filed with the government.

Examples of waste and abuse include but are not limited to:

- Billing for services or items in excess of those needed by the member;
- Unbundling services that are to be bundled or double billing in order to receive increased payment;
- Adding inappropriate or incorrect information to cost reports;
- Collecting in excess of the deductible or co-insurance amounts; and
- Requiring a deposit or other payment from members as a condition for admission, continued care or other provision of service.

Laws that Regulate Fraud and Abuse

False Claims Act

Under the False Claims Act (FCA),31 U.S.C. §§3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $13,508 to $27,018 per false claim for violations occurring after January 30, 2023, and the costs of the civil action against the entity that submitted the false claims. A false claim is a claim or written statement that is for services that were not provided, or asserts a material fact that is false, or omits a material fact.

Qui Tam Provision under False Claims Act

The False Claims Act provides a "qui tam" provision, commonly referred to as the "Whistleblower" provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. If the United States Government agrees to join the qui tam suit, it shall have the primary responsibility for prosecuting the action. If the suit is successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. When the Government agrees to join the suit, the percentage is lower as the Government assumes all expenses associated with the suit. If a whistleblower was involved or planned the false claims violation, the court may reduce the share of proceeds. In the whistleblower is convicted of criminal conduct in regard to the false claims case, they will be dismissed from the civil action without receiving any portion of the proceeds.

The False Claims Act also contains a provision 31 U.S.C. §3730(h), that protects a whistleblower from retaliation

from their employer. The employer may not discharge, demote, suspend, threaten, harass, or discriminate in any manner against the employee as a result of the false claims action. In the event, these actions occur, the whistleblower may bring an action in the appropriate district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination including litigation costs and reasonable attorneys' fees.

Program Fraud Civil Remedies Act of 1986 (PFCRA):

A similar Federal Law that provides administrative remedies for knowingly submitting False Claims and Statements is the Program Fraud Civil Remedies Act of 1986. A violation of the PFCRA results in a maximum civil penalty of $13,508 up to a maximum, of $405,270. (note: civil penalties are adjusted annually for inflation – last amendment was 11/17/2023).

Anti-Kickback Statute

Under the Anti-Kickback Statute, 41 U.S.C, it is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration for any item or service that is reimbursable by any Federal healthcare program. Penalties may include exclusion from Federal health care programs, criminal penalties, jail, and civil penalties for each violation.

Examples of kickbacks include money, discounts, gratuities, gifts, credits, and commissions.

Violation of this law is a felony. Each violation. therefore, is a felony punishable with a fine of up to $100,000 and up to 10 years in prison.

Persons and entities convicted of violating this law are also subject to mandatory exclusion from participating in Covered Health Care Programs. Finally, health care items or services billed to a Covered Health Care Program as the result of an arrangement that violates that Anti-Kickback Statute may be violations of the health care False Claims Act and may be separately punishable as a felony resulting in criminal fines and/or imprisonment for up to five years or both, or civil fines up to three times the amount improperly received from the government health care programs plus up to $25,076 per improperly filed claims.

Changes to Anti-Kickback Statute

The Final Rule implements seven new safe harbors, modifies four existing safe harbors, and codifies on new exception under the Beneficiary Inducements Civil Monetary Penalty (CMP).

Final Safe Harbor Regulations Protect:

Value-Based Arrangements including the following:

- Care Coordination Arrangements to Improve Quality, Health Outcomes and Efficiency
- Value-Based Arrangements with Substantial Downside Financial Risk; and
- Value-Based Arrangements with Full Financial Risk.

These new safe harbors vary by the type of remuneration protected, level of financial risk assumed by the parties and safeguards:

- Patient Engagement and Support – certain tools and supports furnished to patients
- CMS-Sponsored Models – for certain remuneration provided in connection with a CMS sponsored model
- Cybersecurity Technology and Services – for donations of cybersecurity technology and services.
- Electronic Health Records Items/Services – adds protections for certain related cybersecurity technology, updates for interoperability, and to remove sunset data.
- Outcomes-Based Payments & Part-Time Arrangements – adds flexibility for certain of these payments and arrangements.
- Warranties – revises the definition to provide protection for bundled warranties for one or more items and

related services.

- Local Transportation – expands and modifies mileage limits for rural areas for patients discharged from an inpatient facility or released from a hospital after observation for 24 hours.
- Accountable Care Organization (ACO) Beneficiary Incentive Programs – for MSSP codified the statutory exception to definition of "renumeration".
- Under Beneficiary Inducements CMP project:
    - Telehealth for In-Home Dialysis – new statutory exception to the prohibition on beneficiary inducements for "telehealth technologies' furnished to certain patients.

Stark Law

Self-Referral (Stark Law) Statutes, Social Security Act, §1877, pertains to physician referrals under Medicare and Medicaid. Referrals for the provision of health care services, if the referring physician or an immediate family member has a financial relationship with the entity that receives the referral, is not permitted. This law was modified to evolve the regulation to keep pace with the transition of fee-for-service or a volume-based system to a value-based system. In its previous form, the Stark Law prohibited some arrangements that were designed to enhance care coordination, improve quality, and reduce waste. The final rule creates new, permanent exceptions to Stark Law for value-based arrangements. Exceptions apply to both arrangements that relate to care for individuals with Medicare or other patients. Compensation provided to a physician by another healthcare provider generally must be at fair market value and the rule provides guidance on how to determine if compensation meets this requirement. The final rule also provides clarity and guidance on a wide range of other technical compliance requirements intended to reduce administrative burden. There is new flexibility for arrangements such as donations of cybersecurity technology.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Title II, §201-250, provides clear definition for Fraud & Abuse control programs, establishment of criminal and civil penalties and sanctions for noncompliance. This act protects the privacy of the patient. Under the U.S. Department of Health and Human Services, the Office of Civil Rights (OCR) investigates and enforces HIPAA violations. The OCR reported on September 30, 2023, that since the compliance date of the Privacy Rule in April 2003, OCR has received over 343,032 HIPAA complaints and has initiated over 1,178 compliance reviews. They have resolved ninety-nine percent of these cases (338,401).

The OCR reported that they have investigated and resolved over 30,455 cases, and in these cases, they required changes in privacy practices, corrective actions, or provided technical assistance to both HIPAA Covered Entities and their business associates. The OCR has settled or imposed a civil monetary penalty in 137 cases to date resulting in a total dollar amount collected of $136,918,772.00.

From the compliance date to present, the compliance issues that were most frequently present in complaints in order of frequency included:

- Impermissible uses and disclosures of protected health information;
- Lack of safeguards of protected health information;
- Lack of patient access to their protected health information;
- Lack of administrative safeguards of electronic protected health information; and
- Use or disclosure of more than the minimum necessary protected health information.

The most common types of covered entities that have been alleged to have committed violations are, in order of frequency:

- General Hospitals;
- Private Practices and Physicians;

- Pharmacies;
- Outpatient Facilities; and
- Community Health Centers

The OCR does make referrals to the Department of Justice (DOJ) for criminal investigations regarding cases that involve the knowing disclosure or obtaining of protected health information in violation of the Rules. The OCR has made 1938 referrals to DOJ to date.

