

Experience Health Medicare AdvantageSM (HMO)

Provider Administrative Manual

Edition: January 2020^{A1}

Experience Health is a Medicare Advantage organization with a Medicare contract to provide an HMO plan.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols and service marks are of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Experience Health is an independent licensee of the Blue Cross and Blue Shield Association, serving North Carolina.

Please Note:

As referenced in your Participation Agreement, this Provider Administrative Manual is intended to supplement the agreement between you and Blue Cross NC, which allows you to participate in the Experience Health network and related product(s). Nothing contained in this Provider Administrative Manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the participation agreement. If there is an inconsistency between the information contained in this manual and the participation agreement, the terms of the participation agreement shall govern.

If there is an inconsistency between the participation agreement and the member certificate, the member certificate shall govern. Experience Health may provide available information concerning an individual's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of the Experience Health Medicare Advantage (HMO) identification card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Member's actual Experience Health eligibility and benefits should always be verified in advance of providing services.

Contents

Chapter 1: Introduction	10
1.1 About this manual	10
1.2 Provider Administrative Manual – Experience Health Medicare Advantage (HMO).....	11
1.3 Feedback	12
Chapter 2: Contacting Experience Health and General Administration	12
2.1 Provider Line – 1-877-397-4584.....	12
2.2 Written provider claim inquiry	13
2.3 Online availability.....	13
2.4 Plan Contact Information.....	14
2.5 AIM Specialty Health SM (AIM) telephone and fax numbers	15
2.6 Mailing addresses for Experience Health Medicare Advantage (HMO)	15
2.7 Provider Network.....	16
2.8 Changes to your office and/or billing information.....	16
Chapter 3: Administrative Policies and Procedures.....	16
3.1 Participating provider responsibilities	16
3.1.1 Basic principles	16
3.1.2 Criteria for selection and listing as a specialist or sub-specialist	17
3.1.3 Primary care physician-patient relationship.....	17
3.1.4 Reimbursement and billing	18
3.1.5 Self-pay for privacy	19
3.1.6 Utilization Management.....	19
3.1.7 Quality Management.....	19
3.1.8 Use of physician extenders and assistants.....	20
3.1.9 Advance directives	20
3.2 Special procedures to assess and treat enrollees with complex and serious medical conditions	20
3.3 Requirements for agreements with contracting and sub-contracting entities.....	21
3.4 Requirements for provider credentialing and provider rights	21
3.5 Defines payments to contractors and sub-contractors as “federal funds,” subject to applicable laws	21
3.6 Confidentiality and accuracy of medical records or other health and enrollment information (including disclosure to enrollees and other authorized parties).....	21
3.7 Risk adjustment data validation program.....	21
3.8 Health Insurance Portability and Accountability Act (HIPAA) privacy regulation fact sheet ...	22
3.9 Notification required upon discharge determination.....	22

3.10	Fast Track appeals process – enrollee rights / provider responsibilities	24
3.11	What do the SNF, HHA and CORF notification requirements mean for providers?.....	26
3.12	More information	27
3.13	Requirements to provide health services in a culturally competent manner.....	27
3.14	Member input in provider treatment plan	28
3.15	Termination of providers	28
3.16	Waiver of liability	28
3.17	Reminder about opt-out provider status.....	28
Chapter 4: Service Area, ID Cards, and Provider Verification of Membership		29
4.1	Service area for Experience Health Medicare Advantage (HMO)	29
4.2	Experience Health identification cards	29
4.3	Member identification card for Experience Health Medicare Advantage (HMO)	30
4.4	[Reserved for future use].....	30
4.5	Verification of membership	30
4.6	Core Benefits for Experience Health Medicare Advantage (HMO)	30
4.7	[Reserved for future use].....	31
4.8	Enhanced Benefits for Experience Health Medicare Advantage (HMO)	31
4.8.1	Fitness Benefit	31
4.8.2	Hearing Aids Benefit	31
4.8.3	World Wide Coverage Benefit.....	32
4.9	[Reserved for future use].....	32
4.9.1	[Reserved for future use].....	32
4.9.2	[Reserved for future use].....	32
4.9.3	[Reserved for future use].....	32
Chapter 5: Participating Physician Responsibilities		32
5.1	Participating physician responsibilities.....	32
5.2	Mental health and substance abuse	32
5.3	Advance directives.....	32
5.4	Physician case management services	32
5.5	Physician availability	33
Chapter 6: Quality Improvement Program.....		33
6.1	Quality Improvement overview	33
6.2	Access to care standards – primary care physician.....	35
	Wait time for appointment (number of days).....	35
	Time in waiting room (minutes)	35

After hours calls and coverage.....	36
6.3 Access to care standards – specialist (including non-MD specialist)	36
6.4 Facility standards	37
6.5 Medical record standards for primary care providers and OB / GYN providers	39
6.6 Clinical practice and preventive care guidelines overview.....	41
Chapter 7: Emergency Care Coverage.....	43
7.1 Emergency care coverage	43
7.2 Urgently needed services	43
Chapter 8: Utilization Management Programs.....	44
8.1 Affirmation action statement	44
8.2 Pre-authorization review	44
8.3 Inpatient review	44
8.4 Medical case management	44
8.5 Ambulatory review	44
8.6 Hospital observation	44
8.7 Diagnostic imaging services	45
8.8 Medical Director’s responsibility.....	45
8.9 New technology and new application of established technology review.....	45
8.10 Retrospective review.....	46
8.11 Standard data elements.....	46
8.12 Disclosure of Utilization Management criteria	46
8.13 Care coordination services.....	47
8.14 Service determination	47
Chapter 9: Prior Authorization Requirements	48
9.1 Prior authorization guidelines	48
9.2 Requesting durable medical equipment and home health services	48
9.3 Prosthetics	49
9.4 Diagnostic imaging management program	50
9.5 Protocol for potential organ transplant coverage	51
Chapter 10: Pre-Admission Certification.....	52
10.1 Pre-admission certification guidelines	52
10.1.1 Non-emergency pre-admission certification	52
10.1.2 Emergency admissions.....	53
Chapter 11: Case Management	53
11.1 Case management overview.....	53

11.2	Care Support Services	53
11.2.1	Requesting member assessment for Care Support services	53
11.3	Specialist Referrals	53
Chapter 12: Medical Guidelines		57
12.1	Medical guidelines	57
Chapter 13: Claims Billing and Reimbursement		57
13.1	General filing requirements	58
13.1.1	Requirements for professional CMS-1500 (02-12) claim form or other similar forms	59
13.1.2	Requirements for institutional UB-04 claim forms.....	60
13.2	Using the member’s ID for claims submission	60
13.3	Electronic claims filing and acknowledgement	61
13.3.1	Sample electronic claims acknowledgement report.....	62
13.4	Experience Health claims mailing address	63
13.5	Claim filing time limitations	63
13.6	Verifying claim status	63
13.7	Electronic Funds Transfer (EFT)	64
13.8	Reimbursement for services.....	64
13.8.1	Service edits	65
13.9	Amounts billable to members	65
13.9.1	Items for which providers cannot bill members.....	66
13.9.2	Billing members for non-covered services	66
13.9.3	Hold harmless policy	67
13.10	Coordination of Benefits (COB).....	68
13.11	Workers’ Compensation claims	69
13.12	Subrogation	69
13.13	Claims reimbursement disputes	70
13.14	Pricing policy for Part B procedure / service codes	70
13.14.1	Prescription drug CPT and HCPCS codes	71
13.14.2	Policy on payment for remaining codes.....	72
13.14.3	Policy on payment based on charges	72
13.15	What is not covered under the medical benefit.....	72
13.16	Using the correct NPI for reporting your health care services.....	75
13.17	Using the correct claim form for reporting your health care services.....	75
13.17.1	CMS-1500 (02-12) claim form or other similar forms claim filing instructions	76
13.17.2	Sample CMS-1500 (02-12) claim form	80

13.17.3	UB-04 claim filing instructions.....	80
13.17.4	Sample UB-04 claim form	86
13.17.5	Policy on payment for remaining codes.....	86
13.18	HCPCS codes.....	86
13.19	ICD-10 and CPT codes for well exams.....	87
13.20	Immunizations (Part D-covered vaccines).....	89
13.20.1	Safe handling of vaccines	89
13.20.2	Medicare Part D vaccine manager for claims filing.....	89
13.21	Allergy testing.....	90
13.22	Criteria for approving additional providers for allergy testing	90
13.23	Use of office or other outpatient service code 99211	91
13.24	Dispensing DME from the office.....	91
13.25	Assistant surgery.....	92
13.26	Ancillary billing and claims submission.....	92
13.27	Ancillary billing.....	93
13.27.1	Participating reference lab billing	93
13.27.2	Dialysis services billing	93
13.27.3	Skilled Nursing Facility (SNF) billing.....	93
13.27.4	Ambulatory Surgical Center (ASC) billing.....	94
13.27.5	Home Durable Medical Equipment (DME) and billing.....	94
13.27.6	Home Health (HH) billing	96
13.27.7	Home Infusion Therapy (HIT) billing.....	97
13.28	Hospital policies.....	98
13.29	Utilization Management program	98
13.30	UB-04 claims filing and billing coverage policies and procedures	99
13.30.1	Anesthesia	99
13.30.2	Certified Registered Nurse Anesthetist (CRNA)	99
13.30.3	Autologous blood.....	100
13.30.4	Autopsy and morgue fee	100
13.30.5	Critical care units	100
13.30.6	Diabetes education (inpatient).....	100
13.30.7	Dietary nutrition services	100
13.30.8	EKG	100
13.30.9	Hearing aid evaluation	101
13.30.10	Lab / blood bank services.....	101

13.30.11	Labor and delivery rooms	101
13.30.12	Leave of absence days.....	101
13.30.13	Observation services	101
13.30.14	Operating room	101
13.30.15	Outpatient surgery.....	102
13.30.16	Personal supplies.....	102
13.30.17	Pharmacy.....	102
13.30.18	Recovery room.....	102
13.30.19	Emergency room services	102
13.30.20	POA indicators required.....	102
13.30.21	Room and board	103
13.30.22	Special beds.....	103
13.30.23	Special monitoring equipment	103
13.30.24	Speech therapy	104
13.30.25	Take-home drugs.....	104
13.30.26	Take-home supplies	104
Chapter 14: Pharmacy and Specialty Networks.....		104
14.1	The Experience Health formulary	104
14.1.1	Experience Health formulary medications.....	104
14.1.2	Formulary changes / updates.....	104
14.1.3	Generic substitution policy	105
14.1.4	Prior authorization.....	105
14.1.5	Non-formulary requests	105
14.1.6	Quantity limits	106
14.1.7	Step therapy	106
14.1.8	Drugs with Part B and D coverage.....	106
14.1.9	Request for drugs to be added to the formulary	106
14.1.10	Exceptions process.....	106
14.1.11	Types of drugs not covered by prescription drug plan.....	107
14.1.12	Medication therapy management program.....	108
14.2	Medication management programs.....	109
14.2	High Risk Medications in the Elderly.....	109
14.2	Medication Adherence	109
14.3	Medical eye care	109
14.4	Mental health / substance abuse management programs	109

14.5	Laboratory services	109
14.6	Experience Health office laboratory allowable list.....	110
Chapter 15: Post-Service Provider Appeals.....		110
15.1	Level I post-service provider appeals	110
15.2	Level II post-service provider appeals	111
15.2.1	Process for submitting a Level II post-service provider appeal	111
15.2.2	Level II post-service provider appeal for billing disputes.....	112
15.2.3	Level II post-service provider appeal for medical necessity.....	112
15.2.4	Filing fee matrix.....	113
Chapter 16: Member Appeal and Grievance Procedures		113
16.1	Member grievances and appeals	113
16.2	What is an appeal?	113
16.3	Who can file an appeal?	114
16.4	How quickly does Experience Health handle an appeal?	114
16.5	What is a grievance?	114
16.6	What involvement does a contracting physician have with an appeal?	114
Chapter 17: Member Rights and Responsibilities.....		115
17.1	Member rights	115
17.2	Member responsibilities.....	116
Chapter 18: Sanction Process.....		117
18.1	Grievance procedure / sanction process.....	117
18.2	Provider notice of termination for recredentialing.....	118
18.2.1	Level I appeal.....	118
18.2.2	Level II appeal	118
Chapter 19: Credentialing		120
19.1	Credentialing / recredentialing.....	120
19.2	Requirements for provider credentialing and provider rights	121
19.3	Policy for practitioners pending credentialing	121
19.3.1	Credentialing process	121
19.4	Credentialing grievance procedure	122
19.4.1	Provider notice of termination for recredentialing (Level I appeal)	122
19.4.2	Level II appeal (formal hearing)	122
Chapter 20: Marketing, Advertising and Brand Regulations.....		124
20.1	Marketing and advertising	124
20.2	Logo usage.....	124

20.3	Approvals.....	125
20.3.1	Sample Experience Health logo.....	125
Chapter 21:	Health Insurance Portability and Accountability Act (HIPAA).....	125
21.1	Electronic transactions.....	125
21.2	Code sets and identifiers.....	126
21.3	Security.....	126
21.4	Privacy.....	126
21.5	Additional HIPAA information.....	126
Chapter 22:	Privacy and Confidentiality.....	127
22.1	Our fundamental principles for protecting PHI.....	127
22.2	Privacy regarding services or items paid out-of-pocket.....	128
Chapter 23:	Medicare Advantage and Part D Compliance.....	128
23.1	Medicare Advantage and Part D Compliance for participating providers and their business affiliates.....	128
Chapter 24:	Forms.....	130
	Sample Provider Inquiry Form.....	130
	Sample Level I Provider Appeal Form for Experience Health.....	130
	Sample Specialist Referral Form.....	130
Chapter 25:	Glossary of Terms.....	130
	Alphabetical listing of terms.....	130
Attachment A	138
Attachment B	139
Attachment C	140

Chapter 1: Introduction

1.1 About this manual

Experience Health (“the Company”) is a new and innovative health insurance company that is jointly owned by Duke University Health System and Blue Cross NC. This independent, local health plan is located in Durham, NC and offers a Medicare Advantage HMO product in 2020 to residents of eight Triangle counties: Durham, Franklin, Granville, Lee, Orange, Person, Vance, or Wake.

The Plan was designed with the help of local doctors who understand the needs of today’s seniors, including the critical foundation of a strong provider/patient relationship. The Company was founded on the premise that the health care experience can be improved for patients and for providers. We are committed to working collaboratively with providers as partners, listening to and valuing your perspective, and collectively focusing on serving our shared members/patients.

We are pleased to provide you with a comprehensive Experience Health Provider Administrative Manual, a supplemental guide, for providers participating in the Experience Health Provider Network. This manual has been designed to make sure that you and your office staff have the information necessary to effectively understand and administer Experience Health Medicare Advantage (HMO) member healthcare benefit plan (“the Plan”).

Experience Health is a Medicare Advantage organization with a Medicare contract to provide an HMO plan. The Company holds a formal delegation agreement with Blue Cross NC to perform specific administrative and oversight functions. The Company utilizes the participation agreement that you have signed with Blue Cross NC to provide contracted compliant, quality health care services to members. As such, the credentialing process will come directly from Blue Cross NC in support of the participation agreement.

Our goal is to ensure that all members are provided quality healthcare, including preventive care, by a credentialed, compliant, accessible network of participating providers. We want to work with all our participating providers and their staffs to reach that goal. Each HMO member electing coverage must choose a primary care provider (PCP) who is responsible for coordinating his or her care. We strive to offer our members the advantages of a primary care physician and access to a broad panel of qualified specialists, hospitals, ambulatory care facilities and non-physician providers.

Experience Health offers several resources for providers, including:

Provider Network. Our provider network team is available to provide ongoing support to participating providers. You may reach our provider services team at 1-800-777-1643 to answer questions regarding provider network participation.

Healthcare Services. Our healthcare services team is comprised of experienced nurses whom work with providers for pre-certification, case management, utilization review and quality improvement issues. This team is a great resource for you to obtain information that is important in managing your covered patient population. You may reach our healthcare services team at 1-877-397-4584.

Provider Services. Our customer service team is available for general billing, claims or benefit questions at 1-877-397-4584.

Additional provider information is available online at [the Experience Health Provider Resource page](#).

Medical Director. Our Medical Director is available to answer physicians whom have medical or procedural questions. When contacting us for a prior authorization, providers can request a discussion with the Medical Director as part of the review process. Our goal is to be responsive to our participating physicians as they serve members in their practices. We believe that your participation is integral to our success. Our commitment is to work with our providers to continually improve our healthcare delivery system.

We would like to highlight several items that may be of importance to you and the chapters in which to find them:

- Phone numbers for contacting Experience Health – Chapter 2
- Health benefit plans and sample identification card – Chapter 4
- Prior authorization requirements – Chapter 9
- Specialist referrals – Chapter 11
- Information about the Medicare Advantage and Part D Compliance programs at Experience Health and hotline numbers for reporting fraud, waste, abuse, or ethics concerns – Chapter 23

As referenced in your participation agreement, this manual is intended to supplement the agreement between you and Blue Cross NC, which allows you to participate in the Experience Health network and related product(s). Nothing contained in this manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the participation agreement. If there is an inconsistency between the information contained in this manual and the participation agreement, the terms of the participation agreement shall govern.

If there is an inconsistency between the participation agreement and the member certificate, the member certificate shall govern.

All codes and information are current as of the manual proofing date but could change based on new publications and policy changes. Changes will be communicated through channels including, but not limited to: standard mail, electronic mail, and online via the [Experience Health Provider Resource page](#).

Note: To get Experience Health’s latest news and information affecting providers, join our email registry by visiting us at online via [the Experience Health Provider Resource page](#).

Website resource

Please note that we will periodically update this manual. The most current version will be available online at [the Experience Health Provider Resource page](#).

1.2 Provider Administrative Manual – Experience Health Medicare Advantage (HMO)

This manual contains information providers need to effectively administer Plan benefits in an efficient and compliant manner. If you experience any difficulty accessing or opening this manual from our website, please contact Provider Relations (contact information is available in Chapter 2 of this manual). Additionally, if you cannot access the website please contact Provider Relations to receive a copy of the manual in another format.

This manual is maintained online at the [Experience Health Provider Resource page](#). The manual is available to providers for download onto their desktop computers for easy and efficient access.

Important: Please note that providers are reminded that this manual will be periodically updated. Providers are encouraged to always access the manual online via the [Experience Health Provider Resource page](#) to receive accurate and up-to-date information from the most current version.

1.3 Feedback

This manual is your main source of information on how to administer the Experience Health Medicare Advantage (HMO) plan. If you cannot find the specific information that you need within the manual, please utilize the following resources:

- Your participation agreement with Blue Cross NC;
- Online information via the [Experience Health Provider Resource page](#);
- Provider Line at 1-877-397-4584;
- Provider Network team at 1-800-777-1643;
- Health Insurance Portability and Accountability Act ([HIPAA Companion Guide](#)) located via the [Experience Health Provider Resource page](#)
- Experience Health formulary information at [ExperienceHealthNC.com](#)

Chapter 2: Contacting Experience Health and General Administration

2.1 Provider Line – 1-877-397-4584

The Provider Line is available to assist providers with the following information:

- Route inquiries to the appropriate representative only when it is necessary to speak with a representative;
- Identify claims status for each claim when providers file multiple claims for the same patient for the same date of service;
- Provide information relevant to claims payment such as coinsurance amounts, check numbers and check dates;
- Provide eligibility information and benefit information including effective and termination dates of coverage, and deductibles met for current and prior year;
- Provide current and future primary care physician assignment name and telephone number;
- Identify multiple members with the same date of birth to make sure the information is provided for the correct patient;
- Provide Provider Network telephone number;
- Provide Experience Health address information;
- Prior plan approval status – approved / denied / currently in review / unable to locate request; and,
- Provide referral status.

Before calling the Provider Line, have the following information available:

- Patient’s identification number;
- Patient’s date of birth (mm/dd/yyyy);
- Date of service (mm/dd/yyyy); and,
- Amount of charge (\$0.00).

Note: [Blue eSM](#) and the Provider Line are the most accurate and up-to-date resources for verifying claim status. [Blue e](#) allows providers to access eligibility, authorization and claim information from the convenience of their computer screen and is faster than making a phone call.

2.2 Written provider claim inquiry

One alternative to the Provider Line for claims status information is the provider claim inquiry form (see Chapter 24, Forms). Providers may make copies of the form from this manual and send to one (1) of the addresses below. Use of this form will allow:

- Reconsideration of paid or denied claim for professional services that were billed on a CMS-1500 claim form or other similar forms;
- Request for review of incorrectly paid claim for professional services that were billed on a CMS-1500 claim form or other similar forms;
- Request for information regarding denial of services not included in member’s health benefit plan
- Requests for status of filed claims; and,
- Refund of overpayments (**Note:** Different mailing address for refund of overpayments; see below).

The completed provider claim inquiry should be mailed to the address below or faxed to 1-919-765-3940:

Experience Health
PO Box 17509
Winston-Salem, NC 27116

Refund of overpayments ONLY should be mailed to:

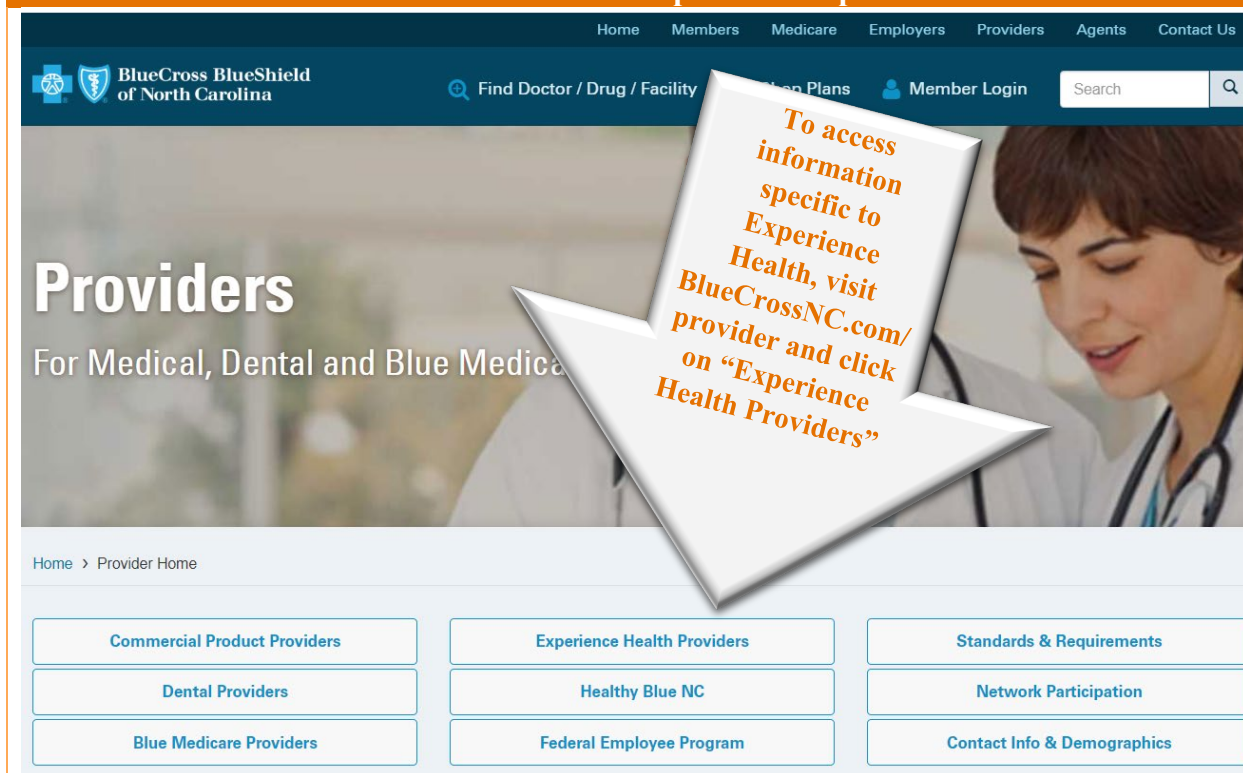
Experience Health
PO Box 30048
Durham, NC 27702

2.3 Online availability

Resource	Location
Blue e	Login
Community Eye Care for Providers	Login
E-Solutions	Resource page
Experience Health Provider Resource Page	Visit the Experience Health Provider Resource page
Prime Therapeutics: Formulary	https://www.myprime.com/v/NEXTYEAR/EXPH/MEDICARE_D/EXPMAHMO/en/medicines/find-medicine.html
Prior Approval Part B and D	Visit: <ul style="list-style-type: none"> • Drug Information (Quantity Limitations, B versus D Drugs, Part B Step Therapy, Compound Drugs, Hospice Requests and Excluded Drugs) • Drug Search (Prior Approval/Non-Formulary Exceptions and Step Therapy drugs, their criteria and their fax forms) • Diagnostic Imaging Management • Oncology

- [Other Services and Procedures](#)

Contact us on the Web at BlueCrossNC.com/provider/Experience-Health-Providers



To access information specific to Experience Health, visit BlueCrossNC.com/provider/Experience-Health-Providers on "Experience Health Providers"

2.4 Plan Contact Information

Resource	Contact Information
Provider Support	<p>Call: 1-877-397-4584 (TTY: 711); Available: 8:00 am – 6:00 pm EST, M-F</p> <ul style="list-style-type: none"> • Option 3: Diagnostic Imaging Management (DIM) or Oncology • Option 4: Skilled Nursing Facility (SNF) (fax cover sheet) • Option 5: Part D Coverage Determination (fax: 919-287-8815) • Option 6: Medical Prior Approval or Precertification (fax: 919-765-7805) • Option 7: Prime Therapeutics (pharmacy or provider) <p>General Fax: 1-919-765-3940 Mail: PO Box 17509 Winston Salem, NC 27116 Website: Online at the Experience Health Provider Resource page</p> <p>Contact Us About: Appeals, Benefits, Claim Payment, Claim Status, Claim Submissions, Explanation of Payment, Formulary, Grievances, Medical Records, Medical Policy, Member Eligibility, Prior Approval, Specialist Referrals</p>
Member Customer Service	<p>Call: 1-833-777-7394 (TTY: 711); Available: 8:00 am – 8:00 pm EST, M-F Mail: PO Box 17509, Winston Salem, NC 27116</p>
Contact Us About: Benefits, Claim Status, Member Eligibility, Multi-language Interpreter Services, Prior Authorizations, Referrals	
Pharmacy	<ul style="list-style-type: none"> • Pharmacy Helpdesk: 1-877-277-7893 • Physician Fax to AllianceRx (mail order):

	<ul style="list-style-type: none"> ○ Phone: 1-877-277-5457 (TTY: 711) ○ Fax: 1-800-332-9581 ● BIN: 020289 ● PCN: EHPARTD ● Rx Group: MAPDEH
Special Investigations Unit – Fraud, Waste and Abuse	Call: 1-844-397-4584 (24 hours a day, 7 days a week) Website: ExperienceHealthNC.com
Contact Us About: Reporting Suspected or Known Misconduct or Misuse	
Civil Rights	Call: 1-833-777-7394 (TTY: 711) Fax: 1-919-287-5613 Mail: P.O. Box 52382, Durham, NC 27717 Email: mailto:civilrightscoordinator@experiencehealthnc.com Website: ExperienceHealthNC.com
Contact Us About: Reporting Civil Rights Concerns	
Ethics and Compliance Hotline	Call: 1-888-247-4075
Contact Us About: Reporting Suspected or Known Misconduct anonymously, if desired	

2.5 AIM Specialty HealthSM (AIM) telephone and fax numbers

Service	Phone	Fax
Diagnostic imaging management program	1-877-397-4584 (option 3) PA List: Click here	Not Available – please call
Medical oncology	1-877-397-4584 (option 3) PA List: Click here	Not Available – please call
naviHealth See Attachment C for additional information.	<p>For Preservice Referrals to SNF Phone: 833-257-4305 Fax: 855-533-9364</p> <p>For Continued Stay Reviews in SNF Phone: 833-257-4305 Fax: 877-869-9154</p> <p>For Discharge Summary and Service Logs Fax: 855-222-4172</p> <p>Important Provider Links: naviHealth.com/PDPM</p>	

2.6 Mailing addresses for Experience Health Medicare Advantage (HMO)

Mailing Address	Physical Address
Experience Health PO Box 17509 Winston-Salem, NC 27116-7509	Experience Health 1965 Ivy Creek Boulevard, Durham, NC 27702 OR 5660 University Parkway Winston-Salem, NC 27105-1312

Claims for Experience Health members should be submitted electronically (or by paper when necessary). Claims sent in error for Experience Health members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

2.7 Provider Network

Experience Health strives to provide a credentialed, compliant, accessible comprehensive network of providers to meet our member’s healthcare needs. Participating physicians’ help ensure the affordability and success of their patient’s health care by referring them to participating network providers. In rare instances, a patient may have a medical need for a non-emergent service that cannot be met by a network provider. If the primary care physician is unable to refer to a network provider, preauthorization from the Medical Management Department will be required before the patient can be referred to a non-participating provider.

The Provider Network department is responsible for developing and supporting relationships with physicians and other practitioners, acute care hospitals, specialty hospitals, ambulatory surgical facilities and ancillary providers. Provider Network’s staff are dedicated and available to assist your organization. Please contact Provider Network for contract issues, fee information and educational needs.

Address	Phone	Fax
Provider Network PO Box 2291 Durham, NC 27702-2291	1-800-777-1643	1-919-765-4349 Provider address changes: 1-336-794-8866

2.8 Changes to your office and/or billing information

Chapter 3: Administrative Policies and Procedures

Experience Health Medicare Advantage (HMO) is offered by Experience Health, an HMO plan with a Medicare contract. Experience Health does not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or demographic location as defined by CMS. All qualified Medicare beneficiaries may apply. Members must be entitled to Medicare Part A, enrolled in Medicare Part B and reside in the CMS-approved service area. Some limitations and restrictions may apply.

