2019 Provider Manual

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Provider Reference Guide

Devoted HEALTH PLANS

Prior Authorizations & Referrals

Select **"Authorizations/Referrals"** then **"Devoted Health"** as the payer

REFERRALS

Choose **"Service & Procedure Authorizations"** and then select **"Referral"** as the Service Type. You will be given an Authorization Number to be used as the Referral ID — you must provide the specialist with this ID.

PRIOR AUTHORIZATIONS

We will post approvals in Availity, and will call you if we need more information.

Or, you can fax requests to 1-877-264-3872.

For a list of services requiring prior authorization, or to refer an out-of-network provider, contact us at 1-877-762-3515.

Claims Submission

ELECTRONIC

PAPER

Devoted Health, Inc.
Attn: Claims
P.O. Box 540069
Waltham, MA 02454

Member Eligibility Status

EFT Services

Contact Us

PROVIDER SERVICES

1-877-762-3515

For questions about your Devoted patients

PROVIDER INFO UPDATES

provider-updates@devoted.com

For changes to your providers or locations

CREDENTIALING

credentialing@devoted.com

FRAUD, WASTE AND ABUSE HOTLINE

1-855-292-7485

Resources

ONLINE PROVIDER RESOURCES

www.devoted.com/providers

PROVIDER & PHARMACY DIRECTORY

www.devoted.com/search-providers

EVIDENCE OF COVERAGE DOCUMENTS

www.devoted.com/plan-documents

FORMULARY

www.devoted.com/search-drugs

OTC CATALOG

www.devoted.com/prescription-drugs

Help for Devoted Members

DEVOTED HEALTH MEMBER SERVICES

1-800-DEVOTED 1-800-338-6833 (TTY 711)

We're standing by to assist your Devoted Health patients.

BEHAVIORAL HEALTH SERVICES

1-844-443-0986

Please have your patients call our network provider, Concordia (dba Carisk), for any mental health or substance abuse questions.

Coordinating Services for Members

If you need to contact any of these service providers for your patients, call the numbers below. Your patients may call 1-800-DEVOTED with any questions.

HOME HEALTH/DME/HOME INFUSION

1-844-215-4264 **Integrated Home Care Services**

Home health services or DME (including requesting authorizations for particular services/equipment)

LAB SERVICES

1-800-877-5227 **LabCorp**

All lab tests should be sent to LabCorp with the exception of those listed on our "In-Office Lab List" that is located on our website at www.devoted.com/providers.

OPTOMETRY AND OPHTHALMOLOGY

1-800-738-1889 **Premier Eye Care**

To obtain a referral for eye-care services or authorization for specific procedures.

BEHAVIORAL HEALTH SERVICES

1-844-443-0986 **Concordia (dba Carisk)**

Find this Guide Online

For the most up-to-date Provider Reference Guide and other resources, go to:

Supplemental Benefits for Members

If you need to contact any of these service providers for your patients, call the numbers below. Your patients may call 1-800-DEVOTED with any questions.

ACUPUNCTURE

1-866-535-1674 **Whole Health Networks (Tivity Health)**

AUDIOLOGY SERVICES

1-855-236-1706 **HearUSA**

Includes hearing exams and equipment.

DENTAL SERVICES

1-844-349-6262 **MCNA**

FITNESS

1-866-584-7389 **SilverSneakers**

MEALS

1-305-262-1292 **ILS**

Meals are covered under specific circumstances (after an inpatient or SNF discharge or as part of a care plan for a chronic condition). Meal benefits are not included in all plans.

TRANSPORTATION

1-888-998-4640 **Epic**

For non-emergency transportation to or from a healthcare provider/pharmacy. Transportation is a limited benefit based on number of rides.

Introduction

About Devoted Health

Devoted Health offers Medicare Advantage plans (MA) that improve the health and health care of America's Medicare beneficiaries. Our mission is to dramatically improve health care for seniors in the United States -- caring for everyone like they are members of our own family. Together with you, our network provider, we want to care for our members with a passionate commitment to service and a relentless drive to ensure our members get the right care at the right time in the right place. We strive every day to earn the trust of our members, our providers and the communities we serve.

What to Expect From Us

We put the member at the center

At the heart of all we do and every decision we make is your patient, our member. We were built to serve Medicare beneficiaries.

We will respect your time

We are striving to make working with us as easy for you as possible. If you have a problem, call or email us - we'll solve it, fast.

We are building new technology

We prioritize the design of more effective tools and technologies because we strongly believe that to improve the relationship between health plans and providers we must improve the technology we use.

We strive to be a paragon of compliance

We aim to ensure that all we do is safe for our members and CMS-compliant. We don't take shortcuts.

Provider Services and Tools

We strive to make working with us as easy as possible, whether it's using our provider portal or dealing with us directly. If you have a problem, please use this manual as a guide. And never hesitate to call or email us; we are here to help.

This Manual

The provider manual is intended to help you effectively deliver covered services to Devoted members. We will modify it over time, if and when policies change and as we incorporate feedback from you on what would make it more useful.

By design, it's intended to complement your provider agreement. If there are any instances where the agreement and this manual conflict, the agreement supersedes this manual.

When to Call

If you have any questions, concerns, or comments, we want to hear from you. Our Provider Services team is here to help you resolve any issues you have. See our Quick Reference Guide in this manual for contact information.

Provider Portal

The Availity portal is available to you for quick and easy access for any of the following:

- Look up member eligibility and benefits
- View past services and patient-related messages for any given member
- Submit and check the status of a claim (including review of remittances)
- Determine need for an authorization/referral
- Submit and check the status of an authorization/referral

If you have not used the Availity provider portal before, go to **www.availity.com** to register.

Complaints and Disputes

If you have a complaint or dispute about working with us, please use the contact information provided in the Quick Reference Guide, or call or email your contract representative. If we are unable to resolve the issue, please refer to your provider agreement for more details on dispute resolution.

Provider Responsibilities

We carefully select providers for our network who we believe will deliver high quality care to our members. We trust you, our providers, to partner with us on our mission — to put the member, your patient, at the center of every decision and action. We strive to build true partnerships with our providers to achieve this shared mission.

Notification of Important Changes

Devoted Health is committed to providing our members with accurate provider information. Please let us know as soon as possible (and within 30 days) of any changes to your information (e.g., new providers in your group, name changes of providers, address changes, whether a provider is no longer accepting new patients, etc). We also ask that you let us know if you have changes to your office staff, so that we can maintain accurate contact information. You may access the most current provider information we have by searching our online provider directory, which is available at www.devoted.com/search-providers.

Please send any changes in provider information, including roster updates, to **credentialing@devoted.com**.

Please also notify Devoted Health immediately if there are any material changes to your practice, such as but not limited to: Practice relocation, Practice closure, Changes to your liability insurance or license to practice, Criminal charges, Sanctions, and Bankruptcy or insolvency.

Access to Care

It is important that our providers adhere to access of care standards.

See the table below for Devoted Health standards regarding appointment availability.

SERVICE TYPE	APPOINTMENT STANDARD
Emergency care	Immediately (available 24/7)
Urgent primary care appointments (non-life threatening)	Within 48 hours
Urgent specialty care	Within 3 days
Referrals to specialists	Within 3 business days
Non-urgent symptoms or concerns	Within 7 days
Annual exams	Within 60 days

In addition:

Persistent symptoms must have a treatment plan in execution no later than the end of the

following working day after initial contact with the PCP.

We also ask our providers to develop and follow telephone protocols, including:

- Answer member telephone inquiries on a timely basis
- Prioritize appointments by scheduling and rescheduling promptly and by respecting appointment times and minimizing waiting time
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule no-show appointments
- Identify special member needs while scheduling an appointment — e.g. the need for a wheelchair, appropriate medical interpretation for Limited English Speaking patients, and transportation to and from appointments
- Adhere to the following guidelines for telephone call-back response times:
    - For non-emergent, symptomatic issues: after-hours telephone care within 45 minutes
    - Non-symptomatic concerns: same-day response
    - Crisis situations: response within 15 minutes
- Schedule continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- Document after-hours calls in writing in the member's medical record within 24 hours of receipt of the call
- Contact urgent care or the emergency room, and inform them of the member's condition if after-hours urgent care or emergent care is needed. Devoted will monitor appointments and after-hours availability on an ongoing basis.

Confidentiality

All providers must respect the confidentiality of member information in accordance with state and federal laws and regulations. This includes HIPAA privacy and security regulations. Providers must also respect the confidentiality of Protected Health Information (PHI) by following internal policies and by limiting PHI access to the minimum necessary required to accomplish the intended purpose.

Please report any member confidentiality issues, questions, or concerns immediately to Devoted Health.

Advance Directives

Providers are required by law to provide information to patients about advance directives. Devoted Health requires providers to adhere to all applicable laws and regulations, and requires that information shared with members about advance directives and their treatment options is easily comprehensible for the member. Providers may not require members to sign or waive an advance directive as a condition of care.

Access to Medical Records

Devoted Health may request member medical records from you for a variety of purposes. You must provide requested medical records within the time frame they are requested. You must maintain medical records for a minimum of ten years, and it is possible that Devoted Health will request medical records after the term of our agreement with a provider is over.

Please see our chapters on Claims and Medical Records in this provider manual for more information about medical records requirements.

Reporting Responsibilities

In addition to reporting requirements listed in your provider agreement, Devoted Health requests that providers report Never Events to Devoted Health. Devoted Health considers the following types of events to be Never Events:

- **Serious Reportable Events (SRE) and Serious Reportable Adverse Events (SRAE):** Unambiguous, serious, preventable adverse incidents involving death or serious harm to a member resulting from a lapse or error in a healthcare facility. Devoted Health utilizes the list of SREs developed and maintained by the NQF, which is available here.
- **Provider Preventable Conditions (PPC):** PPCs are conditions that meet the definition of a "health care acquired condition (HCAC)" or "other provider preventable condition (PPC)" as defined by CMS in Federal Regulations as 42 CFR 447.26 (b).

If and when a SRE, SRAE, or PPC is reported to Devoted Health, we will work directly with the provider involved in the incident to review the event, identify its root causes, develop a strategy to prevent similar incidents from occurring in the future, and resolve any open related payment issues.

Providers must also report serious incidents to the Florida Agency for Health Care Administration (AHCA) as required by the state of Florida.

More information about Devoted Health's quality management program can be found in the Quality Management chapter of this manual.