For information on the history of and details about each of the HIPAA Rules, visit https://www.hhs.gov/hipaa/forprofessionals/index.html and click on "Privacy," "Security," or "Breach Notification" from the left-hand toolbar.

The Deficit Reduction Act (DRA), Public Law No. 109-171, §6032, passed in 2005, is designed to restrain Federal spending while maintaining the commitment to the Federal program beneficiaries. The Act requires compliance for continued participation in the programs. The development of policies and education relating to false claims, whistleblower protections and procedures for detecting and preventing fraud & abuse is required. It includes provisions aimed at reducing Medicare fraud and abuse and applies to all health care providers receiving at least $5 million in annual Medicare payments.

Auditing and Monitoring

Banner Medicare Advantage is required to perform effective auditing and monitoring in order to prevent and detect FWA. Banner Medicare Advantage staff and business partners are encouraged to monitor their work and interactions for any suspected FWA.

As a part of the Corporate Compliance Plan, Banner Medicare Advantage has a program integrity audit/review program that is designed to identify fraud, waste and abuse and to ensure that providers' billing practices are supported by medical record documentation. This process assists Banner Medicare Advantage in tracking inadequate billing practices by providers and identifying trends so that technical assistance and provider education can help avoid future occurrences of problematic billing for contracted Providers. Some of trends that have been identified with the audits include the following:

- Progress notes not signed appropriately by the provider rendering the service or signed weeks, months or even years after the services was provided or in some cases not signed at all or left in a pending status.
- Up coding of Evaluation and Management (E/M) services as the medical record documentation does not support the level of service selected.
- Claims submitted under the NPI of one provider when the services rendered as indicated on the medical progress note are completed by a different provider with a different NPI and oftentimes a mid-level billing under an MD. These cases are not incident-to allowable. In some cases, the mid-level (NP, PA) is not credentialed or contracted with Banner Medicare Advantage.
- Copying and pasting of information from one service to the next service when each entry is worded exactly like or similar to the previous entries. It would not be expected that every patient had the exact same problems, symptoms, and required the exact same treatment.
- Inappropriate use of modifiers.

Banner Medicare Advantage contracts with vendors to administer and/or deliver benefits on Banner Medicare Advantage's behalf. These vendors are referred to as delegated First Tier, Downstream, and Related Entities (FDRs) and they must abide by Banner Medicare Advantage contractual and regulatory requirements. Banner Medicare Advantage is responsible for the lawful and compliant administration of Medicare benefits under our contracts with CMS regardless of delegation.

Banner Medicare Advantage has clearly defined processes and criteria to evaluate and categorize all vendors with which Banner Medicare Advantage contracts and utilizes multiple methods to monitor and audit First Tier Entities to ensure that they are compliant with all applicable laws and regulations, and to ensure that the First Tier Entities

are monitoring the compliance of the entities with which they contract. Methods include on-site audits, desk reviews and monitoring of self-audit reports.

Medicare Contracted Provider Requirements

As a Medicare Advantage contracted provider, you are required to comply with Federal laws and regulations to include, but not limited to:

- False Claims Act
- Federal Criminal Law
- Anti-Kickback Statute.

Training and Documentation

General Compliance and Fraud, Waste and Abuse (FWA) Training

As a contracted provider with Banner Medicare Advantage who provides health care services to Medicare Advantage (MAPD) enrollees on behalf of Banner Medicare Advantage, you are required to provide General Compliance and FWA training to your employees (including temporary employees and volunteers) and to all downstream entities within 90 days of contract with Banner Medicare Advantage. All employees must complete the training within 90 days of hire and annually thereafter.

In order to assist providers with these trainings, Banner Medicare Advantage has added an applicable training on the BMA website for providers at the following link:
https://www.bannerhealth.com/medicare/providers/compliance.

Providers and FDRs can take the BMA training or a comparable training. Documentation of internal training can be through an individual certificate or a list showing the information for all those who completed it through the internal web-based training.

The only exception is for providers who have obtained FWA certification through enrollment into the Medicare program as a health care provider or as an Accredited DMEPOS Supplier (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies); these providers are deemed and have satisfied the FWA training requirement.

The deeming exception for FWA training and education does not apply to the general compliance training and education requirement described above. Providers who have met the FWA training requirements must complete the General Compliance training.

Provider Responsibilities to Report Suspicious Activity or Fraud, Waste and Abuse

Providers are required to report any suspicious activity or Fraud, Waste, and Abuse to Banner Medicare Advantage Health Plan Compliance Department and appropriate federal or state agency. The Banner Medicare Advantage Health Plan adheres to a policy of non-retaliation and will make every effort to protect your identity and will not tolerate any form of retaliation against any person making such a report.

Please report to the Banner Medicare Advantage Compliance Department using one of the following methods:

- ComplyLine (Confidential & Anonymous): (888) 747-7989 (24 hours a day/7 days a week)
- Banner Medicare Advantage Compliance Officers at BMAComplianceOfficer@bannerhealth.com or (602) 747-1194
- U.S. Mail:
  Banner Health Plans
  Compliance Department
  5255 E Williams Circle, Ste 2050
  Tucson, AZ 85711

Reporting to Medicare

Providers are required to report all suspected fraud, waste, and abuse to the Health Plan or to Medicare directly.

Mail:
US Department of Health and Human Services Office of Inspector General
ATTN: OIG HOTLINEOPERATIONS
PO Box 23489
Washington, DC 20026

Phone: 1-800-HHS-TIPS (1-800-447-8477)
Fax: 1-800-223-8164
TTY: 1-800-377-4950

Website: https://oig.hhs.gov/fraud/report-fraud/

Disciplinary Guidelines

Banner Medicare Advantage may identify a contracted provider that is conducting Health Plan business in a manner that is not compliant with Medicare rules, regulations, or requirements; this will be identified as a non-compliant event. If this occurs, Banner Medicare Advantage may take the following disciplinary action:

- Provide education
- Issue a Corrective Action Plan
- Contract sanction
- Immediate contract termination

Section 4 – Grievances and Appeals

Grievances

Any complaint or dispute, other than an organization determination, expressing dissatisfaction. An enrollee or their authorized representative may make the complaint or dispute, either orally or in writing. An Appointment of Representative (AOR) form must be on file for the authorized representative to grieve for the member.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. A grievance must be filed within 60 days of the event and be submitted in writing through mail, fax or email. An oral grievance may also be filed by calling our Customer Care Center.

A standard grievance will be reviewed, and a response will be provided within 30 days of receipt. If an extension is required, Banner Medicare Advantage will call the member for approval of a 14-day extension. If accepted, the grievance resolution will be provided within 44 days of receipt.

Expedited (fast) Grievance

An expedited (fast) grievance may be submitted as a complaint against the health plan for refusal to expedite an organization determination or reconsideration, or upon request of a 14-day extension. For expedited grievances a response will be provided within 24 hours of receipt.