3.1 Participating provider responsibilities

3.1.1 Basic principles

Experience Health participating providers are responsible for providing quality health care to our members according to the standards of care of the community, the medical profession and the various professional organizations and certifying boards. Experience Health has certain policies and guidelines and frequently makes decisions regarding coverage of services; however, these are not intended to be treatment decisions and do not obviate or supersede the responsibility of the physician to provide quality care, acting in the patient’s best interest, in each individual case.

All providers who agree to participate as Experience Health providers accept responsibility for the provision of appropriate medical care according to Experience Health policies and guidelines, and in keeping with the standards of care described in the previous paragraph of this section.

Experience Health Primary Care Physicians (PCP)

Experience Health primary care physicians are responsible for providing or arranging for all appropriate medical services for Experience Health members. Experience Health relies on primary care physicians to decide when specialist care is necessary or when other services such as medical equipment are indicated. To serve as a member's PCP, providers must be credentialed as a PCP.

Typically, the following provider types that specialize in primary medicine may serve as a PCP:

- Family practitioner
- Internist
- Gerontologist
- General practitioner
- Pediatrician (for those under eighteen [18] years of age).

In some cases a specialist, such as an OB / GYN or an oncologist, may serve as a PCP.

Experience Health specialists

Specialists are expected to render high quality care appropriate to the needs of Experience Health members requiring specialized treatment.

Dual eligibility

If the provider meets credentialing standards for both a primary care physician and a specialist physician with respect to Experience Health members, the member may elect to designate him or her as both a primary care physician and a specialist physician, if approved. Contact Provider Network for details.

3.1.2 Criteria for selection and listing as a specialist or sub-specialist

In order to be selected and listed in the Experience Health provider directory as a medical specialist or sub-specialist (excluding general practice), one (1) of the following criteria must be met:

1. The applicant must be board-certified by a certifying board of the American Medical Association and/or the American Board of Medical Specialties.
2. The applicant must be board qualified for a specialty or sub-specialty as defined by the appropriate certifying board for a period of not more than three (3) years following completion of training, unless otherwise defined by the board.
3. The applicant must be board qualified and within a three (3) year period following completion of board qualification.
- or
4. The applicant presents special documentation justifying listing as a specialist.

3.1.3 Primary care physician-patient relationship

The primary care physician-patient relationship for Experience Health members begins at the time the member selects the physician to be his or her primary care physician and coverage for medical services becomes effective. From that time on, unless the relationship is terminated, the physician is responsible for providing necessary medical care, including emergency care. This includes a member who is new to a practice, even if the patient has not made previous contact with that office.

Individual requirements for obtaining medical records, initial physicals and/or other initial contacts with the physician's office may be instituted by a physician but do not alter the responsibility for providing services when the need arises.

If a physician chooses to terminate a physician-patient relationship, either for cause or change in the physician's availability, we must receive sixty (60) days' notice. The member must be given thirty (30) days written notice by Experience Health in order to select another primary care physician. During the thirty (30) day period following receipt of the notice by the member from Experience Health, the physician remains responsible for emergency and/or urgent care for the member. A copy of the termination notice must be sent to the Provider Network department.

Practice limitations

Provider agrees to give thirty (30) days prior written notice regarding the limitations or closing of its practice, or the practice of any participating physician, to Experience Health members.

Availability and coverage

Participating physicians, primary care and specialist, should be available to their patients when needed. When the physician's office is closed, the members should have a clear and readily available access pathway for needed care. Usually this will be through an answering service.

Coverage for members in the event of the physician's absence should be arranged with a physician participating in the Experience Health network if possible. If coverage is arranged with a non-participating physician, the participating physician is responsible for insuring that the covering physician agrees to provide services to Experience Health members according to Experience Health policies, accept Experience Health compensation according to Experience Health fee schedule, and bill only Experience Health for covered services (i.e., patients to be billed only for appropriate copayments or coinsurance).

3.1.4 Reimbursement and billing

What the provider can collect

Participating providers agree to bill only Experience Health for all covered services for Experience Health members, collecting only appropriate copayments or coinsurance from the member. Experience Health members are directly obligated only for the copayment / coinsurance amounts indicated on their member card (and in their Certificate of Coverage or evidence of coverage), payment for non-covered services for which Experience Health has issued an Organization Determination denying coverage, and payment for services after the expiration date of the member's coverage. The provider should not collect any deposits and does not have any other recourse against an Experience Health member for covered services.

In the event that the participating provider provides services which are not covered by the Plan, he or she will not seek any payment from the patient other than the copayment / coinsurance amounts indicated on the member card (and in their Certificate of Coverage or evidence of coverage) unless, prior to the provision of such non-covered services, Experience Health has issued an Organization Determination to the patient denying coverage. Experience Health shall make the relevant terms and conditions of each plan reasonably available to participating providers.

Submission of claims

Claims should be submitted using CMS-1500 claim form or other similar forms; or UB-04 form. To file electronic claims submission, please refer to Section 13.1, General filing requirements, for information on how to get set up to file electronically.

The provider is responsible for proper submission of claims for compensation of services rendered. The guidelines in the current AMA CPT and HCPCS code books and ICD-10-CM must be used for coding. Selection of the procedure and evaluation and management codes should be appropriate for the specific service rendered as is documented in the patient's medical record.

3.1.5 Self-pay for privacy

See Chapter 22 of this manual for important information regarding self-pay for privacy.

3.1.6 Utilization Management

Experience Health Utilization Management charter and annual work plan are reviewed and approved by a Physician Advisory Group comprised of participating physicians, the associate Medical Director, the Director of Care Management and Experience Health staff. The policy relative to a specific procedure or pre-certification requirement may be obtained by contacting Experience Health Provider Services.

All Experience Health providers participate in Experience Health Utilization Management process by providing appropriate medical care and complying with Experience Health administrative guidelines and required provider activities. These include:

1. Prior authorization requirements for admissions (Chapter 9) and certain procedures (Chapter 10)
2. Prior authorization requirements for durable medical equipment and certain pharmaceuticals (Chapters 9 and 14)
3. Participation in Experience Health case management program when applicable (Chapter 11)
4. Requirements for providers to supply relevant information at the time of the request, adequate information to permit concurrent review for patients in an inpatient level of care and medical services.

3.1.7 Quality Management

Experience Health relies on its participating physicians to deliver medical care of high quality.

Experience Health is required to document and demonstrate that medical care provided for our members is of acceptable quality.

Experience Health Quality Management program monitors potential quality of care events, patient complaints about quality of care, and assesses performance in certain areas periodically.

When necessary, a complaint or potential quality problem is presented to the credentialing committee. The decisions of the credentialing committee may be any of the following:

1. No action is necessary.
2. The single event may or may not indicate a problem; the item is filed in the provider's file for reference and to detect trends, if present.
3. The medical care provided is below standard and remedial action is indicated. Institution of the sanction process, however, is not warranted.
4. The medical care provided is below standard and warrants instituting the sanction process.

The provider involved would be notified of decisions three (3) or four (4); however, notification is not considered necessary for one (1) or two (2).

All items reviewed are placed in the provider's file and made available to the credentialing committee at the time of recredentialing.

3.1.8 Use of physician extenders and assistants

Experience Health understands and encourages the use of physician assistants, nurse practitioners and other nursing and specially trained personnel. The physician and the extender are expected to comply with all applicable statutes and regulations as appropriate for the practice site. Claims filing guidelines are determined by the terms of the participating provider agreement with Experience Health.

3.1.9 Advance directives

On December 1, 1991, the requirements for advance directives in the Omnibus Budget Reconciliation Act of 1990 "OBRA 1990" took effect. As of that date Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to exclude advance directives.

Experience Health recognizes the difficulty of making decisions about the medical care of a loved one. The decision to administer treatment of extraordinary means is an issue with no easy answers, an issue which will elicit a variety of responses from different people. Thinking about these issues is difficult; however, a member may wish to set out in advance what sort of treatment he or she would like to receive under serious medical conditions. It may be that a member will become seriously ill or injured and unable to make these decisions for themselves.

Considering and discussing his/her views on life sustaining treatment when they are not under pressure or strain may make the process somewhat less difficult. The member may then wish to draft an advance directive, which instructs his/her physician regarding the types of treatment they want or do not want under special, serious medical conditions. Alternatively, they may wish to designate health care power of attorney to an individual who will make health care decisions should they become unable to do so.

The Experience Health Medicare Advantage (HMO) certificate of coverage informs members of their right to make health care decisions and to execute advance directives. We urge members to become informed about advance directives and then discuss any questions or concerns they have about these directives with their primary care physician. Discussion of advance directives should be noted in the member's medical record. Additionally, Experience Health participating physicians are required to keep a copy of an advance directive a member has written in his/her medical record.

3.2 Special procedures to assess and treat enrollees with complex and serious medical conditions

As a managed care organization with a contract with CMS, Experience Health is required by the balanced budget act to ensure identification of individuals with complex and serious medical conditions, assessment of those conditions, and identification of medical procedures to address and/or monitor the conditions and development of plans appropriate to those conditions. To meet this CMS requirement, Experience Health sends out an initial health risk assessment questionnaire to new members at the time of enrollment asking members to complete the questionnaire. Member participation is voluntary. The members mail the completed survey to Experience Health. The information in the survey is entered into a database. If the sum of the results equal or are greater than a designated score, the member is flagged as potentially at risk for having or developing a complex and serious medical condition. The member receives a letter indicating a care manager will contact him or her for an additional assessment.

Members identified as potentially at risk for having or developing a complex and serious medical condition will be further screened / assessed by their PCP and/or care manager to determine if they have a complex and serious medical condition.

The PCP must develop a treatment plan including an adequate number of visits to a contracting specialist to accommodate the treatment plan. Based on the results of the detailed assessment, the care manager, in cooperation with the PCP or managing physician identifies and documents problems, provides interventions and coordinates services that supports the member's needs and the physician's treatment plan. This function is carried out by Experience Health Care Management staff or designated vendor.

3.3 Requirements for agreements with contracting and sub-contracting entities

The current provider contracts outline provisions which must be agreed to in order to provide services to Experience Health members. These provisions include timeframes regarding record retention for inspection purposes and other key rules a provider must realize when dealing with a government-sponsored program. Please refer to your contract for details.

3.4 Requirements for provider credentialing and provider rights

We follow a documented process governing contracting and credentialing, do not discriminate against any classes of health care professionals, and have policies and procedures which govern the denial, suspension and termination of provider contracts. This includes requirements that providers meet Original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation. For more information, refer to Chapter 19, Credentialing.

3.5 Defines payments to contractors and sub-contractors as “federal funds,” subject to applicable laws

Since Experience Health payments for Medicare services for Experience Health Medicare Advantage (HMO) members are considered “federal funds,” providers are reminded to meet all laws applicable to entities that accept federal funds. These laws relate to anti-discrimination, rehabilitation act, as well as civil rights issues to name a few. Please refer to your contract for details.

3.6 Confidentiality and accuracy of medical records or other health and enrollment information (including disclosure to enrollees and other authorized parties)

Providers are reminded that member identifiable data should not be released to entities other than Experience Health or Experience Health authorized representatives without the consent of the member, except as required by law. Further, providers are advised that members have a right to access their own medical records subject to reasonable guidelines developed by providers.

3.7 Risk adjustment data validation program

The Balance Budget Amendment (BBA) of 1997 mandates that CMS payments to Medicare Advantage (MA) organizations are based on the health status of each beneficiary. The new payment methodology uses risk adjustment, which is sometimes called case-mix adjustment that incorporates diagnoses from hospital inpatient, hospital outpatient and physician services into adjusted capitated payments made to MA organizations.

Since the passage of the BBA, CMS moved from a demographic based payment system to a risk adjusted payment system. MA organizations became fully at-risk rate adjusted beginning in 2007. That means that 100% of the MA's capitation for each member will be based on his or her relative health status.

Once the new payment methodology was implemented, ensuring complete and accurate data is paramount to Experience Health’s ability to maintain a competitive presence in the Medicare Advantage program.

The BBA mandates that MA plans collect and submit beneficiary level ICD-10 CM data to CMS. This data is used to determine the health status of each beneficiary. The capitation for each beneficiary is then adjusted to reflect the dollars needed to care for a beneficiary in a subsequent payment period. CMS performs data validation to verify that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member. Data discrepancies may affect risk-adjusted payment. The data validation process begins with the beneficiary records supplied by the physician to the

MA organization. It is incumbent on physicians and their office staff to ensure that the documentation is complete and accurate in response to the validation request by the MA organization. MA organizations must attest to the completeness and accuracy of the data submitted for risk adjustment.

Experience Health initiated a program to validate this data. The program may require on-site medical record review. In some cases, the validation can be handled via mail using questionnaires. Risk adjustment does not require a change in the way that claims are filed or reported. Any medical record request made for risk adjusted payment validation is allowed under HIPAA regulations.

3.8 Health Insurance Portability and Accountability Act (HIPAA) privacy regulation fact sheet

The collection of risk adjustment data and request for medical records to validate payment made to Medicare Advantage (MA) organizations does not violate the privacy provisions of HIPAA. Therefore, a patient authorized release of information is not required to submit risk adjustment data or to respond to a medical request from CMS for data validation. Specific sections of the HIPAA privacy regulation are referenced below:

General Reference:

45 Code of Federal Regulations (CFR) Part 164, standards for privacy of individually identifiable health information, final rule.

Web addresses:

- www.ecfr.gov
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html?redirect=/Manuals/www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

CFR references:

42 CFR Subpart M, Sections 422.620 and 422.622.

Medicare Managed Care Manual, Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Health plans.

3.9 Notification required upon discharge determination

If the Medicare Health plan denies coverage of the admission, this guidance does not apply. Instead the Plan must deliver the Notice of Denial of Medical Coverage (or Payment) (NDMCP) with appeal rights.

42 CFR 422.620 and 422.622 require hospitals and Medicare Health plans to inform Medicare enrollees who are hospital inpatients of their right to obtain a Quality Improvement Organization (QIO) review of a discharge decision. These instructions delineate the expectations of the enrollee (or their representative, if applicable), responsibilities of hospitals, responsibilities of Medicare Health plans, and the role of the QIOs when the enrollee requests an immediate review by a QIO of the discharge decision. The term enrollee means either enrollee or representative, when a representative needs to act for an enrollee.

The term “hospital” is defined as any facility providing care at the inpatient hospital level, whether that care is short or long term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. The definition includes critical access hospitals, swing beds in hospitals are excluded, because they are considered a lower level of care. Religious non-medical health care institutions are also excluded. These rules apply to Medicare managed care enrollees who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as observation stays or in the emergency department, do not receive these notices unless they are subsequently admitted as an inpatient. Medicare enrollees in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.

Discharge is defined as a formal release of an enrollee from an inpatient hospital. This includes when the enrollee is physically discharged from the hospital, as well as, when the enrollee is discharged “on paper” meaning that the enrollee remains in the hospital, but at a lower level of care (for example, the enrollee is moved to a swing bed or to custodial care).

Section 1866 (a)(1)(M) Delivery of Important Message from Medicare, applies to each individual who is entitled to benefits under Medicare Part A. No matter where in the sequence of payers Medicare falls, these requirements still apply.

Enrollees who are being transferred from one (1) inpatient hospital setting to another inpatient setting, do not need to be provided with the follow up copy of the notice prior to leaving the original hospital since this is considered the same level of care. Enrollees always have the right to refuse care and may contact the QIO if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again.

When a Medicare enrollee is admitted for hospital services that are never covered by Medicare, these notice requirements do not apply.

Instead, Experience Health should deliver the NDMCP letter guiding the enrollee through the standard or expedited appeals process.

Experience Health contracting hospitals are responsible for issuing the Important Message from Medicare About Your Rights (IM) for the Plan. The IM is a statutorily required notice to explain the enrollee’s rights as a hospital inpatient, including discharge appeal rights. All time and delivery requirements that apply to Original Medicare enrollees receipt of this notice and the “follow up” copy apply for plan enrollees as well.

The notices are available at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Any member who is a hospital inpatient has a right to request an immediate review by the QIO when Experience Health and the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary. An enrollee who chooses to exercise the right to an immediate review must submit a request to the QIO that has an agreement with the

hospital where the enrollee is an inpatient. In order to be considered timely, the request must be made no later than midnight of the day of discharge and may be in writing or by telephone. The enrollee should be available to discuss the case upon request by the QIO. The enrollee may but is not required to submit written evidence to be considered by the QIO.

When the enrollee requests a review no later than midnight of the day of discharge the enrollee is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the day after the date the enrollee receives notification of the QIO decision. Liability for further inpatient hospital services depends on the QIO decision.

Unfavorable determinations

If the QIO notifies the enrollee that the QIO did not agree with the enrollee, liability for continued services begins at noon of the day after the QIO notifies the enrollee that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.

Favorable determinations

If the QIO notifies the enrollee that the QIO agreed with the enrollee, the enrollee is not financially responsible for continued care (other than applicable coinsurance and deductibles) until the Medicare health plan and hospital once again determine that the enrollee no longer requires inpatient care, secure the concurrence of the physician responsible for the enrollee's care, and the hospital notifies the enrollee with a follow up copy of the IM.

When the enrollee fails to make a timely request for an immediate review and remains in the hospital, he or she may request an expedited reconsideration by Experience Health as described in Section 422.584, but the enrollee may be held responsible for charges incurred after the day of discharge or as otherwise stated by the Plan. If the enrollee receives a favorable reconsideration, the Medicare health plan must continue covering the care and/or refund the enrollee for any expenses the enrollee incurred, minus applicable coinsurance and deductibles.

When the QIO notifies Experience Health that an enrollee has requested an immediate review, Experience Health will coordinate with the hospital to deliver a Detailed Notice of Discharge (the Detailed Notice) to the enrollee as soon as possible but no later than noon of the day after the QIO's notification. The Plan will consult with the hospital to ensure the language in the Detailed Notice adequately explains to the enrollee why the services are no longer reasonable and medically necessary or are otherwise no longer covered. The hospital will deliver the notice to the patient or their representative. Experience Health is responsible for ensuring proper execution and delivery of the Detailed Notice.

Upon notification by the QIO of the enrollee's request for an immediate review, Experience Health and the hospital are required to submit all information that the QIO needs to make its determination, including copies of the IM and the Detailed Notice, as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the enrollee's request.

Experience Health is financially responsible for coverage of services during the QIO review as provided for in the rules.

3.10 Fast Track appeals process – enrollee rights / provider responsibilities

Enrollees of Medicare Advantage (MA) plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or

Comprehensive Outpatient Rehabilitation Facility (CORF) should end. This right is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is “Grijalva”?

“Grijalva” is Grijalva vs. Shalala, a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations – and significant changes to appeals procedures that resolved many issues – CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

Regulations

SNFs, HHAs and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than two (2) days before coverage of their services will end. If the enrollee does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO and the enrollee’s MA plan must furnish a detailed notice explaining why services are no longer necessary or covered. KEPRO is the QIO for the state of North Carolina. The review process generally will be completed within less than forty-eight (48) hours of the enrollee’s request for a review. The SNF, HHA and CORF notification and appeal requirements distribute responsibilities under the new procedures among four (4) parties:

1. The Medicare Advantage organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, Medicare Advantage organizations may choose to delegate these responsibilities to their contracting providers.) Experience Health policy requires the provider to issue the Notice of Medicare Non-Coverage (NOMNC) within the required timeline when services are scheduled to terminate or when the Plan determines a discharge date.
2. The provider is responsible for delivering the NOMNC to all enrollees no later than two (2) days before their covered services end.
3. The patient / Medicare Advantage enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4. The QIO is responsible for immediately contacting the Medicare Advantage organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

These new notice and appeal procedures went into effect on January 1, 2004. You should be aware that the Medicare law (Section 1869[b][1][F] of the Social Security Act) established a parallel right to an expedited review for “fee-for-service” Medicare beneficiaries. CMS implemented the procedure 7-1-2005 for these beneficiaries.

For additional information on the Fast Track appeals process review the following websites:

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf
- www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html
- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3949.pdf

3.11 What do the SNF, HHA and CORF notification requirements mean for providers? **Notice of Medicare Non-Coverage (NOMNC)**

The NOMNC is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider.

The NOMNC essentially includes only two (2) variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

Plan contact information is added to the last section of the letter in the event the request for a Fast Track appeal is not met, the provider / member may contact the Plan for an appeal through the Plan.

Plan contact information

Experience Health
 Attn: Care Management
 PO Box 17509
 Winston Salem, North Carolina 27116-7509

Experience Health Toll Free:

1-833-777-7394 for members
 TTY: 711
 Fax: 1-919-765-3940
 Attention: Care Management

When to deliver the NOMNC

Based on the MA Organization’s Determination of when services should end, the provider is responsible for delivering the NOMNC no later than two (2) days before the end of coverage. If services are expected to be fewer than two (2) days, the NOMNC should be delivered upon admission. If there is more than a two (2) day span between services (i.e., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. CMS encourages providers to work with MA organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to deliver the NOMNC

The provider must carry out “valid delivery” of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited review process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the MA organization and the provider of the request for a review and the MA organization is responsible for providing the QIO and enrollee with a Detailed Explanation of Non-Coverage (DENC) of

why coverage is ending. The MA organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with MA organization requests for assistance in obtaining needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of timing / need for flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four (4) responsible parties until two (2) days before the planned termination of covered services, CMS emphasizes that whenever possible, it's in everyone's best interest for an MA organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the MA organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or MA organization may have more time to provide required information.

CMS understands that challenges presented by this process and has tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many QIOs are closed on weekends (except for purposes of receiving expedited review requests), as are the administrative offices of MA organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either MA enrollees or MA organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the process work as smoothly as possible.

CMS recognizes that these requirements will be a challenge – at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. CMS intends to work together with all involved parties to identify problems, publicize best practices and implement needed changes.

3.12 More information

Further information on this process, including the NOMNC and related instructions can be found on the CMS website at www.cms.hhs.gov/healthplans/appeals. (Also, see regulations at 42 CFR 422.624, 422.626 and 489.27 and Chapter 13 of the MA manual at this same website).

3.13 Requirements to provide health services in a culturally competent manner

Providers are reminded to provide services in a manner that meets the member's needs. Medicare beneficiaries may have disabilities, language or hearing impairments or other special needs. Experience Health has established TTY/TDD lines and other systems to assist members in getting the benefits to which they are entitled. Please contact our Experience Health Customer Service staff if you are presented with an issue that requires special assistance so that we can assist in connecting the member with community services if such services are not available within the Plan.

Additionally, in North Carolina, providers can locate an interpreter to assist in communicating with Spanish speaking patients through the Carolina Association of Translators and Interpreters (CATI). CATI is an association of working translators and interpreters in North Carolina and South Carolina and is a chapter of the American Translators Association. CATI provides contact information of translators and interpreters within North Carolina at www.catiweb.org.

3.14 Member input in provider treatment plan

Members have the right to participate with providers in making decisions about their health care. This includes the choice of receiving no treatment. Experience Health policy is to require providers to include members and their input in the planning and implementation of their care or, when the member is unable to fully participate in all treatment decisions related to their health care, have an appropriate representative participate in the development of treatment plan for said member, be they parent, guardian, family members or other conservator. This includes educating patients regarding their unique health care needs, sharing the findings of history and physical examinations, and discussing with members the clinical treatment options medically available, the risks associated with treatment options or a recommended course of treatment. Experience Health and providers recognize that the member has the right to choose the final course of action, if any, without regard to plan coverage.

A choice of treatment must not be made without prior consultation with the member as member acceptance and understanding will facilitate successful care outcomes. However, a recommendation by a participating provider for non-covered services does not mean that the services are covered, but as an option may be pursued by member at the member's expense.

3.15 Termination of providers

In the case of provider terminations by the Plan or the provider, Experience Health must notify affected members thirty (30) days before the termination is effective. Thus, we request that providers adhere to termination notice requirements in provider contracts so that members can receive timely notice of network changes.

3.16 Waiver of liability

Original Medicare's waiver of liability provision, which stipulates that the provider must notify the patient if services could be denied as medically unnecessary, does not apply to Experience Health members. Under Original Medicare, if the waiver of liability is signed by the patient, then the patient is liable for charges. With Experience Health, a waiver of liability is not valid. With the exception of normal copayment / coinsurance amounts, a provider cannot charge an Experience Health member for non-covered services unless the member has received an Organization Determination from Experience Health denying coverage before the services are rendered. Waivers of liability are not valid and are not effective to make the member liable for the cost of non-covered services.

3.17 Reminder about opt-out provider status

Experience Health cannot use federal funds to pay for services by providers that opt out of the Original Medicare program and enter into private contracts with Medicare beneficiaries. If you are contemplating this payment approach, please notify Experience Health in advance of sending your termination notice.

Chapter 4: Service Area, ID Cards, and Provider Verification of Membership

4.1 Service area for Experience Health Medicare Advantage (HMO)

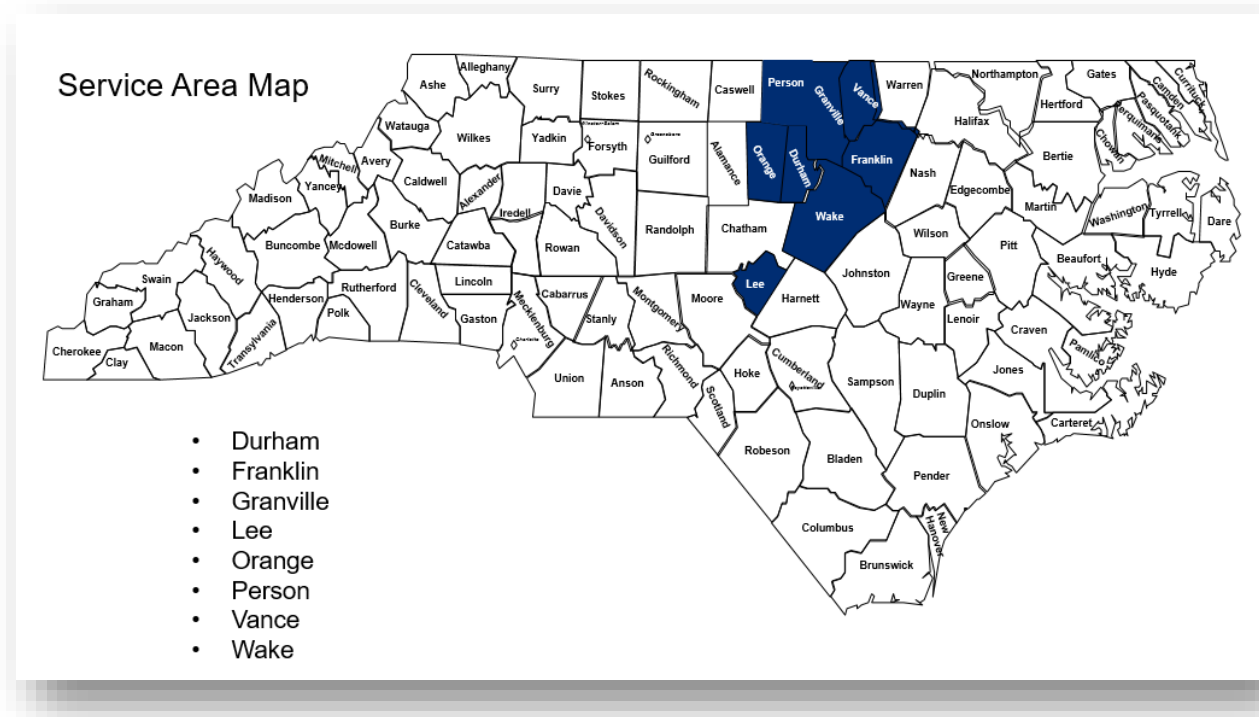
Experience Health Medicare Advantage (HMO) is available to individuals eligible for Medicare Part A and enrolled in Medicare Part B. Due to Federal regulations people with end-stage renal disease may not be eligible unless they meet exception criteria.

Experience Health Medicare Advantage (HMO) is a Medicare Advantage plan that includes health care benefits with prescription drug coverage.

Experience Health Medicare Advantage (HMO) is offered by Experience Health.

Experience Health is available only in select counties across North Carolina within the service area approved by the Centers for Medicare & Medicaid Services (CMS).

Medicare beneficiaries must live in the following service area in order to enroll:



The service area listing is current as of the publication date of this manual. As the service area expands, we will provide updates, available on the web at ExperienceHealthNC.com.

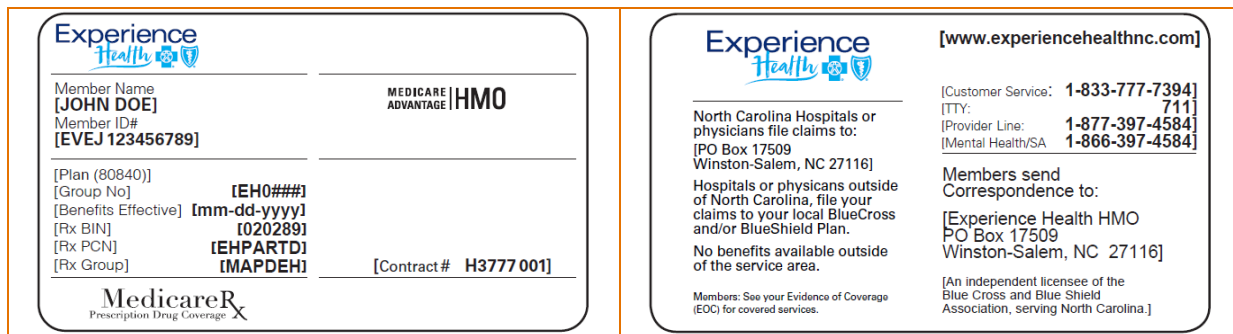
4.2 Experience Health identification cards

Experience Health members will reside in the CMS-approved service area counties of Durham, Franklin, Granville, Lee, Orange, Person, Vance, or Wake, North Carolina.