Non-Discrimination

Devoted Health will not tolerate discrimination against our members. Providers and their staff must not discriminate against any member on the basis of:

- Race, ethnicity, or national origin
- Religion
- Sex/gender or age
- Sexual orientation
- Mental or physical disabilities
- Medical condition, medical history, or genetic information
- Source of payment
- Evidence of insurability or claims history

Responsibilities of All Providers

In addition to everything listed in this manual and in your provider agreement, Devoted Health also has the following expectations of all providers:

Respect members

- Observe the rights of members
- Engage members in their treatment options and planning
- Communicate clearly with members and take measures to confirm shared understanding

Cooperate and coordinate with Devoted Health

- Respond in a timely fashion to any requests or outreach from Devoted Health or any of our partners
- Proactively communicate with Devoted Health about members' health and treatment

Adhere to plan policies

Follow documented policies and procedures for referrals, prior authorizations, admissions, discharges, and other events as indicated in your provider agreement and this provider manual

Maintain a safe practice

- Maintain an office that complies with all environmental safety and hygiene regulations
- Inform Devoted Health immediately of changes to your practice such as licensure status or loss of liability insurance
- Train your staff on proper safety and emergency procedures

Facility Responsibilities

Hospitals must notify Medicare Beneficiaries who are hospital in-patients about their discharge rights by complying with the requirements for providing the Important Message from Medicare, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, see CMS' "Hospital Discharge Appeal Notices," available here.

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of benefits decision by complying with the requirements for providing a Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. Providers may be required to furnish a copy of any NOMNC to Devoted upon request. For copies of the notice and the notice instructions, see CMS' "MAED Notices," available here.

Devoted Health Medicare Advantage members may appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive rehabilitation facility or skilled nursing facility benefits within the time frames specified by law.

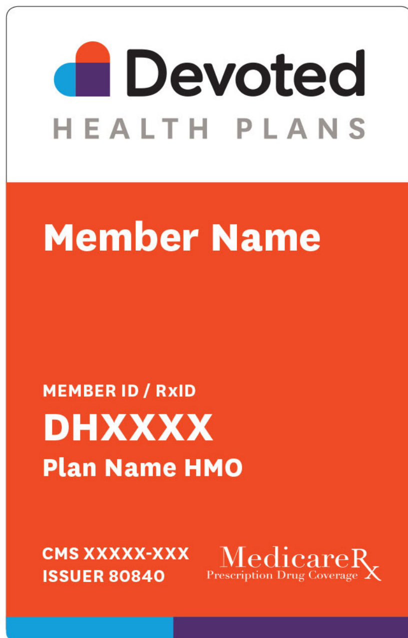
Members

The member is at the center of all we do. We work together with you to keep members as healthy as they can be, satisfied with their care and delighted by the service they receive from Devoted. Here's a rundown of how to recognize a Devoted member and ensure eligibility, as well as information about member benefits, rights, and responsibilities.

Identification of Members and Eligibility

The member ID card is issued to each member upon enrollment and contains information regarding benefit coverage, their PCP, and key contact information for Devoted Health. The card includes a unique member identification number that is assigned by Devoted to protect a member's privacy in accordance with HIPAA regulations.

A sample card is shown on the following page.



Important Note

It is the responsibility of the provider to ensure that any given member is eligible for covered services. To verify member eligibility, please use the Availity portal (www.availity.com). Devoted Health will not be responsible for payment for services provided to individuals who, at the time of service, were not eligible. To minimize potential theft and/or fraud, we encourage providers to request, along with the member ID card, a separate form of identification, such as a driver's license.

Copayments are required for a subset of services. When applicable, a copayment should be collected from or billed to the member at the time of service. Please refer to the Evidence of Coverage for information about copayment amounts.

Providers should have a timely process in place to refund members any difference between their copayment and the allowable amount for the office visit (in instances when the allowable amount is less than the copay collected) when the claim is processed by Devoted Health. For assistance with these questions, please contact Devoted Health Provider Services (see Quick Reference Guide).

Devoted Health Plans

Devoted Health offers Medicare Advantage plans. We provide our members with comprehensive benefit packages that include all the benefits offered by Traditional Medicare as well as a number of additional benefits and covered services. Additional services may include:

- Preventive care at $0 copayments
- Dental, hearing, and vision benefits
- Transportation and meal services for members who meet certain requirements

Covered services must be medically necessary and appropriate as defined in the provider's contract with Devoted Health. (See Quick Reference Guide for how to verify covered or excluded services or refer to the current Evidence of Coverage (EOC) plan document at www.devoted.com for a complete list.)

A member may elect to receive medical care for services not included in their benefit plan or services that are determined by us to be not medically necessary. In such cases, the provider should let the member know that the service is not covered by Devoted Health and that the member will be responsible for payment. In those instances, a provider should direct the member to the EOC plan document. Before treating the member for a non-covered service, the provider must obtain written signed documentation from the member by which the member acknowledges and agrees to responsibility for all such out-of-pocket expenses of the service. Such notice must meet Medicare program requirements.

Member Complaints and Grievances

If a member is dissatisfied with the health plan and/or a provider, including quality of care concerns, disputes, or requests for reconsideration or appeal, they can file a grievance or complaint. Grievances can also be filed by an authorized representative and/or a provider on the member's behalf. Providers who have seen or who are treating a member may file a grievance on the member's behalf without written consent of the member. If the member wishes to use an authorized representative, then they must complete a Medicare Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on Devoted Health's website at www.devoted.com. A Devoted Health member cannot be disenrolled or penalized in any way for making a complaint.

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

Provider Service including, but not limited to:

- Rudeness by provider or office staff
- Refusal to see member (other than in the case of patient discharge from office)
- Office conditions

Services provided by Devoted Health including, but not limited to:

- Hold time on telephone
- Rudeness of Devoted Health staff
- Involuntary disenrollment from Devoted Health
- Unfulfilled requests

Access availability including, but not limited to:

- Difficulty getting an appointment
- Wait time in excess of one hour
- Handicap accessibility

Filing a Member Grievance

Devoted Health members or their representatives with the member's consent can file a standard grievance within 60 calendar days of the date of the incident or when the member was made aware of the incident.

Phone	Call our Member Service at 1-800-DEVOTED (1-800-338-6833) 8am to 8pm EST, Monday to Friday (from October 1 to March 31, 8am to 8pm EST, 7 days a week). TTY users should call 711.
Fax	1-877-234-9988
Mail	Devoted Health, Inc. Attention: Appeals and Grievances PO Box 540279 Waltham, MA 02454

Expedited Grievances

A member may request an expedited grievance if Devoted Health makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. Devoted Health will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review time frame or extend a review time frame does not jeopardize the member's health.
See contact information above or the Evidence Of Coverage (EOC) for information on how to file an Expedited Grievance.

Member Responsibilities

Devoted Health members are responsible for following the rules of their EOC, including their financial responsibilities in the form of copayments, deductibles, or coinsurance associated with their plan.

Members are also responsible for:

- Providing their health care providers accurate information about any ongoing treatments, any medications they are taking, or changes in their health
- Keeping appointments or notifying the provider if unable (when appropriate)
- Following provider rules and being respectful to providers and their teams

Primary Care Providers

The primary care provider (PCP) is the cornerstone of Devoted Health's delivery model. The PCP establishes a long-term relationship and is the primary steward of the patient's care. We encourage our PCPs to be in close contact with Devoted Health as we work together to provide and coordinate the best possible care to Devoted Health members.

PCP Responsibilities

The PCP is responsible for providing all primary care services for Devoted Health members, including but not limited to:

- Supervising, coordinating, and providing care (routine care, wellness and preventive care, chronic disease management, and urgent care)
- Screening for behavioral health needs at each visit and when appropriate, initiating a behavioral health referral
- Maintaining continuity of care for each assigned member
- Initiating referrals for medically necessary specialty care, as relevant
- Ensuring smooth transitions between acute or post-acute stays and ambulatory care
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as consult notes for any specialists, behavioral health, or other referral services to the best of the provider's ability
- Engaging and coordinating with Devoted Health when care navigation can help improve outcomes, quality performance, and experience

PCP Coverage

Devoted Health believes it's incredibly important for members to have access to their PCP. In cases where the PCP is on leave or unavailable, the PCP should arrange to have a substitute provider who is also a credentialed, in-network provider provide care for their members. A complete list of in-network providers is available in the Devoted Health Provider & Pharmacy Directory, available at www.devoted.com/search-providers. The PCP should provide notice to Devoted Health that they will be on leave, and who their substitute provider is.

After-Hours, Weekend, and Holiday Coverage

A provider must be available by telephone 24 hours a day, 7 days a week in accordance with their provider agreement. Members must be able to call the practice's daytime telephone number and reach the after-hours coverage. If a healthcare professional does not answer the phone, there must be an option for a qualified provider to call back within a stated time frame. Members with emergencies should be directed to hang up and call 911 or go to the nearest emergency room.

Panel Changes

All PCPs may reserve the right to state the number of patients they are willing to accept into their practice from Devoted Health. Since PCP assignment for Devoted Health members is based on member choice, Devoted Health does not guarantee any given PCP a certain number of patients.

PCPs who wish to make changes to their panel must contact Provider Services. This is true for:

- PCPs interested in changing their maximum number of assigned Devoted Health members
- PCPs interested in closing their practice to new patients
- PCPs interested in re-opening a closed panel

If Devoted Health determines that a PCP fails to maintain high quality and accessible care, then Devoted Health reserves the right to reassign the members associated with that PCP to a new provider.

PCPs who would like to request to disenroll a member from their panel should contact Provider Services for more information about our process and policy. These requests cannot be based on the member's race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disabilities, medical conditions, the amount of care or cost required, medical history, genetic information, source of payment, evidence of insurability, or claims history. To process such requests, Devoted Health will require documentation from the provider explaining the reasons for the request, the efforts made by the PCP, and the failure of the member to comply. Provider Services will provider further instructions to the provider, and the provider must continue to provide care to the member until the transfer has been approved and completed.

Medical Management

Devoted Health plays an active role in managing the care of our members. We partner with each member's PCP and work closely with their other providers and facilities. The purpose of this section is to highlight the ways we will do this and how you might engage with Devoted Health in providing covered services to our members.

Referrals

Referrals help PCPs coordinate their patients' care, and are required for most specialist visits.

When a Referral is Needed

Devoted HMO plans require PCPs to submit referral requests for members to see most types of specialists. For more information about what kind of medical care does and does not require a referral, please see Devoted Health's Evidence of Coverage (EOC).

Some notes on when a referral is needed:

- While referrals are not required for behavioral health services, you may contact Concordia at 1-844-443-0986 if you wish to schedule an appointment for a member.
- For optometry and ophthalmology, please refer members to Premier Eye Care: 1-800-738-1889

How to Request a Referral

To request a referral for all other services, please follow these steps:

1. Go to www.availity.com, login, select "Authorizations/Referrals."
2. Select "Devoted Health" as the payer.
3. Choose "Service & Procedure Authorizations" and select "Referral" as the Service Type, then fill out required fields.
4. You will be provided with a Referral ID. Make sure the specialist has the Referral ID.
5. To refer to an out-of-network provider, please contact Devoted Health Provider Services at 1-877-762-3515.