Please submit your grievances, to:

Banner Medicare Advantage
Attn: Grievance & Appeals Department
5255 E. Williams Circle, Ste 2050
Tucson, AZ 85711

Banner Medicare Advantage Prime HMO: (844) 549-1857
Banner Medicare Advantage Plus PPO: (844) 549-1859
Banner Medicare Advantage Dual: (877) 874-3930

Fax: (866) 465-8340

Email: BUHPGrievances&Appeals@bannerhealth.com

If your grievance involves a quality of care issue you have a right to file a grievance with a Medicare Quality Improvement Organization (QIO). In the state of Arizona, the agency contracted for this service is:

Livanta, LLC
Phone: 1-877-588-1123
TTY: 1-855-887-6668
Fax for Appeals: 1-855-694-2929
Fax for all other reviews: 1-844-420-6672
Website: https://www.livantaqio.com/en/states/arizona

Organization Determination

Any determination made by the Health Plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post- stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Health Plan that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished arranged for, or reimbursed by the Health Plan;
- The Health Plan's refusal to provide or pay for services, in whole or in part, including the type or level of

- services, that the enrollee believes should be furnished or arranged for the Health Plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Health Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Coverage Determination

Any decision made by or on behalf of the Health Plan regarding payments or benefits to which an enrollee believes he or she is entitled.

Reconsideration

Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service.

An appeal must be filed in writing within 60 calendar days from the date of the notice of the organization or coverage determination. An enrollee, an enrollee's representative or a non-contracted physician or provider may request that the determination be reconsidered. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

When a non-contracted physician or provider seeks a standard reconsideration, for purposes of obtaining payment only, then the non-contracted physician or provider must submit a signed waiver of liability, i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service. The non-contracted physician or provider can obtain a Waiver of Liability in the "Downloads" section at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

Filing a (Part C) Reconsideration

You may also call the Customer Care Center and ask to speak to an Appeals Department representative to file an oral appeal or you may also submit your request by fax or via email. Banner Medicare Advantage may request additional medical information, if necessary, to complete the appeal review. The appeals will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review.

The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person or in writing. Banner Medicare Advantage will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request.

Pre-Service Reconsiderations Timeframes

Standard appeals for a pre-service request will be resolved as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the request is received by Banner Medicare Advantage. The time frame may be extended by up to 14 calendar days with the members approval if the enrollee requests the extension or if Banner Medicare Advantage requires additional information and the delay is in the best interest of the enrollee.

Expedited Pre- Service Reconsiderations Timeframes

An expedited reconsideration request not supported by the physician will be reviewed to determine if the life or health of the enrollee, or the enrollee's ability to regain maximum function could be seriously jeopardized by applying the standard time frame. If the request is approved, Banner Medicare Advantage will resolve the request no later than 72 hours after receiving the request, unless an extension is required. If the request is not approved, Banner Medicare Advantage will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal was automatically transferred to the standard processing timeframes.

Claim Payment Reconsiderations

Will be resolved no later than 60 calendar days from the date the request is received by Banner Medicare Advantage. The expedited appeal process is not available for payment requests.

Claims payment reconsiderations will not be accepted verbally.

All reconsideration requests should include a cover letter indicating your reason for filing the claim dispute and please include the following information in your letter:

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service;
- Denial reason;
- Reason for appeal;
- A copy of Banner Medicare Advantage's Remittance Advice or Pre-Service Denial notice;
- Any additional documentation that supports your appeal
- All redeterminations must be submitted individually with all required information and/or documentation.

Independent Review for Reconsiderations (Part C)

Banner Medicare Advantage decides to uphold the original adverse decision, either in whole or in part, the Health Plan will automatically forward the entire file to the Independent Review Entity (IRE) for anew and impartial review. In addition, the Health Plan will also forward the entire file to IRE if the notice of decision is not provided within the required timeframe. Banner Medicare Advantage must send IRE the file within 30 days of the request for services and 60 days of a request for payment. MAXIMUS is CMS's independent contractor for appeal reviews involving Medicare Advantage plans.

Banner Medicare Advantage will notify the interested parties that the file has been forwarded for review. For cases submitted for review, IRE will make a reconsideration decision and notify the appellant in writing of their decision. If IRE decides in favor of the appellant, Banner Medicare Advantage must pay for, provide or authorize the service as expeditiously as the member's health condition requires, but no later than 14 calendar days from the date it receives notice that the IRE reversed the determination and 72 hours for expedited reviews. If IRE upholds Banner Medicare Advantage's decision, their notice will inform the member of rights to a hearing before an Administrative Law Judge (ALJ).

Any initial reconsideration decision made by the Plan, MAXIMUS, the ALJ or the MAC can be reopened by any party (a) within 12 months, (b) within 4 years for good cause in accordance with §120.3.

Redetermination

Banner Medicare Advantage may re-evaluate an adverse coverage determination, upon request by an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber on behalf of the member with his or her knowledge and approval. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

Filing a (Part D) Redetermination

You may call the Customer Care Center and ask to file an oral appeal. Banner Medicare Advantage may request additional medical information and the redetermination will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review. The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing. Banner Medicare Advantage will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member

or provider during the appeal process, upon request.

Standard Redetermination Timeframes

Standard redetermination will be resolved as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date the request is received by Banner Medicare Advantage.

Expedited Redetermination Timeframes

An expedited redetermination request will be reviewed when submitted by the enrollee or the enrollee's representative to determine whether the request indicates that the enrollee's life, health, or ability to regain maximum function could be jeopardized by applying the standard time frame for processing the request. If the request is not approved, Banner Medicare Advantage will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal will automatically transfer to the standard appeal processing timeframes.

Banner Medicare Advantage must provide written notice of its decision, whether favorable or adverse, as expeditiously as the enrollee's health condition requires, but no later than 24 hours from the date Banner Medicare Advantage receives the request for an expedited redetermination.

All adverse coverage determinations will include a copy of the "Request for Redetermination of Medicare Prescription Drug Denial" form. This CMS approved form can be used to file a (Part D) redetermination. If you don't have a copy, you can still submit a request in writing by providing the below information:

All Part D redetermination requests should include the following for faster processing:

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service, if applicable;
- Denial reason;
- Reason for appeal, include any additional documentation that supports your appeal;
- All redeterminations must be submitted individually with all required information and/or documentation.

Redetermination Denials- Next Steps

If you disagree with Banner Medicare Advantage's decision you have the right to request an independent review. You have 60 days from the date of Banner Medicare Advantage's Redetermination Notice to ask for an independent review for MAXIMUS.

Continuation of Benefits

Members have the right to receive continued benefits pending resolution of their appeal, continuation of benefits must be requested when filing the appeal. The member may be required to pay for the cost of these services if the appeal is denied.

Reopening's

Contracted providers have reopening rights, not appeal rights. A reopening is a review of a final determination or decision of a payment (claim) decision. Reasons available for reopening are:

- Mathematical or computational mistakes;
- Inaccurate data entry;
- Denials of claims as duplicates; or
- Additional evidence for consideration which was not available at the time of the decision.

Filing a Re-opening

A request for a re-opening must be submitted in writing, to the Grievance and Appeals Department.

The reopening request should include the following for faster processing:

- Member name, date of birth, ID number;
- Claim Number;
- Date of Service;
- The specific reason for requesting the reopening
- Any additional documentation that supports the request;
- All requests must be submitted individually with all required information and/or documentation.