Below is a sample of the Experience Health Member ID:

Membership ID Card – Front

Membership ID Card – Back



4.3 Member identification card for Experience Health Medicare Advantage (HMO)

All Experience Health Medicare Advantage (HMO) members will receive a member ID card when they are enrolled. Patients should be asked to present their Experience Health Medicare Advantage (HMO) ID card at the time of their visit. You will find it helpful to make a copy of both sides of the member ID card when it is presented by the member. Members should present this card to receive services and not their Traditional Medicare card.

4.4 [Reserved for future use]

4.5 Verification of membership

Possession of an Experience Health member ID card does not guarantee eligibility for benefits coverage or payment. Providers should verify eligibility with Experience Health in advance of providing services.

Except in an emergency medical condition, providers are required prior to rendering any services to Experience Health members, to request and examine the member’s Experience Health identification card. If a person representing himself or herself as an Experience Health member lacks an Experience Health membership card, the provider shall contact Experience Health by telephone for verification before denying such person provider services as an Experience Health member. In an emergency medical condition, the provider will follow these procedures as soon as practical. In the event member is determined to be ineligible for coverage due to retro-active enrollment activity and/or incorrect information submitted to Experience Health, Experience Health will not be responsible for payment for services rendered and provider may seek compensation from member.

Please refer to the formulary at <https://www.myprime.com/en/medicines.html#find-medicine>

4.6 Core Benefits for Experience Health Medicare Advantage (HMO)

This summary of benefits for Experience Health members is not a guarantee of benefits coverage. Always verify member eligibility and benefits prior to providing services.

Experience Health provides coverage for:

- Inpatient/outpatient services
- Skilled nursing facility care
- Home health care
- Prescription drugs
- Worldwide emergency medical care
- Ambulance and urgent care

- Preventive care

Experience health is a Medicare Advantage plan that provides members care and services from doctors and hospitals that are within the Plan’s defined network.

Experience Health has one (1) plan: Medicare Advantage HMO. This plan is available in selected counties.

Note: Benefits, premium and/or copayment / coinsurance may change on January 1 of each year. The benefit information provided herein is a brief summary, but not a complete description of available benefits. A member’s complete benefits should always be verified in advance of providing service.

1. A formulary applies for all plans that include Medicare prescription drug coverage.

4.7 [Reserved for future use]

4.8 Enhanced Benefits for Experience Health Medicare Advantage (HMO)

4.8.1 Fitness Benefit

Members have access to more than 11,000 participating fitness and wellness facilities throughout the country, many offering amenities such as pools, exercise equipment, treadmills and free weights. Plus, they can participate in SilverSneakers® FLEX classes taught by certified instructors at recreation centers, retirement communities, parks and other local venues.

For members who cannot get to the gym, they can use the SilverSneakers GO™ fitness app to watch exercise videos from their smartphone or other device.

4.8.2 Hearing Aids Benefit

Up to two TruHearing-branded hearing aids every year (one per ear, per year). Benefit is limited to TruHearing’s Advanced and Premium hearing aids, which come in various styles and colors. Members must see a TruHearing provider to use this benefit. Call 1-866-201-9212 to schedule an appointment (for TTY, dial 711).

Hearing aid purchase includes:

- 3 provider visits within first year of hearing aid purchase
- 45-day trial period
- 3-year extended warranty
- 48 batteries per aid for non-rechargeable models

Note: Exclusions and limitations apply - See the member’s [Evidence of Coverage](#) “Hearing Services” benefit for more information.

- 4.8.3 World Wide Coverage Benefit
- 4.9 [Reserved for future use]
 - 4.9.1 [Reserved for future use]
 - 4.9.2 [Reserved for future use]
 - 4.9.3 [Reserved for future use]

Chapter 5: Participating Physician Responsibilities

5.1 Participating physician responsibilities

Experience Health Primary Care Physicians (PCPs) are responsible for providing or arranging for all appropriate medical services for Experience Health members, including preventive care, and the coordination of overall Care Management for the patient. Members enrolled in the Experience Health Medicare Advantage (HMO) plan may be referred for specialist care outside of their primary care physician’s office, through the Specialist Referral process (see chapter 11). The following specialists may serve as PCPs in certain situations:

- Family practice / general practice doctors provide care for infants, children, adolescents and adults in the areas of community medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.
- Internists (internal medicine) provide service for treatment of diseases in adults. Normally, they do not deliver babies, treat children or perform surgery.
- Geriatric doctors provide care for older adults.

Specialists are expected to render high quality care appropriate to the needs of Experience Health members requiring specialized treatment.

5.2 Mental health and substance abuse

Mental health and substance abuse services do not require a referral from the primary care physician. Please contact Provider Services at 1-877-397-4584 for assistance.

5.3 Advance directives

(Please also refer to Chapter 3, Administrative policies and procedures)

Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to exclude advance directives. The physician providing care for adult Experience Health members will inquire about each adult member’s intention to complete these directive documents and note in the member’s medical record whether he/she has executed an advance directive. Such notations will be reviewed at the time of the recredentialing medical record review.

5.4 Physician case management services

Physician case management services including, but not limited to, team conferences, telephone calls for medical management and/or consultation, prescriptions and prescription refills for Experience Health patients. Compensation for such services is subject to Experience Health fee schedules and policies, however, Experience Health fee schedule at this time allows no compensation for services billed separately by CPT or HCPCS case management codes. Experience Health considers such services part of

overall case management and compensation is included in other payments to our providers. Experience Health patients must not be billed directly for case management services.

5.5 Physician availability

Primary Care Physicians (PCPs)*

Experience Health PCPs are available twenty-four (24) hours a day, seven (7) days a week. If a physician is not available, another contracted doctor will be available to provide access to care.

OB / GYNs*

Experience Health gives women the advantage of having a PCP plus an OB / GYN. Women may see any Experience Health contracted OB / GYN without a referral from the PCP.

Vision care specialists*

No referral is required to access participating optometry or ophthalmology providers for vision care.

Physician specialists*

Specialists servicing Experience Health members are available twenty-four (24) hours a day, seven (7) days a week. Referrals are required for most Specialist services. Please see section 11.3 of this manual for more information.

* Please see your Certificate of Coverage for more details, or call Experience Health Customer Service at 1-833-777-7394, Monday -Friday, 8:00 a.m. until 8:00 p.m. (TTY: 711).

Chapter 6: Quality Improvement Program

6.1 Quality Improvement overview

Experience Health believes Quality Improvement (QI) is an imperative component of its managed care product offering.

The Quality Improvement Program (QIP) supports Experience Health’s ongoing commitment to quality.

Experience Health promotes an environment dedicated to being caring, creative, collaborative, and committed. Remaining true to the culture will help us achieve our vision to “be a leader in improving the health care system in North Carolina.”

- Caring – We distinguish ourselves through superior customer focus and focusing on the larger good of the organization through Enterprise thinking.
- Collaborative – We trust our colleagues. We do our best and most important work through teamwork. We know openness to new ideas will help us shape the future of North Carolina’s health system.
- Committed – We show dedication to do our best work. We take personal accountability by having the courage to identify problems, and the vision to create solutions.
- Creative – We know that embracing change is critical to our success. We focus on innovation and problem solving. We share our ideas and seek opportunities for simplification and continuous improvement every day.

Consistent with current professional knowledge, Experience Health defines **quality of care** for individual populations as the degree to which health services increase the likelihood of desired health outcomes.

Quality of service is defined as the ease and consistency with which customers obtain high quality care, as measured by customer perception and objective benchmarks.² This includes appropriate access to care.

In determining the scope and content of its Quality Improvement Program (QIP), Experience Health recognizes several concepts related to the delivery of health care, including:

- Quality of care and service is a crucial and integral component of health care delivery.
- Existing and potential customers' / groups' unique needs and expectations must be satisfied and exceeded.
- Provider relationships with patients and the Plan must be continually improved.
- Legislative and regulatory requirements must be met and Experience Health must provide leadership for efforts to reform the health care system.

The Quality Improvement Program (QIP) is ongoing and designed to be proactive. It objectively and systematically monitors the quality and appropriateness of the care, service, and access provided to members through Experience Health's Provider Network. The QIP then identifies, implements, monitors and evaluates appropriate interventions to improve the quality of care and service. In other words, the QIP is intended to link the concern for quality and the demonstrated improvement.

The QIP advocates the principles of Continuous Quality Improvement (CQI).

CQI concepts and techniques including the Shewhart Cycle or Plan, Do, Study, Act (PDSA) model; population statistics; and other relevant data sources help focus QI efforts and point to the need for specific projects (Exhibit I). The QIP undergoes constant revision in order to more effectively monitor, evaluate, and improve care.

The program goals are:

- To support corporate objectives and strategies, including cost-effectiveness and efficiency of care, while continuously improving care outcomes and service delivered to Experience Health members.
- To increase the accountability for results of care and service.
- To maintain member confidentiality, dignity, and safety as they seek and receive care.
- To foster a supportive environment to help practitioners and providers improve the safety of their practice.
- Utilizing evaluative feedback from customers and providers to assess and continually enhance care delivery and outcomes.
- To improve clinical effectiveness.
- To incorporate QIP results into the selection and recredentialing of network providers and enhance the network providers' ability to deliver appropriate care and meet or exceed the expectations of the patient / member.
- To enhance the overall marketability and positioning of Experience Health as the best health care company in North Carolina.
- To promote healthy lifestyles and reduce unhealthy behaviors in our members and throughout the communities served.
- To collaborate with providers to promote continuity and coordination between medical and behavioral health care.
- To minimize the administrative costs and burdens incurred by managed care methods.

- To maintain and enhance Quality Improvement processes and outcomes that satisfies the requirements of the Centers for Medicare & Medicaid Services (CMS).
- Serve a culturally and linguistically diverse membership by:
 - Conducting patient focused interventions with culturally competent outreach materials.
 - Providing information, training, and tools to staff and practitioners to support culturally competent communication.
- Demonstrate commitment to improving safe clinical practice by:
 - Improve continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes.
 - Use site-visit results from practitioner and provider credentialing to improve safe practices.
 - Analyze and take action on complaint and satisfaction data that relate to clinical safety.
 - Implement pharmaceutical management practices that require safeguards to enhance patient safety.

¹ Adapted from the Institute of Medicine.

6.2 Access to care standards – primary care physician

Experience Health has established the following access to care standards for primary care physicians.

EMERGENT CONCERNS (LIFE THREATENING) SHOULD BE REFERRED DIRECTLY TO 911 OR THE CLOSEST EMERGENCY DEPARTMENT. IT IS NOT NECESSARY TO SEE THE PATIENT IN THE OFFICE FIRST.

Wait time for appointment (number of days)

- Urgent – not life threatening, but a problem needing care within 48 hours
 - Pediatrics: See within 48 hours
 - Adults: See within 48 hours
- Symptomatic non-urgent – e.g., cold, no fever
 - Pediatrics: Within 30 calendar days
 - Adults: Within 30 calendar days
- Follow-up of urgent care
 - Pediatrics: Within 7 days
 - Adults: Within 7 days
- Chronic care follow-up – e.g., blood pressure checks, diabetes checks
 - Pediatrics: Within 14 days
 - Adults: Within 14 days
- Complete physical / health maintenance
 - Pediatrics: Within 30 calendar days
 - Adults: Within 30 calendar days

Time in waiting room (minutes)

- Scheduled: 30 minutes – After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes
- Work-ins / Walk-ins (Called that day prior to coming): Pediatrics and Adults – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time = 90 minutes. Walk-ins are discouraged but reasonable efforts should be made to accommodate patients. Life threatening emergencies must be managed immediately.

After hours calls and coverage

- Response time returning call after-hours and during lunch
 - *Urgent: 20 minutes
 - Other: 1 hour

***Note:** Most answering services cannot differentiate between urgent and non-urgent. Times indicated make assumption that the member notifies the answering service that the call is urgent, and that the physician receives enough information to make a determination.

- Coverage: Practice has a recorded telephone message instructing the patient to go to the ER for any life-threatening event or refer them to the physician on-call or to an answering service.
- Language: Interpreter services are available either in the practice, with a contracted company or through hospital services.
- Office hours: Indicates the posted hours during which appropriate personnel is available.
 - Daytime Hours / Week: 7 hours per day x 5 days = 35 hours
 - Night Hours / Weekend: 24 hour / day coverage

6.3 Access to care standards – specialist (including non-MD specialist)

The following access to care standards for specialists have been established by our physician advisory group. Non-MD specialists are Chiropractors (DC), Podiatry (DPM), Physical Therapy (PT), Speech Therapy (ST), and Occupational Therapy (OT).

1. Waiting time for appointment (number of days)	
1. Urgent – not life threatening, but a problem needing care within 48 hours	
PEDIATRICS	See within 48 hours
ADULTS	See within 48 hours
2. Symptomatic non-urgent – e.g., cold, no fever	
PEDIATRICS	Within 30 calendar days
ADULTS	Within 30 calendar days
3. Follow-up of urgent care	
PEDIATRICS	Within 7 days
ADULTS	Within 7 days
4. Chronic care follow-up – e.g., blood pressure checks, diabetes checks	
PEDIATRICS	Within 14 days
ADULTS	Within 14 days
5. Complete physical / health maintenance	
PEDIATRICS	Within 30 calendar days
ADULTS	Within 30 calendar days
2. Time in waiting room (minutes)	
A. Scheduled	
30 minutes	
After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes	
B. Work-ins / Walk-ins	
(Called that day prior to coming)	
Pediatrics and Adults – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time = 90 minutes.	

Walk-ins are discouraged but reasonable efforts should be made to accommodate patients. Life threatening emergencies must be managed immediately.	
3. After hours calls and coverage	
1. Response time returning call after-hours and during lunch	
*URGENT	20 minutes
OTHER	1 hour
*Note: Most answering services cannot differentiate between urgent and non-urgent. Times indicated make assumption that the member notifies the answering service that the call is urgent, and that the physician receives enough information to make a determination.	
2. Coverage	
Practice has a recorded telephone message instructing the patient to go to the ER for any life-threatening event or refer them to the physician on-call or to an answering service.	
4. Language	
Interpreter services are available either in the practice, with a contracted company or through hospital services.	
5. Office hours	
Indicates the posted hours during which appropriate personnel is available.	
DAYTIME HOURS / WEEK	7 hours per day x 5 days = 35 hours
NIGHT HOURS / WEEKEND	24 hour / day coverage

6.4 Facility standards

The following standards for the facilities of practices participating in the Experience Health network have been adopted by Experience Health and endorsed by the physician advisory group for use in assessing the environment in which health care is provided to our members.

1. The general appearance of the facility provides an inviting, organized and professional demeanor including, but not limited to, the following:
 - a. The office name is clearly visible from the street.
 - b. The grounds are well maintained; patient parking is adequate with easy traffic flow.
 - c. The waiting area(s) are clean with adequate seating for patients and family members.
 - d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. Conversations in the office / treatment area should be inaudible in the waiting area.
2. There are clearly marked handicapped parking space(s) and handicapped access to the facility or a documented process for assisting handicapped patients into the building.
3. A smoke-free environment is promoted and provided for patients and family members.
4. Fire Extinguishers
 - a. A fire extinguisher is clearly visible and is readily available.
 - b. Fire extinguishers are checked and tagged yearly.

5. Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e., grab bars).
6. Building Emergency
 - a. There is an evacuation plan posted in a prominent place or exits are clearly marked, visible, and unobstructed.
 - b. There is an emergency lighting source.
7. Halls, storage areas, and stairwells are neat and uncluttered.
8. Patient Confidentiality
 - a. There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses: 1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e., specialists, hospitals, 3rd party payers, state or federal agencies; and 2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.
 - b. All employees including the contract transcriptionists, if applicable, sign a written confidentiality statement.
9. Medications and Supplies Access
 - a. Restricted, biohazard, or abusable materials (i.e., drugs, needles, syringes, prescription pads, and patient medical records) are secured and accessible only to authorized office /medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.
 - b. Controlled substances are maintained in a locked container / cabinet. A record is maintained of use.
 - c. There is a procedure for monitoring expiration dates of all medications in the office (i.e., medications log)
10. * Patient Emergencies
 - a. Dedicated emergency kit is available which must include sufficient equipment / supplies to support life until patient can be moved to an acute care facility (at minimum: ambu bag (adult and pediatric, if applicable) and oxygen).
 - b. At least one (1) staff member is certified in CPR or basic life support.
 - c. Emergency procedures are in place and are reviewed with staff members annually. Review must be documented.
 - d. Emergency supplies include, but are not limited to, emergency medications (aspirin
 - e. [adults only], oral glucose, epinephrine, and Benadryl¹).
 - f. Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.
11. There is a written procedure which is in compliance with state regulations for oversight of mid-level practitioners.
12. There is a procedure for ensuring that all licensed personnel have a current, valid license.
13. A written infection control policy / program is maintained by the practice.
14. There is an annual review and staff in-service on infection control.
15. Sterilization procedures and equipment are in place and being followed.
16. The practice has an Automated External Defibrillator (AED) as part of the emergency equipment.

Note: Standards preceded by an asterisk (*) are critical elements. Failure to comply with any of these (numbers eleven [11] and twelve [12] inclusively) could result in a shortened credentialing cycle or

possible removal from the network. Failure of a critical indicator is taken to the credentialing committee the month of the review. nd maintains a log to check functionality (not scored).

6.5 Medical record standards for primary care providers and OB / GYN providers

Standard	Supporting Documentation
1. All pages contain patient identification	Each page in the medical record must contain the patient's name or I.D. number.
2. Each record contains biological / personal data	Biographical / personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth and marital status. This data should be updated periodically.
3. The provider is identified on each entry	Each entry in the medical record must contain author identification (signature or initials).
4. All entries are dated	Each entry in the medical record must include the date (month, day, and year).
5. The record is legible	The medical record must be legible to someone other than the writer.
6. There is a completed problem list	The flow sheet includes age appropriate preventive health services. A BLANK PROBLEM LIST OR FLOW SHEET DOES NOT MEET THIS STANDARD.
7. Allergies and adverse reactions to medications are prominently displayed	Medication allergies and adverse reactions are PROMINENTLY noted in a CONSISTENT place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA (no known allergy) or NKDA (no known drug allergy) to signify this. It is best to date all allergy notations and update the information at least yearly.
8. The record contains an appropriate past medical history	Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, illnesses. For children and adolescents (age 18 and younger) past medical history relates to prenatal care, birth, operations and childhood illness. The medical history should be updated periodically.
9. Documentation of smoking habits and alcohol use and substance abuse is noted in the record	The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes, and smokeless tobacco), alcohol (beer, wine, liquor), and substance abuse (prescription, over-the-counter, and street drugs) for all patients age 12 and above who have been seen 3 or more times. It is best to include the amount, frequency, and type in use notations.

10. The record includes a history and physical exam for presenting complaints	The history and physical documents appropriate subjective and objective information for presenting complaints.
11. Lab and other diagnostic studies are ordered as appropriate	Lab and other diagnostic studies are ordered as appropriate to presenting complaints, current diagnosis, preventive care, and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12. The working diagnoses are consistent with the diagnostic findings	The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.
13. Plans of action / treatments are consistent with the diagnosis(es)	Treatment plans are consistent with the diagnosis.
14. Each encounter includes a date for a return visit or other follow-up plan	Each encounter has a notation in the medical record concerning follow-up care, calls, or return visits. The specific time should be noted in days, weeks, months, or PRN (as needed).
15. Problems from previous visits are addressed	Unresolved problems from previous office visits are addressed in subsequent visits.
16. Appropriate use of consultant services is documented	Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17. Continuity and coordination of care between primary and specialty physicians or agency documented	If a consult has been requested and approved, there should be a consultation note in the medical record from the provider (including consulting specialist, SNF, home infusion therapy provider, etc.)
18. Consultant summaries, lab and imaging study results reflect review by the primary care physician	Consultation, lab, and x-ray reports filed in the medical record are initialed by the primary care physician or some other electronic method is used to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
19. Care is demonstrated to be medically appropriate	Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.
20. A complete immunization record is included in the chart	Pediatric medical records contain a completed immunization record or a notation that “immunizations are up-to-date.”
21. Appropriate use of preventive services is documented	There is evidence in the medical record that age appropriate preventive screening and services are offered in accordance with the organization’s practice guidelines. (Refer to the Medical Policy section of your provider manual.) It is best to note if patient refuses recommended screenings and/or services (3 or more visits every 3 years).
22. Charts are maintained in an organized format	There is a record keeping system in place that ensures all charts are maintained in an organized

	and uniform manner. All information related to the patient is filed in the appropriate place in the chart.
23. There is an adequate tracking method in place to insure retrievability of every medical record	Each medical record required for patient visit or requested for review should be readily available.
24. Review of chronic medications, if appropriate, for the presenting symptoms	There is documentation in the record, either through the use of a medication sheet or in the progress notes, that medications have been discussed as appropriate.
25. Each record of an Experience Health Medicare Advantage (HMO) member includes information regarding advanced directives.	The medical record of an Experience Health Medicare Advantage (HMO) member has a documented notation of whether the member has executed an advanced directive.
26. The primary care medical record of Experience Health Medicare Advantage (HMO) members include documentation of the Health Risk Assessment (HRA).	The report of the initial Health Risk Assessment (HRA) of Experience Health Medicare Advantage (HMO) members determined to be potentially at a high-risk status should be evident in the medical records. There is documentation of review by the PCP, and the treatment plan incorporates information from the risk assessment.
Documentation of medical record format used in practice	<ul style="list-style-type: none"> • Paper • EMR – Electronic Medical Record system is a medical record in an electronic format. • EHR – Electronic Health Record is a system that is electronic and has searchable data fields that allow reports to be run. • Name of EHR system and the version being used.

6.6 Clinical practice and preventive care guidelines overview

Clinical practice and preventive care guidelines help clarify care expectations and, when possible, are developed based on evidence of successful practice protocols and treatment patterns. Clinical practice guidelines are intended to be used as a basis to evaluate the care that could be reasonably expected under optimal circumstances. Preventive care guidelines provide screening, testing, and service recommendations based upon national standards.

Nationally accepted guidelines

Experience Health endorses the following nationally recognized clinical practice and preventive care guidelines:

Practice Guidelines		
Diagnosis	Source	Website
COPD	Global Initiative for Chronic Obstructive Lung Disease (GOLD), based on the collaborative	www.goldcopd.com

	recommendations of the World Health Organization and the National Heart, Lung and Blood Institute: Executive Summary: Global Strategy for the Diagnosis, Management, and Prevention of COPD (Guidelines)	
Diabetes	American Diabetes Association: Clinical Practice Recommendations	www.diabetes.org
Heart failure	ACCF / AHA Guideline for the Management of Heart Failure	www.heart.org
Hypertension	National Institutes of Health National Heart Lung Blood Institute – Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)	www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.htm
Coronary Artery Disease (CAD)	American Heart Association	www.heart.org
Tobacco counseling	U.S. Preventive Services Task Force	https://www.uspreventiveserVICEStaskforce.org/Page/Name/recommendations
Perinatal care	American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, 7th edition	https://sales.acog.org/Guidelines-for-Perinatal-Care-Eighth-Edition-P262.aspx
Depression	American Psychiatric Association	http://www.psychiatryonline.org/content.aspx?bookid=28&sectionid=1667485

Preventive health guidelines

Preventive health guidelines are standards of care developed to encourage the appropriate provision of preventive services to patients, according to their age, gender, and risk-status. These services include screenings, immunizations, and physical examinations.

Service	Source	Website
Initial medical evaluation of adults	U.S. Preventive Services Task Force; American Academy of Family Physicians	www.aafp.org/online/en/home/clinical/exam.html www.uspreventiveserviceSTaskforce.org
Periodic health assessment for newborn / infants to 24 months	U.S. Preventive Services Task Force	www.uspreventiveserviceSTaskforce.org
Periodic health assessment for children and	U.S. Preventive Services Task Force; American Academy of Family Physicians	www.aafp.org/online/en/home/clinical/exam.html www.uspreventiveserviceSTaskforce.org

adolescents, 2-19 years old		
Periodic health assessment for adults, 20-64 years old	United States Preventive Services Task Force (USPSTF), Guide to Clinical Preventive Services; American Academy of Family Physicians, Summary of Recommendations for Clinical Preventive Services	www.uspreventiveservicestaskforce.org www.aafp.org/online/en/home/clinical/exam.html
Periodic health assessment for adults, 65 years and older	United States Preventive Services Task Force (USPSTF), Guide to Clinical Preventive Services; American Academy of Family Physicians, Summary of Recommendations for Clinical Preventive Services	www.uspreventiveservicestaskforce.org www.aafp.org/online/en/home/clinical/exam.html
Routine immunizations	Centers for Disease Control and Prevention	www.cdc.gov/vaccines

Please note that guidelines are subject to change. Providers are encouraged to visit the websites for the nationally recognized clinical practice and preventive care guidelines regularly, to receive the most current and up-to-date information available.

Chapter 7: Emergency Care Coverage

7.1 Emergency care coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity; including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition, that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

Emergency services are covered inpatient or outpatient services which are (1) furnished by a provider qualified to furnish emergency services and (2) needed to stabilize or evaluate a emergency medical condition.

Coverage is provided worldwide and prior authorization is not required.

If a member experiences an emergency medical condition, he / she is advised to seek care from the nearest medical facility, call 911 or to seek direction and/or treatment from a physician.

7.2 Urgently needed services

Urgently needed services are covered services, that are not emergency services, provided when an enrollee is temporarily absent from the Plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the Plan's Provider Network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

- 1) As a result of an unforeseen illness, injury or condition, and
- 2) It was not reasonable given the circumstances to obtain the services through plan providers

If such a medical need arises, we request that the member or a representative contact the member's PCP if possible, then seek care from a local doctor or other provider as directed by the PCP. If the member is unable to do the above, he / she may seek care from a hospital emergency room or urgent care center. Prior authorization is not required for urgently needed services.

Chapter 8: Utilization Management Programs

8.1 Affirmation action statement

Experience Health and its associated delegates require practitioners, providers and staff who make Utilization Management-related decisions to make those decisions solely based on appropriateness of care and existence of coverage. Experience Health does not compensate or provide any incentives to any practitioner or other individual conducting Utilization Management review to encourage denials. Experience Health makes it clear to all staff that make Utilization Management decisions that no compensation or incentives are in any way meant to encourage decisions that would result in barriers to care, service or under-utilization of services.

8.2 Pre-authorization review

Experience Health reviews health care service requests prior to an admission or initiation of a course of treatment for those services that require pre-authorization (as specified elsewhere in this manual). Pre-authorization decisions will be made as expeditiously as the member's condition requires, but no later than fourteen (14) calendar days after the Plan receives the request (or within seventy-two [72] hours for expedited requests). An extension of up to fourteen (14) calendar days may be given if the member so requests or if the Plan justifies a need for additional information and exhibits how the delay is in the best interest of the member. Authorized services and subsequent review dates are communicated to the requesting provider, either verbally or in writing in accordance with CMS regulations. Notification of Organization Determinations will comply with requirements outlined by CMS.

8.3 Inpatient review

Experience Health licensed nurses perform telephonic reviews for emergency admissions and ongoing hospital stays to determine medical necessity, facilitate early discharge planning and to assure timely and efficient health care services are provided. Coverage decisions are made as expeditiously as the member's health condition requires.

8.4 Medical case management

Experience Health reviews specific needs of members whose conditions are complex, serious, complicated, chronic or indicative of long term or high cost medical care and assists physicians and health care team members to coordinate delivery of high quality services for members in the most effective manner possible. See additional information online at [the Experience Health Provider Resource page](#).

8.5 Ambulatory review

Some services performed or provided in an outpatient setting, such as physician offices, hospital outpatient facilities or, freestanding surgi-centers, require prior authorization. If prior authorization is not required, retrospective review may be conducted to ensure that care provided is necessary and medically indicated.

8.6 Hospital observation

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and

necessary to evaluate a patient’s outpatient condition or determine the need for a possible admission to the hospital as an inpatient.

An admission to observation by the attending physician does not require prior plan approval.

In order to be successful in assuring medically appropriate quality care, we rely on your cooperation. Timely, appropriate reviews require prompt notification of inpatient admissions, the submission of complete medical information or access to patient charts and specification of discharge needs. If after the initial observation period the member’s clinical status deteriorates or remains unstable and/or additional clinical information is provided which meets health guidelines for admission, the nurse may authorize an inpatient stay retroactive to the date of the member’s admission to the facility as an observation patient.

If the member has been discharged, at the time the hospital notifies the Plan of the inpatient admission, the review of the observation to inpatient level of care will be completed when the claim is processed.

8.7 Diagnostic imaging services

Experience Health wants to ensure that high-tech diagnostic imaging services are performed at the appropriate time and in the appropriate sequence. The Centers for Medicare & Medicaid Services encourage the avoidance of over-utilization and promotes patient safety in connection with diagnostic imaging.

To promote these goals, Experience Health requires prior authorization for the (non-emergency) high tech diagnostic imaging services listed below when performed in a physician’s office, the outpatient department of a hospital, or a freestanding imaging center:

- CT / CTA scans
- MRI / MRA scans
- Nuclear cardiology studies
- PET scans
- Echocardiography

Additional information about the diagnostic imaging program for Experience Health Medicare Advantage (HMO) members is available in this manual located in Chapter 9, Section 9.4 and online at [the Experience Health Provider Resource page](#).

8.8 Medical Director’s responsibility

It is the policy of Experience Health to have a Medical Director review any case involving questionable medical necessity.

This policy is designed to ensure that Medical Directors are involved in the Utilization Management (UM) decision process. Final determinations ensure that medically necessary, safe and cost-effective care is rendered in the most appropriate setting or level of care.

The Medical Director may be able to make a determination based on the information provided; however, in some cases, the Medical Director may request additional clinical information or elect to contact the attending physician to obtain additional information, to discuss an alternative treatment plan, or to review the decision with the provider.