Referrals for Out-of-Network Providers

In order for a Devoted Health member to see a specialist that is not in our network, additional authorization is required. Please contact Provider Services to make a request.

Second Opinions

In some cases, Devoted Health will support members in their efforts to obtain expert second opinions. For the purposes of determining medical necessity, Devoted may suggest or request a second opinion from an independent clinical expert. Devoted Health may also decide to delegate authority about whether a treatment is appropriate to the physician providing this expert opinion and the member. In such cases, Devoted Health asks that the clinician who rendered the initial opinion and the member's PCP share with the clinician providing the second opinion all clinical data that is needed to evaluate the case in an expedited fashion and within the time frame that the information is requested.

Prior Authorizations

Devoted Health is dedicated to making sure our members get the right care at the right time in the right place. Our Utilization Management team works to ensure that members, their providers, and Devoted Health are all aligned on treatment decisions. “Prior authorization” is defined as approval in advance by Devoted Health in order for a member to receive certain services or drugs. Providers are responsible for obtaining a prior authorization for all qualifying, non-emergent services prior to the service being scheduled or delivered. Please see Devoted Health’s Prior Authorization List for a complete list of these services.

Clinical Decision Making

Our prior authorization criteria are based on Medicare requirements defined in CMS National Coverage Determinations (NCDs) and relevant Local Coverage Determinations (LCDs) and generally accepted criteria such as InterQual®. Please refer to the Quick Reference Guide for contact info and where to locate a list of all services requiring prior authorization.

We use InterQual® criteria to review certain services (e.g. inpatient hospital care); we make these criteria available, upon request, to members and providers impacted by a denial decision. Please note: Failure to obtain the required prior authorization may result in a claim being denied or in a reduction in payment. Devoted Health members cannot be billed for services that require prior authorization and are delivered without a prior authorization. Devoted Health may suspend the need for prior authorization requests during an emergency/disaster, or other situations in which providers are unable to reach Devoted Health for an extended period.

Submitting a Prior Authorization Request

The preferred method for submitting prior authorization requests is through the Availity web portal. Please see the Quick Reference Guide for direction on how to submit authorization requests.

Please Note: For certain specialties, Devoted Health has delegated utilization management to an organization that focuses on that particular specialty. These organizations have their own processes for utilization management that Devoted Health providers should follow. For more information about Devoted Health’s delegated entities, please see the Delegation section in this manual.

Prior Authorization Time Frames

Devoted Health expects that prior authorization requests will be received from providers in a timely manner. Delivery expectations vary by service type, as shown in the table below.

SERVICE TYPE	PRIOR AUTHORIZATION DECISION TIME FRAME
Elective or scheduled admissions, procecures, services	Required 10 business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one business day of admission
Emergency room and post stabilization, urgent care, crisis intervention, observation	Notification requested within one business day of admission

The requesting or rendering provider must provide the following information as part of a request for a prior authorization (regardless of the method utilized):

- Member's name, date of birth, and Devoted Health ID number
- Provider's National Provider Identifier (NPI) number, taxonomy code, name, and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Valid, specific ICD-10 diagnosis code, and relevant CPT procedure code(s)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date and/or proposed surgery date, if the request is for a surgical procedure
- Expected discharge plans

Utilization Determination Time Frames

Devoted Health will review and make utilization management decisions in keeping with the time frames referenced in the table below. To meet these time frames, we ask that providers provide all relevant information and documentation in a timely manner. In the event that Devoted Health needs to request an extension, we will communicate clearly why we need additional time and adhere to Medicare Advantage rules.

Expedited organization determinations are made when the member or their physician believes

that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited requests must be called into Devoted Health by telephone.

Please refer to the Quick Reference Guide for phone numbers and contact information for submitting authorizations.

CATEGORY OF UTILIZATION MANAGEMENT DECISION	REVIEW AND DETERMINATION TIME FRAME
Standard	Determination and notification within 14 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of request
Expedited Extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within one business day of request

Prior Authorization Denials

Devoted Health may deny a request for prior authorization for the following reasons:

- Your patient is not an eligible Devoted Health member
- The service requested is not a covered benefit
- The service requested is determined not to be medically necessary
- The member's benefit has run out for the service requested

We will let you know in writing if we deny your request (either entirely or partially), and this written notice will include an explanation for why the request was denied. These denials are also called an "adverse determination."

Notifications

In certain situations, such as emergency room visits or emergent admissions, providers are required to notify Devoted Health about our members as soon as possible, and within a specified time frame. This notification is important as it allows us to follow up with the member to help with managing the care and appropriate follow up.

A few notes on notifications:

- If a member is admitted through the emergency room, notification is required no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives emergent or urgent care services, the provider must notify us within 48 hours of the services being rendered.

Please use the Availity portal to submit notifications to Devoted Health.

Discharge Planning

We believe it is critical that the member or member's authorized representative, Devoted Health, the facility, the admitting provider, and the PCP are all in agreement about the treatment plan and next steps by the time the member is to be discharged from a facility.

The facility or admitting physician is required to contact Devoted Health and provide clinical information to support discharge decisions for:

- Requests for facility stay extensions (Note: Contact must be made prior to the expiration of the approved days)
- Requests to move members to a different level of care
- Discharge plans that include any of the following:
    - Home health services or specialized durable medical equipment
    - Multiple medications
    - Programs for lifestyle changes like weight management, nutrition, smoking cessation, exercise, diabetes education, or stress management

Appealing a Decision

Appeals are different than grievances and are processed by Devoted Health differently. An appeal (or a request for reconsideration) is a written or oral request to change or reconsider a service decision made by Devoted Health. Examples of appeals include a request to overturn a denial of a prior authorization, or a denial of coverage for health care services or prescription drugs. Appeals can be received prospectively or after services have been rendered or supplies procured.

Appeals can be submitted by either:

- A member (or their legal guardian, authorized representative, or power of attorney)
- A non-participating provider (who has signed a waiver indicating they will not seek payment from the member for the item or service in question).

A physician who is providing treatment to a member, upon providing notice to the member, may request an expedited or standard reconsideration on the member's behalf without having been appointed as the member's authorized representative. Devoted Health will follow applicable Medicare Advantage regulations and requirements concerning member appeals.

Devoted Health will identify and remove any communication barriers that may impede members or their representatives from effectively making appeals. Devoted Health will facilitate the request to file an appeal for a member or treating provider who has a communication challenge affecting their ability to communicate or read, through the following means:

- TTY line is available for the hearing impaired
- Translation service for members with limited English communication capabilities or comfort

Additional accommodations will be made for any member with special needs who is unable to follow the standard process.

Appealing a Hospital Discharge

Members have the statutory right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Florida is KEPRO. The BFCC-QIO notifies the facility and Devoted Health of an appeal.

A primary care provider (PCP) or a provider who is actively treating a member may file an appeal on behalf of the member without having been appointed as the member's authorized representative.

Care Management Programs

Devoted Health will engage some members in either case or disease management programs. While Devoted Health will be using multiple approaches and resources to identify members, we also encourage our network providers to alert us to members who would benefit from participating in a case or disease management program. We expect providers will cooperate with Devoted Health in regards to these programs. To refer a member to Devoted Health for one of its care management programs, please see the Quick Reference Guide.

Behavioral Health

Devoted Health recognizes the importance of appropriately managing our members' behavioral health issues. Therefore, we have contracted with Concordia to deliver and coordinate behavioral health services for our members. Devoted Health and Concordia work collaboratively with the member's primary care provider (PCP) to coordinate care and ensure that our member's medical and behavioral health needs are met.

For information regarding a member's behavioral health benefits, please see the Quick Reference Guide.

Quality Management

Devoted Health works with our network providers to improve the health and well-being of our members through a range of quality programs. Together, we believe we can deliver 5 star quality to those we serve.

Program Goals

The primary goal of Devoted Health's quality management program is to significantly and sustainably improve the health and well-being of members, as represented by Devoted Health's Star rating. Additional goals include:

- Continuously improve the quality of clinical care and services that members receive
- Optimize members' satisfaction with their clinical care and Devoted Health
- Continuously improve the quality of service that providers receive from Devoted Health
- Increase provider satisfaction with Devoted Health
- Improve the health of the communities that Devoted Health serves

Program Activities

As part of our commitment to continuous quality management, Devoted Health will engage in the following activities:

- Medical records review: Devoted Health will undertake periodic medical records reviews. For example, Devoted Health may conduct an annual review of a sample of clinical records from one or more provider practices. Please see the Medical Records chapter of this manual for more information.
- Healthcare Effectiveness Data and Information Set (HEDIS®): Devoted Health will monitor and collect data needed to assess performance on HEDIS® quality measures for all members throughout the course of the year and will report these measures to CMS annually.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey: CAHPS is a survey that includes questions designed to evaluate member satisfaction with their care, their clinicians, and their health plan.
- Health Outcomes Survey (HOS): The Medicare HOS measures the physical and mental health of the Medicare population at the beginning (baseline measure) and after two years (follow-up measure) to provide an indication of how a Medicare Advantage plan is managing the health of its membership.
- Risk management occurrences and adverse events: Unexpected occurrences, adverse clinical events, medical errors, and "near misses" will be reviewed in accordance with Devoted Health's Quality Management Process, and as required by law and accrediting agencies.
- Analysis of member complaints: Review of all member complaints and grievances related to concerns about care quality.

In addition to the programs described above, Devoted Health also works on several other quality initiatives specific to preventable hospital admissions, discharge planning, appropriate nursing facility institutionalization, fall prevention, and identification of abuse or neglect. The reporting requirements of such events are described in the Reporting Responsibilities section of this manual.

Star Rating

As a Medicare Advantage plan, Devoted Health will be evaluated by the Centers for Medicare and Medicaid Services (CMS) and assigned a Star Rating. The Star Rating is an indicator of a plan's ability provide high quality care and service to its members. Ratings range from 1 to 5 stars with 5 stars representing the highest possible grade for quality. The Star Rating is informed by many sources of information:

- Preventive health and other clinical indicators from Healthcare Effectiveness and Information Set (HEDIS®)
- Member satisfaction and experience from the annual Consumer Assessment of Healthcare Providers & Systems (CAHPS®)
- Member-reported health outcomes from the Health Outcomes Survey (HOS)
- Health plan performance from CMS data

Over the course of the year, Devoted Health will use a number of programs to ensure our members receive the highest possible quality care. In many cases, this involves direct member engagement campaigns (for example, call and letter campaigns for certain clinical programs) and provider engagement (for example, alerting PCPs to members with gaps in care).