Reopening Timeframes

A reopening must be submitted to Banner Medicare Advantage within:

- 1 year from the date of the determination or reconsideration;
- Within 4 years from the date of the determination or reconsideration for good cause; at any time if there exists reliable evidence that the determination was procured by fraud or similar fault;
- At any time if the determination is unfavorable, in whole or in part, but only for the purpose of correcting a clerical error on which the determination was based;
- At any time to effectuate a decision issued under the coverage (National Coverage Determination) appeals process.

Banner Medicare Advantage ensures that no punitive action will be taken against a provider who requests a reopening or supports a member's appeal.

Please submit all your reconsideration or reopening requests to:

Banner Medicare Advantage
Attn: Grievance & Appeals Department
5255 E. Williams Circle, Ste 2050
Tucson, AZ 85711

Banner Medicare Advantage Prime HMO: (844) 549-1857
Banner Medicare Advantage Plus PPO: (844) 549-1859
Banner Medicare Advantage Dual: (877) 874-3930

Fax: (866) 465-8340

Email: BUHPGrievances&Appeals@bannerhealth.com

Section 5 – Claims

It is Banner Medicare Advantage's (Banner Medicare Advantage) commitment to ensure claims payments are accurate and timely. The guidelines presented on the following pages contain information and instructions that should be followed in order to ensure timely and accurate payment. Claim Submission Guidelines

Submission of Claims

The Claims Department will adjudicate all properly submitted, authorized claims that meet "clean claims criteria" within 60 days of receipt unless otherwise stipulated in your contract. A claim is considered a "clean claim" if it is submitted on the appropriate form, contains the correct billing information according to CMS 1500, ADA 2002 and UB-04 requirements and has all the supporting documentation as required for medical and claims review. If any standard information is omitted on the claim, it may be denied or returned for correction. Handwritten claims may be accepted but require pre-approval. Claims with whiteout visible will not be accepted to protect you and us from potential instances of fraud. If the claim form is returned to the provider for correction without being adjudicated (i.e. entered into Banner Medicare Advantage's claim system), the original filing limit still applies from the date of service, not the date of return. These claim forms should be resubmitted with a copy of the original return letter attached. Detailed requirements for CMS 1500, ADA 2002 and UB-04 forms are in this section.

Providers must submit all claims for covered services provided to members within one hundred and twenty (120) days after the Covered Services are rendered, whether fee-for-service or capitation. Unless another timeframe is specified in your contract, claims initially received more than 120 days from the date of service will be denied.

Non-contracted providers must submit within six months from the date of service. Secondary claims must include a copy of the primary payer's remittance advice and be received within 60 days of the primary payer's remittance advice. Non-contracted providers have 60 days from date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

Acceptable proof of timely filing requirements must establish that Banner Medicare Advantage or its agent has received a claim or claim related correspondence.

Acceptable examples of proof of timely filing include:

- Signed courier routing form documenting specific documents contained
- Certified mail receipt that can be specifically tied to a claim or related correspondence
- Successful fax transmittal confirmation sheet documenting the specific documents faxed

Acceptable confirmation report from the appropriate clearing house Unacceptable examples of proof of timely filing include:

- Provider billing history
- Any form or receipt that cannot be specifically tied to a claim or related correspondence

Claims initially received outside of the timely filing deadlines will be denied as Past Filing Deadline (PFD). The deadline will be determined by the ending date of service for claims involving hospitalization. If a claim is accepted but denied for a reason which can be corrected and resubmitted, the claim form should be resubmitted following the resubmission guidelines.

Medical Claims Submission Information

Banner Medicare Advantage Prime HMO
P.O. Box 35769
Phoenix, AZ 85021-9998
Electronic Payor ID: 16664

Banner Medicare Advantage Plus PPO
Address: P.O. Box 35277

Phoenix, AZ 85021-9998
Electronic Payor ID: 16663

Banner Medicare Advantage Dual
P.O. Box 38549
Phoenix, AZ 85021-9998
Electronic Payor ID: 09830

Electronic Data Interchange (EDI)

Banner Medicare Advantage encourages providers to submit their claims electronically. Claims may be submitted electronically through your clearinghouse to one of our EDI partners. Please contact your Provider Relations Representative or Customer Care for more information.

Banner Medicare Advantage Plus PPO (Banner Medicare Advantage): 16663

Banner Medicare Advantage Prime HMO (Banner Medicare Advantage): 16664

Banner Medicare Advantage Dual HMO D-SNP: 09830

Duplicate Claims

Please allow 14 days following the initial submission to validate claims status and allow 60 days prior to resubmitting your claim. This allows Banner Medicare Advantage time to pay the claim and enough time for your staff to post the payment. This practice will decrease the volume of duplicate claims and reduce processing times and administrative costs.

Resubmissions

A resubmission is a claim previously denied due to unclean claim status, billing corrections, supporting documentation and/or the need for review due to an error in payment. Resubmitted claims are not considered grievances or appeals and will not be treated as such. The following documentation is required when filing resubmissions to the Claims Department:

- Clean, corrected claim with "resubmission" clearly marked on the claim with the original claim number. Claims corrections with writing, white out or marker cannot be accepted with the exception of handwriting "Resubmission", or in those instances where handwritten claims were pre-approved.
- Supporting documentation if needed.
- Brief explanation of the correction needed

The claim must be clearly marked as a resubmission. The word "resubmission" and/or the original claim number must be written on the front of the CMS 1500 (box 22), UB-04 (box 84) or ADA 2002 (box 35) claim form. When resubmitting a claim previously filed electronically, a paper claim can be resubmitted. Electronic resubmissions must reference the original claim number in the Loop 2300 ElementREF02.

Resubmissions must be received within one (1) year from the date of discharge or date of service. Claims not received within the timeline will be denied as Past Filing Deadline.

Coordination of Benefits and Third-Party Recoveries

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

i. first bill the primary payer;

ii. share with Banner Medicare Advantage the information regarding the primary payer; and

iii. report to Banner all third-party recoveries received by Provider as a result of providing Covered Services to the Member.

At Banner Medicare Advantage's request, Provider agrees to complete any and all necessary forms and consents to permit Banner to bill and process forms from other payers, if necessary, where the Plan is determined to be secondary. Provider further agrees that Plan will be billed on a secondary basis for Covered Services on the

balance due, only after Provider has received reimbursement from the primary payer. However, in no event will payment be made if Provider would receive combined payments in excess of the amount Provider would have received for services rendered to a Member solely under the applicable Plan coverage. Provider further agrees to cooperate in Plan's subrogation, workers' compensation, and other third-party recovery programs to the extent permitted by applicable law.

Provider Experience Center Representatives

The Provider Experience Center Representatives are available to providers to answer questions regarding claims submissions and to assist in resolving problems and issues regarding the status of a claim. The representatives will explain claim adjudication and assist in tracking the disposition of specific claims. The Provider Experience Center Representatives can also assist in identifying and correcting claim processing errors.

The Provider Experience Center Representatives are not able to correct a provider error in claims preparation and submission. The Provider must resubmit claims requiring corrected information. Corrected claims must be submitted per the resubmission guidelines.

The Provider Experience Center Representatives may be contacted Monday through Friday. Your call may be answered by our automated service. Please leave a message and your call will be returned within 48 hours.