8.9 New technology and new application of established technology review

Experience Health reviews new technologies and new applications of established technologies in a timely manner and may approve or deny coverage for use of a new technology or new application of an

established technology. “Technologies” may include treatments, supplies, devices, medications and procedures. The review of new technologies and new applications of existing technologies is based on a standardized process which considers formal research, existing protocols, potential risks and benefits, costs, effectiveness and governmental approvals. Experience Health complies with decisions of local carriers based on local coverage determinations and CMS national coverage determinations and guidelines.

8.10 Retrospective review

Retrospective medical necessity review may be conducted when notification is received for services already provided. The review of the retrospective service will be completed when the claim is processed.

Non-certification of service requests

Experience Health may deny coverage for an admission, continued stay or other health care service. Non-certification determinations based on Experience Health requirements for medical necessity, appropriateness, health care setting or level of care or effectiveness, are made by a Medical Director.

Written notification of general non-certifications are mailed by Experience Health to the member and provider(s) within the CMS timelines for the case under review. Non-certifications will include reasons for the non-certification, including the clinical rationale, alternative for treatment that Experience Health deems appropriate, and instructions for initiating a voluntary appeal or reconsideration of the non-certification. Non-certifications related to continued care in skilled nursing facilities, home health and comprehensive outpatient rehabilitation facility services are distributed by the provider within two (2) days prior to the end of the service authorization or termination of services.

Coverage for services which are subject to the exclusions, conditions and limitations outlined in the member’s evidence of coverage and consistent with Original Medicare coverage guidelines, may be denied by the Review staff without review by a Medical Director.

8.11 Standard data elements

Information required to make Utilization Management decisions and to certify an admission, procedure or treatment, length of stay and frequency and duration of health care may include:

- Clinical information, including primary diagnosis, secondary diagnosis, procedures or treatments, if any.
- Pertinent clinical information to support appropriateness and level of service requests, such as history and physical, laboratory findings, progress notes, second opinions and any discharge planning.
- Resources, including facility type, name, address and telephone, any surgical assistant information, anesthesia if any, admission date, procedure date and requested length of stay.
- Continued stay if any, including date, entity contact, provider contact, additional days or visits requested, reason for extension, diagnosis and treatment plan.

Occasionally after making a reasonable effort, the necessary clinical information may not be available or obtainable to make a coverage decision. Coverage decisions will be based on the clinical information available at the time of review.

8.12 Disclosure of Utilization Management criteria

Participating providers, covered members and bona fide prospective participants may receive copies of the following upon request:

- An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by covered or prospective members. The explanation may be in writing if so requested.
- Written reasons for denial of recommended treatments and an explanation of the clinical review criteria or treatment protocol upon which the denial was based.
- The Experience Health formulary and prior authorization requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a non- formulary drug may be covered.
- The Experience Health procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental.

8.13 Care coordination services

Because of the unique health care needs of the Medicare population, health care providers must work as a team to provide and arrange for those necessary health care services. To accomplish this, Experience Health and some of the contracting providers are using a care coordination approach.

Care coordination is personal, individualized and proactive assistance / intervention for providers and members. Continuing interaction between a nurse case manager and a patient under the supervision of the primary care physician can accomplish the following goals:

- Improve access to appropriate care through the availability of a full continuum of health care services including: preventive care, acute care, primary care, specialty care, long term care and home health services
- Match and manage patient health care needs to ensure appropriate, effective and efficient delivery of care
- Instruct and reassure the patients and families
- Increase the utilization and benefit of patient education, particularly in the areas of understanding disease processes and therapy, promotion of wellness and health risk reduction
- Coordinate care between different providers
- Avoid duplication of diagnostic tests and procedures

The case manager functions as an ombudsman for the patient and the patient’s family and as a facilitator and extender for the primary care physician. In this role, the care coordinator:

- Conducts health status / risk assessments
- Investigates, reports and assists in resolving complicating social and environmental problems
- Increases compliance with preventive and therapeutic programs
- Facilitates transfer of information between providers and sites of care
- Reviews and follows pharmaceuticals and other therapy to improve compliance and avoid unwanted drug interactions and reactions
- Coordinates social services outside the hospital setting

8.14 Service determination

Requests from providers for coverage of services will be responded to as expeditiously as the member’s health requires (Experience Health normally has up to fourteen [14] calendar days). In instances where the member’s health or ability to regain maximum function could be jeopardized by waiting up to fourteen (14) calendar days, the provider requesting coverage of services may request an expedited review, in which case the request will be responded to within seventy-two (72) hours. In either case, an

extension of up to fourteen (14) calendar days is permitted, if the member requests the extension or if the Plan justifies a need for additional information and the extension of time benefits the member. For example, the Plan might need additional medical records from non-contracting medical providers that could change a denial decision. When the Plan takes an extension, the member will be notified of the extension in writing. Also, in either case, the member will be notified in writing of any adverse coverage determination.

In situations where a member requests that a physician provide a service, and the provider does not believe that the service is appropriate and therefore chooses not to provide it, the member or authorized representative may contact Experience Health to appeal the provider's decision. To ensure that a member is notified of appeals rights regarding determinations, providers must notify the member of his / her right to receive from Experience Health, upon request, a detailed written notice regarding the denial and provide the member with information regarding how to contact Experience Health.

Chapter 9: Prior Authorization Requirements

9.1 Prior authorization guidelines

Prior authorization is a system whereby a provider or the member must receive approval from Experience Health before certain services will be covered in accordance with the member's evidence of coverage.

Cosmetic procedures are excluded in the evidence of coverage. Please contact the Care Management department for assistance in determining whether a procedure would be considered cosmetic or medically necessary. Refer to the Experience Health formulary for medications which may require prior authorization.

Refer to member's evidence of coverage for specific coverage of benefits.

To obtain prior authorization, providers can call 1-833-777-7394 and follow the prompts to reach Experience Health prior authorization.

Services on the Experience Health prior authorization guideline list require the provider or member to contact Experience Health to obtain an authorization. This list is reviewed periodically and may be changed with appropriate notification to physicians. Prior authorization guidelines are available for review online at the [Experience Health Provider Resource page](#).

9.2 Requesting durable medical equipment and home health services

Our contracting providers agree to follow Experience Health's prior authorization guidelines when ordering or dispensing Durable Medical Equipment (DME) for Experience Health members. Experience Health's prior authorization guidelines can be found online at the [Experience Health Provider Resource page](#).

Prior authorization is not required for DME that costs less than \$1,200 when certain criteria are met.

Prior authorization from Experience Health is required for all DME in the following circumstances:

1. DME items which cost more than \$1,200.
2. All rental items require prior authorization from Experience Health.
3. Support devices and supplies require prior authorization if the cost exceeds \$1,200.
4. Any eligible DME item that is provided as incidental to a physician's office visit.
5. DME provided by a home care provider during a covered home care visit.

6. Equipment and/or supplies used to assure the proper functioning of Experience Health approved DME (equipment or prosthetic).
7. DME provided by a home infusion provider during a covered visit.
8. DME without a valid HCPC code (not miscellaneous code). Providers may obtain prior authorization by calling Experience Health Provider Services at 1-877-397-4584. Please be prepared to provide the relevant clinical information to support the medical necessity of the DME request along with the following required information:
 - Patient’s name
 - Patient’s Experience Health ID number
 - Type of service or DME requested
 - Patient’s diagnosis / medical justification in relation to the requested service
 - Start and stop date of services
 - Ordering physician’s name

Participating home health / DME vendors are listed in the online provider directory for information only and should not be directly contacted for services.

Home health / DME services requiring arrangement on weekends and after Experience Health business hours may be retrospectively authorized the next business day if medical justification is met and participating vendors are utilized.

9.3 Prosthetics

Contracting providers in Experience Health Medicare Advantage (HMO) agree to follow Experience Health’s prior authorization guidelines when ordering or dispensing prosthetics for Experience Health members. Experience Health’s prior authorization guidelines can be found online at the [Experience Health Provider Resource page](#).

Coverage will be provided for prostheses and components when it is determined to be medically necessary and when the medical criteria and guidelines are met as outlined in Experience Health’s Medicare Part C Medical Coverage Policy. Experience Health’s Medical Coverage Policies can be found online at the [Experience Health Provider Resource page](#).

Covered services requiring prior authorization from Experience Health:

- A lower limb prosthetic is covered when the member:
 - Will reach or maintain a defined functional state within a reasonable period of time and;
 - When the member is motivated to ambulate.
- An upper limb prosthetic is covered to replace all or part of the function of permanently inoperative or malfunctioning extremity
- Prosthetic substitutions and/or additions of procedures and components are covered in accordance with the functional level assessment when an initial above or below knee prosthetic or a preparatory above knee prosthetic is provided. An explanation of “functional levels” is outlined in the Medical Coverage Policy titled, “[Prostheses – Artificial Limbs and Components](#)”. The Medical Coverage Policy can be accessed online at [the Experience Health Provider Resource page](#).
- Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Non-covered services:

- Coverage will not be approved when the member’s functional level is “0”. Experience Health’s Medical Coverage Policy defines a member’s functional level as “0” when the member does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthetic does not enhance their quality of life or mobility.
- A user-adjustable heel height feature will be denied as not reasonable and necessary.
- Routine periodic servicing, such as testing, cleaning, and checking of the prosthetic.
- Prosthetic donning sleeve.
- Repair time used for the following:
 - Evaluating the member
 - Taking measurements
 - Making modifications to a prefabricated item to fit the member
 - Follow-up visits
 - Making adjustments at the time of delivery, or within ninety (90) days after delivery;

Providers may obtain prior authorization by calling Experience Health Provider Services at 1-877-397-4584. Please be prepared to provide the relevant clinical information to support the medical necessity of the prosthetic request.

9.4 Diagnostic imaging management program

AIM administers the diagnostic imaging management program for Experience Health for the management of outpatient, high-tech diagnostic imaging services for members covered under the Experience Health Medicare Advantage (HMO) plan. Participating providers arranging and providing outpatient diagnostic imaging services for these members are required to comply with the program’s prior authorization requirements for the services listed below when performed in a physician’s office, outpatient department of a hospital, or freestanding imaging center:

- CT / CTA scans
- MRI / MRA scans
- Nuclear cardiology studies
- PET scans

Prior authorization can be obtained and/or confirmed online by logging onto [Blue e](#), online at [the Experience Health Provider Resource page](#) to access AIM’s web-based application AIM ProviderPortalSM. If you are not currently registered to use [Blue e](#), you will need to register online at [the Experience Health Provider Resource page](#). Experience Health provides [Blue e](#) to providers free of charge. You may also request prior authorization by calling AIM toll free at 1-866-455-8414.

Neither AIM nor Experience Health will issue retro-certification. However, if the requested scan is of an urgent nature, the ordering physician can request the certification within forty-eight (48) hours of the procedure.

Prior authorization is required for all Experience Health Medicare Advantage (HMO) members.

Services included	MRI / MRA, CT / CTA, PET, nuclear medicine
Places of service included	Outpatient hospital, provider office, free-standing imaging center (inpatient hospital, hospital observation and urgent care centers are excluded).
Suppliers of the Technical Component	*Providers (non-hospitals) must be accredited by a CMS-approved organization in order to submit

	claims for the technical component of certain high-tech diagnostic imaging services.
Prior authorization	via Blue e or by calling AIM at 1-866-455-8414
Member program participation	All Experience Health Medicare Advantage (HMO) members.
Prior authorization CPT code list	Online at the Experience Health Provider Resource page
<p>* Information about the accreditation process is available on the Medicare Provider-Supplier Enrollment page. Advanced Diagnostic Imaging Accreditation, available at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html?redirect=/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp.</p>	

If you are not currently registered to use [Blue e](#), you will need to register online at [the Experience Health Provider Resource page](#). Experience Health provides [Blue e](#) to providers free of charge.

If you currently access the AIM ProviderPortal to request prior authorization for Experience Health members, you will not need to make any changes or create an additional account. Experience Health Medicare Advantage (HMO) member information became available in the AIM ProviderPortal as of January 1, 2020.

Note: [Blue e](#) is available to access AIM’s web-based application AIM ProviderPortal, however [Blue e](#) currently cannot be utilized to conduct other electronic transactions for the Experience Health Medicare Advantage (HMO) health care plan.

If you have questions regarding the diagnostic imaging management program, please contact Provider Network for assistance.

9.5 Protocol for potential organ transplant coverage

When a member is considered for any type of transplant, the following information needs to be submitted to Care Management’s staff for review:

- Member’s name
- Member’s Experience Health ID number
- Type of transplant being considered
- All transplants require prior authorization except corneal transplant
- Sufficient data to document diagnosis including a recent complete history and physical examination
- Treatment history
- Procedures / scans used to determine current stage of disease
- Reports of any specialty evaluations
- Copy of reports confirming diagnosis such as bone marrow examinations and/or biopsies

Upon receipt of the information, we will evaluate the records to determine coverage by Experience Health.

Our process needs to be completed before a referral is scheduled to any transplant facility for transplant evaluation. If the transplant is approved for coverage, Experience Health will provide you with a list of our approved hospitals for you and your patient to select a facility.

Chapter 10: Pre-Admission Certification

10.1 Pre-admission certification guidelines

All non-emergency hospital admissions require pre-certification by calling the Experience Health Care Management department. The following information will be requested:

- Member's name
- Member's Experience Health ID number
- Hospital name
- Admission date
- Admitting physician name
- Admitting diagnosis as well as any supportive or related information (i.e., lab / x-ray results, symptoms, relevant social and medical history, prior treatment and other medical conditions)
- Description of the proposed plan of treatment (i.e., surgery, medical justification for any pre-operative days, lab / radiological testing, medications, need for inpatient care vs. outpatient, admission orders if available, anticipated number of hospitalized days).

If a member is in the hospital longer than the anticipated initial length of stay, the Care Management department will contact you for updates. The information requested will include the following:

- Current medical status
- Current treatment warranting hospitalization
- Anticipated length of stay
- Anticipated discharge plan, including home care or equipment

10.1.1 Non-emergency pre-admission certification

In non-emergency situations, the hospital will permit admissions of Experience Health members to the hospital only upon the written or verbal authorization of a participating physician who has medical staff membership and admitting privileges at the hospital, and upon verification prior to admission that such admission is approved by Experience Health by telephoning a number supplied by Experience Health to the hospital, or if the hospital is unable to obtain such authorization by telephone, the hospital may permit the admission of the Experience Health member provided it verifies that such admission is approved by Experience Health on the morning of the next business day. For coverage and payment, the hospital agrees that in the event a physician is not designated as a participating physician on the Experience Health roster of participating providers, and the physician seeks to admit an Experience Health member to the hospital, the hospital shall contact Experience Health prior to admission or treatment, to verify such physician's status and/or the referral before rendering provider services, unless it is an emergency medical condition. The hospital shall not be entitled to compensation from Experience Health for provider services rendered if the hospital admits an Experience Health member without following the procedures set forth herein or Experience Health determines that the admission was not medically necessary or not in compliance with Experience Health policies, procedures and guidelines.

This does not prevent the hospital from providing services to Experience Health members admitted by non-contracting physicians in non-emergency situations when such admission is not approved by Experience Health.

10.1.2 Emergency admissions

In cases of emergencies concerning Experience Health members, the hospital is required to notify Experience Health within twenty-four (24) hours after admission of an Experience Health member as an inpatient to the hospital, or by the end of the first business day following the rendering of the emergency care, whichever is later, and to permit review of the admission by a Plan Medical Director or his or her designated representative. The hospital shall not be entitled to compensation from Experience Health for provider services rendered if the hospital fails to notify Experience Health of an admission of an Experience Health member within the time period agreed to above or Experience Health determines that the admission was not a covered service, or medically necessary and/or not in compliance with the terms of this agreement. The hospital's obligation to notify Experience Health shall be deemed to be satisfied when an employee of the hospital notifies a representative of Experience Health by telephone of the admission.

Chapter 11: Case Management

11.1 Case management overview

Case management is designed for members identified at risk for complex, chronic or rare medical conditions or with complicated health care needs. This program provides a nurse case manager who can assist physicians and health care team members to coordinate delivery of health care services for members in the most effective manner. Case managers are also available to assist members in navigating through the health care system, educate members regarding their medical condition, and promote members' compliance with the physician directed treatment plan.

11.2 Care Support Services

Experience Health offers a range of care support services for members to assist in coordinating care and managing certain health conditions. In addition to health and wellness coaching, these services include case management programs for qualifying individuals with chronic diseases and other complex conditions at no cost to the patient.

11.2.1 Requesting member assessment for Care Support services

Providers can request that a member be assessed for care support services by calling 1-919-660-3427 or by going online at ExperienceHealthNC.com/caresupport and submitting a request for assessment.

11.3 Specialist Referrals

Experience Health encourages Members to develop a relationship with a Primary Care Provider (PCP) in order to manage their overall health, coordinate care with other providers, and to have a resource for when they have questions about their health or health care. Members must choose a PCP upon enrollment in the Plan and may change their selection of PCP at any time by calling customer service. In most cases a referral is required from the PCP to see a Specialist in the Experience Health Medicare Advantage (HMO) Plan. The decision to get specialist care and which in-network specialist to choose, is entirely between members and their PCP. PCPs will simply let us know of the decision, so that benefits are applied correctly.

Certain services, like yearly screening mammograms, do not require a referral. PCPs will help arrange or coordinate health care services. This includes x-rays, laboratory tests, therapies, specialists, hospital admissions, and follow-up care. PCPs also contact other Providers for updates about the member's care and/or treatment. In some cases, the PCP or another Provider will need to get [Prior Authorization](#) (prior approval for services).

PCP Referral to Participating Specialist

In most cases, the member would be required to get a referral from their Primary Care Physician (PCP) on record, to see a specialist. Participating specialists are those specialists listed in the Experience Health Provider Directory, located on our website at ProviderDirectory.ExperienceHealthNC.com.

Prior to the member receiving services, a referral form must be completed by the PCP. The PCP will notify the specialist office of the diagnosis on the [Referral Form](#) and the number and types of services the member is being referred for.

The specialist is responsible for ensuring services are not rendered, outside of the referral made and for communicating with the PCP, if additional services and/or visits are necessary.

The specialist is required to remind the patient about the number of authorized visits and assist the member in obtaining a new referral, when indicated. The specialist cannot bill the member for services rendered, without a referral, where a referral is required.

11.3.2.1 Services Requiring a Referral

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Wound Clinic
- Nutritional Counseling
- Diabetic Teaching
- Other Services (not included in 11.3.2.2)

11.3.2.2 Services Not Requiring a Referral

Experience Health members can seek services from network providers, for the following services, without a referral from the PCP:

- Mental Health/Behavioral Health Services
- Medicare-covered and Supplemental Preventive Services identified in Chapter 4 of the member's evidence of coverage
- Vision Services
- Dental Services
- Hearing Services
- On-call services provided by the PCP's on-call provider
- Emergency room visits and associated services, such as labs and x-rays
- Durable Medical Equipment (DME)

Prior Approval and Specialist Referrals

Prior Approval requirements supersede the Specialist Referral requirements. For services requiring Prior Approval, the Specialist Referral process does not apply. Experience Health will follow the Prior Approval process, without consideration of the existence of a referral from the PCP. Prior Approval information can be located online at [the Experience Health Provider Resource page](#).

Multi-Specialty Practices

For referrals within multi-specialty practices, where multiple services will be rendered, a separate [Referral Form](#) is required for each specialist and or service in order to process the services appropriately. For example, if a member is referred to two specialists within the same practice and only one referral is received by the Plan, the claim for services rendered by the specialist, where the Plan did not receive a referral, will be denied.

Referrals from Primary Care Physicians to Primary Care Physicians for Members in Long Term Care Facilities

Experience Health members residing in long-term care (LTC) facilities may benefit from a contracting physician managing their medical care, when their PCP does not provide services at the LTC facility in question.

To facilitate the medical care of LTC members, Experience Health may allow the member’s PCP to complete a referral to another participating PCP. This referral option is available when the member’s PCP is unable to manage the member’s medical condition due to the PCP not providing services in the LTC facility. A new referral will be required every 90 days while the member is living in the LTC.

If the physician who is managing the care of the resident at the LTC facility is not in the Experience Health network, the member’s PCP must obtain prior approval from Experience Health, to refer the member to an out-of-network physician. The member’s PCP may request prior authorization for out-of-network services by calling Experience Health at 1-833-777-7394.

Preparation of the Referral Form

Note: If multiple services or specialists are required, complete a separate Referral Form for each service or specialist.

Box Number	Description	Instructions
R1	Date Form Created	This is the date that the PCP completes the referral form
R2	Member Name	
R3	Member ID#	Include only the “J” plus 8 numbers, from the member’s ID card
R4	Member Date of Birth	
R5	PCP Name	Member’s PCP on file with the Plan
R6	Specialist Name	In-network Specialist
R7	PCP Individual NPI	
R8	Specialist Individual NPI	
R9	Is this a new referral Y/N?	If this referral should replace an existing referral, check “no” and be sure the information in R6 and R8 match an existing referral on file
R10	Total # of Visits	
R11	Diagnosis Code	
R12	Referral Dates	If a previous referral for same provider/service has been submitted, assure the start date does not overlap the end date of the last referral.
R13	Start	Claims for dates of service prior to this date, will be denied, unless another referral is on file with the Plan. Referrals should only be for a maximum of 90 days.

R14	End	Claims for dates of service after to this date, will be denied, unless another referral is on file with the Plan
R15	Cardiac Rehab	
R16	Chiropractic	
R17	Diabetic Teaching	
R18	Nutritional Counseling	
R19	Physical & Occupational Therapy	
R20	Pulmonary Rehab	Maximum of 72 lifetime visits
R21	Speech Therapy	
R22	Wound Clinic	
R23	Other Services Not Requiring Prior Approval	Indicate what level of service this referral is for: <ul style="list-style-type: none"> • Level 1 – Evaluation Only • Level 2 – Evaluation & Diagnostics (including labs and x-rays) • Level 3 – Evaluation, Diagnostics & Treatment (up to and including surgery)

Referrals to Non-Participating Providers

Referrals to all non-participating providers/facilities must be preauthorized by Experience Health, except for emergency conditions.

See [section 9](#) of this manual for prior authorization requirements.

Unauthorized, non-emergency referrals to non-participating providers will not be treated as specialist referrals and will result in claim denials.

Mental Health/Substance Abuse

Mental health and substance abuse services do not require a referral from the primary care physician. Please contact Provider Services at 1-877-397-4584 for assistance.

Retrospective Referrals

Generally, Members may not self-refer to specialists, excluding those rendering the services identified in section 1.2. Claims for members who have self-referred will be denied. If the member wishes to appeal that denial, they may do so, following the Appeal process, described in their [Evidence of Coverage](#).

An exception will be made for claims resulting from a self-referral, only in the unusual events, such as:

- The member did not understand that a PCP referral was required and did not have a reasonable opportunity to learn about this requirement
- The member was unable to contact his/her PCP to obtain a referral, despite making reasonable efforts to do so
- Under the circumstances, it was medically necessary for the member to self-refer, rather than follow the Plan’s referral process

Members should contact their PCP to begin a retrospective referral.

Grace Period

The grace period is a thirty-day timeframe where the Plan will accept a retroactive referral. The member or provider can contact the Plan, within thirty days from the date of the denied claim, to request a retroactive referral. Examples:

- 10.1 DOS = 2/1, claim denied on 2/20, Plan is contacted on 3/1 to ask for a retro referral (A retro Referral is acceptable)
- 10.2 DOS = 2/1, claim denied on 2/20, Plan is contacted on 7/1 to ask for a retro referral (A retro Referral is Not acceptable)

Referrals to In and Out-of-Network Providers

The [Specialist Referral Form](#) is for covered services by participating providers. If the PCP believes that the member needs to be referred to an out-of-network provider, the Prior Approval process should be followed, rather than the Specialist Referral process.

Chapter 12: Medical Guidelines

12.1 Medical guidelines

Medical guidelines detail when certain medical services are considered medically necessary and are based on Original Medicare National Coverage Determinations (NCD's) and Local Coverage Determinations (LCD's) when available. The guidelines are reviewed and updated in response to changing CMS guidelines for medical coverage or change in scientific literature if applicable.

As a Medicare Advantage (MA) plan, we are required by Centers for Medicare & Medicaid Services (CMS) to provide, at a minimum, the same medical benefits to our members as Original Medicare. As an MA plan, we cannot be more restrictive than Original Medicare, however, we are allowed to clarify or more fully explain coverage in our policies. If Original Medicare does not have an NCD or LCD applicable to the service under review, the MA plan can develop a guideline to define the Plan's coverage. Each individual's unique, clinical circumstances may be considered in light of current CMS guidelines and scientific literature.

Experience Health Medicare Advantage (HMO) medical coverage policies are available for viewing online. Providers can search for a policy to determine the medical necessity criteria needed for a coverage approval. These policies are located online at the [Experience Health Provider Resource page](#).

Medical policies can be searched by alphabetical listing, as well as, a categorical listing to aid you in locating a coverage policy. Questions relative to a specific procedure or pre-certification requirements may be obtained by contacting Provider Services at 1-877-397-4584.

Chapter 13: Claims Billing and Reimbursement

ICD-10 Compliance

The federal government mandated implementation of the 10th version of the International Classification of Diseases codes set (ICD-10) by October 1, 2015. The new code set provides more detail in diagnosis and hospital procedure codes used by doctors, hospitals and insurers.

In compliance with the United States Department of Health and Human Services regulations, the industry-wide conversion to ICD-10 occurred on October 1, 2015. All HIPAA-covered entities are required to use ICD-10 codes on all transactions, claims, authorizations, referral requests, verification of benefits, and eligibility requests beginning on this date. Providers should be aware that claims submitted

with ICD-9 codes for services provided on or after the compliance deadline will not be paid by Experience Health.

Claims billing and reimbursement information contained as part of this administrative guide, supersedes any other guides. In the event that any information stated within this administrative guide conflicts with other information, providers should defer to this administrative guide when submitting claims for Experience Health Medicare Advantage (HMO).

13.1 General filing requirements

All Experience Health claims must be filed directly to Experience Health at our Winston-Salem location and not to an intermediary, or carrier such as CIGNA or Palmetto GBA. Claims must be submitted within one hundred and eighty (180) days of providing a service. Claims submitted after one hundred and eighty (180) days will be denied unless mitigating circumstances can be documented.

Experience Health is committed to processing claims efficiently and promptly. Our imaging system requires that the print on claims submitted be dark and legible to enable accurate scanning. Claims that are complete and accurate are normally processed and paid within seven (7) to fourteen (14) calendar days. A claim is not complete and accurate and may be delayed or returned for revision when the claim is difficult to interpret, incomplete, does not follow usual and customary procedures, does not comply with policies and procedures in this manual, requires manual adjudication or review or is received with a faint image. If filing on paper, please submit Optical Character Recognition (OCR) originals and do not submit carbon copies or photocopies.

The following general claims filing requirements will help ensure that your claims are complete and accurate and will allow us to process and pay your claims faster and more efficiently:

- ***For fastest claims processing, file electronically!*** If you're not already an electronic filer, please visit Experience Health provider resources for electronic commerce online at [the Experience Health Provider Resource page](#) and find out how you can become an electronic filer.
- Submit all claims within one hundred and eighty (180) days of the date the service was rendered.
- Do not submit medical records unless they have been requested by Experience Health.
- If Experience Health is secondary and you need to submit the primary payor Explanation of Payment (EOP) with your paper claim, do not paste, tape or staple the Explanation of Payment to the claim form.
- Always verify the patient's eligibility. Prior authorization can be obtained and/or confirmed online by logging onto [Blue e](#), online at [the Experience Health Provider Resource page](#). If you are not currently registered to use [Blue e](#), you will need to register online at [the Experience Health Provider Resource page](#). Experience Health provides [Blue e](#) to providers free of charge.
- Always file claims with the correct member ID number including the alpha prefix J and member suffix. This information can be found on the member's ID card.
- File under the member's given name, not his or her nickname.
- Watch for inconsistencies between the diagnosis and procedure code, sex and age of the patient.
- Use the appropriate provider / group NPI(s) that matches the NPI(s) that is / are registered with Experience Health, for your health care business.
- If you are a paper claims filer that has not applied or received an NPI, or if you have not yet registered your NPI, claims should be reported with your provider number (and group number if applicable) that's been assigned specifically for Experience Health use.
 - Remember that a distinct number may be assigned for different specialties.

- Refer to your welcome letter to distinguish the appropriate provider number for each contracted specialty.
- If your provider number has changed, use your new number for services provided on or after the date your number changed.
- Terminated provider numbers are not valid for services provided after the assigned end date.
- Experience Health cannot correct claims when incorrect information is submitted. Claims will be mailed back.

13.1.1 Requirements for professional CMS-1500 (02-12) claim form or other similar forms

(Not to be considered an all-inclusive list)

- All professional claims should be filed on a CMS-1500 (02-12) claim form or other similar forms.
 - If filing on paper, the red and white printed version should be used.
- Once you have registered your NPI, you should include your NPI on each subsequent claim submission to us.
 - If you have not obtained or registered your NPI with us, your assigned provider number should be reported on each paper claim submission.
 - If your physician or provider number changes, use your new number for services provided on or after the date your number was changed.
 - The tax ID number should correspond to the physician or provider number filed in block 33.
- When submitting an accident diagnosis, include the date that the accident occurred in block 14.
- Anesthesia claims are to be submitted using anesthesia CPT codes as defined by the American Society of Anesthesiologists. Claims submitted using surgery codes instead of anesthesiology codes will be returned requesting anesthesiology codes.
- File supply charges using HCPCS health service codes. If there is no suitable HCPCS code, give a complete description of the supply in the shaded supplemental section of field 24.
- If you are billing services for consecutive dates (from and to dates), it is critical that the units are accurately reported in block 24G.
- To ensure correct payment, include drug name, NDC #, and dosage in field 24.
 - Please note that the supplemental area of field 24 is for the reporting of NDC codes. Report the NDC qualifier “N4” in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit).

Please note that fields 21 and 24e of the CMS-1500 claim form or other similar forms are designated for diagnosis codes and pointers / reference numbers. Twelve (12) diagnosis codes may be entered into block 24e. Any CMS-1500 claim form or other similar forms submitted with more than 12 diagnosis codes or pointers / reference numbers will be mailed back to the submitting provider.