There are a few things you can do to help Devoted Health's Star rating efforts:

- Regularly update your provider roster and contact information so that we can contact you with important star rating information in a timely manner
- Comprehensively and accurately capture diagnosis information when submitting claims and encounters so that we can identify members eligible for potential disease management programs
- Maintain appointment availability to minimize potential access to care issues
- Coordinate with the member's PCP and provide follow-up notes promptly
- Cooperate with requests for medical records

Credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a health care professional who seeks to participate with Devoted Health and provide care for our members. The credentialing process exists to verify that participating providers meet the criteria established by Devoted Health, as well as applicable government regulations and accreditation agency standards. Credentialing is important to ensure a high quality network. We try to make this process as rapid and smooth as possible for each provider. If you have any questions about credentialing, please email our credentialing department at credentialing@devoted.com.

Initial Credentialing

Provider must complete a credentialing application, including all supporting documentation as identified in the application. To initiate the credentialing process, Devoted Health must receive a complete application, inclusive of signature, date, and an attestation by the applicant of the correctness and completeness of the application. Devoted Health requests that providers use the Council for Affordable Quality Health (CAQH) credentialing application.

Once we have received a complete and compliant application, Devoted Health will review it and verify the information contained therein. Some information may be verified from a primary source and some information may be verified from a secondary source. We partner with CredSimple for application information verification. Devoted Health or CredSimple may reach out to providers who have an incomplete application, or if we are seeking additional information.

After the application has been reviewed, the Credentialing Committee will render a decision on acceptance, or ask for more information as necessary. Devoted Health's Credentialing Committee, including the Medical Director or a physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including approval and denial guidelines.

Failure of an applicant to submit a complete and compliant credentialing application, or to respond to requests for more information may result in the denial of a provider. Providers have the right to appeal credentialing decisions, as explained further in this section of the provider manual.

Following the Credentialing Committee's decision of approval or denial, a notification will be sent to the provider. These notifications are generally sent by email from credentialing@devoted.com.

Providers must be credentialed prior to submitting claims to Devoted Health for treating members. Primary care providers (PCPs) cannot accept member assignments until they are credentialed.

Site Visits

Site visits are performed at provider offices and other facilities at the discretion of Devoted Health and in accordance with our policy for conducting site visits. At a minimum, each site visit will evaluate:

- Physical accessibility
- Physical appearance
- Adequacy of equipment
- Conformity to Devoted Health's standards for medical record keeping practices and confidentiality requirements including management of Protected Health Information (PHI)

Site visits will be conducted by appropriately qualified staff who are trained in the evaluation of provider sites.

Recredentialing & Monitoring

Devoted Health conducts provider recredentialing at least every 36 months from the date of the initial credentialing decision and/or most recent recredentialing decision. The purpose of this process is to identify any changes in the provider's areas of clinical expertise and capabilities, licensure, sanctions, certification, competence, health status, or other status which may affect the provider's ability to perform services under the contract. This process applies to all providers, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Devoted Health conducts ongoing provider performance monitoring activities on all network providers. This includes monitoring any new adverse actions taken by regulatory bodies, including the Medicare program (for sanctions and opt-outs) and state licensure against providers. Additionally, Devoted Health reviews reports released by the Office of the Inspector General (OIG) to identify any network providers who have been newly sanctioned or excluded from participation in Medicare.

A provider's participation agreement may be suspended or terminated at any time, or not renewed, if it is determined by the Devoted Health Credentialing Committee that credentialing requirements or standards are no longer being met. Any suspension, termination or renewal will follow the process, if any, required by the Centers for Medicare and Medicaid Services (CMS) in its Medicare Managed Care Manual.

Institutional Provider Certification

Devoted Health will also determine that each institutional provider or supplier in our network has met the following requirements:

- Approval by CMS for participation in Medicare
- Licensed to operate in the state
- Approval by an appropriate accrediting body (or meets Devoted Health's standards)

Devoted Health will obtain documentation and attestation at least every three years.

Provider Right to Review and Correct Information

All providers participating within the network have the right to review and improve the quality and accuracy of information obtained by Devoted Health to evaluate their credentialing or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB) Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be erroneous, or should any information gathered as part of the primary or secondary source verification process differ from that submitted by the provider.

A request to review credentialing information must be submitted to the Credentialing Department by email at credentialing@devoted.com. If a provider chooses to provide a written explanation to the Credentialing Committee, they must submit their information within 30 days of receiving the credentialing information from Devoted Health. The Credentialing Committee will then include this information as part of the credentialing or recredentialing process.

Provider Right to be Informed of Application Status

At any time, all providers who have submitted an application to join the network have the right to be informed of the current status of their application upon request. To obtain application status, the provider should contact the Credentialing Department by email at credentialing@devoted.com.

Provider Right to Appeal Credentialing Decisions

New applicants who are declined participation may request a reconsideration by contacting credentialing@devoted.com within 60 days from the date of the notice and by following the instructions in their official denials notification. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than six months from the receipt of the additional documentation.

Applicants who are existing providers and who are declined continued participation due to adverse recredentialing determinations have the right to request an appeal of the decision. Requests for an appeal must be made by email at credentialing@devoted.com within 60 days of the date of the notice.

Devoted Health does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of their license or certification under state law, solely on the basis of the license or certification.

Pharmacy

All of Devoted Health's Medicare Advantage (MA) plans offer Part D prescription drug coverage (MA-PD). We understand the importance of having a holistic view of a member's health care needs, including prescriptions. Devoted Health has delegated management of its Medicare Part D prescription drug benefit to CVS Caremark (Devoted Health's Pharmacy Benefit Manager, or PBM). Together with CVS and our network providers, we will work to deliver the highest quality pharmacy programs.

Formulary Overview

Devoted Health contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The Part D pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. Devoted Health will work with its PBM to administer and oversee all pharmacy benefits, including the prior authorization process.

Devoted Health's Drug Formulary is organized into five sections, or tiers. Each section is divided by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic or by brand name, depending on formulary coverage. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the Devoted Health Formulary.

The PBM's pharmacy and therapeutics committee (P&T) reviews all medications selected for inclusion in the Devoted Health Formulary. The P&T meets regularly to ensure that the formulary remains current, and that it provides members with optimal access to effective and cost-effective pharmacotherapies.

Formulary documents, including a comprehensive list of medications included on the Devoted Health Formulary, can be found on Devoted Health's website at www.devoted.com/formulary.

Formulary Tiers

Devoted Health covers both brand name drugs and generic drugs. The branded version of the drug is the first version to be discovered and the patented version. Generic drugs contain the same active chemical substance as the branded version, but can only be sold once the patent(s) on the original, branded drug have expired. Generally, generic drugs are less expensive than brand name drugs.

Drugs included in the Devoted Health Formulary may have varying costs to members. For members, these costs will take one of two possible forms:

- Copays: a fixed dollar amount paid per prescription
- Cost-shares: a payment equal to a fixed percentage of a drug's price

Prescription drugs are grouped into one of five tiers:

Tier	Description
Tier 1 **Preferred Generic Drugs**	Generic or brand drugs that are available at the lowest cost share for the plan
Tier 2 **Generic Drugs**	Generic or brand drugs that the plan offers at a cost to members that is equal to or higher than the cost share for Tier 1 drugs
Tier 3 **Preferred Brand Drugs**	Generic or brand drugs that the plan offers at a lower cost to members than Tier 4 drugs
Tier 4 **Non-Preferred Drugs**	Generic or brand drugs that the plan offers at a higher cost to members than Tier 3 drugs
Tier 5 **Specialty Tier**	A select subset of high cost drugs, including injectables, infusions, and monoclonal antibodies. These drugs are the most expensive drugs on the formulary. The copay or cost share for these drugs will be higher than for Tier 4 drugs.

Part D Utilization Management

Certain prescription drugs on the Devoted Health Formulary have additional requirements or limits on coverage. These requirements and limits ensure that members can use these drugs in the most effective way and help to control drug costs.

Devoted Health uses prior authorization (PA) criteria and requirements, quantity limits (QL), and step therapy (ST) to ensure members receive safe, cost-effective, and efficacious medicines. These terms are defined as follows:

Prior Authorization (PA)	Devoted Health requires that members or their physicians obtain PA for certain drugs. For these drugs, a member will need to get approval from Devoted Health before filling a prescription. If this approval is not obtained, Devoted Health may not cover the drug.
Quantity Limits (QL)	For certain drugs, Devoted Health limits the amount of the drug that Devoted Health will cover. For example, Devoted Health provides 30 tablets per 30 days for JANUVIA.
Step Therapy (ST)	In some cases, Devoted Health requires that a member try one or more drugs to treat a medical condition before agreeing to cover another drug for this same condition. For example, if Drug A and Drug B both treat a medical condition, Devoted Health may not cover Drug B unless a member first tries Drug A. If Drug A does not work for the member, or the member experiences side effects when taking Drug A, then Devoted Health will cover Drug B. Additional information about step therapy is available on Devoted Health's website at www.devoted.com/prescription-drugs

Generic Substitution: When generic versions of a brand-name drug are available, Devoted Health's network pharmacies will automatically dispense the generic version unless the brand-name drug was requested. If the brand-name drug is not on the Devoted Health Formulary, the member and/or their physician will need to file a formulary exception request with Devoted Health seeking approval for coverage of the non-formulary medication. If the formulary exception request is approved, then Devoted Health's pharmacy benefit manager (PBM) will cover the drug. However, the member may be asked to pay a higher copay for this brand-name version.

Devoted Health may occasionally make an exception to its formulary coverage rules. When requesting a utilization restriction exception, the provider should submit a supporting statement along with a completed "Request for a Medicare Prescription Drug Coverage Determination form,"

found on Devoted Health's website (www.devoted.com/plan-documents) to CVS Caremark.

In general, Devoted Health will make a decision about all exception requests within 72 hours. Providers can request that an exception request be expedited if the member's health could be seriously harmed by waiting the full 72 hours for a decision. If the request to expedite the decision is granted, Devoted Health must provide a decision within 24 hours of receiving the prescriber's supporting statement.