Current and Accurate Provider Information

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Banner Medicare Advantage for payment of covered services. It is important that providers ensure Banner Medicare Advantage has accurate billing information on file. Please confirm that the following information is current in our files:

- Provider Name (as noted on his/her current W-9 form)
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- Tax Identification Number
- Provider NPI

Providers must bill with their NPI in box 24J. Banner Medicare Advantage returns claims when billing information does not match the information that is currently in our files. Claims missing the requirements in bold will be returned, and a notice sent to the provider. Such claims are not considered "clean" and therefore cannot be entered into the system.

Update Billing Information

We recommend that providers notify Banner Medicare Advantage in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit on the date of service
- Referral and prior authorization processes were followed

Claims Forms Instructions

Instructions for CMS 1500s Claim Form

A CMS-1500 claim form should be used to bill for non-facility services, including professional services, transportation and durable medical equipment. Claims received April 1, 2014 and after must be submitted on the

revised CMS-1500 Claim Form (version 02-12). Claims submitted on the old claim form will be denied.

Instructions for UB-04 Claim Form

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, emergency room, hospital- based clinic charges, pharmacy charges for services provided as part of a hospital service. Dialysis clinic, nursing home, home health (dependent on the product line), freestanding birthing center, ambulatory surgery center, residential treatment center, and hospice services also are billed on the UB- 04.

Imaging Requirements for Paper Claims

Banner Medicare Advantage uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12", or larger envelope
- Do type all fields completely and correctly
- Do use black or blue font color only
- Do submit on a proper form . . . CMS 1500 or UB 04
- Claim form MUST BE RED AND WHITE

Don'ts

- Don't submit handwritten claim forms
- Don't use red font on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't use "whiteout" or correction tape/fluid
- Don't cross out, cross through, or alter information to avoid fraud

Encounters versus Claims

What is an Encounter Versus a Claim?

You are required to submit an encounter or claim for each service that you render to a Banner Medicare Advantage member.

If you are the PCP for a Banner Medicare Advantage member and receive a monthly capitation amount for services, you must file a "proxy claim" (also referred to as an "encounter") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the "proxy claim" or "encounter" is paid at zero-dollar amounts. It is mandatory that your office submits all encounter data.

Banner Medicare Advantage utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by AHCCCS and by Centers for Medicare and Medicaid Services (CMS).

- A claim is a request for reimbursement submitted either electronically or by paper for any medical

service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial.

- For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim

Remittance Advice

Remittance Advice uses the information from your claim and the information from the claims processing system used by Banner Medicare Advantage to provide you information specific to each claim you submitted. You can access this information electronically, or obtain a paper version with your paper check, to help you reconcile your outstanding accounts receivable to what the health plan determined for each claim. NOTE- if you have access to Change Healthcare 's ECHO system, you can access copies of your paper RA as well.

Remittance Notices (also known as an RA or Explanation of Benefits –EOB)

Checks and electronic funds transfers (EFT) are processed on a minimum of a bi-weekly basis. Written and electronic notice of claims payment or denial will be reported on your remittance advice or 835 file based on your contract with the Health Plan. The Health Plan has a partnership with Change Health\ Echo, where providers are given access to ProviderPayments.com. This is a 24/7 accessible website that contains Remittance Advice, EOB, EFT/ ERA Information.

Section 6 – Referrals and Prior Authorization

Definitions

Prior Authorization Form	The form used to request Prior Authorizations, notify specialty care providers or the Health Plan of referrals.
Referral	Services that are outside the scope of the Primary Care Provider may be referred to a contracted specialty care provider.
No Notification	If no notification to the Health Plan is required, the Primary Care Provider will provide written instructions (i.e. note on prescription pad) and applicable test results and other applicable documents to the specialty care provider.
Prior Authorization	If Prior Authorization is required the Primary Care Provider or specialty care provider will complete the Prior Authorization Form, attach supporting documentation and fax to the Prior Authorization Department. Some medications (including non-generic medications) require Prior Authorization. For Prior Authorization please complete a non-formulary drug and fax to the Hospital and Pharmacy Coordinator.

Although administration of chemotherapy does not require Prior Authorization, in some cases the chemotherapy drugs may. Please contact Pharmacy Prior Authorization to assist in that determination.

General Guidelines

1. The Primary Care Provider is the coordinator for medical services. For services requiring authorization, all providers must receive Prior Authorization BEFORE rendering services to member. The Prior Authorization Guidelines follow in this section. Please call your Provider Relations Representative if you would like a copy of any guideline.
    a. Primary care physicians, specialists, hospitals and vendors should fax Prior Authorization requests to the Prior Authorization Department.
    b. If PA is not required, per the Prior Authorization Grid, the primary care physician must refer the patient with a form of written instruction (i.e. note on prescription pad or Referral Form) with reason for visit (consult only – consult & treat, diagnosis, findings, etc.) to present to the specialty care provider.
    c. Specialty care providers must obtain Prior Authorization from the Prior Authorization Department for all services as listed on the Prior Authorization Grid.
        - Referrals and Prior Authorizations are typically valid for at least 90 days from the date of the request. Length of approval is dependent upon the medical condition being treated.
        - All providers should verify a member's eligibility on the day services are rendered. Contact the Customer Care Center to verify a member's eligibility. A Prior Authorization is not a guarantee of payment.
        - All inpatient admissions must be called or faxed to the Utilization Management department.
        - All referral requests must be to contracted providers. Contact the Provider Experience Center to verify that a provider is contracted. **All referrals to non-**

contracted providers must have prior authorization through the prior authorization department.

- Members inquiring about the status of a referral should contact the requesting provider's office. The provider should call the Prior Authorization line for information.
- Requests for planned admissions, elective surgery/procedures, and specialist appointments that require authorization should be sent at least two weeks in advance whenever possible.
- Determinations for requested services will be made within the following timeframes:
    - Medicare members, standard requests will be completed within 14 calendar days from receipt of the request, unless an extension is requested by the Health Plan.
    - Medicare members, standard Part B medication requests will be completed within 72 hours from the time of request. Extensions cannot be granted.
    - Medicare members, expedited requests will be completed within 72 hours from the time of receipt of the request.
    - Medicare members, expedited Part B medication requests will be completed within 24 hours from the time of request. Extensions cannot be granted.
- To ensure timelines of determinations for your request, please submit clinical notes to support the services you are requesting. All Prior Authorization referrals must be submitted with supporting documentation and completed Prior Authorization form.
- Members may have a second opinion from a qualified health care professional within the network, or out of network if there is not one available in network. Prior Authorization is required for out of network referrals.

Outpatient Services, Planned, Hospital Admissions

Prior Authorization is required for many outpatient services. All planned hospital admissions require Prior Authorization. The notification requirements may vary depending upon the members plan. Please check with your assigned Provider Relations Representative for notification requirements. All Unplanned and Planned hospitalizations require Notification to the Utilization Management Department must be provided within 24 hours of inpatient admission status. If the required notification day falls on a weekend or State holiday, notification must be provided no later than the next business day.

Medical Records

Upon the request for medical records from the concurrent review nurse, medical records must be received within 24 hours of request or may be subject to denial of day, until records are received. If the required notification day falls on a weekend or State holiday, notification must be provided no later than the next business day. Utilization Fax Number: (520) 874-3420.