- \$0 claims will be rejected and mailed back to the provider if the NPI number that is registered with us or the assigned provider number is not listed on the claim form.
 - Once a provider has registered their NPI information with us and have confirmed receipt, claims should be reported using the NPI only, and the provider’s use of the assigned provider and/or group number should be discontinued.

13.1.2 Requirements for institutional UB-04 claim forms

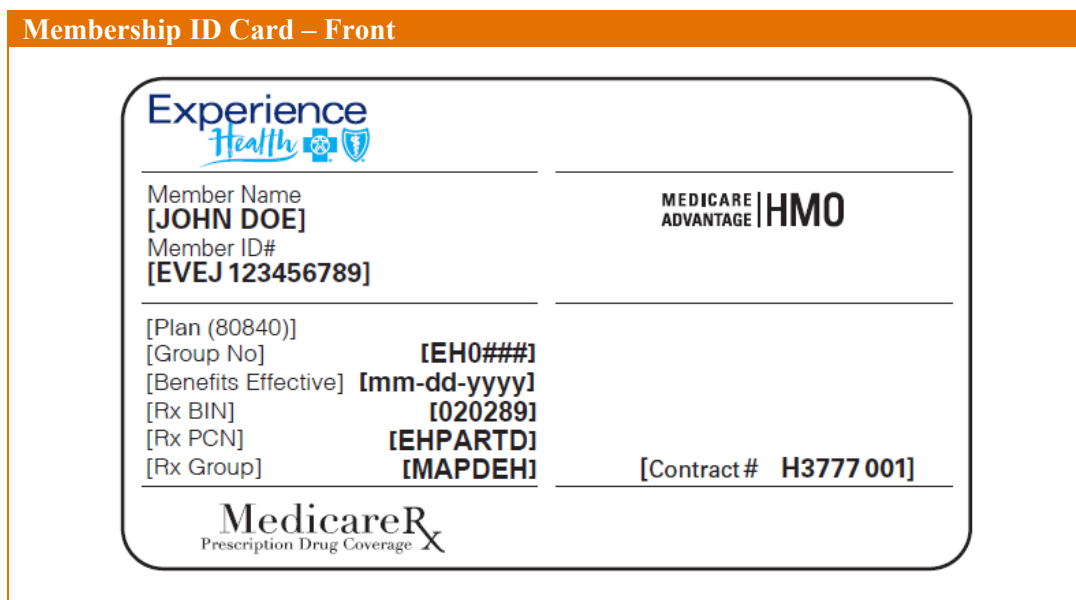
(Not to be considered an all-inclusive list)

- All claims should be filed on a UB-04 claim form.
 - If filing on paper, the red and white printed version should be used.
- The primary surgical procedure code must be listed in the principle procedure field locator 74.
 - ICD-10 code required on inpatient claims when a procedure was performed.
 - Field locator 74 should not be populated when reporting outpatient services.
- Please do not submit a second / duplicate claim without checking claim status first on [Blue e](#).
 - Providers should allow thirty (30) days before inquiring on claim status via [Blue e](#).
 - Please wait forty-five (45) days before checking claim status through the Provider Line.

13.2 Using the member’s ID for claims submission

When sending claims for services provided to Experience Health Medicare Advantage (HMO) members, it’s important that the member’s ID be included on the claim form (electronic and paper claims). The alpha-prefix helps North Carolina providers identify what plan type a member has enrolled, but only the last alpha-character of J is utilized for claims filing and claims processing. As an example, use the card image for John Doe below:

Front of Card



- The above sample card displays the member ID for John Doe as: < EVEJ1#####801 >
- The alpha-prefix of EVE identifies the member’s plan type but is not necessary for claims submission (EVE = Experience Health HMO).
- The letter J is always the last alpha-character of an Experience Health member’s ID. It is used in conjunction with the member’s identifying numeric code and is essential for claims routing and processing.
- The numbers 1#####8 are part of the member’s identifying numeric code – as part of our on-going efforts to help protect member’s privacy, Experience Health assigns member identification codes by use of randomly selected numbers instead of using social security numbers.

- The numbers 01 comprise the member’s numeric suffix, identifying a specific member.

To submit claims for Experience Health members always include the member’s alpha-prefix of J, the member’s numeric code and the member’s two (2) digit suffix. As example, J1#####801 would be reported on a claim submission for member John Doe.

Back of Card



13.3 Electronic claims filing and acknowledgement

The best way to submit claims to Experience Health is electronically. Electronic claims process faster than paper claims and save on administrative expense for your health care business. For more information about electronic claims filing and other Electronic Data Interchange (EDI) capabilities, please refer to electronic commerce online at [the Experience Health Provider Resource page](#).

EDI Services supports applications for the electronic exchange of health care claims, remittance, enrollment and inquiries and responses. EDI Services also provides support for health care providers and clearinghouses that conduct business electronically. If you are already submitting electronically, and need assistance, contact EDI Services through the Provider Line at 1-877-397-4584.

Our procedures are designed to have claims, which are complete and accurate, processed within twenty-four (24) to thirty-six (36) hours upon claims receipt and provide an EDI acknowledgment report to indicate the status of your claim submission. Please note that payments and Explanation of Payments (EOPs) are based on financial processing schedules. Providers are expected to work their rejected claims report so claims can be resent to Experience Health and accepted for payment.

Requests for service

Health care providers or clearinghouses electing to transmit electronic transactions directly with Experience Health must sign a trading partner agreement and submit the original copy to EDI Services. The trading partner agreement establishes the legal relationship between us and the trading partner. Health care providers, who submit their transmissions indirectly to Experience Health via a clearinghouse, do not need to complete the trading partner agreement but are required to fill out an

electronic connectivity form. The following procedures should be followed to obtain the electronic connectivity form:

- The health care provider calls 1-833-941-0107 and makes the request to be set up for electronic submission. The health care provider will need to supply a contact name, phone number and email address.
- An email containing an electronic form will then be emailed to the health care provider, which can be filled out electronically. The form will then need to be printed, must be signed and the hard copy returned to EDI Services by mail.
- Once the form is received containing all the required information, the health care provider will be set up in the system to submit electronically.
- After successful set up, the provider will be mailed a confirmation letter containing their payor ID, user ID, password and instructions for claims filing.
- The health care provider must call EDI Services once the confirmation letter is received, and an EDI specialist will go over the instructions with the provider and answer any questions at that time. The health care provider should allow eight to ten (8-10) business days to complete the setup process.

Acceptable file type:

- ANSI 837 version 4010A1 professional and institutional implementation 2b (used by Medicare)

Hardware requirements:

- Hayes compatible modem
- 9600 baud rate or higher
- Xmodem, Zmodem or Kermit protocols

Filing requirements:

- Once a transmission is established, all claims (including new claims, additions, corrections and 2nd notices) are to be submitted via EDI
- Coordination of benefits and office notes are to be filed on paper

13.3.1 Sample electronic claims acknowledgement report

SUMMARY SECTION								
			REJECTED STATUS			ACCEPTED		
Submitted BBS ID	Provider ID Number	Total Claims	Total Lines	Map Errors	Load Errors	Denied Claims	Pended Claims	Accepted Claims
A	B	C	D	E	F	G	H	I
<p>A: Submitter identifier B: Provider’s unique identifier as defined by the Plan C: Number of claims submitted per provider D: Number of service lines submitted per provider E: Number of claims failed in the existence of data check F: Number of claims failed in the data cross-reference validation G: Number of claims denied H: Number of claims pended</p>								

I: Number of claims accepted for payments $C = E + F + G + H + I$

DETAILED REJECTION SECTION			
Original Claim Number	Experience Health Claim Number	Error Type	Error Description
1	2	3	4
<p>1: Invoice number or patient account number as provided by the submitter</p> <p>2: Claim number</p> <p>3: Relates to the summary section under rejected status and can be one (1) of three (3) possibilities: map, load or denied</p> <p>4: Reason why a claim was rejected</p>			

13.4 Experience Health claims mailing address

Main Mailing Address

Experience Health
 PO Box 17509
 Winston-Salem, NC 27116-7509

FedEx, UPS and 4th Class

Experience Health
 5660 University Parkway
 Winston-Salem, NC 27116-7509

Claims sent in error to Experience Health for Experience Health members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

13.5 Claim filing time limitations

Participating providers agree to complete and submit a claim to Experience Health for services and/or supplies provided to Experience Health members.

The claim should include all information reasonably required by Experience Health to determine benefits according to the member's benefit plan and the provider's typical charge to most patients for the service and/or supply.

The claim should be submitted only after all complete services have been provided, with the exception of continuous care services or ongoing services.

Claims must be submitted within one hundred and eighty (180) days of providing the service.

Unless qualifying as an eligible exception under guidance of the Centers for Medicare & Medicaid Services (CMS), corrected claims must be submitted no later than one (1) year (twelve [12] months) from the date of service.

File claims for rental services monthly (after thirty [30] consecutive days of rental), or at the time the rental is determined to no longer be medically necessary, whichever is first.

13.6 Verifying claim status

You can inquire about the status of a claim in one (1) of the following ways:

- Check claim status from your desk top computer using [Blue e](#).
- Complete a Provider Inquiry Form (see Chapter 24, Forms) and fax it to Experience Health Customer Service Department at 1-919-765-3940.

Please note that we will be able to research claims and provide better service to you if you wait until after forty-five (45) days from a claims submission date before initiating an inquiry or resubmitting a previously filed claim. Routinely refile all claims at the end of the month may cause extra paperwork for everyone involved. We advise all offices to file claims at least once per week, post payments to your accounts within three (3) working days and deposit your checks daily. Also, we would advise you to generate a listing of past due claims at least quarterly. If you need to check on the status on more than five (5) claims at a time, please complete a Provider Inquiry Form.

13.7 Electronic Funds Transfer (EFT)

Experience Health Financial Services offers EFT for claim payments from Experience Health to a contracted health care provider's bank account. Generally, EFT funds are accessible by providers sooner than remittances received through a traditional process of paper checks deposited by the provider. EFT enrollment forms can be accessed via [Blue e](#). Health care providers that do not have access to [Blue e](#), can access the form online at [the Experience Health Provider Resource page](#).

The following outlines the process for setup of an EFT payment to a provider's bank account.

- Health care providers are required to submit:
 - Copy of a voided check; (an account verification letter on blank letterhead is also acceptable)
 - Completed Electronic Funds Transfer Authorization form
- The completed Electronic Funds Transfer Authorization form, along with the voided check copy, must be either faxed or mailed to:

Fax Number: 1-919-765-7063
 (Contact Phone Number: 1-919-765-2293)
 Financial Services
 Attention: Electronic Funds Transfer
 PO Box 2291
 Durham, NC 27702-2291

Please Note:

- A separate Electronic Funds Transfer Authorization is required for each provider-group number to be set up for EFT.
- A provider-group number may be associated to only one (1) bank account number.
- Financial Services verifies the bank name and the bank transit or routing number.
- After verification, EFT status is loaded to the claims system. The average time to set up a provider-group for EFT remittance is five (5) days from receipt of all documentation.
- All EFT payments are made at the provider-group number / NPI level vs. payments to individual providers, unless payments are being directed to a solo practitioner.

13.8 Reimbursement for services

Participating providers agree to bill only Experience Health for all covered services for Experience Health members, collecting only appropriate copayments or coinsurance from the member. Experience Health members are directly obligated only for the copayment amounts indicated on their member card (and in

their Certificate of Coverage or evidence of coverage), payment for non-covered services for which Experience Health issued an Organization Determination denying coverage before the services are rendered, and payment for services after the expiration date of the member’s coverage. The provider should not collect any deposits and does not have any other recourse against an Experience Health member for covered or non-covered services.

In the event that the participating provider provides services which are not covered by the Plan, the provider will, prior to the provision of such non-covered services, confirm that the member has received an Organization Determination from Experience Health denying coverage. Experience Health shall make the relevant terms and conditions of each plan reasonably available to participating providers. If a participating provider is not sure whether a service is covered under a member’s Certificate of Coverage, he or she may call the Provider Line at 1-877-397-4584 or 1-336-774-5400. The participating providers may only bill a member directly for non-covered services when Experience Health has issued an Organization Determination informing the member that the services are not covered before the services are rendered (see Section 13.9.2.1 for information about how to request an Organization Determination from Experience Health).

13.8.1 Service edits

Experience Health reserves the right to implement service edits to apply correct coding guidelines for CPT, HCPCS, and ICD-10 diagnosis and procedure codes. Service edits are in place to enforce and assist in a consistent claim review process. The coding edits reflect Experience Health Medical Coverage Guidelines, benefit plans, and/or other Experience Health policies. Unbundling, mutually exclusive procedures, duplicate, obsolete, or invalid codes are identified through the use of coding edits.

13.9 Amounts billable to members

- Applicable copayments may be collected at the time service is rendered. Copayment amounts are indicated on the members ID card.
- Applicable coinsurance and deductible amounts may be collected from members only after the provider has received the Notification of Payment (NOP) or Explanation of Payment (EOP).
- Following are examples of services that may be eligible for the collection of copayment and/or coinsurance:
 - Office visit
 - Office visit with lab and/or x-ray
 - Office based surgery (when performed in the office and appropriate to be billed in conjunction with an office visit – please refer to current CPT professional edition coding).
 - ER visit
 - Outpatient services
 - Inpatient admission
 - Non-covered services may be collected, only if they meet the criteria outlined in the instruction of the hold harmless policy (see Chapter 13.9.3 for details).
 - Any amounts collected erroneously by you from a member for any reason shall be refunded to the member within forty-five (45) days of the receipt of the notification / explanation of payment from the Plan or your discovery of the error.

13.9.1 Items for which providers cannot bill members

Except for any applicable copayment, coinsurance and/or deductible amounts, providers may not collect any payments from members for covered services or for non-covered services for which Experience Health did not issue an Organization Determination of non-coverage before the services were rendered.

For covered services, providers may not balance bill Experience Health members for the difference between billed charges and the amount allowed by Experience Health, as set forth in the agreement. For non-covered services for which Experience Health did not issue an Organization Determination denying coverage before the services were rendered, providers may not balance bill Experience Health members for the difference between billed charges and any applicable copayment, coinsurance, and/or deductible amounts. Any such differences are considered contractual adjustments and are not billable to members or Experience Health.

Providers may not bill or otherwise hold members or Experience Health responsible for payment for services, which are deemed by Experience Health to be out of compliance with Experience Health Utilization and Management programs and policies or medical necessity criteria or are otherwise non-covered.

Providers may not seek payment from either members or the Plan if a proper claim is not submitted to Experience Health within one hundred and eighty (180) days of the date a service is rendered.

13.9.2 Billing members for non-covered services

From time to time a provider may be asked to provide services to members that are not covered by their benefit plan with Experience Health. A provider can only bill a member for such services when the member has received an Organization Determination from Experience Health denying coverage before the services are rendered.

A provider cannot use an advanced beneficiary notice or similar type of waiver or release that purports to obligate the member to pay the provider for the non-covered services.

Providers may inquire about eligibility of services by calling the Customer Service number on the back of the member's ID card or by calling the Provider Line at 1-877-397-4584 or 1-336-774-5400.

Confirmation of benefit eligibility does not guarantee payment as other factors may affect payment (e.g. Experience Health Utilization and Management programs and policies or medical necessity criteria).

13.9.2.1 Pre-service Organization Determination requests

A provider cannot charge a member of an Experience Health for non-covered services (beyond normal cost-sharing) unless (1) the member has received a Notice of Denial of Medical Coverage from Experience Health before the services are provided and (2) the member elects to receive the non-covered services after receiving that Notice of Denial of Medical Coverage.

If a provider believes that an item or service may not be covered and the member has not received a Notice of Denial of Medical Coverage from Experience Health, the provider must advise the member to request a pre-service Organization Determination from Experience Health or must request the Organization Determination on the enrollee's behalf.

The member or the provider may request an Organization Determination from Experience Health Customer Service by:

- Calling 1-877-397-4584 (Option 6)

- Writing to:
Experience Health Attention – Part C Organization Determinations PO Box 17509
Winston-Salem, NC, 27116-7509
- Faxing a request to 1-919-765-7805

If a provider supplies non-covered services to a member who has not received a Notice of Denial of Medical Coverage, the provider must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing.

13.9.3 Hold harmless policy

The member will not be held financially responsible for the cost of covered services except for any applicable copayment, coinsurance, or deductible if ALL of the following are true:

- The member has followed the guidelines of the Plan.
- The PCP or participating specialist fails to obtain pre-certification with the health care services department for those covered services which require pre-certification.
- The non-pre-certified covered services have already been rendered.

The member will not be held financially responsible for the cost of non-covered services except for any applicable copayment, coinsurance, or deductible if the non-covered services are rendered before the member receives an Organization Determination from Experience Health denying coverage.

In either instance, the participating provider will be advised that they must write-off the cost of the non-certified or non-covered services and hold the member financially harmless according to contract provisions.

Ancillary services provided in conjunction with non-pre-certified services are also not payable by the Plan unless the ancillary provider is a non-participating provider.

This policy will also apply when the Plan is the secondary payer of claims.

Members will be held responsible for non-certified services when the member receives an Organization Determination from Experience Health denying coverage before the services are rendered.

13.9.3.1 CMS-required provisions regarding the protection of members eligible for both Medicare and Medicaid “dual eligibles”

Federal legislation has made changes to the Medicare program. Current network provider agreements; in the section entitled “Hold Harmless” incorporates certain CMS-required provisions regarding the protection of members. Changes to CMS’s requirements that became effective January 1, 2010 resulted in our obligation to amend our contracts to incorporate specific Hold Harmless provisions as they relate to members that are dually eligible for both Medicare and Medicaid. The amendment is as follows:

The section entitled “Hold Harmless” is hereby amended to include the following:

- Members eligible for Medicaid. Providers agree that members eligible for both Medicare and Medicaid “dual eligibles” will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Provider agrees to accept the MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

Only Qualified Medicare Beneficiary (QMB) designated beneficiaries are exempt from copays / coinsurance. Not all dual eligibles receive assistance with copays / coinsurance. Specified Low-Income Medicare Beneficiaries (SLMB), for example, receive premium assistance only.

13.9.3.2 CMS-required provisions regarding the protection of members who receive non-covered services or supplies from a participating provider

Regulatory guidance issued by CMS resulted in our obligation to amend our contracts to incorporate specific Hold Harmless provisions as they relate to the provision of non-covered services.

Section 2.2, Hold Harmless is hereby amended as follows:

- Provider agrees that except for applicable deductibles, copayments or coinsurance, and except as otherwise required by law, in no event, including but not limited to non-payment, Experience Health insolvency, or breach of this agreement, shall provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any direct or indirect recourse for covered services against an Experience Health member, a person acting on such Experience Health member’s behalf, or a third party including but not limited to subrogation and Workers’ Compensation carriers. Provider agrees that it is the provider’s obligation, to collect applicable Experience Health member deductibles, copayment, and coinsurance, if any, as well as fees for non-covered services. Provider may not collect fees for non-covered services or supplies unless, before services are rendered or supplies are provided, the Experience Health member has received an Organization Determination from Experience Health informing the member that the specific services to be rendered and/or supplies to be provided are not covered by his or her health benefits plan.

13.10 Coordination of Benefits (COB)

Coordination of Benefits (COB) is an approach used by health plans and health insurers to divide the obligation for payment of health care expenses. It is not uncommon to encounter patients who are covered under more than one (1) health plan. Patients could be receiving coverage from sources that could include a large private insurer, another managed care plan, Medicaid, a self- insured plan or a COBRA-continued plan.

In the event a benefit is covered by both Experience Health and another policy or plan, Experience Health will coordinate benefits and benefit payments with such plans or policies, whether or not a claim is made for benefits.

- If the member is aged sixty-five (65) or older and have coverage under an employer group health plan either through his / her own current employment or the employment of a spouse, (including COBRA coverage), that plan will be the primary payer. This rule applies to the health plans of employers with twenty (20) or more employees. Experience Health will be the secondary payer. COBRA policies are an extension of active group coverage. If the member is actively working, group size determines who is primary.
- If the member is under age sixty-five (65) and entitled to Medicare due to a disability (other than end stage renal disease) and has coverage under a large employer group plan, either through his / her own employment or the employment of a family member, that plan will be the primary payer. Experience Health will be the secondary payer. If the member is actively working, group size determines who is primary.
- If automobile medical or no-fault or liability insurance is available to you, in the event of an accident, then that carrier will be the primary payer.

- If the member is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD) and is covered under an employer group plan, that plan will be the primary payer for the first thirty (30) months after becoming eligible for Medicare.
- Workers' Compensation for treatment of a work-related illness or injury or veteran's benefits for treatment of service-connected disability or under the Federal Black Lung Program would be primary.
- Coverage through Medicaid or through the Tricare for Life program will be coordinated based on Medicare rules.

Experience Health uses the same guidelines in these cases as does Medicare. Because of this, we do ask the member about other insurance they may have. If the member has other insurance, they are asked to help us obtain payment from the other insurer by promptly providing any information we may request.

Experience Health will assist you with information concerning a patient's coverage. In addition, Experience Health will assist you by working directly with patients and their primary insurance sources to ensure that you, the provider, are entitled to the maximum benefit available. Consistent with our contractual obligations, it is also our intent to maximize a member's benefit under our plan. Therefore, if a patient's primary insurance issues a benefits payment that is greater than the Experience Health copayment, the copayment will be waived.

13.11 Workers' Compensation claims

If an Experience Health member sustains an injury while at work, it is important that the member follow Experience Health's rules and procedures in order to be eligible for Experience Health Medicare Advantage (HMO) benefits, should Workers' Compensation deny the claim. All applicable authorizations must be obtained under Experience Health guidelines in order for Experience Health Medicare Advantage (HMO) benefits to be payable in the event Workers' Compensation denies the claim.

Failure to follow Experience Health policies will release Experience Health from any payment responsibility.

If you are informed or have reason to believe a patient has sustained an injury at work, please call Experience Health to notify us. We may need to inform other Providers so they may also file for benefits under Workers' Compensation.

For further details on governing rules, or assistance with COB, Medicare or Workers' Compensation, please contact Experience Health Customer Services Department.

13.12 Subrogation

An Experience Health member may incur medical expenses due to injuries suffered in an accident. The accident may have been caused by the alleged negligence or misconduct of another person. If so, the member may have a claim against that person for payment of medical bills.

Subrogation means the right of Experience Health to pursue the claim for medical expenses against the other person, so that the other person (or their insurer) pays for the member's medical expenses.

Experience Health as the medical policy holder is responsible for paying these claims up front and then our vendor handles the subrogation on those third-party claims. We cannot deny claims for Workers' Compensation, Veterans', auto-related or potential subrogation.

Subrogation of benefits is allowed. Therefore, Experience Health has the right to pursue and recover from a claim that may have been filed against another person.

If the member has a claim against another person, Experience Health will be subrogated to the right of recovery the member has against that person. Therefore, Experience Health will deny payment of all medical bills pending settlement of the claim against the other person. If there is not a prompt settlement, Experience Health will conditionally pay the medical bills and require that the member reimburse Experience Health. For this purpose, the definition of prompt will be one hundred and twenty (120) days after the earlier of the following:

- The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or the date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

Experience Health's right of subrogation will not exceed the lesser of the following:

- The amount of benefits paid by Experience Health; or the portion of the recovery attributable to covered medical expenses.

If the portion of the recovery that is attributable to medical expenses is not specified in a judgment or settlement, then one-third (1/3) of the net recovery shall be deemed to be the portion of the recovery attributable to medical expenses. Net recovery shall mean the total amount of the recovery less reasonable attorneys' fees and expenses incurred in obtaining the recovery.

13.13 Claims reimbursement disputes

In the event an error is found on an Explanation of Payment (EOP) on behalf of the provider; a request for correction may be initiated either via telephone or in writing. To request a review for correction in writing, the following information must be included:

- Letter of explanation relative to any error in the processing of claim
- Copy of the original claim
- Copy of corresponding EOP with the claim in question circled
- Requests for correction should be mailed to the following address:
- Experience Health
PO Box 17509
Winston-Salem, NC 27116

To request a review for correction via telephone, please contact Experience Health Provider Line at 1-877-397-4584 and be prepared to give the following information:

- Patient name and Experience Health member ID
- Date of service
- Claim number
- Explanation of any suspected error

13.14 Pricing policy for Part B procedure / service codes

Effective June 1, 2005, updated 08/23/2010 and revised 09/09/2013.

The following policy applies to payments to contracted providers for procedure / service codes billed on a CMS-1500 (Part B Medicare) claim form or other similar forms. When services billed on UB-04 forms are contracted using FFS rates, this procedure would also apply.

General pricing policy

When the pricing for an existing code is updated and an external pricing source exists for such code, pricing will be implemented no later than April 1st of each year based on the applicable pricing source in effect on January 1st of that year. When new codes are published, or updates to existing codes occur, and an external pricing source exists for such codes, such pricing will be implemented by no later than April 1st of each year or within thirty (30) days of source publication. Such updates and new pricing will apply for all dates of services on or after the source pricing effective date, but only for claims received after the date of our implementation of the update / new pricing. Pricing will not be adjusted once established for a given year until the following calendar year. We are not required to make retroactive pricing adjustments for claims received prior to our implementation date. Updates will be made using the following procedure:

- If NC Medicare pricing is available, the most current NC Medicare pricing available will be applied to that code.
- If NC Medicare pricing is unavailable, Experience Health will apply the most current Medicare allowable pricing if available, using the same methodology described above and the following external resources:
 - Burgess Reimbursement System
 - Optum Ingenix
 - Palmetto GBA (www.palmettogba.com)
 - CIGNA Government Services (www.cgsmedicare.com) for DMEPOS
- For durable medical equipment, the CIGNA Government Services DME Jurisdiction C fee schedule will be used in place of the above referenced external sources.

Source: www.cignagovernmentservices.com/jc/coverage/fees/index.html

- Experience Health reimburses the lesser of your charge or the applicable pricing.
- Nothing in this policy will obligate Experience Health to make payment on a claim for a service or supply that is not covered under the terms of the applicable benefit plan. Furthermore, the presence of a code and allowable on your sample fee schedule does not guarantee payment.

External source pricing

All references in this procedure to external source pricing refer to the following:

- NC Medicare (available at www.cms.hhs.gov)
- CIGNA Medicare allowables

In the event that the names of such external source pricing change (e.g. a new Medicare intermediary is selected), references in this procedure will be deemed to refer to the updated names. In the event that new external source pricing generally acceptable in the industry and acceptable the Plan becomes available, such external source pricing may be incorporated into this procedure.

13.14.1 Prescription drug CPT and HCPCS codes

These codes are priced following CMS guidelines and do not include those services covered under the CMS Part D program. Codes not falling under a separate prospective payment system will be based on a percentage of Average Sales Price (ASP) or average wholesale price, depending on the drug. Resources used to arrive at rates include websites for CMS and CIGNA as well as Red Book References.

For HIT services, drugs covered by Medicare will be based on the current year DME Regional Carrier priced AWP if infused through DME per Section 303(b) of the Medicare Modernization Act.

Infused drugs not covered by Medicare will be based on Average Wholesale Price (AWP) listed in the most recently published and available edition of the Medicare Economics Red Book Guide to Pharmaceutical Prices as of the date of service. The name and dose of the drug provided is required. Parenteral and enteral nutrition will be based on the PEN rates contained in the DME POS fee schedule published quarterly by the DME Regional Carrier (CIGNA government services at this time).

Drugs not assigned a specific HCPCS codes by CMS will be priced using the Not Otherwise Classified (NOC) file as published by the Part B fiscal intermediary (CIGNA Medicare at this time).

13.14.2 Policy on payment for remaining codes

Procedure / service codes that remain unpriced after each application of the above procedure will be paid in the interim at the lesser of the provider's charge or a reasonable charge established using a methodology that is applied to comparable providers for similar services. Our methodology is based on several factors including payment guidelines as published in the provider manual. Under these guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

We may use clinical judgment to make these determinations and may use medical records to determine the exact services rendered. For codes that we approve as clinically necessary, have no price applied using any of the procedures described above, and are billed as less than \$100, we will pay 50% of the provider's billed charge.

13.14.3 Policy on payment based on charges

If a general code (e.g. 21499, unlisted musculoskeletal procedure, head) or unlisted code is filed because a code specific to the service or procedure is non-existent, we will assign a fee to the service which will be the lesser of the provider's charge or a reasonable charge established using a methodology which is applied to comparable providers for similar services under a similar health benefit plan. We may use clinical judgment to make these determinations and may use medical records to determine the exact services rendered.

Durable medical equipment claims or medical or surgical supply claims that are filed under general or unlisted codes must include the applicable manufacturer's invoice and will be paid at the invoice price. We will not pay more than 100% of the respective charge for these claims.

If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, we will apply the more specific code to determine payment under our applicable reimbursement policies.

Assignment of a fee for a given general or unlisted code does not preclude us from assigning a different fee for subsequent service or procedure under the same code. Fees for these services may need to be changed based on new or additional information that becomes available regarding the service in question or other similar services.

13.15 What is not covered under the medical benefit

This is a list of general exclusions. In some cases, a member's benefit plan may cover some of these services or have additional exclusions. Please call the Provider Line at 1-877-397-4584 to verify benefit coverage.

- Abortion: Any abortion which is considered illegal under laws which govern the state in which the Plan is licensed, and any abortion which is not covered by Medicare.
- Acupuncture: Unless performed by a Plan-approved physician.