Medicare Advantage Formulary Coverage Exclusions

Devoted Health's Part D Prescription Drug Benefit does not cover the following drugs and drug categories:

- Agents used to treat weight loss (even if used for a non-cosmetic purpose, such as for morbid obesity)
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription over-the-counter (OTC) drugs. However, Devoted Health's health plans do include a separate supplemental benefit for OTC drugs for all members.
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

Transition Policy

Under certain circumstances, Devoted Health will approve a temporary supply of a non-formulary Part D drug, which is defined as meeting one of the following criteria:

- Part D drugs that are not on Devoted Health's formulary
- Part D drugs previously approved for coverage under an exception once the exception expires
- Part D drugs that are on a Devoted Health's formulary but require prior authorization (PA), quantity limits (QL), and step therapy (ST) lower than the member's current dose under Devoted Health's utilization management rules

Members with at least one of the following characteristics may be eligible for a transition fill:

- New beneficiaries enrolled into the plan following the annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage
- The transition of beneficiaries who switch from one plan to another after the start of a contract year
- Current beneficiaries affected by negative formulary changes across contract year
- Beneficiaries residing in long-term care (LTC) facilities, including beneficiaries being admitted to or discharged from an LTC facility

For those members who are new to Devoted Health and are not in a LTC, Devoted Health will cover a temporary supply of the drug one time only during the first 90 days of the member's enrollment in Devoted Health. This temporary coverage will supply a maximum of 30 days, or fewer if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For new Devoted Health members who are residents in LTC facilities, Devoted Health will cover a temporary supply of the drug during the first 90 days of the member's enrollment in Devoted Health. This temporary coverage will supply a maximum of 31 days, or fewer if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For members who have been a member of Devoted Health for more than 90 days, reside in LTC facilities, and need a drug refilled immediately, Devoted Health will cover up to a 31 day supply of the medication, or less if the prescription is written for fewer days. This coverage is in addition to the above LTC transition supply. An exception or PA must be requested at the time the prescription is filled.

For all transition fills, members will be required to pay for the requisite copay or coinsurance. Non-formulary brand-name drugs approved for a transition fill will be assigned copays equal to those for drugs on Tier 4 of Devoted Health's Formulary, while generic drugs approved for a transition fill will be assigned copays equal to those for Tier 2 drugs.

Additional information about the Devoted Health Transition Policy is on Devoted Health's website. www.devoted.com/prescription-drugs.

Pharmacy Network

Devoted Health and CVS Caremark have developed and will maintain a network of pharmacies where members can fill prescriptions. With a few exceptions, members must go to a network pharmacy to receive covered drugs. Refer to the Devoted Health Provider & Pharmacy Directory, available online at www.devoted.com/search-providers for a list of participating retail, chain, long-term care, home infusion, and mail-order pharmacies, and other relevant information. Members may obtain the Mail Order form at www.devoted.com or may call Member Services at 1-800-DEVOTED (1-800-338-6833) TTY 711.

Drug Utilization Review

Devoted Health and CVS Caremark will conduct drug utilization reviews (DURs) to make sure members are getting safe and appropriate care. These reviews are especially important for members who are receiving prescription medications from more than one physician. Devoted Health and CVS Caremark perform DURs every time a prescription is filled, and when Devoted Health reviews the member's medical records.

DURs focus on identification of one or more of the following medication-related problems:

- Prescriptions which could lead to medication errors, including prescribing of drugs to which a member has a listed allergy, or incorrect dosing
- Duplicate drugs that are unnecessary because the member is taking another drug to treat the same medical condition
- Drugs with prohibitively dangerous side effects, and/or which pose undue risk when used by older people or by people of a particular gender
- Combinations of drugs which should not be taken together due to the risk of drug-drug interactions

If Devoted Health identifies any medication-related problems that could warrant a modification to a member's prescription, Devoted Health will share these findings with the prescriber and help the prescriber to address the issue if and as needed. Accordingly, prescribers may receive calls or faxes from Devoted Health's pharmacy department following up on any findings. Prescribers should contact 1-800-DEVOTED (1-800-338-6833) TTY 711 with any questions about this or other policies.

Medication Therapy Management

The Medication Therapy Management (MTM) program is offered at no additional cost to Devoted Health members. Devoted Health's MTM program will focus on members who meet all of the following criteria:

- Have multiple chronic conditions
- Are taking at least a defined number of unique Part D Drugs
- Incur an annual cost of a defined amount for all covered Part D drugs

Devoted Health will use the MTM program to help make sure that members are using appropriate drugs to treat their medical conditions, and to identify potential medication errors. We attempt to educate members as to drugs currently on the market, and recommend lower-cost, generic drugs where applicable.

Devoted Health may also relay MTM information to the prescribing clinician and provide them with the opportunity to change the member's treatment if and as appropriate. Providers may receive calls or faxes from Devoted Health's Pharmacy department as part of our efforts to follow up on the outcomes of any interventions discussed with a member.

Claims

Devoted Health is committed to paying claims accurately and on time so that you can focus on patient care. This chapter describes how to submit claims, our payment integrity programs, dispute resolution process and coordination of benefits.

Electronic Claims Submission

To expedite the claims process, please submit claims electronically. Submitting claims electronically (rather than through the mail) is faster, more reliable, and less prone to front-end process rejections. Devoted Health supports electronic submission via the Health Insurance Portability and Accountability Act (HIPAA) transaction set (837P & 837I) and follows Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You may submit electronic claims to Devoted Health via the Availity clearinghouse. If you use a clearinghouse other than Availity for your electronic transactions, please contact your clearinghouse to establish an electronic claim submission process to Devoted Health via Availity.

Availity
Devoted Health Payer ID:

DEVOT

You can also submit claims to Devoted Health via the Availity portal. Go to www.availity.com to register if you have not used the Availity provider portal before.

Providers submitting claims electronically should receive an acknowledgement from Availity or their current clearinghouse; if you experience any problems with your transmission, please contact Availity or your local clearinghouse representative.

To review Availity's EDI Companion guide, log into the Availity portal and go to My Account Dashboard | EDI Companion Guide.

Paper Claims Submission

Devoted Health also accepts the CMS-1500 and the CMS-1450 (UB-04) paper claim forms. Please see the CMS Medicare Claims Processing Manual for more details on the data to include in each of the fields

Paper claims must be submitted to:

Devoted Health, Inc.
Attn: Claims
PO Box 540069
Waltham, MA 02454

If you have not registered for EFT as outlined below, Devoted Health requires providers to indicate where paper checks should be send on the applicable claim for.

CMS-1500: Checks will be sent to the address submitted in box 33
UB-04: Checks will be sent to the address submitted in box 1 or box 2 (if different than box 1)

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

In partnership with Payspan, Devoted Health has implemented an enhanced online provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services. Once registered, this no-cost secure service offers providers a number of options for viewing and receiving remittance details; ERA files can be imported directly into practice management or patient accounting systems, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanations of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from Payspan's website, once registration is completed. EOPs can also be accessed on the Availity portal.

Providers can register using Payspan's enhanced Provider registration process at www.payspanhealth.com.

Payspan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 1-877-331-7154 or on the web at www.payspanhealth.com.

Timely Filing of Claims

Each provider should refer to their Provider Agreement for filing guidelines and documentation requirements, though Devoted Health encourages its providers to submit claims as quickly and accurately as possible.

Unless otherwise specified in the Provider Agreement, Devoted Health's timely filing limit is 365 days from the claim's date of service. Claims not submitted by the claims' filing deadline are not eligible for reimbursement and a provider may not bill a member for claims submitted after the timely filing limit.

Claims Processing

Devoted Health uses a combination of guidelines established by the Centers for Medicare and Medicaid Services (CMS) and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claims edits, specifying adjustments to payment, and/or require review of medical records that relate to the claim.

Clean Claims

Devoted uses the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage (MA) definition for a clean claim (available in Chapter 11 of the Medicare Managed Care Manual), which consists of a properly completed claim that can be processed as soon as it is received. Clean claims include:

- Member name, date of birth, sex, and their Devoted Health unique member identification number
- Date(s) of service, place of service(s), and number of days or units, if applicable
- Provider tax identification (TIN) and National Provider Identifier (NPI) number
- ICD-10 diagnosis codes by specific service to the highest level of specificity
- Current CPT, revenue, and HCPCS procedure code(s) with modifiers, if appropriate
- Billed charges per service(s) provided and total charges
- Provider name and address, signature, and phone number
- Information about other insurance coverage, workers' compensation, accident or auto information, if available
- Detailed description of the service or procedure for the claim submitted with unlisted medical or surgical codes
- For resubmissions and corrections of a claim, please submit a new CMS 1500 or UB-04 indicating the correction (see below)

Failure to submit a clean claim may result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, and provider data mismatches.

Timely Processing of Claims

Devoted Health will adhere to standard Centers for Medicare and Medicaid Services (CMS)-compliant claims timeline guidelines, which are stipulated in the Provider Agreement.

Claims Payment

A provider will be reimbursed according to the compensation provisions of the Compensation Exhibit included in the Provider Agreement.

Claims Corrections

Devoted Health will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, the provider may re-submit a corrected claim within the timely period as indicated in the Timely Filing of Claims section above.

As set forth in your Provider Agreement, providers cannot bill members for services submitted beyond the timely filing limit.

Correcting or Voiding Electronic Claims

Professional claims (837p)	• Enter Frequency Code 7 for corrections, or Frequency 8 to void, in Loop 2300 Segment CLM05-3 • Enter the original claim number on the 2300 loop in the REF*F8*
Institutional claims (837i)	Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void

Correcting or Voiding Paper Claims

Professional claims CMS-1500	• Stamp “Corrected Billing” on the CMS 1500 form • Complete box 22 when re-submitting a claim • Enter the appropriate bill frequency code left justified in the left-hand side of the field: 6 - Corrected Claim 7 - Replacement of prior claim 8 - Void/Cancel prior claim • Enter the original Devoted claim number as the Original Ref. Num
Institutional claims UB-04	Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims

Corrected claims should be submitted with all line items completed for that specific claim, and should not be filed with just the line items that need to be corrected.

Pass-through Billing/CLIA

If you are a health care provider, you must only bill for services that you or your staff perform. For laboratory services, you will only be reimbursed for the services you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification. Labcorp is Devoted Health's preferred lab vendor for all other services.

Sequestration

Devoted Health will use the same sequestration reductions as those imposed by the Centers for Medicare and Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage (MA) premium or Medicare-allowed amount (resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the 2% sequestration reduction applied the same way it would be applied by CMS. This reduction applies to all MA plans.