To Request a Medical Prior Authorization

Fax a completed prior authorization form to: (520) 874-3418 or (866) 210-0512.

Making Referrals to Specialists

Primary care physicians are responsible for making appropriate referrals to specialty care providers when members have medical needs the PCP cannot reasonably be expected to treat. Primary care physicians

should refer members to specialty care providers who are part of the provider network. Please call your Provider Relations Representative if you need additional information about our contracted provider network or you may access an updated Provider Directory on the plan specific websites.

Services Requiring Prior Authorization

The Prior Authorization Grid is your source for determining what services require Prior Authorization. The Prior Authorization grid can be found at www.BannerMA.com. Be sure to reference the date of the grid since revisions to the grid may occur.

Prior Authorization Form Completion

The referring provider, during business hours, may obtain Prior Authorization by faxing the pre-printed referral form or calling the Prior Authorization Department. Administrator-on-call will respond after-hours and on weekends. Prior Authorization is staffed 24 hours per day, 7 days per week with both professionals and para- professionals. Referring providers must use the pre-printed referral forms. Prior Authorization can only be given for services that will be provided to eligible and enrolled members.

The following information is required on the referral form:

a. **DATE:** The date the Prior Authorization form is initiated.

b. **REQUESTING PROVIDER:** Name of the provider requesting the Prior Authorization.

c. **PCP:** Name of Primary Care Provider if different from requesting provider.

d. **OFFICE CONTACT:** Name of office staff personnel completing Prior Authorization Form. This should be a staff member that can be contacted by the Prior Authorization Nurses for further information. Staff member's direct phone, fax and office address are required.

e. **PRIORITY:** Check either Standard or Expedited. Please note: Providers should use "Expedited" ONLY when medically necessary. Inappropriate use of the "Expedited" request may cause PA to be down-graded to Standard if appropriate.

f. **MEMBER NAME:** Name of patient

g. **DATE OF BIRTH:** Birth date of member

h. **MEMBER ID#:** The identification number of the member found on member's ID card.

i. **SPECIALIST CONSULT TO:** Name of specialist being referred to (if applicable)

j. **SPECIALIST LOCATION:** Address of specialist (if applicable)

k. **NAME OF PROCEDURE:** Be specific and include all CPT codes and descriptions applying to the requested services. Indicate estimated length of stay for inpatient procedures.

l. **CONTRACTED FACILITY TO BE USED:** Place where procedure will take place

m. **DATE SCHEDULED (IF KNOWN):** Date procedure is scheduled for. Note: It is not recommended that procedures be scheduled prior to receipt of Prior Authorization.

n. **ANCILLARY SERVICE REQUEST:** If requesting an ancillary service, please check the appropriate box.

o. **DIAGNOSIS/ICD-10 CODE:** Include both the description and the code numbers

p. **PROCEDURE/CPT CODE:** Include all CPT codes that apply to the procedure listed above

q. **COMMENTS:** Please include any comments pertinent to this request

r. **RESPONSE:** This section is for the Health Plan use only. Please do not mark in this section.

All parties have the right to submit a grievance or an appeal. To initiate a grievance or appeal contact the Health Plan by calling Customer Care to get the specific timeframes and processes.

Continuity of Care:

In compliance with the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2024, Banner Medicare Advantage will provide new members up to a 90-day transition period when a member is undergoing an active course of treatment and switches from a previous Medicare Advantage plan or Medicare Fee for Service to a Banner Medicare Advantage plan. If a member has newly enrolled with Medicare and joins a Banner Medicare Advantage plan the transition policy will also apply. The option to request extended coverage up to 90 days from their previous benefit, out-of-network health care professional at network rates for a limited time due to a specific medical condition, until the safe transfer to a network health care professional can be arranged. BMA members may access the continuity of care form on our website.

Examples of medical conditions that may qualify for Continuity of Care includes, but is not limited to:

- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery).
- Pregnant and undergoing a course of treatment for pregnancy. – Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select an in network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.
- Serious acute conditions in active treatment such as heart attacks or strokes.
- Other serious chronic conditions that require active treatment.

Medicare Benefit Coverage

Medicare Advantage plans are required by CMS to provide the same medical benefits to Medicare Advantage members as original Medicare. As such, whenever possible, Medicare Advantage medical necessity decisions are based on general coverage and benefit conditions included in traditional Medicare coverage manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) used in conjunction with an LCD, when available.

If there is no applicable NCD, LCD, or LCA (used in concert with an LCD), for the service under review, then other evidence-based criteria may be applied. In addition, each member's unique clinical situation is considered in conjunction with current CMS guidelines. The following hierarchy is used to determine Medicare Advantage Medical Policy:

1. CMS Coverage Manuals or other CMS-Based Resource: Coverage provisions in interpretive manuals are instructions that are used to further define when and under what circumstances items or services may be covered (or not covered)
2. National Coverage Determinations (NCD)
    a. Local Coverage Determinations (LCD)
    b. Local Coverage Articles (LCA), when used on conjunction with LCD
3. In the absence of an applicable NCD, LCD, or other CMS published guidance, Banner Medicare Advantage plan(s) utilizes third party clinical guidelines that reflect the Generally Accepted Standards of Medical Practice scientific evidence.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical

community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. These guidelines are based on current evidence in widely used treatment guidelines or clinical literature. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta analyses summarizing the literature of the specific clinical question.

Section 7 – Quality

Reporting

Incidents, Accidents and Deaths Reporting

Banner Medicare Advantage requires its providers to report all incidents of abuse, neglect, exploitation, suicide attempts, unexpected deaths, human rights violations, healthcare acquired conditions (HCAC) and other provider preventable conditions (OPPC) to Banner Medicare Advantage.

Banner Medicare Advantage providers are required to report to Banner Medicare Advantage and proper authorities all cases of abuse and neglect incidents, injuries (e.g., falls and fractures), allegations of exploitation, HCACs, OPPCs, and/or unexpected deaths as soon as the providers are aware of such incidents.

Banner Medicare Advantage Quality Management (QM) Department is the Plan's central repository for all member incidents. These are inclusive of the following:

1. Deaths;
2. Medication error(s)/ Adverse Drug Events;
3. Abuse or neglect allegation made about staff member(s);
4. Suicide attempt;
5. Self-inflicted injury;
6. Injury requiring emergency treatment;
7. Physical injury that occurs as the result of personal, chemical, or mechanical restraint;
8. Unauthorized absence from a licensed behavioral health facility, group home of children or recipients under court order for treatment;
9. Suspected or alleged criminal activity;
10. Discovery that a client, staff member, or employee has a communicable disease.
11. In cases of abuse of a member, providers must report these to the police and/or Adult or Child Protective Services as required by statute.
12. Banner Medicare Advantage requires all providers to answer questions that may arise after Banner Medicare Advantage Quality Team reviews.
13. Banner Medicare Advantage requires all providers to attend to and respond to improvement/corrective actions arising from its review of Incidents that may warrant improvement/corrective action.