- Allergy testing: Skin titration (RINKEL method); cytotoxicity testing (Bryan's test); MAST testing; urine auto-injections; subcutaneous or sublingual provocative and neutralization testing for allergies.
- Behavioral disorders: Services, treatment or diagnostic testing related to behavioral (conduct) problems or behavioral training.
- Chiropractic care: Except for manual manipulation of the spine for subluxation, x-rays ordered by a chiropractor to diagnose subluxation of the spine.
- Circumcision: For non-medically indicated reasons after one (1) month of age.
- Clinical trials: Services not covered under Original Medicare, and not covered by Experience Health.
- Custodial care: The provision of room and board, nursing care, and personal care designed to assist member in the activities of daily living; or such other care which is provided to member who, in the Plan's opinion, has reached the maximum level of physical or mental function and will not make further significant improvement. Custodial care rendered in the home and adult day care facilities.
- Dental services: All dental services, unless otherwise specified, including bridges, dentures, crowns, treatment for periodontal disease, dental root form implants, root canals, orthodontic appliances or any other treatment primarily to align teeth, appliances, orthognathic surgery (unless deemed medically necessary) or extraction of wisdom teeth except as provided in the member Certificate of Coverage; treatment for teeth which are chipped or broken from biting or chewing; and anesthesia for dental procedures, except as provided in the member Certificate of Coverage.
- Foot care: Routine foot care including corn and callous removal; nail trimming; and other hygienic or maintenance care; cleaning, soaking and skin cream application for ambulatory and bed-confined patients unless covered by Original Medicare.
- Hospice: Not covered by the Plan. A Medicare beneficiary with Medicare Part A, may elect Traditional Medicare hospice coverage (through Traditional Medicare, not Experience Health) and can decide to keep Experience Health Medicare Advantage (HMO) coverage for services not related to the terminal illness or elect Traditional Medicare coverage for everything by disenrolling from the Plan. Claims for all hospice related services must be billed to Traditional Medicare, not the Plan.

Note: Even though Traditional Medicare covers the services related to the terminal illness, the Plan will provide the member with a listing of Medicare-certified hospice providers in their area.

- Lenses: Contact lenses or the fitting thereof, except for the first pair of lenses or eyeglasses following a cataract operation (this may include contact lens or placement of intraocular lens).
- Long-term skilled care services: Skilled care services in the home that do not qualify as part-time or intermittent, as defined by Medicare, or skilled care services in a skilled nursing facility or unit, or a sub-acute facility or unit, for a period exceeding one hundred (100) days per benefit period (beginning with the first day a member received these services).
- Naturopathy
- Obesity: Services and drugs in connection with obesity, including but not limited to, surgical procedures such as gastric bypass surgery, balloon insertion and removal; and experimental services and complications. Services specifically used for treatment of obesity, except other services and treatments within standard medical practice policies or covered by Original Medicare and which are authorized and approved by the Plan.

- Occupational injury or sickness: The cost of services for any injury which occurs in the work place, or a sickness which occurs as a result of employment, normally covered under Workers' Compensation or other employer's liability laws. Should a member have the cost of services denied by one (1) of the above insurance programs, the Plan will consider payment of covered services. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
- Organ transplants: Experimental / investigational transplants. Combined kidney and liver transplant is not covered. Coverage is limited to Medicare covered services. Pancreas transplantation for diabetic patients who have not experienced end stage renal failure secondary to diabetes continues to be excluded from Medicare.
- Orthopedic shoes: Unless covered by Medicare (for individuals with diabetic foot disease) or part of a leg brace and included in the cost of the leg brace.
- Orthotics: Foot orthotics, i.e., custom shoes or custom inserts for shoes or boots except as covered by Original Medicare or as specified in the member Certificate of Coverage.
- Personal comfort or convenience items, convenience fees, household fixtures and equipment and member refused items and services: Chairs, personal comfort or convenience items such as household fixtures and equipment or related services and supplies not directly related to the care of the member, including but not limited to, guest meals and accommodations; telephone charges; travel expenses; take-home supplies and similar costs; health and fitness club expenses an providers to members; convenience products for injections; home or vehicular evaluations and modifications to meet the environmental needs of the member or caregiver; fees charged by providers for services, supplies, or equipment requested by member, but later refused by member. The purchase or rental of household fixtures, including, but not limited to: exercise equipment; air purifiers; central or unit air conditioners, water purifiers; humidifiers / dehumidifiers; hypoallergenic pillows; whirlpools and spas; mattresses or waterbeds unless covered by Original Medicare.
- Prosthetic and corrective devices: Prosthetics that are primarily for patient convenience or are more costly than equally effective alternative equipment. The Plan and Medicare coverage determinations will be used.
- Religious, marital, family and sex counseling: Services and treatment related to religious counseling, family counseling, marital / relationship counseling, sex therapy, adoption and pastoral counseling unless covered by Original Medicare.
- Respite care: Medical care required to be arranged for, and provided to, a patient whose condition has not changed (i.e., is stable) due only to the fact that the patient's caregiver is absent.
- Sclerotherapy: Except when covered by Original Medicare as medically necessary and prior approved by the Plan.
- Services the member is not legally obligated to pay, and services performed by a relative: Any service for which the member legally would not be required to pay in the absence of this coverage; services performed by a relative of member.
- Services furnished under a private contract: Services (other than for emergency or urgently needed services) furnished by a physician as defined by the Social Security Act who has filed with the Medicare carrier an affidavit promising to furnish Medicare covered services to Medicare beneficiaries only through private contracts with the beneficiaries under section 1802(b) of the Social Security Act.
- Treatment in a federal, state or governmental entity: To the extent allowed by applicable laws, coverage for care and treatment provided in a hospital owned or operated by any federal, state or

other governmental entity, and care of military service-connected conditions for which the member is legally entitled to services. This includes services provided to veterans in Veteran’s Affairs (VA) facilities. However, reimbursement is allowed for the cost-sharing for emergency services receive at a VA hospital, up to the appropriate cost sharing under the Plan.

- Vision: Vision care, except as provided by Original Medicare or as specified in the member’s Certificate of Coverage. This exclusion / limitation includes, but it is not limited to: eye exercises; visual training; orthoptics; and all types of contact lenses or corrective lenses unless specified in this Certificate of Coverage.
- Vehicular modifications: Unless covered by Medicare.
- Weight control: All services and supplies for the purpose of weight control; weight management and commercial weight loss / reduction programs, unless covered by Original Medicare.

13.16 Using the correct NPI for reporting your health care services

The National Provider Identifier (NPI) is a HIPAA mandate effective May 2007 for electronic transactions. The NPI is a ten (10) digit unique health care provider identifier, which replaces the Proprietary Provider Number (PPN) on electronic transactions. Additional information about NPI can be found at the Centers for Medicare & Medicaid Services (CMS) website at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Instructions-for-Notice-of-Medicare-Non-Coverage-NOMNC.pdf>.

If your health care business submits claims using:

- **Electronic transactions** – filing with NPI is required
- **Paper only (never electronically)** – file with NPI or an Experience Health assigned provider number

There are two (2) types of NPI that are assigned via the Centers for Medicare & Medicaid Services (CMS) enumeration system, National Plan and Provider Enumeration System (NPPES):

- **Type 1:** Assigned to an individual who renders health care services, including physicians, nurses, physical therapists and dentists. An individual provider can receive only one (1) NPI.
- **Type 2:** Assigned to a health care organization and its subparts that may include hospitals, skilled nursing facilities, home health agencies, pharmacies and suppliers of medical equipment (durable medical equipment, orthotics, prosthetics, etc). An organization may apply and receive multiple NPIs to support their business structure.

13.17 Using the correct claim form for reporting your health care services

The Plan recognizes and accepts the CMS-1500 (02-12) claim form or other similar forms for professional providers and the UB-04 (CMS-1450) claim form for institutional / facility providers. The National Uniform Billing Committee (NUBC) approved these forms that accommodate the reporting of the National Provider Identifier (NPI), as the replacements of the forms predecessors CMS-1500 (02-12) and UB-04.

Most providers, billing agencies or computer vendors file claims to Experience Health electronically using the HIPAA compliant 837 formats. Providers who are not set up to file claims electronically should refer to the chart below to determine the correct paper claim form to use:

Item	Explanation
Providers office	CMS-1500 (02-12) claim form or other similar forms

Home Durable Medical Equipment (HDME)	CMS-1500 (02-12) claim form or other similar forms
Reference lab	CMS-1500 (02-12) claim form or other similar forms
Licensed registered dietitian	CMS-1500 (02-12) claim form or other similar forms
Specialty pharmacy	CMS-1500 (02-12) claim form or other similar forms
Ambulance provider	CMS-1500 (02-12) claim form or other similar forms
Hospital facility	Form UB-04 (CMS-1450)
Ambulatory surgical center	Form UB-04 (CMS-1450) or CMS-1500 (02-12) claim form or other similar forms
Skilled nursing facility	Form UB-04 (CMS-1450)
Lithotripsy provider	Form UB-04 (CMS-1450)
Dialysis provider	Form UB-04 (CMS-1450)
Home health care	Corresponding form
<ul style="list-style-type: none"> • Home health provider • Private duty nursing • Home infusion provider 	<ul style="list-style-type: none"> • Form UB-04 (CMS-1450) • Form UB-04 (CMS-1450) • CMS-1500 (02-12) claim form or other similar forms

Please note that providers with electronic capability who submit paper claims will be asked to resubmit claims electronically.

For more information on the CMS-1500 (version 02-12) claim form or other similar forms; or the UB-04 claim form, visit the National Uniform Claim Committee (NUCC) website at www.nucc.org.

13.17.1 CMS-1500 (02-12) claim form or other similar forms claim filing instructions

Field Number	Description
1	Leave blank
1a	Insured's ID - Enter the member identification number exactly as it appears on the patient's ID card. The member's ID number is the letter J followed by the subscriber number and the 2-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters.
2	The patient's name should be entered as last name, first name, and middle initial.
3	Enter the patient's birth date and sex. The date of birth should be 8 positions in the MM/DD/YYYY format. Use 1 character (X) to indicate the sex of the patient.
4	Enter the name of the insured. If the patient and insured are the same, then the word same may be used. This name should correspond with the ID # in field 1a.
5	Enter the patient's address and telephone number.
6	Use 1 character (X) to indicate the patient's relationship to the insured.
7	Enter insured's address and telephone number. If patient's and insured's address are the same then the word "same" may be used.
8	Enter the patient's marital and employment status by marking an (X) in 1 box on each line.

9	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient. If the same as Item 4, enter same (complete this block only when the patient has other insurance coverage). Indicate none if no other insurance applies.						
9a	Enter the policy and/or group number of the other insured's policy.						
9b	Enter the other insured's date of birth (MM/DD/YYYY) and sex.						
9c	Enter the other insured's employer's name or school name.						
9	Enter the other insured's insurance company name.						
10a-c	Use 1 character (X) to mark yes or no to indicate whether employment, auto accident, or other accident involvement applies to services in Item 24 (diagnosis).						
11	Enter member's policy or group number.						
11a	Enter member's date of birth (MM/DD/YYYY) and sex.						
11b	Enter member's employer's name or school name.						
11c	Enter member's insurance plan name.						
11d	Check yes or no to indicate if there is, or not, another health benefit plan. If yes, complete items 9 through 9d.						
12	Have the patient or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.						
13	Have the subscriber or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the member or other authorized person on file authorizing assignment of payment to you.						
14	Enter the date of injury or medical emergency. For conditions of pregnancy enter the LMP. If other conditions of illness, enter the date of onset of first symptoms.						
15	If patient has previously had the same or similar illness, give the date of the previous episode.						
16	Leave blank.						
17	Enter name of referring physician or provider.						
17a	Enter ID number of referring physician or provider.						
17b	Enter 1B (Blue Cross NC ID qualifier) in the shaded area and to the immediate right of 17a. Enter the Blue Cross NC ID number of the referring provider in the shaded box to the right of the ID qualifier. (This field is only required if the NPI number is not reported in Box 17B. Example: <table border="1" data-bbox="527 1386 912 1507"> <tr> <td>17a.</td> <td>1B</td> <td>12345</td> </tr> <tr> <td>17b.</td> <td>NPI</td> <td>1234567891</td> </tr> </table>	17a.	1B	12345	17b.	NPI	1234567891
17a.	1B	12345					
17b.	NPI	1234567891					
18	If services are provided in the hospital, give hospitalization dates related to the current services.						
19	Leave blank.						
20	Complete this block to indicate billing for clinical diagnosis tests.						
21	Enter the ICD indicator to identify the version of ICD codes being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes left justified on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.						

	<p>The “Diagnosis of Nature of Illness or Injury” is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. This field allows for the entry of a 1 character indicator and 12 diagnosis codes at a maximum of 7 characters in length.</p> <p>Example:</p> <table border="1"> <tr> <td colspan="4">21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)</td> <td>ICD Ind.</td> <td>0</td> </tr> <tr> <td>A.</td> <td>0139</td> <td>B.</td> <td>06012x0</td> <td>C.</td> <td>J0190</td> </tr> <tr> <td>E.</td> <td></td> <td>F.</td> <td></td> <td>G.</td> <td></td> </tr> <tr> <td>I.</td> <td></td> <td>J.</td> <td></td> <td>K.</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>L.</td> <td></td> </tr> </table> <p>\$0 claims for additional diagnoses with asterisk.</p>	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	0	A.	0139	B.	06012x0	C.	J0190	E.		F.		G.		I.		J.		K.						L.																																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	0																																																																												
A.	0139	B.	06012x0	C.	J0190																																																																												
E.		F.		G.																																																																													
I.		J.		K.																																																																													
				L.																																																																													
22	Leave blank.																																																																																
23	Enter certification of prior review number here if services require it.																																																																																
24	<p>The 6 service lines in section 24 have been divided horizontally to accommodate submission of both the NPI number and Blue Cross NC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service. The top area of the 6 service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Use of the supplemental information fields should be limited to the reporting of NDC codes. If reporting NDC codes, report the NDC qualifier “N4” in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit).</p> <p>Example:</p> <table border="1"> <thead> <tr> <th colspan="3">24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C.</th> <th colspan="4">D. PROCEDURES, SERVICES, OR SUPPLIES</th> <th>E.</th> <th colspan="2">F.</th> <th>G.</th> <th>H.</th> <th>I.</th> <th>J.</th> </tr> <tr> <th colspan="3">From To</th> <th>RAJ</th> <th>EMG</th> <th colspan="4">(Explain Unusual Circumstances)</th> <th>DIAGNOSIS</th> <th colspan="2">\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>SPST</th> <th>ID.</th> <th>RENDERING</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>CPT</th> <th>HCPCS</th> <th>MODIFIER</th> <th>POINTER</th> <th></th> <th></th> <th></th> <th>Fee</th> <th>QUAL.</th> <th>PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>N4</td> <td>00026064871</td> <td></td> <td>Immune Globulin Intravenous</td> <td></td> <td></td> <td></td> <td></td> <td>UN2</td> <td></td> <td>13</td> <td>500 00</td> <td>20</td> <td>N</td> <td>1B</td> <td>12345678901</td> </tr> <tr> <td>10</td> <td>01</td> <td>05</td> <td>10</td> <td>01</td> <td>05</td> <td>11</td> <td></td> <td>J1563</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0123456789</td> </tr> </tbody> </table>	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.	From To			RAJ	EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	SPST	ID.	RENDERING	MM	DD	YY	MM	DD	YY	CPT	HCPCS	MODIFIER	POINTER				Fee	QUAL.	PROVIDER ID. #	N4	00026064871		Immune Globulin Intravenous					UN2		13	500 00	20	N	1B	12345678901	10	01	05	10	01	05	11		J1563							0123456789
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.																																																																		
From To			RAJ	EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES		DAYS OR UNITS	SPST	ID.	RENDERING																																																																		
MM	DD	YY	MM	DD	YY	CPT	HCPCS	MODIFIER	POINTER				Fee	QUAL.	PROVIDER ID. #																																																																		
N4	00026064871		Immune Globulin Intravenous					UN2		13	500 00	20	N	1B	12345678901																																																																		
10	01	05	10	01	05	11		J1563							0123456789																																																																		
24a	Enter the month, day, and year (6 digits) for each procedure, service and/or supply in the unshaded date fields. Dates must be in the MM/DD/YY format.																																																																																
24b	Enter the appropriate place of service codes in the unshaded area.																																																																																
24c	Leave blank.																																																																																
24d	Enter procedure, service, or supplies using the appropriate CPT or HCPCS code in the unshaded area. Also enter, when appropriate, up to 4 two-digit modifiers.																																																																																
24e	Enter the diagnosis reference number (pointer) in the unshaded area. The diagnosis pointer references the line number from field 21 that relates to the reason the service(s) was performed (ex. 1, 2, 3, or 4, or multiple numbers if the service relates to multiple diagnoses from field 21). The field accommodates up to 4 digits with no commas between numbers.																																																																																
24f	Enter the total charges for each line item in the unshaded area. Enter up to 6 numeric positions to the left of the vertical line 2 positions to the right. Dollar signs are not required.																																																																																
24g	Enter days / units in the unshaded area. This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be 1 unit equals a 1-minute increment. Do not include base units of the procedure with the time units. If you are billing services for consecutive dates (from and to dates) it is critical that you provide the units accurately in block 24g.																																																																																
24h	Leave blank.																																																																																
24i	Enter 1B (Blue Cross NC ID qualifier) in box 24i above the dotted line (not required if submitting NPI number).																																																																																
24j	Enter the assigned Blue Cross NC provider identification number for the performing provider in the shaded area. If several members of the group shown in Item 33 have																																																																																

	<p>furnished services, this item is to be used to distinguish each provider of service. (This field is only required if the NPI number is not being reported.)</p> <p>Enter the NPI number of the performing provider below the dotted line. If several members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service.</p> <p>Example:</p> <table border="1"> <tr> <td>I. ID. QUAL.</td> <td>J. RENDERING PROVIDER ID. #</td> </tr> <tr> <td>1B</td> <td></td> </tr> <tr> <td>NPI</td> <td>12345678901</td> </tr> </table>	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	1B		NPI	12345678901				
I. ID. QUAL.	J. RENDERING PROVIDER ID. #										
1B											
NPI	12345678901										
25	<p>Enter federal tax identification number.</p> <p><input checked="" type="checkbox"/> Indicate whether this number is Social Security Number (SSN) or Employer Identification Number (EIN).</p>										
26	Enter the patient account number assigned by physician's / provider's / supplier's accounting system.										
27	<p>Accept assignment</p> <p><input checked="" type="checkbox"/> Yes must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.</p>										
28	Enter the total charges for all services listed on the claim form in item 24F. Up to 7 numeric positions can be entered to the left of the vertical lines and 2 positions can be entered to the right. Dollar signs are not required.										
29	Enter the amount paid by the primary insurance carrier. (Reminder: Only copayments may be collected at time of service.)										
30	Enter total amount due - charges minus any payments received.										
31	Signature and date of the physician/provider/supplier. (Stamped signatures are accepted.)										
32	Enter the name and address of the facility site where services on the claim were rendered. This field is especially helpful when this address is different from billing address in item 33.										
32a	Enter the NPI number of the service facility.										
32b	<p>Enter the ID qualifier 1B immediately followed by the Blue Cross NC assigned 5-digit provider identification number for the service facility (this field is not required if submitting the NPI number in field 32a).</p> <p>Example:</p> <table border="1"> <tr> <td colspan="2">32. SERVICE FACILITY LOCATION INFORMATION</td> </tr> <tr> <td colspan="2">CRABTREE MEDICAL CENTER</td> </tr> <tr> <td colspan="2">100 AIRPORT ROAD</td> </tr> <tr> <td colspan="2">RALEIGH, NC 27610</td> </tr> <tr> <td>a. 12344567891</td> <td>b. 1B01234</td> </tr> </table>	32. SERVICE FACILITY LOCATION INFORMATION		CRABTREE MEDICAL CENTER		100 AIRPORT ROAD		RALEIGH, NC 27610		a. 12344567891	b. 1B01234
32. SERVICE FACILITY LOCATION INFORMATION											
CRABTREE MEDICAL CENTER											
100 AIRPORT ROAD											
RALEIGH, NC 27610											
a. 12344567891	b. 1B01234										
33	Enter the name, address, and phone number for the billing provider or group.										
33a	Enter the NPI number of the billing provider or group.										
33b	Enter the ID qualifier 1B immediately followed by the Blue Cross NC assigned 5-digit provider identification number for the billing provider or group (this field is not required if submitting the NPI number in field 33a).										

Example:	33. BILLING PROVIDER INFO & PH # ()	
	DR. JUDD KILGORE P O BOX 1678 RALEIGH, NC 27610	
	a. 1987654321	b. 1B03456

13.17.2 Sample CMS-1500 (02-12) claim form
See [Attachment A](#) at the end of this manual.

13.17.3 UB-04 claim filing instructions

Form Locator Number	Description of Content
1	<ul style="list-style-type: none"> • Provider name • Street address or post office box • City, state, zip code • (Area code) telephone number
2	Required when the address for payment is different than that of the billing provider information located in form locator ¹ <ul style="list-style-type: none"> • Pay-to name • Pay-to address • Pay-to city, state, zip
3a	Provider assigned patient control number
3b	Provider assigned medical / health record number (if available)
4	Type of bill (4 digit classification) <ul style="list-style-type: none"> • Digit 1: Leading zero • Digit 2: Type of facility <ul style="list-style-type: none"> ○ 1 = Hospital ○ 2 = Skilled nursing facility ○ 3 = Home health ○ 7 = Clinic ○ 8 = Special facility • Digit 3: Bill classification <ul style="list-style-type: none"> ○ 1 = Inpatient ○ 3 = Outpatient ○ 4 = Other • Digit 4: Frequency <ul style="list-style-type: none"> ○ 1 = Admit through discharge claim ○ 2 = Interim - first claim ○ 3 = Interim - continuing claim ○ 4 = Interim - last claim ○ 5 = Late charge ** For further explanation on type of bill, please refer to the NUBC UB-04 official data specifications manual.
5	Provider's federal tax identification number
6	Date(s) of service (enter MMDDYY, example 010106)

7	Leave blank																																																				
8a	Patient ID (required if different than the subscriber / insured ID in form locator 60)																																																				
8b	Patient's name (last name, first name, middle initial)																																																				
9a	Patient's address – street																																																				
9b	Patient's address – city																																																				
9c	Patient's address – state																																																				
9d	Patient's address zip																																																				
9e	Patient's address – county code (if outside US) (Refer to USPS Domestic Mail Manual)																																																				
10	Patient's date of birth (enter MMDDYYYY, example 01012006)																																																				
11	Patient's sex (M / F / U)																																																				
12	Admission / start of care date (MMDDYY)																																																				
13	<p>Admission hour</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Time AM</th> <th>Code</th> <th>Time PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00-12:59 midnight</td> <td>12</td> <td>12:00-12:59 noon</td> </tr> <tr> <td>01</td> <td>01:00-01:59</td> <td>13</td> <td>01:00-01:59</td> </tr> <tr> <td>02</td> <td>02:00-02:59</td> <td>14</td> <td>02:00-02:59</td> </tr> <tr> <td>03</td> <td>03:00-03:59</td> <td>15</td> <td>03:00-03:59</td> </tr> <tr> <td>04</td> <td>04:00-04:59</td> <td>16</td> <td>04:00-04:59</td> </tr> <tr> <td>05</td> <td>05:00-05:59</td> <td>17</td> <td>05:00-05:59</td> </tr> <tr> <td>06</td> <td>06:00-06:59</td> <td>18</td> <td>06:00-06:59</td> </tr> <tr> <td>07</td> <td>07:00-07:59</td> <td>19</td> <td>07:00-07:59</td> </tr> <tr> <td>08</td> <td>08:00-08:59</td> <td>20</td> <td>08:00-08:59</td> </tr> <tr> <td>09</td> <td>09:00-09:59</td> <td>21</td> <td>09:00-09:59</td> </tr> <tr> <td>10</td> <td>10:00-10:59</td> <td>22</td> <td>10:00-10:59</td> </tr> <tr> <td>11</td> <td>11:00-11:59</td> <td>23</td> <td>11:00-11:59</td> </tr> </tbody> </table>	Code	Time AM	Code	Time PM	00	12:00-12:59 midnight	12	12:00-12:59 noon	01	01:00-01:59	13	01:00-01:59	02	02:00-02:59	14	02:00-02:59	03	03:00-03:59	15	03:00-03:59	04	04:00-04:59	16	04:00-04:59	05	05:00-05:59	17	05:00-05:59	06	06:00-06:59	18	06:00-06:59	07	07:00-07:59	19	07:00-07:59	08	08:00-08:59	20	08:00-08:59	09	09:00-09:59	21	09:00-09:59	10	10:00-10:59	22	10:00-10:59	11	11:00-11:59	23	11:00-11:59
Code	Time AM	Code	Time PM																																																		
00	12:00-12:59 midnight	12	12:00-12:59 noon																																																		
01	01:00-01:59	13	01:00-01:59																																																		
02	02:00-02:59	14	02:00-02:59																																																		
03	03:00-03:59	15	03:00-03:59																																																		
04	04:00-04:59	16	04:00-04:59																																																		
05	05:00-05:59	17	05:00-05:59																																																		
06	06:00-06:59	18	06:00-06:59																																																		
07	07:00-07:59	19	07:00-07:59																																																		
08	08:00-08:59	20	08:00-08:59																																																		
09	09:00-09:59	21	09:00-09:59																																																		
10	10:00-10:59	22	10:00-10:59																																																		
11	11:00-11:59	23	11:00-11:59																																																		
14	<p>Type of admission / visit</p> <ol style="list-style-type: none"> 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma 9. Information not available 																																																				
15	<p>Source of admission or visit</p> <ol style="list-style-type: none"> 1. Physician referral 2. Clinic referral 3. HMO referral 4. Transfer from a hospital 5. Transfer from a skilled nursing facility 6. Transfer from another health care facility 7. Emergency room 8. Court / law enforcement 9. Information not available <ol style="list-style-type: none"> a. Transfer from a critical access hospital b. Transfer from another home health agency 																																																				

	<ul style="list-style-type: none"> c. Readmission to same home health agency d. Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer <p>For newborns</p> <ul style="list-style-type: none"> 1. Normal delivery 2. Premature birth 3. Sick baby 4. Extramural birth 																																																				
16	<p>Discharge hour</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Time AM</th> <th>Code</th> <th>Time PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00-12:59 midnight</td> <td>12</td> <td>12:00-12:59 noon</td> </tr> <tr> <td>01</td> <td>01:00-01:59</td> <td>13</td> <td>01:00-01:59</td> </tr> <tr> <td>02</td> <td>02:00-02:59</td> <td>14</td> <td>02:00-02:59</td> </tr> <tr> <td>03</td> <td>03:00-03:59</td> <td>15</td> <td>03:00-03:59</td> </tr> <tr> <td>04</td> <td>04:00-04:59</td> <td>16</td> <td>04:00-04:59</td> </tr> <tr> <td>05</td> <td>05:00-05:59</td> <td>17</td> <td>05:00-05:59</td> </tr> <tr> <td>06</td> <td>06:00-06:59</td> <td>18</td> <td>06:00-06:59</td> </tr> <tr> <td>07</td> <td>07:00-07:59</td> <td>19</td> <td>07:00-07:59</td> </tr> <tr> <td>08</td> <td>08:00-08:59</td> <td>20</td> <td>08:00-08:59</td> </tr> <tr> <td>09</td> <td>09:00-09:59</td> <td>21</td> <td>09:00-09:59</td> </tr> <tr> <td>10</td> <td>10:00-10:59</td> <td>22</td> <td>10:00-10:59</td> </tr> <tr> <td>11</td> <td>11:00-11:59</td> <td>23</td> <td>11:00-11:59</td> </tr> </tbody> </table>	Code	Time AM	Code	Time PM	00	12:00-12:59 midnight	12	12:00-12:59 noon	01	01:00-01:59	13	01:00-01:59	02	02:00-02:59	14	02:00-02:59	03	03:00-03:59	15	03:00-03:59	04	04:00-04:59	16	04:00-04:59	05	05:00-05:59	17	05:00-05:59	06	06:00-06:59	18	06:00-06:59	07	07:00-07:59	19	07:00-07:59	08	08:00-08:59	20	08:00-08:59	09	09:00-09:59	21	09:00-09:59	10	10:00-10:59	22	10:00-10:59	11	11:00-11:59	23	11:00-11:59
Code	Time AM	Code	Time PM																																																		
00	12:00-12:59 midnight	12	12:00-12:59 noon																																																		
01	01:00-01:59	13	01:00-01:59																																																		
02	02:00-02:59	14	02:00-02:59																																																		
03	03:00-03:59	15	03:00-03:59																																																		
04	04:00-04:59	16	04:00-04:59																																																		
05	05:00-05:59	17	05:00-05:59																																																		
06	06:00-06:59	18	06:00-06:59																																																		
07	07:00-07:59	19	07:00-07:59																																																		
08	08:00-08:59	20	08:00-08:59																																																		
09	09:00-09:59	21	09:00-09:59																																																		
10	10:00-10:59	22	10:00-10:59																																																		
11	11:00-11:59	23	11:00-11:59																																																		
17	<p>Patient discharge status</p> <ul style="list-style-type: none"> 01 – Discharged to home/self care (routine discharge) 02 – Discharged / transferred to hospital 03 – Discharged / transferred to skilled nursing facility 04 – Discharged / transferred to an intermediate care facility 05 – Discharged / transferred to another type of institution 06 – Discharged / transferred to home under care of Home Health 07 – Left against medical advice 20 – Expired 30 – Still patient 43 – Discharged / transferred to a federal health care facility 50 – Hospice - home 51 – Hospice - medical facility (certified) providing hospice level of care 61 – Discharged / transferred to a hospital based Medicare approved swing bed 62 – Discharged / transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital 63 – Discharged / transferred to a Medicare certified Long Term Care Hospital (LTCH) 64 – Discharged / transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 – Discharged / transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 – Discharged / transferred to a Critical Access Hospital (CAH) 																																																				