Overpayment Recovery

We abide by Centers for Medicare and Medicaid Services (CMS) guidelines for overpayment recoupments, which include:

- provider notification
- opportunity for dispute
- possibility of auto-recoupments from future claims payments

Devoted Health may reopen and revise its initial determination or redetermination on a claim on its own motion, including any of the following:

- Within one year from the date of the initial determination or redetermination for any reason
- Within four years from the date of the initial determination or redetermination for good cause as defined in 42 CFR 405.986
- At any time if there exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in 42 CFR 405.902

Devoted Health will provide written documentation that identifies affected claims and justifies the reimbursement request. Overpayments can stem from coding edits, improper coordination of benefits, technical denials, and medical necessity review, among other reasoning outlined by applicable law. Devoted Health will not, however, base a reimbursement request for a particular claim on extrapolation of other claims, except where applicable law permits, including any of the following circumstances:

- In judicial or quasi-judicial proceedings, including arbitration

- In administrative proceedings
- Where relevant records a provider was required to maintain have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable
- Where Devoted Health has investigated the claim in accordance with its fraud prevention plan and there is clear evidence of fraud by the provider.=

In seeking reimbursement from a provider for any overpayment the provider may have received, except as expressly otherwise stated in the Provider Agreement, Devoted Health attempts to collect the funds for reimbursement according to the following guidelines:

- Provider agrees to repay such amounts within 60 days of receiving notice from Devoted Health. Repayment can be made via check or deducted from future payment.
- If the provider disputes the request and initiates a review after Devoted Health has sent the reimbursement request, Devoted Health will not collect the amount until the dispute is resolved.
- Devoted Health may assess the amount against payments of any future claims the provider submits. Devoted Health will collect the funds after sending a written explanation to the provider that has sufficient detail to allow the provider to reconcile each member's bill. Additionally, Devoted Health may also collect a monetary penalty in addition to outstanding value of the reimbursement request.

Overpayment refund checks can be sent to:

Devoted Health, Inc.
ATTN: Program Integrity
PO Box 540069
Waltham, MA 02454

If Devoted Health determines upon investigation that the overpayment was a result of fraud the provider has committed, we will report the fraud as required by law. We may then take action to collect any overpayment by assessing it against payment of any future claim submitted to the provider. We may also remove you from our network.

Payment Disputes and Reconsiderations

Payments that are made to in-network providers are based on the terms of the Provider Agreement with Devoted Health. If you feel that the claim was not processed correctly, you may file a payment dispute. Our dispute resolution process allows for disputes to be filed for either of the following:

- A dispute of medical necessity or administrative determinations resulting in no payment
- A dispute of the amount Devoted Health paid on a claim and a request to obtain a higher level of payment

You can submit your dispute within the contractually agreed-upon time frame, or within 90 days of receipt of your remittance notice, if not specified otherwise in your Provider Agreement.

Disputes should be submitted in writing and must include supporting documentation, including a copy of the Explanation Of Payment (EOP) and full explanation of why the payment should be adjusted. Submit payment disputes to:

Devoted Health, Inc.
ATTN: Provider Disputes
PO Box 540069
Waltham, MA 02454

A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within 60 calendar days.

Payment Integrity (Pre- and Post-payment Review)

In our relationship with the Centers for Medicare and Medicaid Services (CMS), we are obligated to monitor for signs of fraud, waste, and abuse, ensuring well-managed care through a payment integrity review, including both pre- and post-payments. Devoted Health uses software tools designed to identify providers and facilities whose billing practices indicate suspect conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by Devoted Health to determine the reason(s) for the outlier behavior or appropriate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions may involve fraud, waste, or abuse, the provider or facility will be notified and given an opportunity to respond, and Devoted Health may institute an overpayment recovery process as described above.

Providers may also then be placed under prepayment review and may be subject to one or more clinical utilization management guidelines. The impacted providers and/or facilities are notified of a request for additional clinical information in support of the medical necessity of services billed for/coded on the identified claims in prepayment review.

Access to Medical Records

Access to medical records is essential to Devoted Health's efforts to assess payment integrity and evaluate whether or not services delivered were medically necessary.

If we determine that we need more clinical data or documentation to process a claim, our team (or a trusted third party) may request medical records and stipulate that the processing of the claim is dependent upon receiving and evaluating the records.

Devoted Health will also request medical records to substantiate risk-adjustment, verify diagnoses and corresponding treatment plans, extract quality data required by the Centers for Medicare and Medicaid Services (CMS), and identify gaps in care and opportunities to improve quality of care. Having access to medical records will also enable us to:

- better ascertain a member's overall level of health
- predict future health services needs
- leverage our predictive analytics expertise to furnish providers with targeted information about patients' risks for different outcomes
- support provider's efforts to use this information to improve patients' health and wellbeing

Ultimately, having access to these data and documentation will help Devoted Health make it easier for a provider to deliver outstanding care to your patients.

Unless stated otherwise in the Provider Agreement, the provider will provide to Devoted Health or its designee, medical records or access to electronic records within 7 calendar days of Devoted Health's request.

Member Cost-Sharing

Each provider plays a critical role in Devoted Health's network and in the delivery of high quality health care services to our members. In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, and as included in the Provider Agreement, no provider may bill or collect payment for services rendered to our members, except for applicable copayments, coinsurance, or deductibles.

Members are only responsible for applicable copayments, deductibles, and coinsurance associated with their benefit plans.

If a provider collects an amount from a member that exceeds the payment responsibility, the provider must reimburse the excess amount to the member. To determine the member's responsibility, please refer to the Evidence of Coverage or the Remittance Advice. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is the provider's responsibility to reimburse the excess amount to the member.

Furthermore, the provider must advise members of any charges they will accrue that are not covered services in Devoted Health's plan and obtain prior approval signed by a member from the member before requesting payment for any out-of-pocket expenses.

Balance Billing and Inappropriate Billing of Members

Inappropriate billing of members includes billing members for services where payment from Devoted Health has not been obtained due to claim cleanliness issues or other billing issues.

It is a violation of the Provider Agreement and applicable law for Devoted Health-contracted providers to balance bill or inappropriately bill members. Providers who willfully or repeatedly balance bill members will be referred by Devoted Health to the relevant regulatory agency for further action, and such practices may serve as the basis to terminate the Provider Agreement.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of Devoted Health's overall objective of providing healthcare to members on a cost-effective basis. Devoted Health members may not be billed for covered services rendered except for any copayments for which the member may be responsible. Devoted Health members who have coverage under the Medicaid Qualified Medicaid Beneficiary (QMB) Program are not responsible for copayment. A provider's contract with Devoted Health requires the provider to accept Devoted Health's payment as payment in full.

Definitions

Primary Plan	Determines a member's health benefits without taking into consideration the existence of any other plan
Secondary Plan	Pays the remaining costs after the primary plan has paid

All Devoted members must follow these procedures:

- All Devoted Health members, excluding those on Medicaid, will pay or be billed copayments at the time of their office visit
- Under no circumstances may members be directly billed beyond the amount due for their cost-share (e.g., deductibles, copayments and coinsurance)

Coordination of Benefits for Medicare Advantage Members with Medicaid

Devoted Health members who have limited income and resources may receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, the provider should obtain a copy of the member's Medicaid card to bill Medicaid after receiving the Remittance Advice from Devoted Health. No copayment should be collected or billed at the time of the visit from a member with Medicaid coverage. For further

information, the provider's office can contact Provider Services (see Quick Reference Guide).

Coordination of Benefits for Medicare Advantage Members with Multiple Payer Sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If a provider has knowledge of alternative payer(s) who are primary, the provider must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to Devoted Health.

Providers are also expected to provide Devoted Health with relevant information regarding coordination of benefits and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to Devoted Health. To the extent permitted by law, if Devoted Health is not the primary payer, a provider's compensation from Devoted Health will be no more than the difference between the amount paid by the primary payer(s) and the provider's applicable rate with Devoted Health, less any applicable copayments or coinsurance.

Because members accept Devoted Health benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all Devoted Health members, such as use of the primary care provider (PCP) and/or prior approval for out-of-plan services.

Devoted Health cannot deny a claim in whole or in part, on the basis of COB unless we have a reasonable basis to believe that the member has other insurance coverage that is primary for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of non-receipt of information about other coverage.

Delegation

Devoted Health may delegate particular functions to organizations that have capabilities around specific plan operations. In the event we delegate these functions, we work closely with the delegated entity to ensure member satisfaction, clinical appropriateness and compliance with CMS guidelines. In these cases, Devoted Health retains accountability to our members and to CMS, and will therefore exercise ongoing oversight and compliance monitoring through collaborative processes.

Delegated Functions

Devoted Health will, at times, delegate certain functions that it normally performs for its Medicare Advantage plan members. The list of functions that may be delegated includes:

- Credentialing
- Provider Network Management
- Utilization Management
- Claims/Payment
- Member Service
- Pharmacy Benefit Management related services

Delegated Entity Requirements

The delegated entity will provide all staffing and systems necessary to exchange data and reporting pertaining to delegated functions with Devoted Health, as noted below. This includes data required by state and federal laws, rules and regulations, and Devoted Health. Delegated entities are required to maintain records of any documents exchanged for a period of 10 years.

For any functions that the delegated entity is sub-delegating, the delegated entity must obtain prior written approval from Devoted Health and provide Devoted Health with a copy of the agreement. Devoted Health is required to notify the Centers for Medicare and Medicaid Services (CMS) of any location outside of the United States that receives, processes, transfers, stores, or accesses Medicare Beneficiary protected health information in oral, written, or electronic form. Moreover, the delegated entity must furnish Devoted Health with the oversight plan in place between it and the sub-delegate, copies of reports, and issue logs demonstrating the ongoing oversight relationship.

Delegated entities must agree to provide appropriate reporting and ongoing performance documentation. These may include the following:

- Part C reporting requirements for applicable organization determinations
- Call center performance reporting (i.e., hold times and abandonment rates)
- Member call logs and call recordings where member service is delegated
- Authorization and referral logs and reports (including TAT, denial rate, etc.)
- Claims aging and payment reports, denial rates and reasons

Delegated entities are also responsible for ensuring Devoted Health is regularly (per contract guidelines and no less frequently than quarterly) notified of changes to any important information. This includes providing any updates to the set of providers and facilities represented by delegated entities (such as additions, deletions, and address updates) to ensure timely credentialing and the accuracy of Devoted Health's provider directory.

Delegated Oversight Program

In order to ensure that delegated entities are providing the appropriate care and service to our members, Devoted Health maintains an active and collaborative oversight program. Devoted Health will work with delegated entities on the following elements of the delegated oversight program:

- Policy and Procedure Review: During the implementation and over the course of the relationship, Devoted Health will review the delegated entity's policies, procedures, and workflows to make sure they meet compliance and operational standards.
- Electronic Data Exchange: Devoted Health will work with each delegated entity to develop and maintain suitable data exchanges for the transmission and receipt of transaction data.
- Periodic Reporting: Devoted Health will work with the delegated entity to develop a set of reports to ensure transparency of operational performance.
- Grievance and Appeal Review: Devoted Health will share with the delegated entity all grievances and appeals related to members' experience with their delegated services. Devoted Health will use this information to identify issues and develop improvement plans.
- Joint Operating Committee: A critical part of the collaboration will be regular and ongoing meetings to review performance and the quality of the relationship.