Reporting Quality of Care Concerns

Quality of Care Concerns

It is Banner Medicare Advantage policy to investigate and resolve potential quality of care concerns, or allegations of abuse raised by enrolled members (and/or their guardian or representative), contracted providers, and others in a timely manner. Potential quality of care concerns may also include quality of service concerns that have the potential to impact care.

Referral of Potential Quality of Care Concerns:

Potential quality of care concerns may be received or identified throughout the organization, delegated entities as well as from external organizations

Any potential quality of care concerns, which are reported through the above various avenues are then

routed to the Health Plan's QM Department by internal email/referral through Care Management Module, through Grievance department, or other appropriate avenue in compliance with HIPAA.

Quality of Care Investigation Process:

1. Immediate jeopardy:
    a. If the event of immediate jeopardy where the member's health and safety is at risk, or has the potential to cause the member serious injury, harm or impairment, the Director Quality of Management will be notified immediately and is responsible for coordinating the health plan's response;
    b. Health and Safety and Immediate Jeopardy On-site visits are unannounced and QM staff is to be present and leading on-site visits. Providers are to welcome these staff and grant access to the Health Plans members, their medical records and to a staff person who can answer any of the questions posed by the Quality of Care Staff.
    c. Immediate jeopardy affecting multiple members could provoke the implementation of the business continuity plan, and involve a multi -department coordinated effort to minimize the risk of jeopardizing the health and safety of members;
    d. Immediate jeopardy of an individual member will result in immediate action by the health plan to minimize the risk of the health and safety of members, e.g., if the quality of care delivered by a facility places member in immediate jeopardy the health plan will coordinate alternative placements.

Severity of quality of care issues are categorized as follows:

1. Not a potential quality of care issue. Track and Trend Level 0: No Quality Issue Finding
2. Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/ recipient
3. 3. Level II: Quality issue exists with significant potential for adverse effects to the patient/ recipient if not resolved timely.
4. Level III: Quality issue exists with significant adverse effects on the patient/ recipient, is dangerous and / or life threatening.
5. Level IV: Quality issue exists with the most severe adverse effects on the patient/recipient, no longer impacts the patient/recipient with the potential to cause harm to others.

Substantiation

1. Any case leveled "1" or greater is considered substantiated.
2. All Substantiated case receive a Determination of the recommended Interventions to resolve the issue.

Corrective Action Plans

Providers are required to submit a Corrective Action when needed, this may include all or any of the following:

1. Corrective action plan(s) or action(s) taken to resolve the concern and/or to reduce/eliminate the likelihood of the issue reoccurring
2. Documentation that education/training was completed.
3. Assigning new interventions/approaches when necessary. These may include, but are not limited to:

4. In-service attendance sheets and training objectives,
5. New policies and/or procedures, and
6. Follow - up with the member that includes, but is not limited to:
7. Providing assistance as needed to ensure that the immediate health care needs are met,
8. Determining, implementing and documenting appropriate interventions,
9. Monitoring and documenting the success of the interventions,
10. Incorporating interventions into the organization's Quality Management (QM) program if successful.

Section 8 – Dental Care Services

Overview

DentaQuest is delegated for the benefit administration of dental services for the Banner Medicare Advantage members.

DentaQuest is responsible for contracting with all dental providers, including clinics, and providing necessary authorizations and utilization management. Additionally, DentaQuest will process all dental claims, except claim disputes, which should be sent to the Health Plan for processing, conduct some oversight of quality of care and provide all dental network communications and provider education.

Submit Dental Claims to:

DentaQuest of AZ, LLC
PO Box 2906
Milwaukee, WI 53201-2906

To submit claims electronically via eclaims, the Payor ID: CX014

Dedicated telephone line: 1-800-440-3408

DentaQuest Contact: 1-800-341-8478 or www.dentaquest.com

Please note: Outpatient and Anesthetic medical prior authorizations related to dental care will continue to be managed by the Health Plans.

Section 9 – Pharmacy Benefit/Drug Formulary

The Banner Medicare Advantage (Banner Medicare Advantage) the Drug Formulary is available on the plan specific websites. If a printed copy is needed, please contact your provider representative. Non-formulary drugs are not covered without prior authorization and documentation in the patient's medical record that a formulary drug is ineffective or cannot be taken due to an adverse reaction.

If a provider supplies sample medication to a member and the medication is not on the formulary, the provider must be willing to:

Convert the patient to a formulary medication, or Continue providing samples for the patient's use

Note: Provider shall obtain approval before prescribing medications in accordance with prior authorization policy.

The formulary process is ongoing with changes occurring at any time. For questions about formulary medications, please call Provider Experience Center Representatives.

The comprehensive formulary for each plan can be found at https://www.BannerMA.com.

Prior Authorization Required

Prior authorization may be required:

- If the drug is not included on the formulary
- If the drug is included on the formulary but has utilization management criteria such as prior authorization, quantity limits, or step therapy

For Banner Medicare Advantage members, decisions will be rendered on prior authorization requests within 24 hours for expedited requests and 72 hours for standard requests.

In instances where a prescription is written for drugs not on the formulary, the pharmacy may contact the prescriber to either request an alternative or to advise the prescriber that prior authorization is required for non-covered drugs.

Prior authorization requests submitted for review must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited, to the following:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes.
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- The following references may be used in the evaluation of the request including Drug Facts and Comparisons, American Hospital Formulary Service Drug Information, DRUGDEX Information System, and UpToDate.

To Request a Pharmacy Prior Authorization

Fax a completed Pharmacy Prior Authorization Form to: 1-858-357-2541

Section 10 – Eligibility and Enrollment

Banner Medicare Advantage (Banner Medicare Advantage) issues an identification card for Banner Medicare Advantage when a member becomes eligible for benefits. This card includes the following information:

- Member's name,
- Identification number
- Health Plan name
- Pharmacy Information
- Claims Mailing Address

To verify a member's eligibility, Providers can use the plastic identification card with the Medifax system, the Health Plan website, and the Customer Care Center at:

- Banner Medicare Advantage Prime: (844) 549-1857; TTY 711
- Banner Medicare Advantage Plus: (844) 549-1859; TTY 711
- Banner Medicare Advantage Dual: (877) 874-3930, TTY 711

Please remember it is the provider's responsibility to verify eligibility and benefits prior to providing services.

Providers should always verify a member's PCP assignment by calling the Provider Experience Center Representatives or by visiting eServices.

You may determine a member's eligibility in the following ways:

- Providers who are electronically linked to the Health Plan computer system will have access to daily membership updates.
- PCP's will receive a member roster on a regular basis. However, the Customer Care Center can provide the most current member eligibility information

Eligibility can also be verified at the Health Plan specific websites. Choose the Providers Services and then check Enrollment Inquiry. Providers must register for this service. This service is provided at no charge.

Appendix – Banner Medicare Advantage Dual Specific

Please note, this section of the provider manual for **Banner Medicare Advantage Dual requirements only.**

Special Needs Plans Background

Special Needs Plans (SNPs) were created by the Medicare Modernization Action (MMA) of 2003. The MMA authorized SNPs to limit enrollment to specific vulnerable populations.

- Chronic Condition (C-SNP)
- Dual Eligible (D-SNP)
- Institutional(I-SNP)

Banner Medicare Advantage manages the D-SNP plan (eligible for both Medicaid and Medicare). Banner Medicare Advantage serves dual eligible members residing in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Yuma, and Santa Cruz counties.