<p>18-28 <i>(as applicable)</i></p>	<p>Condition codes 09 – Neither patient nor spouse is employed 11 – Disabled beneficiary but no LGHP 71 – Full care in unit C1 – Approved as billed C5 – Post payment review applicable C6 – Admission pre-authorization ** For additional condition codes, please refer to the NUBC UB-04 official data specifications manual</p>
<p>29</p>	<p>Accident state (situational) Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code.</p>
<p>30</p>	<p>Leave blank</p>
<p>31-34 <i>(as applicable)</i></p>	<p>Occurrence codes and dates 01 – Accident / medical coverage 02 – No fault insurance involved 03 – Accident / tort liability 04 – Accident employment related 05 – Accident no medical/liability coverage 06 – Crime victim Medical condition codes 09 – Start of infertility treatment cycle 10 – Last menstrual period (only applies for maternity related care) 11 – Onset of symptoms / illness Insurance related codes 24 – Date insurance denied 25 – Date benefits terminated by primary payer Covered by EGHP A1 – Birthdate of primary subscriber B1 – Birthdate of second subscriber C1 – Birthdate of third subscriber A2 – Effective date of the primary insurance policy B2 – Effective date of the secondary insurance policy C2 – Effective date of the third insurance policy ** For additional occurrence codes, please refer to the NUBC UB-04 official data specifications manual</p>
<p>35-36 <i>(as applicable)</i></p>	<p>Occurrence span codes and dates 70 – Qualifying stay dates for SNF use only 71 – Prior stay dates 72 – First / last visit dates 74 – Non-covered level of care / leave of absence dates ** For additional occurrence span codes, please refer to the NUBC UB-04 official data specifications manual</p>
<p>37</p>	<p>Leave blank</p>
<p>38</p>	<p>Responsible party name and address</p>
<p>39-41</p>	<p>Value codes 01 – Most common semi-private rooms 02 – Provider has no semi-private rooms 08 – Lifetime reserve amount in the first calendar year</p>

	<p>45 – Accident hour 50 – Physical therapy visit A1 – Inpatient deductible Part A A2 – Inpatient coinsurance Part A A3 – Estimated responsibility Part A B1 – Outpatient deductible B2 – Outpatient coinsurance ** For additional value codes, please refer to the NUBC UB-04 official data specifications manual</p>
42	Revenue code (refer to UB-04 manual)
43	Revenue description (refer to UB-04 manual)
44	<p>HCPCS / rates</p> <ul style="list-style-type: none"> • The HCPCS applicable to ancillary service and outpatient bills • The accommodation rate for inpatient bills
45	<p>Service date (MMDDYY)</p> <ul style="list-style-type: none"> • Applies to lines 1-22 <p>Creation date (MMDDYY)</p> <ul style="list-style-type: none"> • Applies to line 23 – the date bill was created / printed
46	Unit of service
47	Total charges by revenue code category (0001 = total charges should be reported on line 23 with the exception of multiple pages which should be reported on line 23 of the last page)
48	Non-covered charges
50 (A, B, C)	<p>Insurance carrier name (payer)</p> <ul style="list-style-type: none"> • Line A - primary payer • Line B - secondary payer • Line C - tertiary payer
51	Health plan identification number (leave blank until mandated)
52 (A, B, C)	<p>Release of information</p> <ul style="list-style-type: none"> • I = Informed consent to release medical information for conditions or diagnoses (signature is not on file) • Y = Provider has a signed statement permitting release of medical / billing date related to a claim
53 (A, B, C)	<p>Assignment of benefits</p> <ul style="list-style-type: none"> • N = No • Y = Yes (must be indicated in order to receive direct reimbursement) • Contracting providers have agreed to accept assignment
54 (A, B, C)	<p>Prior payments / source</p> <ul style="list-style-type: none"> • A - Primary payer • B - Secondary payer • C - Tertiary payer
55 (A, B, C)	Estimated amount due (not required)
56 (A, B, C)	National Provider Identifier (NPI) – billing provider
57 (A, B, C)	Other billing provider ID (Blue Cross NC provider number on appropriate line) – required if NPI is not reported on FL56
58 (A, B, C)	Subscriber's / insured name (last name, first name)

59 (A, B, C)	Patient's relationship to subscriber / insured 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ donor 40 – Cadaver donor 53 – Life partner G8 – Other relationship
60 (A, B, C)	Subscriber's / insured identification number
61 (A, B, C)	Subscriber's / insured group name
62 (A, B, C)	Subscriber's / insured group number
63 (A, B, C)	Treatment authorization code
64 (A, B, C)	Document Control Number (DCN) [leave blank]
65 (A, B, C)	Subscriber's / insured employer name
66	Diagnosis and procedure code qualifier (ICD version indicator)
67	Principal diagnosis code “ICD-10” (do not enter decimal, it is implied) <ul style="list-style-type: none"> • Eighth position indicates Present on Admission indicator (POA) <ul style="list-style-type: none"> ○ Y = Yes ○ N = No ○ U = No information in the record ○ W = Clinically undetermined
67 (A-Q)	Other diagnosis codes “ICD-10” <ul style="list-style-type: none"> • Eighth position indicates Present On Admission indicator (POA) – required for inpatient claims <ul style="list-style-type: none"> ○ Y = Yes ○ N = No ○ U = No information in the record ○ W = Clinically undetermined
68	Leave blank
69	Admitting diagnosis (inpatient only)
70 (A, B, C)	Patient's reason for visit (outpatient only)
71	Prospective Payment System code (PPS) [not required]
72 (A, B, C)	External cause of injury code “E-Code”
73	Leave blank
74	Principal procedure code and date <ul style="list-style-type: none"> • ICD-10 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format MMDDYY
74 (A-E)	Other procedures codes and dates (procedures performed during the billing period other than those coded in FL74)

	<ul style="list-style-type: none"> • ICD-10 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format (MMDDYY)
75	Leave blank
76	Attending physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
77	Operating physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
78-79	Other physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
80	Remarks
81 (A-D)	Code - code field (overflow field to report additional codes)

13.17.4 Sample UB-04 claim form

See [Attachment B](#) at the end of this manual.

13.17.5 Policy on payment for remaining codes

Sample versions of completed claim forms are available in The [Blue Book](#)SM Provider Manual, located in Chapter 9, Claims billing and reimbursement. These forms may be viewed on the [BlueCrossNC.com](#) website for providers. When viewing the sample claim forms contained in [Blue Book](#), it's important to remember that when submitting claims for Experience Health Medicare Advantage (HMO) members, always use your assigned provider and/or group number for Experience Health transactions, if not filing via NPI.

13.18 HCPCS codes

Reminder:

Experience Health has been and will continue to allow the submission of HCPCS codes. In fact, their use is encouraged especially when filing for the administration of medications.

When submitting claims with a medication code of “J,” it is important to refer to the HCPCS code book, paying particular attention to the dose that is listed to ensure appropriate reimbursement exactly as they appear in the HCPCS book.

Example 1:

A patient is given ten (10) mg of Valium. The HCPCS code for Valium, J3360, reads “injection, diazepam up to five (5) mg.” The provider should enter two (2) (# of units) in the “G” field (days and unit field) to indicate that a total of ten (10) mg of Valium was given. If the number of milligrams is entered instead of the number of units, the claim will be incorrect.

Also, when filing code J3490, unclassified drugs, a description or name of the medication and dose given must be submitted on the claim form for payment. The claim cannot be processed without this vital piece of information and would more than likely be denied for medical justification.

Example 2:

A forty-eight (48) year-old man with mild diabetes on single drug therapy with an oral agent receives a comprehensive examination. He had not had a similar evaluation in three (3) years, being seen only rarely for brief visits, as he was asymptomatic and doing well on his previous examination. A CBC, Chem Profile, Urinalysis and Glycosolated Hemoglobin are obtained. The patient is counseled regarding cigarette smoking; with control and prudent low cholesterol diet is advised and briefly described.

For this visit, the diagnosis code Z00.00 should be used. Code E11.9 for Diabetes Mellitus should be listed next to the Glycosolated Hemoglobin as a secondary diagnosis.

The appropriate procedure code would be 99396, which is the preventive medicine CPT code for an established patient forty to sixty-four (40-64).

Example 3:

A sixty-three (63) year-old female received a comprehensive evaluation after not being seen in the physician's office for over one (1) year. Two (2) years prior to this visit she had a successful resection of colon carcinoma and four (4) years prior to the visit she had an uncomplicated myocardial infarction. The current visit was precipitated by the development of shortness of breath, swelling of the lower extremities and weight gain. The patient was known to have mild diabetes but was taking no medication. Physical examination was normal except for obesity and a trace of pretibial edema.

Since it had been several years since she had had an internal examination and pap smear, that procedure was performed. There were no symptoms or findings related to that part of her examination. Multiple laboratory tests, as well as an electrocardiogram and chest x-ray were requested. The patient was counseled regarding weight loss and a low sodium diet. A return visit was scheduled.

For this visit, the procedure code 99215 should be used. An appropriate diagnosis code should be utilized as the primary diagnosis. The preventive code Z00.01 should also be listed as a secondary diagnosis since certain preventive services are rendered. Code Z01.419 should be used beside the pap smear to justify this as a routine procedure.

Example 4:

An eighteen (18) year-old high school student is seen for a scheduled covered routine general health evaluation. The student also requests completion of a pre-employment form for a summer job. He plans to enter college in the fall and anticipates needing student health forms and immunization records at that time. The patient is healthy and has no complaints. He had been seen in the office before, but not for several years. No problems are revealed by a complete review of his history, and a complete physical examination is normal. The required pre-employment form is completed. No counseling of significance is necessary. For this visit, the appropriate diagnosis code would be Z00.00.

The procedure code should be preventive code 99385 or 99395, depending on whether the patient had been seen prior to this visit, within the last three (3) years.

Note: If a physical was scheduled for the pre-employment physical alone, this would not be covered, as this is an exclusion per the Certificate of Coverage.

13.19 ICD-10 and CPT codes for well exams

When filing claims for well exam, you must use the correct ICD-10 and CPT codes. Please refer to the chart or call Customer Services or your Provider Network representative if you need assistance.

Preventive medicine CPT codes 99381-99397 include counseling.

Field Number	New	New
Less than 1 year	99381	99391
Less than 1 year	99382	99392
5 to 11	99383	99393
12 to 17	99384	99394
18 to 39	99385	99395
40 to 64	99386	99396
65 years and over	99387	99397
Routine GYN exam	99203 or 99204 or 99384-99387	99213 or 99214 or 99394-99397
Preventive counseling codes*	99401-99404	99401-99404
* Codes used to report services provided at a separate encounter. These codes are not appropriate to use with CPT codes 99381-99397 or 99201-99215 or to use with ICD-10 codes Z00.00, Z00.01, Z00.121, Z00.129, Z01.411 or Z01.419.		

Diagnosis codes:

- ICD-10 general medical examination code Z00.00 or Z00.01 (adults, age eighteen [18] and over) and Z00.129 (children, newborn to seventeen [17] years of age) should be used as the primary code for services that are predominantly preventive.
- ICD-10 code Z01.411 or Z01.419 should be used as the diagnosis code for the annual routine pelvic examinations including pap smears.

Procedure codes:

- Preventive medicine codes 99385-99387 and 99395-99397 must be used when ICD-10 code Z00.00 or Z00.01, adult preventive care, is the primary or submitted diagnosis; 99381-99384 and 99391-99394 must be used when ICD-10 code Z00.121 or Z00.129, pediatric preventive care, is the submitted diagnosis.
- CPT evaluation and management service codes 99201-99205 and 99211-99215 should be used when services are predominantly for patient complaints and/or illness and should be selected according to criteria described in the CPT manual.

Initial Preventive Physical Examination (IPPE) or Welcome to Medicare Visit

- CPT code G0402 is used to bill the IPPE visit. The “Welcome to Medicare” visit is billed only within the first twelve (12) months the member has had Medicare.

Annual Wellness Visits (AWV)

- G0438 is used for the initial AWV and must occur at least twelve (12) months after the member’s “Welcome to Medicare” visit.
- G0439 is used for the subsequent AWV.
- AWVs are allowed once, every twelve (12) years.

13.20 Immunizations (Part D-covered vaccines)

Physicians and other providers who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for the administration of Part D-covered vaccines to Medicare cannot bill Medicare Part B (i.e., Experience Health medical claims) for the administration of Medicare Part D-covered vaccines. Providers billing staff should be aware of Part D-covered vaccine administration guidance for 2008. Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of “covered Part D drug” under the Part D statute. During 2007, in transition to the policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377). However, special edition (SE) 0723 reminds providers of the requirement that payment for the administration of Part D-covered vaccines was only during 2007. Therefore, effective January 1, 2008 and dates after, providers may no longer bill the “G” code to Part B, instead the Part D plan should be billed for reimbursement.

13.20.1 Safe handling of vaccines

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Experience Health members are not to pick-up vaccines from the pharmacy for transport to a provider’s office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by an Experience Health member. Providers with questions are encouraged to contact their Provider Network representative.

13.20.2 Medicare Part D vaccine manager for claims filing

Participating providers have an easy online option to submit Medicare Part D vaccine claims through eDispense™. eDispense™ Part D vaccine manager, a product of Dispensing Solutions, Inc. (DSI), is a web-based application, that offers a solution for the submission and adjudication of claims for physician administered Part D vaccine covered by member’s Medicare Part D pharmacy benefits (vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form or other similar forms).

eDispense™ makes real-time claims processing for in-office administered Medicare Part D vaccines available through its secure online access. Services offered with eDispense™ allow providers to quickly and electronically verify member’s Medicare Part D vaccination coverage and submit claims to our pharmacy benefits manager directly from your in-office internet connection.

eDispense™ offers providers the ability to:

- Verify members’ Medicare Part D vaccination eligibility and benefits in real time
- Advise members of their appropriate out-of-pocket expense for Medicare Part D vaccines
- Submit Medicare Part D vaccine claims electronically to our Pharmacy Benefits Manager (PBM)

Enrollment is an easy two (2) step process:

- Step 1 – select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
 - Tax identification number
 - National Provider Identifier (NPI)
 - Medicare ID number

- Drug Enforcement Administration (DEA) number
- State medical license number
- Step 2 – go to Dispensing Solutions’ website and complete a simple onetime online enrollment application at mytransactrx.com/WebPortal/logout.do.

Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their Customer Support Center at 1-866-522-EDVM (3386).

Provider enrollment in eDispense™ vaccine manager and eDispense™ facilitated transactions between the PBM and providers is a voluntary option for providers. Medicare Part D vaccine claims eligible for electronic processing with eDispense™

Part D vaccine manager are reimbursed according to the PBM allowance, less member liability. Experience Health offers network providers access to eDispense™ vaccine manager for Medicare Part D transactions through our PBM.

13.21 Allergy testing

All allergy testing for members must be provided by participating allergists who are board certified by the American Board of Allergy and Immunology, or participating board certified ENT allergists who have completed requirements for fellowship in the American Academy of Otolaryngic Allergy and have been approved by the Experience Health credentials committee.

The following are the exceptions:

- Allergy patch testing has been approved to be performed by our participating dermatologists. CPT code is 95044.
- Ophthalmic mucous membrane testing has been approved to be performed by our ophthalmologists. CPT code is 95060.
- Inhalation bronchial challenge testing has been approved to be performed by our participating pulmonary specialists. CPT code is 95070-95071.

Subsequent allergy injections may be provided by other participating physicians such as the primary care physician or other participating specialists when referred by the primary care physician.

CPT codes used for allergy testing are 95004-95075

CPT codes used for allergy immunotherapy are 95115-95180.

Skin tests for specific drug immediate reactions would be appropriate for any participating physician specialty.

13.22 Criteria for approving additional providers for allergy testing

- To certify that allergy testing throughout the Experience Health network of otolaryngic providers is performed in a consistent manner, and by physicians who have been adequately trained in evaluation of allergic manifestations, the need has arisen for standardization of criteria for credentialing of privileges by otolaryngologists.
- The Plan will recognize and approve allergy testing to otolaryngologists who are participating providers in the Experience Health network and who have fulfilled the requirements and received certification by the American Academy of Otolaryngic Allergy (AAOA). Verification of certification by the American Academy of Otolaryngic Allergy should be provided by the otolaryngologist upon application for privileges for otolaryngic allergy testing.

- Background: Allergy testing for Experience Health members can be an important part of determining causes of significant illnesses, as well as being the basis for selecting a treatment regimen for members who exhibit allergic manifestations. After review of available information, it appears appropriate and reasonable to expect otolaryngic providers to have gone through the requirements of the American Academy of Otolaryngic Allergy and to receive certification as ENT allergists in order to be certified as a participating provider of otolaryngic allergy testing.
- Exceptions may be made, on an individual basis, by Experience Health credentialing committee, based on evidence of sufficient training and experience in the field of ENT allergy.

13.23 Use of office or other outpatient service code 99211

CPT code 99211 is described as “office or other outpatient visit for evaluation and management of an established patient, that may not require the presence of a physician.” Usually the presenting problems are minimal. Typically five (5) minutes are spent performing or supervising these services.

The CPT code should not be used for an additional charge when only laboratory, immunizations or other diagnostics are performed.

For Experience Health patients, this service code requires a copayment to be charged and patients should not have to pay a copayment if they are only reporting for laboratory tests or x-rays.

For the service described by CPT code 99211 to be billed:

- There should be a documented service by the physician or physician office staff that is separate from other procedures that are being performed at the same time, such as injections and diagnostic tests.
- The service should be clearly identifiable.
- A record of the service performed should be entered into the patient’s medical record.

Examples:

- Office visit for a sixty-seven (67) year-old established patient to re-dress an abrasion.
- Office visit of a seventy-two (72) year old established patient, for a blood pressure check and review medication.

13.24 Dispensing DME from the office

Prior authorization will not be required for covered Durable Medical Equipment (DME) or medical supply items if the item is:

- \$1,200 or less by contracted rate and
- Filed with a valid HCPCS code and
- Filed by a participating provider / vendor

Prior authorization is required for all Durable Medical Equipment (DME) less than \$1,200 for payment by Experience Health. Unlisted, miscellaneous or customized items will not have a contracted price as they are priced based on individual consideration; therefore, these items generally will require prior authorization. This allows us to make a determination of coverage and inform you of the member’s copayment. To pre-authorize the item, call Medical Services at 1-877-397-4584 (option 6) with the following information:

- Name of item required and the HCPCS code

- Diagnosis
- What the device will be used for
- Clarification that the device is medically necessary

The following are some examples of non-covered items or services:

- Theraputty
- Lumbar pillows or rolls
- Cervical pillows or rolls
- Educational supplies, such as books or manuals
- Theraband

You may bill the member if services are denied as non-covered, (for example, EX 02). These services are excluded in the member's Certificate of Coverage.

You may not balance bill the member if services denied exceeds HMO guidelines (for example, EX 56) or are considered included in a global service, EX 36.

You should not have any problem receiving reimbursement for the HCPCS "L" codes submitted if you prior authorize the DME. Be aware that all authorized HCPCS "L" code devices are considered durable medical equipment and the applicable DME copayment / coinsurance will be deducted by Experience Health at the time of claims submission.

13.25 Assistant surgery

Following is the Experience Health Medicare Advantage (HMO) criteria for reimbursement for assistant surgery procedures:

- The practitioner assisting surgery must be credentialed by and participating with the Experience Health network but does not have to be the same specialty or have training equal to the primary surgeon. The assistant surgeon is expected to comply with all applicable statutes and regulations as appropriate for assistant surgery.
- Physician reimbursement is limited to 16% of the Plan's allowable for the CPT code submitted by the primary surgeon or charges, whichever is less. Multiple surgery guidelines apply to assistant surgeons when they are assisting on multiple procedures. Physician reimbursement for the second procedure is limited to 8% of the Experience Health allowable or charge, whichever is less. Reimbursement for mid-level practitioners providing assistant surgery is limited to 85% of the assistant surgeon physician allowable for primary and multiple procedures.
- The Plan utilizes assistant surgeon indicators identified by industry standard coding software to determine if the procedure indicates the use of an assistant surgeon. When assistant at surgery services are eligible for reimbursement, providers are to bill using industry standard modifiers.

13.26 Ancillary billing and claims submission

For Experience Health Medicare Advantage (HMO) members, authorization of certain outpatient services such as home health, durable medical equipment, rehabilitation and requests for non-participating providers may be required prior to the initiation of services. Please verify member benefits and review Experience Health prior authorization requirements detailed in Chapter 9, Prior authorization requirements, of this manual, prior to providing services.

DME providers should file claims for rental services monthly, after thirty (30) consecutive days of rental, or at the time the rental is determined to no longer be medically necessary (whichever is first).

13.27 Ancillary billing

13.27.1 Participating reference lab billing

Definition – Reference clinical laboratory testing services as may be requested by Experience Health participating providers. This would include, but not be limited to, consulting services provided by provider, courier service, specimen collection and preparation at designated provider locations, and all supplies necessary solely to collect, transport, process or store specimens to be submitted to provider for testing.

Billing

- Bill on CMS-1500 claim form or other similar forms using CPT / HCPCS coding
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- Use appropriate provider number
- File claims after complete services have been provided
- Laboratory procedure reimbursement includes the collection, handling and conveyance of the specimen
- All services provided should be billed as global

13.27.2 Dialysis services billing

Definition – For services involved in the process of removing blood from a patient whose kidney functioning quality is faulty, purifying that blood by dialysis, and returning it to the patient’s bloodstream.

Billing – Provider agrees to:

- Billing on the UB-04 claim form using only those revenue codes indicated as billable dialysis facility services, along with the corresponding CPT codes and HCPCS codes.
- Not bill for routine laboratory, pharmaceutical, and supplies that Medicare considers to be included under the composite dialysis rate (dialysis inclusive rate).
- Bill for non-routine (separately billable) laboratory, and pharmaceuticals that Medicare considers to be not included under the composite dialysis rate.

The in-home hemodialysis inclusive rate per treatment is the same as the in-center hemodialysis inclusive rate per treatment.

13.27.3 Skilled Nursing Facility (SNF) billing

Definition – Skilled nursing care is care and/or skilled rehabilitation services, which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a physician to assure the safety of the member and achieve the medically desired result. Skilled rehabilitation therapy includes services provided by physical therapists, occupational therapists, and speech pathologists or audiologists. The member must require continuous (daily) skilled nursing services for the level of care to be considered covered.

Billing

- Bill on UB-04 claim form.
- The patient must require continuous (daily) skilled nursing services for the level of care to be considered covered.

- The medical record will contain documentation substantiating coding classification, such as in the form of a completed Minimum Data Set (MDS) scoring tool.
- The following exclusionary services require prior approval from the Plan: specialty beds, DME for personal and/or home use, customized prosthetics and orthotics, ambulance transport, diagnostic procedures and lab work not routinely carried out by the facility.

13.27.4 Ambulatory Surgical Center (ASC) billing

Definition – Surgical procedures grouped by complexity (as defined by Medicare).

Billing

- Outpatient surgery, radiology, laboratory, and other diagnostic services must be billed by CPT code.
- Providers should always submit the appropriate CPT code to indicate the primary procedure.
- All ancillary services and supplies provided in conjunction with an ambulatory surgical procedure, including those delivered within seventy-two (72) hours prior to the surgical procedure, must be billed on the same UB-04 form.

Incidental procedure – An incidental procedure is one that is carried out at the same time as a more complex primary procedure and requires little additional resources and/or is clinically integral to the performance of the primary procedure. For these reasons, an incidental procedure should not be reimbursed separately on a claim. Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied. Incidental procedures are identified by medical review and are considered a contractual adjustment.

Integral procedure – Procedures considered integral occur in multiple surgery situations when one (1) or more of the procedures are considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service and will not be reimbursed separately.

13.27.5 Home Durable Medical Equipment (DME) and billing

Definition – Durable medical equipment services are defined by CPT codes, and by HCPCS codes as set forth in the AMA HCPCS Level I and Level II guidelines.

Billing – Bill on a typed electronic CMS-1500 claim form or other similar forms.

Payment – rentals

- All rentals and all rentals converted to purchase require prior authorization.
- Always include rental modifier code on rental claim forms.
- Bill each month of rental as one (1) unit.

Payment – repairs / maintenance

- Non-routine repairs that require the skill of a technician may be eligible for reimbursement.
- The labor component of the repair should be billed under the appropriate repair code.
- All replacement parts should be billed separately under the appropriate HCPCS code(s).
- Repairs may only be billed on purchased items and require prior authorization.
- Repairs may not be billed on rented equipment.
- All claims with a repair code should be submitted with a complete description of the services provided.

- When submitting a claim with a repair or maintenance modifier code and other modifier codes, list the repair or maintenance modifier code first after the procedure code.
- Losses resulting from abuse / misuse of equipment or items are excluded from coverage.
- Maintenance services require prior authorization.

Certain drugs and supplies

With the January 1, 2006, implementation of Medicare Part D, which is Medicare prescription drug coverage, certain drugs and supplies are covered only under the Experience Health member's prescription drug benefits.

This means that providers need to know whether or not they are in-network for the prescription drug benefits, as well as be able to distinguish between Medicare Part B and Part D coverage in order to know how to bill properly for a given drug or supply.

In order to be in-network for the Medicare Part D prescription drug benefits, durable medical equipment providers must be in the Prime Therapeutics, LLC (Prime) network. Prime is Experience Health's Part D pharmacy benefits manager. Durable medical equipment providers who contract only with Blue Cross NC as part of the Experience Health network, but not with Prime, are in-network only for Part B benefits and are out-of-network for Part D benefits. Durable medical equipment providers that are also pharmacies that would like to participate with Prime may contact Prime directly at 1-877-823-6373 or by email to: PharmacyOps@PrimeTheraPeutics.com.

When billing for the drugs and supplies that are covered under Medicare Part B, providers need to follow all Medicare Part B coverage guidelines. Providers must follow the Medicare Part D coverage guidance when billing for drugs and supplies that are covered under Medicare Part D.

Modifiers RP applicable to purchased items only

- Modifier RP must be filed when submitting claims for maintenance and repairs

Miscellaneous

- For manual and motorized wheelchairs and scooters, the Plan has the right to authorize these items as rental items if Medicare has rental rates.

Use of E1399 and other miscellaneous codes

Do not use E1399 or other miscellaneous HCPCS codes for items which have a designated HCPCS code.

- Special documentation is required for claims using miscellaneous codes, including E1399.

Always submit:

1. With each claim a complete description of the item.
 2. With each initial claim a factory invoice for the item (catalogs and retail price listings are not acceptable).
- Failure to provide appropriate documentation when using E1399 and other miscellaneous codes can result in processing delays and/or denials.

Please Note:

- Do not staple these or any other enclosures to the claim form.

- Submit all initial claims on paper to ensure the appropriate documentation is received in the same envelope.
- Electronically submitted claims will not transmit additional documents.

13.27.6 Home Health (HH) billing

Definition – Home health services are defined as follows: Visits to the home to provide skilled services, including:

Home Health Services	Must Be Rendered By
Skilled Nursing (SN)	Registered nurse or licensed practical nurse
Physical Therapy (PT)	Licensed physical therapist or licensed physical therapist assistant
Occupational Therapy (OT)	Licensed occupational therapist
Speech Therapy (ST)	Licensed speech pathologist
Medical Social Service (MSW)	Medical social service (MSW)
Medical Social Service (MSW)	Home health aide

Billing

Provider agrees:

- To bill on UB-04 claim form. Appropriate HCPCS codes are required in box 44 of the UB-04 in order to receive payment.
- To bill your retail charges.
- To use your appropriate provider number.
- To file claims after complete services have been provided.
- In addition to the home health visit, bill only the non-routine medical supplies listed in the agreement. These are the only covered supplies that may be billed under the revenue codes listed (all other covered supplies are considered routine). If on prospective payment contract, FFS contract can file intermittent claims.
- Experience Health will not pay overtime / holiday rates.
- For non-routine supplies, include a valid HCPCS code with the revenue code on the UB-04.

Revenue codes and service units

Service	Revenue Code	Payment
Home health aide	571	Visit
Medical social worker	561	Visit
Occupational therapy	431	Visit
Physical therapy	421	Visit
Skilled nursing LPN	550	Visit
Skilled nursing RN	551	Visit
Speech therapy	441	Visit

Home health services not billable as separate services (integral part of home health visit):

- Routine medical supplies provided in conjunction with home health services including those left at the member’s home are considered an integral part of the home health visit reimbursement and

cannot be billed separately (under Home Durable Medical Equipment [HDME] provider number or any other provider number).

- Assessment visits unless a skilled service is also rendered during the same visit.
- Supervisory visits unless a skilled service is also rendered during the same visit.
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.

Billable non-routine home health supplies

Routine medical supplies provided in conjunction with home health services including those left at the member’s home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under HDME provider number or any other provider number).

13.27.7 Home Infusion Therapy (HIT) billing

Definition – Home infusion therapy is defined as follows:

- The administration of prescription drugs and solutions in the home via one (1) of these routes:
 1. Intravenous
 2. Intraspinous
 3. Epidural
 4. Subcutaneous

Notice: Other medications eligible for reimbursement under the Home Infusion Therapy (HIT) schedule must be injections administered during the same visit as the infusion therapy and require administration by a health care provider such as a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Benefits for home infusion services are limited. The following is applicable only to services that have been authorized by Experience Health.

Billing

- Home infusion therapy requiring regular nursing services must be billed in three (3) components by the home infusion therapy provider:
 1. Per diem component (covering all home infusion services, equipment and supplies except the prescription drug and licensing nursing services) for each day the drug is infused.
 2. Nursing services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), and
 3. Drug component (only bill for the quantity of drug actually administered, not unused mixed, compounded or opened quantities)
- Bill on the CMS-1500 claim form or other similar forms
- Use your appropriate provider number
- File claims after services have been provided
- File claims within one hundred and eighty (180) days of providing service
- Miscellaneous codes are valid for use only if no suitable billing code is available. All claims using miscellaneous codes must be submitted with a complete description of the services rendered, including the NDC numbers for the drugs administered. Failing to provide appropriate documentation when using miscellaneous codes can result in delays and/or denials.

Bundled services

The following are included in the home infusion therapy rates established in your contract and reimbursement schedule and may not be billed separately unless defined:

- All training and nursing visits and all nursing services
- Initial assessment and patient set-up
- Providers may not request members obtain supplies or treatment from an office; to get supplies / treatment, home infusion must be done in the home.