Delegated Entity Compliance Oversight

Devoted Health is committed to assuring quality of care and service from delegated entities, including the entity's compliance with all federal and state regulations related to the delegated function. Delegated entities are considered First Tier, Downstream, and Related Entities (FDRs) by the Centers for Medicare and Medicaid Services (CMS). As a Medicare Advantage (MA) plan, contracted with CMS, Devoted Health has specific oversight requirements.

FDRs describe different contractual relationships with an MA plan:

First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services to a Medicare eligible individual under the Medicare Advantage Program or Part D Program.
Downstream Entity	Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA or Part D benefit, below the level of the arrangement between an MA organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Related Entity	Any entity that is related to an MA organization or Part D sponsor by common ownership or control and conducts one of the following actions: • Performs some of the Medicare Advantage Organization or Part D plan Sponsor's management functions under contract or delegation • Furnishes services to Medicare enrollees under an oral or written agreement • Leases real property or sells materials to the Medicare Advantage Organization or Part D Plan sponsor at a cost of more than $2,500 during a contract period

All FDRs supporting Devoted Health's MA programs must be able to demonstrate and document their ability to perform the necessary functions and meet all of the regulatory, compliance, contractual and performance standards applicable to the functions they perform for Devoted Health. In addition, Devoted Health must be able to demonstrate that it has maintained appropriate oversight of FDRs.

Devoted Health's compliance monitoring process is designed to assess whether FDRs are fulfilling CMS compliance program requirements. If the requirements are not being met, the process aims to identify issues and require corrective actions to address identified issues. The compliance monitoring process will also ensure that first tier entities are applying appropriate compliance program requirements to relevant sub-delegates.

Risk Adjustment

Well-coordinated and high quality healthcare depends on a shared understanding of each member's complete health profile, which relies on comprehensive and specific diagnosis capture. Diagnosis codes also serve as the basis for the Centers for Medicare and Medicaid Services (CMS)'s Hierarchical Condition Category (HCC) risk adjustment model. Medicare Risk Adjustment refers to the methodology CMS uses to adjust payments to Medicare Advantage (MA) plans based on the diagnosis information the plan submits to CMS.

Medicare Risk Adjustment

The Medicare Risk Adjustment model relies on the ICD-10-CM diagnosis codes accurately documented in one year to prospectively pay MA organizations based on the health status of their enrolled beneficiaries in the next year. In order to be compliant with CMS guidance, complete and accurate diagnosis reporting according to the official ICD-10-CM coding is required along with reporting the ICD-10-CM diagnosis codes to the highest level of specificity and report these codes accurately.

Reporting the ICD-10-CM coding and diagnosis requires accurate and complete medical record documentation. Providers are encouraged to notify Devoted Health of any erroneous data submitted and to follow Devoted Health's procedures for correcting erroneous data. Finally, providers should report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Provider Responsibilities

Devoted Health has a number of programs to ensure the complete and compliant collection, transmission, and curation of diagnosis codes. As a Devoted Health network provider, it is important that you provide complete and accurate diagnosis information when submitting claims or responding to a Devoted Health request for medical records.

In addition, providers should:

- Consistently follow general principles of medical record documentation
- Respond quickly to requests for medical records and other related queries
- Send all records in an organized, secure and confidential manner
- Ensure all documentation to support a reported diagnosis on a given date or range of dates is provided to Devoted Health upon request
- Include supporting documents referred to in the encounter notes, such as test results or problem lists
- Notify Devoted Health of any diagnoses that are erroneously associated with a Devoted Health member

Medical Records

Medical records are an important component of delivering high quality care to members. Providers are required to maintain accurate and complete paper or electronic medical records for each of the Devoted Health members for whom they provide care.

Requirements

Medical records should include all information as required by applicable state and federal laws. In addition (and at a minimum), Devoted Health expects that medical records contain the following information:

Patient Demographic Information	• Name • Devoted Member identification number • Date of birth • Address • Phone number(s) • Marital status • Sex • Primary language spoken • Emergency contact information • Consent forms and guardianship information, if applicable
Medical History	• Surgical history • Obstetric history • Medications and medical allergies • Family history • Social history • Habits • Immunization history
Medical Encounters	• Chief complaint • History of the present illness • Physical examination • Assessment and plan
Other Information	• Orders and prescriptions • Progress notes • Test results • Referral documentation • Preventative screenings • Problem list • Advance directives (namely, an indicator that the member was provided written information regarding advance directives - See the Advance Directives section of this manual for additional information)

Documentation

All medical record documentation must be legible, detailed, organized in a consistent and logical matter, and in adherence with each provider's internal practice protocols. All entries into the medical record should be dated and signed or initialed by the author and must include the author's credentials (e.g., medical doctor (MD) or advanced registered nurse practitioner (ARNP)). Providers are also responsible for maintaining the confidentiality of medical records and the information contained within them.

Reviews

Devoted Health performs medical record reviews for multiple purposes, including but not limited to our quality management program and our credentialing and recredentialing program. If a provider's medical records are found to contain significant deficiencies during the review process, the provider will be notified by Devoted Health of the deficiency as well as implications and next steps.

Medicare Compliance, Fraud, Waste, and Abuse

As a Medicare Advantage (MA) plan, Devoted Health has a responsibility to make sure that the guidelines set by the Centers for Medicare and Medicaid Services (CMS) are followed, and that beneficiaries as well as the ethical integrity of the MA program are protected. We take this responsibility seriously and it is a significant part of our compliance program. The purpose of this section is to provide you with an overview of relevant parts of our compliance program related to marketing MA plans to beneficiaries and Fraud, Waste, and Abuse programs.

Provider Promotional Activities

Please refer to the Medicare Marketing Guidelines, applicable to Medicare Advantage (MA) and Medicare Advantage Part D (MA-PD) plans for more detailed information about provider promotional activities.

As used in specific guidance about provider activities, the term "provider" refers to all providers contracted with Devoted Health Plan of Florida and their subcontractors, including but not limited to: pharmacists, pharmacies, physicians, hospitals, and long term care facilities (LTCs). Devoted Health shall ensure that any provider contracted with Devoted Health (and its subcontractors) performing functions on Devoted Health's behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education) agrees to the same restrictions and conditions that apply to Devoted Health, and shall prohibit any provider from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of providers, offered either by Devoted Health or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents) or otherwise. While conducting a health screening, providers may not distribute plan information to patients.

The Centers for Medicare and Medicaid Services (CMS) is concerned with the provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs
- Providers may confuse the individual if the provider is perceived as acting as an agent of the plan versus acting as the individuals' provider

Providers may face conflicting incentives when acting as a plan representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their patients' health status. The potential for financial gain by the provider steering a patient's selection of a plan could result in recommendations that do not address all of the concerns or needs of an individual or potential member. These provider marketing guidelines are designed to guide Devoted Health and providers in assisting individuals with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interests of the beneficiary.

Providers should remain neutral parties in assisting plan sponsors with marketing to members or potential members or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in members or potential members not receiving information needed to make an informed decision about their health care options.

The subsections below provide information about the requirements associated with provider activities. Devoted Health requires that any provider contracted with Devoted Health (and its subcontractors) comply with these requirements.

Provider Activities and Materials in the Healthcare Setting

Members and potential members often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a member or potential member in an objective assessment of the individual's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with members or potential members when patients seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications).

Providers cannot:

- Offer scope of appointment forms
- Accept enrollment applications
- Make phone calls or direct, urge, or attempt to persuade members or potential members to enroll in a specific plan based on financial or any other interests of the provider
- Mail mandatory materials on behalf of Devoted Health
- Offer anything of value to induce individuals to select them as their provider
- Offer inducements to personal individuals to enroll in a particular plan or organization
- Conduct health screenings as a mandatory activity
- Accept compensation directly or indirectly from Devoted Health or any plan for enrollment activities
- Distribute materials/applications in an exam room

Providers may inform prospective individuals where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, www.medicare.gov, or 1-800-MEDICARE.

The "Medicare and You" Handbook or "Medicare Compare Options" (from www.medicare.gov), may be distributed by providers without additional approvals.
Keep in mind, Devoted Health's determination (if any) to deny payments for services which Devoted Health determines are not Covered Services or which were not provided in accordance with the provider contract or agreement, the attachments or the Provider Manual, are administrative decisions only. Notwithstanding any language in the contract agreement, any attachment, or the Provider Manual to the contrary, such administrative decisions by Devoted

Health in no way limit, restrict, or absolve providers or groups of their responsibility to exercise independent judgment in the provision of care and treatment of Covered Persons.

Plan Activities and Materials in the Health Care Setting

While providers are prohibited from accepting Medicare enrollment applications in the health care setting, plans or plan agents may conduct sales activities in health care settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Providers are prohibited from conducting sales presentations, distributing and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, pharmacy counter areas, and dialysis center treatment areas (where patients interact with their clinical team and receive treatment).

The prohibition against conducting marketing activities also applies to activities planned in these settings outside of normal business hours. An example of such activity includes providers sending out authorization from their patients, such as nursing home residents, to request that the member give permission for a plan sponsor to contact them about available plan products (through mailing, hand delivery or attached to an affiliation notice).

Only upon request by the member or potential member are plan sponsors permitted to schedule appointments with individuals residing in long-term care facilities (LTCs). Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or LTC distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials, the provider should do so knowing it must accept future requests from all other plan sponsors with which the provider participates. Providers are also permitted to display posters or other materials in common areas within the LTC and in admission packets announcing all plan contractual relationships. LTC staff are permitted to provide residents that meet the I-SNP criteria an explanatory brochure for each I-SNP with which the facility contracts. The brochure can explain the qualification criteria and the benefits of being an I-SNP. The brochure may have a reply card or telephone number for the resident or responsible party to call to agree to a meeting or request additional information.

Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., radio, television). New affiliation announcements are permitted, for example, by providers who have entered into a new contractual relationship with Devoted Health. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail, email, or phone. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept all future requests from other plan sponsors with which it participates.

Fraud, Waste, and Abuse

Fraud Policy Notice

The corporate policy of Devoted Health is to report cases of fraud or suspected fraud to Devoted Health Compliance hotline.

All employees of Devoted Health, members, vendors, and providers who suspect fraud are encouraged to report any possible fraudulent activities, over-billing by providers and/or other matters which they deem suspicious. No adverse action will be taken against any person for reporting possible corrupt, criminal or fraudulent activities, over-billing or other suspicious matters in good faith.