Model of Care

SNP plans were mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to have a Model of Care (MOC) to ensure that these vulnerable populations receive the care and services necessary to help them manage and improve their health status. The MOC is the framework for Provider Network, Case Management, Quality Management policies, procedures, and operational systems. The MOC sets guidelines for:

- Description of the SNP Population: that includes a complete description of the most vulnerable beneficiaries;
- Care Coordination: the health plan's staff structure, completion of the health risk assessment tool, individualized care plans, the interdisciplinary care team, and care transition protocols;
- SNP Provider Network: detailed description of the specialized expertise available to the beneficiaries, provider use of appropriate clinical practice guidelines and nationally recognized protocols, and provider training on the Model of Care;
- Quality Measurement & performance Improvement: a quality performance improvement plan, measurable goals, and health outcomes, measuring patient experience of care, ongoing performance improvement evaluation, and dissemination of SNP quality performance.

Through the MOC every member is evaluated annually via a Health Risk Assessment. The Interdisciplinary Care Team (ICT) works with members, caregivers, and families as appropriate in order to develop an individualized Plan of Care that meets each member's needs. Through the assessment process members are also directed to the appropriate Banner – Medicare Advantage case management program. The case managers and PCPs work closely together to monitor the member's progress against the goals established in the Plan of Care. The case managers also work to help members identify problems and barriers to care, provide health education, coach members, and offer community resources when appropriate.

The partnership with the providers is a critical component to the success of the MOC. The MOC offers the opportunity for Banner Medicare Advantage and providers to work together to benefit our members, your patients.

The Providers Role in the Model of Care

As a contracted provider, you play an important role in the delivery of the MOC. As a key partner in the MOC your role is to:

- Know who your SNP members are
- Outreach and assist members with scheduling the annual wellness visit

- Communicate with the case managers regarding the care needs of your member
- Collaborate with the ICT as needed
- Contribute to the development of the member's Plan of Care
- Maintain the Plan of Care as part of the member's medical record
- Assist the member to navigate the health care delivery system, including transition of care

Banner Medicare Advantage has developed a comprehensive MOC document which includes information on all the required elements. Below is a summary of the approach Banner Medicare Advantage has taken in implementing the MOC for the D-SNP plan.

- Description of SNP Population:
    - Dual eligible: members qualify for both Medicare and Medicaid;
    - Younger in comparison to the general Medicare population and tend to be single;
    - A larger percentage of minority members;
    - A population that has a high poverty rate;
    - Typically, in poor physical and mental health;
    - Over half of the population have four (4) or more chronic medical conditions;
    - Over half of the population have a positive screen for depression.
- SNP Model of Care Coordination:
    - Qualified personnel responsible for enrollment, coordination of benefits and assist with access to care;
    - Utilization of a comprehensive health Risk Assessment tool to measure all aspects of the member's physical health, cognitive status, medication regimen, medical history, surgical history, behavioral health status, cultural preferences, linguistic needs, pregnancy state, nutrition status, functional need and psychosocial needs;
    - A team of staff review, analyze and stratifies the health care needs of the members;
    - All members are assigned a case manager who oversees the member's needs and assists with the development of the individualized care plan.
    - The health plan utilizes HRAs, Medical Risk Assessments, utilization claims data, pharmacy data, input from providers, and predictive modeling with a goal of creating an Individualized Care Plan (ICP) for each enrollee.
    - The patient's primary physician is notified via phone, mail, fax or electronically if there are changes to the ICP that they need to be aware of.
    - Provide coordinated planned and unplanned care transitions for the members with the transition of care team as the assigned primary contact for the member and caregiver.
- SNP Provider Network
    - Banner Medicare Advantage ensures that all contracted providers are vetted through a credentialing review process. Banner Medicare Advantage contracts with a full spectrum of medical specialists, sub specialists, inpatient facilities, dialysis facilities, pharmacies, PCPs, nursing professionals, outpatient clinics, durable medical equipment (DME) vendors, behavioral health professionals, and other health services providers.
    - Banner Medicare Advantage supports physician management of chronic conditions my disseminating best practice, and evidence-based guidelines to promote the delivery of quality care

to our members.

- Banner Medicare Advantage monitors the network on a bi-annual basis to assess, address and manage beneficiaries' access to care and ensure that the needs are met.
- Network Development utilizes GeoNetworks to ensure covered services are provided promptly and are reasonably accessible in terms of locations and hours of operation. Ninety-five percent of current members travel 5 miles or less to reach a contracted PCP or dentist.
- The PCP is the gatekeeper for members and directs services for the members.
- The health plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols. The health plan relies on both nationally recognized evidenced based medical tools such as Milliman and Hayes and our clinical practice guidelines which are based upon nationally accepted standards.

- Quality Measurement and Performance Improvement
  - Banner Medicare Advantage uses standardized quality improvement outcome and process measure to assess the performance of the Model of Care and measure member health improvements. Sources for this data include but is not limited to:
    - Healthcare Effectiveness Data and Information Set (HEDIS)
    - Chronic Condition Improvement Programs (CCIP);
    - Health Outcome Survey (HOS)
    - Consumer Assessment of Health Plan and Provider Survey (CAHPS)
    - Utilization metrics
  - HEDIS: Quality Management works closely with the assigned PCP to assure the member receives needed preventative health and wellness services;
  - CCIP: the health plan offers a disease management program to assist the members manage their chronic health condition;
  - QIPs: the health plan participates in national quality improvement projects overseen by CMS, such as the reduction in hospital readmissions.
  - HOS: Quality Management assesses the members self-reported physical and mental health assessment over time and initiates quality improvement projects to improve the member's health.
  - CAHPS: Annually the SNP members are surveyed by CMS about:
    - How quickly they receive care;
    - Getting needed care
    - Care coordination
    - Overall rating of their health care
    - Care coordination
    - Getting needed prescription drugs.
    - Communication with their doctor
    - Rating of specialists

Summary

Banner Medicare Advantage's Model of Care for D-SNP members provides a comprehensive process and infrastructure to meet the unique needs of our dual eligible population. Through the establishment of

measurable goals, the delivery of care through a specialized network of provider, and services Banner Medicare Advantage can ensure that members receive needed care. In addition, through the assessment, interdisciplinary care team and case management services, Banner Medicare Advantage is able to provide individualized care that meets the unique medical, psychosocial, and functional needs of our members. If you would like more information about the Model of Care for request a copy of the Model of Care document, please contact your Care Transformation Consultant.

Cost Share:

Providers must adopt measures to protect dually eligible enrollees from improper billing and educate network providers about applicable billing requirements. All providers and suppliers, including pharmacies, must refrain from collecting Medicare cost sharing for Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) program, a dually eligible program which exempts individuals from Medicare cost-sharing liability. (42 C.F.R. § 422.504(g)(1)(iii)

Customer Care Center

Banner Medicare Advantage Prime:
(844) 549-1857 | TTY 711

Banner Medicare Advantage Plus:
(800) 549-1859 | TTY 711

Banner Medicare Advantage Dual:
(877) 874-3930 | TTY 711

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