Devoted Health Compliance Hotline

1-855-292-7485
compliance@devoted.com

Devoted Health and its employees are committed to working closely with state and federal authorities in their investigation of such fraud cases. Providers are required to adopt and enforce a zero-tolerance policy for retaliation or intimidation against anyone who reports suspected misconduct.

Compliance Fraud and Abuse Training for First Tier, Downstream, and Related Entities (FDRs)

Your applicable employees and Downstream Entities assigned to provide administrative health care services for Devoted Health can access the training at the CMS Medicare Learning Network (MLN) website. https://learner.mlnlms.com/Default.aspx. FWA training is called "Combating Medicare Parts C and D Fraud, Waste, and Abuse Training." Once completed, download and retain the certificate of completion. The certificates must be made available to Devoted Health and/or CMS upon request. Your organization can also download the materials and incorporate them into your internal training; however, you cannot change the content of the MLN training. If your organization decides to incorporate into your internal training, you must have a tracking mechanism that the training was completed.

Not every employee needs to take training. Below are examples of critical roles within First Tier, Downstream, and Related Entities (FDRs) that clearly should be required to fulfill the training requirements:

- Senior administrators or managers directly responsible for the FDR's contract with Devoted Health
- Individuals involved with decision-making authority on behalf of Devoted Health
- Reviewers of beneficiary claims and services submitted for payment
- Individuals with job functions that place the FDR in a position to commit significant noncompliance with CMS program requirements or healthcare FWA

Reach out to Devoted Health's Medicare Compliance Officer with any questions regarding required trainings.

- **The only exception to this training requirement is if you/your organization is deemed to have met the FWA certification requirements through enrollment into Medicare Part A or B of the Medicare program or though accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). You can find the training requirements and information about deemed status in: 42 CFR § 422.503(b)(4)(vi)(C) for MA
- 42 CFR § 423.504(b)(4)(vi)(C) for Part D
- Medicare Managed Care Manual, Chapter 21 § 50.3

Regardless of the method used, the training must be completed:

- Within 90 days of initial hire or the effective date of contracting
- At least annually during each calendar year (January 1 – December 31) thereafter

If you have any questions regarding these instructions, concerns about what and who to report information to regarding what is required in this document, please reach out to the Devoted Health Compliance Hotline at 1-855-292-7485.

Health Insurance Portability and Accountability Act (HIPAA)

We anticipate that providers may have questions about whether the Health Insurance Portability

and Accountability Act of 1996 (HIPAA) Privacy Rule permits a provider to disclose any patient's (our member's) medical information to Devoted Health for these activities without written authorization from the member.

Section 164.506(c)(4) of the Privacy Rule explicitly permits a provider to make this type of disclosure to Devoted Health without a written authorization from the member. The Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) agrees; as written in its December 3, 2002, "Guidance on the Privacy Rule": "A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality-related health care operations activity."

As the Privacy Rule and the Office of Civil Rights have made clear, a provider does not need a written authorization from the provider's patients, who are or have been members of Devoted Health, to disclose their medical information to us for Healthcare Effectiveness Data and Information Set (HEDIS) and other quality improvement, accreditation, or regulatory purposes.

In addition, providers must comply with the provisions of HIPAA, including the effective dates of regulations adopted to implement HIPAA and HITECH or other such amendment. Devoted Health requires that providers protect the privacy, integrity, security, confidentiality, and availability of the protected health information disclosed to, used by, or exchanged by the parties by implementing appropriate privacy and security policies, procedures, and practices and physical and technological safeguards and security mechanisms, all as required by, and set forth more specifically in, the HIPAA Privacy Regulations and the HIPAA Security Regulations, codified at 45 C.F.R. Part 164. Providers will provide written verification of compliance with all applicable laws and confirm its full licensure and certification to the extent appropriate to its then current operations.

- 45 CFR §164.506(c)(4). The full text of the Privacy Rule is available at www.hhs.gov/policies/index.html Section 164.506(c) is on page 13 of this document.
- The full text of the Office of Civil Rights December 3, 2003 Guidance is available at: www.hhs.gov/ocr/privacy/hipaa/understanding/index .

Providers must notify Devoted Health (and Devoted Health will notify providers) via the compliance hotline of any modifications they believe necessary to bring Devoted Health into compliance with any new HIPAA regulations and/or HIPAA.

Glossary & Acronyms

Advance Directives
A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor

Adverse Event
An unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death."

Appeal
Something a member does if they disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs they already received. They may also make an appeal if they disagree with our decision to stop services that they are receiving. For example, they may ask for an appeal if we don't pay for a drug, item, or service they think they should be able to receive.

Balance Billing
When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. Devoted Health members only have to pay our plan's cost-sharing amounts when they get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge members more than the amount of cost-sharing their plan says they must pay.

Brand Name Drug
A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Centers for Medicare and Medicaid Services (CMS)
Government agency responsible for overseeing the Medicare and Medicaid Programs.

Complaint
The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service members receive.

Comprehensive Outpatient Rehabilitation Facility (CORF)
A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "Copay")
An amount a member may be required to pay as their share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, a member might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-sharing
Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when a doctor prescribes less than a full month's supply of certain drugs for a member and the member is required to pay a copayment.

Coverage Determination
A decision about whether a drug prescribed for a member is covered by the plan and the amount, if any, the member is required to pay for the prescription. In general, if a member brings a prescription to a pharmacy and the pharmacy says the prescription isn't covered under their plan, that isn't a coverage determination. The member will need to call or write to their plan to ask for a formal decision about the coverage.

Covered Drugs
The term we use to mean all of the prescription drugs covered by our plan.

Covered Services
The general term we use to mean all of the health care services and supplies that are covered by our plan.

Deductible
The amount a member must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment
The process of ending a membership in our plan. Disenrollment may be voluntary (the member's choice) or involuntary (not the member's choice).

Durable Medical Equipment (DME)
Certain medical equipment that is ordered by a member's doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency
A medical emergency is when a member, or any other prudent layperson with an average knowledge of health and medicine, believes that they have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care

Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information

Documents that explain the member's coverage, what we must do, the member's rights, and what each member has to do as a member of our plan. Documents include the EOC, the member's enrollment form and any other attachments, riders, or other optional coverage selected.

Exception

A type of coverage determination that, if approved, allows the member to get a drug that is not on the plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). Each member may also request an exception if their plan sponsor requires the member to try another drug before receiving the drug being requested, or the plan limits the quantity or dosage of the drug being requested (a formulary exception).

Florida Agency for Health Care Administration (AHCA)

State agency responsible for the administration of the Florida Medicaid program, licensure, and regulation of Florida's health facilities and for providing information to Floridians about the quality of care they receive

Generic Drug

A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance

A type of complaint a member makes about Devoted Health or pharmacies, including a complaint concerning the quality of their care. This type of complaint does not involve coverage or payment disputes.

Health Insurance Portability and Accountability Act (HIPAA)

A US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers

Medicaid (or Medical Assistance)

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if the member qualifies for both Medicare and Medicaid.

Medicare

The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA)

Medicare Beneficiaries can receive their Medicare benefits through Original Medicare,

or a Medicare Advantage Plan (like an HMO or PPO). Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare. Medicare pays these companies to cover all Part A and B Medicare benefits.

Medical Error

An act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome.

Medically Necessary

Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of a member’s medical condition and meet accepted standards of medical practice.

Medicare Prescription Drug Coverage (Medicare Part D)

Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Member (Member of our Plan, or “Plan Member” or “Covered Person”)

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

Member Services

A department within our plan responsible for answering member questions about membership, benefits, grievances, and appeals.

Near Miss

Any event that could have had adverse consequences but did not and was indistinguishable from fully fledged adverse events in all but outcome.

Network Pharmacy

A pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider

“Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “network providers” when they accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide the member with plan-covered services. Network providers may also be referred to as “plan providers.”

Never Events

Errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.

Organization Determination
The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much the member has to pay for covered items or services.

Original Medicare
The traditional fee-for-service program offered directly through the federal government. It is sometimes called Traditional Medicare or Fee-for-Service Medicare. Under Original Medicare, the government pays directly for the health care services the member receives.

Out-of-Network Provider or Out-of-Network Facility
A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to the member.

Part D
The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs
Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Cost-sharing
Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Primary Care Provider (PCP)
The doctor or other provider a member sees first for most health problems. A PCP makes sure the member gets the care they need to stay healthy. The PCP may talk about the member's care with other doctors and health care providers, referring the member to the other providers as needed. In many Medicare health plans, the member must see a PCP before they can see any other health care provider.

Prior Authorization
Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if the member's doctor or other network provider gets "prior authorization" from our plan.

Prosthetics and Orthotics
These are medical devices ordered by the member's doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Protected Health Information (PHI)
Any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity (or a Business Associate of a Covered Entity), and can be linked to a specific individual.

Provider Preventable Conditions (PPC)
PPCs are Conditions that meet the definition of a "health care acquired condition (HCAC)" or "other provider preventable condition (PPC)" as defined by CMS in Federal Regulations as 42 CFR 447.26 (b).

Quality Improvement Organization (QIO)
A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Serious Reportable Events (SRE) and Serious Reportable Adverse Events (SRAE)
Unambiguous, serious, preventable adverse incidents involving death or serious harm to a member resulting from a lapse or error in a healthcare facility.

Skilled Nursing Facility (SNF) Care
Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan
A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy
A utilization tool that requires a member to first try another drug to treat a medical condition before Devoted Health will cover the drug the physician may have initially prescribed.

AHCA	Agency for Health Care Administration
AOR	Appointment of Representative
BFCC-QIO	Beneficiary Family Centered Care Quality Improvement Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAQH	Council for Affordable Quality Health
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPD	Claims Payment Dispute
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DRG	diagnosis-related group
DUR	drug utilization reviews
EFT	Electronic Funds Transfer
EOC	Evidence of Coverage
EOP	explanation of payment
ERA	Electronic Remittance Advice
FDR	First Tier, Downstream, and Related Entity
HCAC	health care acquired condition
HCC	Hierarchical Condition Category
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
LCD	Local Coverage Determination
LTC	long-term care
MA	Medicare Advantage
MA-PD	Medicare Advantage Part D prescription drug coverage
MD	medical doctor
MLN	Medicare Learning Network
MTM	Medication Therapy Management

NOMNC	Notice of Medicare Non-Coverage
NPI	National Provider Identifier
OIG	Office of the Inspector General
P&T	pharmacy and therapeutics committee
PBM	Pharmacy Benefit Manager
PCP	primary care provider
PHI	Protected Health Information
PPC	Provider Preventable Conditions
QMB	Qualified Medicaid Beneficiary
RBRVS	resource-based relative value scale
SRAE	Serious Reportable Adverse Events
SRE	Serious Reportable Events
TIN	tax identification number