13.28 Hospital policies

The following are excerpts from the hospital agreement that outlines the provider's responsibility as a participating facility. These policies are provided in addition to the remainder of the policies in this manual. Please review all sections of this manual that pertain to you.

Access to medical records

The hospital agrees, as stated in the hospital agreement, that Experience Health shall have the right, upon request and during normal business hours, to inspect and copy records maintained by the hospital pertaining to claims for hospital services.

Concurrent review

The hospital will participate in and cooperate with Experience Health in its Utilization Management and Quality Improvement Programs. Summaries of these programs follow.

Credentialing

The hospital will participate in and cooperate with Experience Health credentialing and recredentialing processes and will comply with determinations made pursuant to the same. Please also see Chapter 19, Credentialing.

The hospital will complete requests for verifications of privilege status regarding individual providers. These verifications will include information regarding a provider's:

- Status and standing with hospital
- Specialty classification
- Level of privileges
- Description of past actions
- Description of limitations

13.29 Utilization Management program

Experience Health has developed and implemented a UM program with the objective of assuring that medical services delivered to Experience Health members are timely, appropriate and cost-effective.

Utilization Management applies to all covered members. For inpatient services, Utilization Management activities include pre-admission and admission review, continued stay or concurrent review and discharge planning.

Pre-admission review is designed for monitoring and evaluating the medical necessity, appropriateness and required level of care for an elective admission prior to its occurrence. The patient's primary care physician or the consulting specialist typically initiates this process by obtaining authorization through the Experience Health Care Management department.

Admission review and concurrent review are performed by Experience Health registered nurses either telephonically or through on-site visits to the facility. Both processes, whether performed on-site or telephonically, are coordinated through the hospital's utilization review department.

Admission review involves the determination of the type of admission, either emergency or urgent, and documentation that acute care is the appropriate level of care for the patient's illness or condition. Concurrent review is a review of the member's medical record by Experience Health registered nurses during hospitalization to assess the continued medical necessity and appropriateness of care. This information is also used to begin the discharge planning process.

Experience Health primary objective of discharge planning is to help patients, their families, health care professionals and the community to ensure that the gains achieved from hospital care are maintained or enhanced for the continued health and welfare of the patients following discharge. The discharge plan is a process where patients' needs are identified, evaluated and assistance given in preparing them to move from one level of care to another.

During the discharge planning process, Experience Health nurses assist in arranging and authorizing the services needed upon discharge. They work with the attending physicians, hospital discharge planners or social workers, the patients and their families and Experience Health participating home health vendors who participate in the Experience Health network to coordinate the services that are covered by Experience Health.

The nurses follow the ongoing treatment, status and needs of the patient until services are no longer needed or covered.

Retrospective review or claims review may also be conducted as part of the Utilization Management process. This process reviews the necessity and appropriateness of medical services by compilation and analysis of data after medical care is rendered to determine practitioner and consumer patterns of care.

If a hospital cannot provide adequate services to an Experience Health member seeking provider services from a hospital, the hospital shall cooperate with the Experience Health member and the participating physician who ordered the Experience Health member's admission or treatment in obtaining appropriate care for the Experience Health member. Referrals shall be made to a participating provider if required services are available from such a facility.

13.30 UB-04 claims filing and billing coverage policies and procedures

13.30.1 Anesthesia

- May be charged individually as used or included in a charge, based on time.
- A charge that is based on time must be computed from the induction of anesthesia until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies and all gases.
- Anesthesia stand-by services are not covered unless they are actually used. Bill anesthesia services using revenue code R370.

13.30.2 Certified Registered Nurse Anesthetist (CRNA)

- Must be filed on a CMS-1500 claim form or other similar forms
- Minutes of time must be included
- Anesthesia codes must be submitted

13.30.3 Autologous blood

- Charges for autologous donations are covered when such services are rendered for a specific purpose (e.g., surgery is scheduled or the need for using autologous blood is documented) and then only if the patient actually receives the blood.
- Prophylactic autologous donations and long-term storage (e.g., freezing components) for an indeterminate time period in case of future need are not considered eligible for benefits.
- Blood used must be billed on the same claim as the related surgery charges.

13.30.4 Autopsy and morgue fee

- Autopsy and morgue fees are not covered under Experience Health certificates.

13.30.5 Critical care units

The following conditions must be met to be considered a critical care unit:

- The unit must be in a hospital and physically separate from general patient care areas and ancillary service areas.
- There must be specific written policies that include criteria for admission to and discharge from the unit.
- Registered nursing care must be furnished on a twenty-four (24) hour basis. A nurse-patient ratio of one (1) nurse to two (2) patients per patient day must be maintained.
- A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for critical care unit (i.e., coronary care or intensive care unit) has two (2) components:

- The room charge includes all items listed under acute care.
- The nursing increment / equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

To ensure appropriate benefit payments, the critical care room charge should equal the corresponding routine room rate (i.e., either the routine semi-private or private rate). An accurate breakdown of these components ensures correct claims processing. Any claims received without a breakdown of these components may be returned for correction.

13.30.6 Diabetes education (inpatient)

- Admissions solely for the purpose of diabetic education are not covered under Experience Health certificates

13.30.7 Dietary nutrition services

- Medically necessary nutritional counseling may be a covered benefit
- Other nutritional assessment services (e.g., Optifast) are not covered under Experience Health certificates
- If covered nutritional counseling is included on the UB-04 claim form use revenue code R942

13.30.8 EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel)

13.30.9 Hearing aid evaluation

- Hearing aid evaluation, hearing aid fitting and hearing screening are not covered under Experience Health certificates

13.30.10 Lab / blood bank services

- The charge for clinical laboratory must include the cost of all supplies related to the tests performed and a fee for the administration of the department.
- Arterial puncture charge should be included in the charge for the test.

13.30.11 Labor and delivery rooms

The labor room charge and delivery room charge must include the cost of:

- The use of the room
- The services of qualified technical personnel
- Linens, instruments, equipment and routine supplies

The hospital should not bill Experience Health for an obstetrics room in addition to the labor room when patient is still in the labor room at the time of patient census.

13.30.12 Leave of absence days

- Experience Health does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient.
- This charge should be billed directly to the patient as it is the patient's liability.
- If billed on the UB-04 claim form use revenue code R180 with zero charge in form locator 47.

13.30.13 Observation services

Observation beds are covered outpatient services when it is determined that the patient should be held for observation, but not admitted to inpatient status. Use the following guidelines when billing observation charges:

- Bill observation services under revenue code R762.
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate.
- Experience Health should not be billed for both an observation charge and a daily room charge for the same day of service.
- Observation charges must include all services and supplies included in the daily room charge.
- The daily room rate should not be billed for an observation patient sent home before the midnight census hour.
- When a patient receives services in, and is admitted directly from an observation holding area, such services are considered part of inpatient care.
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.

13.30.14 Operating room

- The operating room charge may be based on time or per procedural basis. When time is the basis for the charge, it must be calculated from the induction of anesthesia to the completion of the procedure.
- Operating room services should be billed using revenue code R360.

13.30.15 Outpatient surgery

- All ancillaries and supplies associated with an outpatient surgical procedure should be billed on one (1) claim. This includes use of facility (pre-operative area, operating room, recovery room), all surgical equipment, anesthesia, surgical supplies, drugs and nourishment.
- All charges associated with preoperative testing performed within seventy-two (72) hours of the surgical procedure should also be billed on the same claim with the ancillaries and supplies for outpatient surgery.

13.30.16 Personal supplies

- Personal supplies include items not ordered by the physician or not medically necessary.
- These items are not covered by Experience Health. These items should be billed using UB-04 revenue code R999.
- Example of personal supplies include:
 - Hair brush
 - Mouthwash
 - Nail clippers
 - Powder
 - Razor
 - Shampoo and conditioner
 - Shaving cream
 - Shoe horn
 - Toothpaste
 - Toothbrush

13.30.17 Pharmacy

Please also refer to Chapter 14.1, The Experience Health formulary in Chapter 14, Pharmacy and specialty networks.

- All pharmacy charges should be billed to Experience Health using revenue code R250-R259.

13.30.18 Recovery room

- The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac, and pulse oximeter), defibrillator, etc.
- Warming systems (e.g., Bair Hugger Patient Warming System, hypo / hyperthermic unit, radiant warmer, etc.) should not be billed to Experience Health or the patient.

13.30.19 Emergency room services

- Charges for ER visits and services resulting in an admission, must be billed on the UB-04 for the inpatient admission. These charges should not be split out and billed separately.
- Charges for ER visits that do not result in an approved admission, must be submitted separately for consideration of payment. These services will be subject to existing Prudent Layperson Language and if approved will reimburse according to the current outpatient reimbursement for your facility.

13.30.20 POA indicators required

The Centers for Medicare & Medicaid Services (CMS) requires completion of the Present on Admission (POA) indicator for every diagnosis on an inpatient acute care hospital claim.

Hospitals providing care for Experience Health Medicare Advantage (HMO) members are required to follow CMS' POA reporting guidelines when submitting claims for services provided to our members.

For inpatient acute care Prospective Payment System (PPS) discharges on or after October 1, 2008, certain diagnosis codes on claims could trigger a higher paying Diagnosis Related Groups (DRG) at the time of discharge (but not at the time of admission). The DRG that must be assigned to the claim will be the one that does not result in the higher payment.

The Experience Health Medicare Advantage (HMO) product should apply CMS POA adjudication logic. Providers will not be compensated for those services that are non-reimbursable as identified in CMS' hospital-acquired conditions and present on admission indicator reporting program, or successor program(s), in accordance with CMS payment policies.

13.30.21 Room and board

- The following are included in daily hospital service acute care and should not be billed as separate items to Experience Health or its members:
 - Room and complete linen service
 - **Dietary service:** meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list
 - General nursing services include patient education such as instruction and materials. This does not include or refer to private duty nursing.
 - All equipment needed to weigh the patient (e.g., scales)
 - Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
 - Use of examining and/or treatment rooms for routine examination
 - Routine supplies as a part of normal patient care
 - Administration of enemas and medications including IVs
 - Postpartum services
 - Recreation therapy
 - Enterostomal therapy (the costs of enterostomal supplies are covered ancillary)

13.30.22 Special beds

- Bill these beds using UB-04 revenue codes R946 and R947.
- The following beds are covered as a separate charge when medically necessary:
 - Bio-Dyne bed
 - Clinitron bed
 - Flexicare bed
 - Fluidair bed
 - Just Step mattress
 - Ken-Air bed
 - Kinetic therapy bed
 - Pegasus airwave system
 - Restcue bed (Hill-Rom EFICA CC)
 - Roto-Rest bed
 - Therapulse bed

13.30.23 Special monitoring equipment

- Includes dinemapp, swan ganz, cardiac, pressure monitor and telemetry.

- Charges include the use of supplies (e.g., electrodes, guidewires and telemetry pouches).
- When special monitoring equipment is used by a patient in routine or general accommodations, a separate monitoring equipment charge may be billed.
- When a patient is using special monitoring equipment in the operating room, recovery room or anesthesia department and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed.
- Monitoring equipment used during transport is considered a continuation of services.
- Set up fees that only represent personnel time are considered part of the procedure / treatment fee.

13.30.24 Speech therapy

- Covered speech therapy services should be billed using UB-04 revenue code R440-R449.
- The itemization must be submitted on the claim.
- Speech therapy is covered only when used to restore function following surgery, trauma or stroke.
- Speech therapy is not considered medically necessary treatment for the following diagnoses:
 - Attention disorder
 - Behavior problems
 - Conceptual handicap
 - Mental retardation
 - Psychosocial speech delay
 - Developmental delay
- To be considered eligible for coverage, speech therapy services must be delivered by a qualified provider of speech therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

13.30.25 Take-home drugs

- Experience Health certificates do not provide basic inpatient hospital benefits for take-home drugs.

13.30.26 Take-home supplies

- Covered take-home supplies should be billed using UB-04 revenue code R273.
- Experience Health certificates do not provide basic inpatient hospital benefits for take-home items.
- Benefits are provided for take-home items by major medical and extended benefits when these items are properly identified on the claim.

Chapter 14: Pharmacy and Specialty Networks

14.1 The Experience Health formulary

14.1.1 Experience Health formulary medications

Experience Health formulary is a list of drugs selected by Experience Health in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Experience Health will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Experience Health network pharmacy, meets the definition of a Part D drug and other plan rules are followed.

14.1.2 Formulary changes / updates

To get updated information about the drugs covered by Experience Health Medicare Advantage (HMO)'s prescription drug coverage, please visit our website at ExperienceHealthNC.com or call Customer Service

at 1-833-777-7394, Monday - Friday, 8 a.m. to 8 p.m. An online drug search can be accessed at ExperienceHealthNC.com and a printable version of the formulary is also available, upon request.

Experience Health may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug (or move a drug to a higher cost-sharing tier), we must notify members who take the drug that it will be removed at least sixty (60) days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a sixty (60) day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

To request a copy of the Experience Health Medicare Advantage (HMO)'s prescription plan formulary, please contact Customer Service at 1-833-777-7394 (TTY: 711).

14.1.3 Generic substitution policy

Most drugs which have generic equivalents are covered only at a generic reimbursement level. Prescribing generic drugs when available can mean significant savings for your patients and may improve adherence to chronic drug regimens.

14.1.4 Prior authorization

Experience Health requires prior authorization for certain drugs. Physicians on behalf of members may request prior authorization for these drugs. Designations that prior authorizations are required are indicated on the online drug search and printable formulary. Prior authorization criteria are posted online at [the Experience Health Provider Resource page](#).

- For these drugs, prior authorization must be obtained prior to drug coverage at the pharmacy.
- The physician or the physician's representative must contact Experience Health to request prior authorization.
- Within the timeline required by Experience Health, the physician must supply a clinical supporting statement that demonstrates that the use of the drug meets criteria.

14.1.5 Non-formulary requests

Non-formulary drug requests require members to use the drug for a medically acceptable use and, in general, to have tried and failed formulary alternatives in the same drug class. For non-formulary requests, the member or the member's prescribing physician may contact Experience Health. A physician's supporting statement is required for all requests before the prescription can be approved for payment. Tier exceptions cannot be granted for non-formulary drugs. Physicians may contact the Plan by calling Experience Health at 1-877-397-4584 or using the applicable fax request form to request an exception.

Experience Health pharmacy fax forms can be accessed online at [the Experience Health Provider Resource page](#).

Medicare Advantage

Prescription drug plan prior authorization requests and non-formulary drug requests:

Fax number: **1-888-446-8535**

Address:

Experience Health

Attention: Exceptions - Health Care Services

PO Box 17509
Winston-Salem, NC 27116-7509
 Provider Telephone: 1- 877-397-4584

14.1.6 Quantity limits

For certain drugs, Experience Health limits the amount of the drug covered. For example, Experience Health provides nine (9) tablets per thirty (30) days for prescriptions for sumatriptan 100mg tablets. If a patient requires a quantity in excess of the quantity limit for a specific drug strength, the physician must supply a statement supporting the clinical need for the higher quantity and any additional therapies being used to treat the patient’s medical condition.

14.1.7 Step therapy

In some cases, patients are required to first try one (1) drug to treat their condition before another drug is covered for that condition. If a prerequisite drug is not found in recent past claims, a drug requiring step therapy is not covered. The physician or physician’s representative, on the patient’s behalf, may contact Experience Health to request an exception. A clinical supporting statement will be required stating that the patient has a documented intolerance, contraindication or hypersensitivity to the prerequisite drug(s), plus any additional clinical information regarding the patient’s need for the step therapy drug. Step therapy may also be required on drugs that qualify as Part B drugs.

14.1.8 Drugs with Part B and D coverage

Some drugs can be covered under either Part B or Part D depending on the circumstances. Drugs that are currently authorized by law as covered under Part B will remain covered under Part B and should be billed to the Part B payer. For information about drugs covered under Part B, visit the CMS coverage database or DME-MAC Jurisdiction C web page.

14.1.9 Request for drugs to be added to the formulary

To request an addition to the formulary, physicians may forward a written request indicating the advantage of the drug over current formulary medications to:

Experience Health
PO Box 17168
Winston-Salem, NC 27116-7509

14.1.10 Exceptions process

Experience Health provides a process for situations when a member demonstrates a medical need for Experience Health Medicare Advantage Prescription Drug Plan (MAPD) to make an exception to its standard plan terms. A member, member’s authorized representative, or member’s prescribing physician may request an exception in one (1) of the following situations:

- Coverage of a drug not on the formulary (list of drugs the Plan covers) or that requires step therapy
- Continued coverage of a drug that has been removed from the formulary for reasons other than safety or because the Part D prescription drug was withdrawn from the market by the drug’s manufacturer.
- Coverage of a drug requiring prior authorization
- Exceptions to quantity limits

To request an exception to the coverage rules for the member’s Medicare prescription drug plan, the member or the member’s prescribing physician may call or submit a written request. The prescribing physician must provide a supporting statement that the exception is medically necessary to treat the

enrollee's disease or medical condition. Care Management will review the exception request and make a determination as expeditiously as the Plan requires, but no later than seventy-two (72) hours from the date we receive the request. The member and the member's prescribing physician will be given notice of the coverage determination. If the decision is not in the member's favor, the notice must be given orally followed within three (3) days by a written notice which includes notification of the appeals and grievance processes to be followed if the member is dissatisfied with our decision.

Physicians may request an exception by calling, faxing, or writing to health services:

Telephone: **1- 877-397-4584**

Fax: **1-888-446-8535**

Written requests:

Experience Health
Attention: Exceptions - Care Management
PO Box 17509
Winston-Salem, NC 27116-7509

Members may request an exception by calling the Customer Service department at 1-833-777-7394 (TTY: 711) or may send a written request to:

Experience Health
Attention: Exceptions - Care Management
PO Box 17509
Winston-Salem, NC 27116-7509

Members should refer to their evidence of coverage for more details on the exception process.

14.1.11 Types of drugs not covered by prescription drug plan

Three general rules about drugs that Medicare drug plans will not cover under Part D:

- 1) Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- 2) Our Plan cannot cover a drug purchased outside the United States and its territories.
- 3) Our Plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books.

These reference books are:

The American Hospital Formulary Service Drug Information, The DRUGDEX Information System, and the USPDI or its successor.

If the use is not supported by any of these reference books, then our Plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)

- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

14.1.12 Medication therapy management program

Members enrolled in the Experience Health Medicare Advantage (HMO) plan with Medicare prescription drug benefits may be eligible for the Medication Therapy Management Program (MTMP), in accordance with CMS requirements. The purpose of the program is to provide medication therapy management services to targeted members. These services are designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes by improving medication use and reducing the risk of adverse drug events including adverse drug interactions. The MTMP is developed in cooperation with licensed and practicing pharmacists and physicians.

The goals of the program are to educate members regarding their medications, increase member adherence to medication therapy, and identify and prevent medical complications related to medication therapy. Individual members eligible for the MTMP services must meet all three (3) criteria:

- Have at least three (3) of the following chronic diseases: diabetes, chronic obstructive pulmonary disease, asthma, hypertension, dyslipidemia, congestive heart failure, osteoporosis, osteoarthritis or depression.
- Have claims for a minimum of six (6) different chronic / maintenance Part D covered medications.
- Are likely to incur annual costs for covered Part D medications that exceed \$4,255 in the year 2019 or as specified by CMS annually.

Eligible members are automatically enrolled in the program. A letter and participation form will be mailed to the eligible members informing them of their enrollment in the program. Participation in the program is voluntary and the program and services are provided at no additional cost to the member. Members are encouraged to return the participation form in the envelope provided or call a toll-free number (1-866-686-2223 or TTY users call 711 or 1-800-855-2881) between 10 a.m. and 6 p.m. eastern time, Monday through Friday.

MTM services include the following interventions for members and prescribers:

- An annual Comprehensive Medication Review (CMR) which includes an interactive, person-to-person consultation via the telephone between the member and the pharmacist or nurse. The purpose of the CMR is to review all prescription and non-prescription medications the member is taking, provide education on their medications, identify care gaps and patterns of underuse or overuse and medication safety issues. After the CMR, the member is mailed a personalized medication list to carry to his provider visits as well as a summary of what was discussed.
- Quarterly targeted medication reviews (completed electronically based on prescribed medications). Member's prescribers may be sent a letter about specific medication-related problems or about opportunities to optimize medication use.

14.2 Medication management programs

14.2 High Risk Medications in the Elderly

The use of High Risk Medications (HRM) in the Elderly (adults over age sixty-five [65]) is an NCQA, HEDIS, and CMS quality measure. The High Risk Medications program goal is to reduce the utilization of high risk medications in the older patient which may place them at risk for an adverse drug-related event.

Through our claims database, Experience Health identifies members with recent prescriptions for a drug considered to be a high risk medication. Based on this information, we may send a letter to the member's provider or most recent prescriber asking them to evaluate whether the drug is still appropriate. Some of the drugs included on high risk medication list are not necessarily contraindicated in the elderly but recommendations are to consider formulary alternatives that would place an older member at less of a safety risk.

Examples of High Risk Medications for adults over age sixty-five (65) include the following classes of drugs: first-generation or older antihistamines, skeletal muscle relaxants, estrogens, non-benzodiazepine hypnotics for greater than ninety (90) days, and nitrofurantoin for greater than ninety (90) days.

14.2 Medication Adherence

Medication Adherence is a program that monitors prescription claims for members and identifies those members whose adherence to a chronic maintenance medication falls below the 80% threshold based on prescription drug claims data. Experience Health may send a letter to the prescriber notifying them that a member has a gap in their refill history so that you can discuss this with your patient. In addition, a member may receive a phone call or mailing with an educational message about the importance of taking their medications to their health.

Examples of medications monitored through this program are Antiretroviral medications, oral diabetes medications, renin angiotensin blockers, and statins.

14.3 Medical eye care

Experience Health is contracted with Community Eye Care to provide medical / routine vision care to Experience Health members using a panel of optometrists and ophthalmologists.

- No referral needed
- Direct access to contracting ophthalmologists and optometrists
- Routine vision
- Medical surgical

Community Eye Care 1-888-254-4290

14.4 Mental health / substance abuse management programs

Mental health and substance abuse services do not require a referral from the primary care physician. Please contact Provider Services at 1-877-397-4584 for assistance.

14.5 Laboratory services

Reference labs:

If a specimen is drawn and the laboratory work is sent to a reference lab, the only services billable to Experience Health is the administrative / handling charge (i.e., 36415 - Venipuncture). The reference lab will bill directly to Experience Health for the services it provides.

In-office labs:

If you are performing the laboratory service in your office, and your lab is CLIA certified, the services can be filed directly with Experience Health for reimbursement. Selected counties are subject to Experience Health laboratory office allowable lists. Under that program only procedures included in the appropriate office allowable lists can be billed directly to Experience Health. Questions regarding this lab program should be directed to your Provider Network representative.

14.6 Experience Health office laboratory allowable list

If you are performing laboratory service in your office and your lab is Clinical Laboratory Improvement Amendments (CLIA) certified, many lab services can be filed directly to Experience Health for reimbursement.

However, services identified by Medicare as requiring CLIA certification are not eligible for reimbursement by Experience Health unless you have provided Experience Health evidence in advance of having the CLIA certification necessary for billing these services as CLIA approved for your laboratory. CLIA excluded means that the laboratory is not subject to CLIA edits. No CLIA certificate is required for CLIA excluded services.

Prior to performing in-office laboratory services, providers are encouraged to verify their laboratory CLIA certification and review the Experience Health allowable service code list that's applicable to their laboratory CLIA certification. Experience Health currently maintains allowable service code lists, which display the in-office lab services a provider may bill Experience Health. These lists are available online at the [Experience Health Provider Resource page](#).

Chapter 15: Post-Service Provider Appeals

15.1 Level I post-service provider appeals

Post-service provider appeals consist of retrospective claim reviews and do not require a member signed authorization. Post-service provider appeals are performed based on your belief that a claim has been denied or adjudicated incorrectly.

The post-service provider appeal process is separate from the member appeals and grievance process and is listed in Chapter 16 of this provider manual. If at any time the member files a post-service claim appeal during the review of a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues on their own behalf. Post-service provider appeals for review of a processed claim may be submitted for the following reasons:

- Coding / bundling, or fees
- Cosmetic
- Experimental / investigational
- Financial recovery (available to physicians, physician groups and physician organizations only)
- Global period denial
- No authorization for inpatient admission
- Non-contracted provider payment dispute
- Not medical necessary

- Re-bundling
- Services not eligible for separate reimbursement

Level I post-service provider appeals for billing / coding disputes and medical necessity determinations are handled by Experience Health and are available to physicians, physician groups, physician organizations and facilities. Providers have ninety (90) calendar days from the claim adjudication date to submit a Level I post-service provider appeal for billing / coding disputes and medical necessity determinations adjudicated claims.

Level I financial recovery physician appeals are handled by Experience Health and are available to physicians, physician groups and physician organizations. Physicians, physician groups and physician organizations will have thirty (30) calendar days from the date of the invoice or demand letter to submit the Level I financial recovery appeal for refund requests. To request a review, contact Experience Health using one (1) of the following methods:

- Call the Provider Services at 1-877-397-4584
- Complete the Level I Appeal Form for Experience Health Medicare Advantage (HMO) available to copy from the Forms section of this manual and for download online at the [Experience Health Provider Resource page](#) (when sending to Experience Health, include objective medical documentation).
- Mail a letter of explanation, including objective medical documentation, to the following address:
 Experience Health
 Provider Appeals Unit
 PO Box 17509
 Winston-Salem, NC 27116-7509
- Fax your inquiries to: Provider Appeals Unit: 1-919-287-8815

All inquiries regarding the status of an appeal should be routed through Customer Service.

Level I post-service provider appeals are handled within thirty (30) days from the date of receipt of all information. Supporting objective medical documentation should be submitted for post-service provider appeal reviews.

15.2 Level II post-service provider appeals

Level II post-service provider appeals are available to physicians, physician groups, and physician organizations and will be performed by an independent review organization. Physicians, physician groups, and physician organizations may file a Level II post-service provider appeal for medical necessity or billing disputes with MES Solutions, an independent review organization. There is a filing fee associated with all requests for a Level II post-service provider appeal.

15.2.1 Process for submitting a Level II post-service provider appeal

The Level II post-service provider appeal requests should clearly identify the issue that is in dispute and rationale for the appeal. Demographic information including subscriber name, patient name, patient Experience Health ID number, provider name, and provider ID number should also be included with any request for appeal. Level II post-service provider appeals require a filing fee to be submitted before the review can begin.

A physician, physician group, or physician organization may file a Level II post-service provider appeal if an adverse determination was given on a Level I post-service provider appeal billing dispute or medical necessity denial, as described below.

15.2.2 Level II post-service provider appeal for billing disputes

The Experience Health billing dispute resolution process is available to resolve disputes over the application of coding and payment rules and methodologies to specific patients. Physicians, physician groups, or physician organizations must submit a written request for Level II post-service provider billing dispute appeal within ninety (90) calendar days of the date of the Level I post-service provider appeal denial letter.

Physicians, physician groups, or physician organizations must exhaust Experience Health’s Level I post-service provider appeal process before submitting a Level II post-service provider appeal. A physician, physician group, or physician organization is deemed to have exhausted Experience Health’s Level I post-service provider appeal process if Experience Health does not communicate a decision within thirty (30) calendar days of Experience Health’s receipt of all documentation reasonably needed to make a determination on the Level I post-service provider appeal.

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a Level II post-service provider appeal for a billing dispute.

Mailing Address:

MES Solutions BDRP Department
100 Morse Street, Norwood, MA 02062
 Phone: **1-800-437-8583** | Fax: **1-888-868-2087**
www.mesgroup.com

A request submitted online through the MES website, requires new user registration. Once registered, the user should sign-in and select the Love Settlement link to proceed with their request.

Level II provider appeals for billing disputes administered by an independent review organization, will be reviewed based on the information previously submitted with the Level I provider appeal. Experience Health will supply all documentation from the Level I provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

15.2.3 Level II post-service provider appeal for medical necessity

Level II post-service provider appeals are available to physicians, physician groups, and physician organizations to resolve disputes over the denial of investigational, experimental, cosmetic, and medical necessity determinations.

Physicians, physician groups, or physician organizations must submit a written request for a Level II post-service provider medical necessity appeal within sixty (60) calendar days of the date of the Level I post-service provider appeal denial letter. Physicians, physician groups, or physician organizations must exhaust Experience Health Level I post-service provider appeal process before submitting a Level II post-service provider appeal.

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a Level II post-service provider appeal for medical necessity.

Mailing Address:

MES Solutions BDRP Department
100 Morse Street, Norwood, MA 02062
 Phone: **1-800-437-8583** | Fax: **1-888-868-2087**
www.mesgroup.com

A request submitted online through the MES website, requires new user registration. Once registered, the user should sign-in and select the Love Settlement link to proceed with their request. Level II post-service provider appeals for medical necessity administered by an independent review organization, will be reviewed based on the information previously submitted with the Level I post-service provider appeal. Experience Health will supply all documentation from the Level I post-service provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

15.2.4 Filing fee matrix

Billing Dispute	
Amount of Dispute	Filing Fee Calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$50 plus 5% of the amount by which the amount in dispute exceeds \$1000 but in no event shall the fee be greater than 50% of the cost of the review.

Medical Necessity Dispute	
Amount of Dispute	Filing Fee Calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$50

Billing disputant of dispute

Note: For Level II post-service provider appeals related to billing disputes, the disputed amount must exceed \$500.00. In instances where the disputed amount is less than \$500, the physician, physician group, or physician organization may submit similar disputes to the independent review organization within one (1) year of the original submission date. If the physician, physician group, or physician organization intends to submit additional similar disputes during the year, the physician must contact the billing dispute reviewer to notify that additional similar submissions will be sent. If the one (1) year lapses and the disputes submitted are not in excess of \$500 in the aggregate, the original dispute will be dismissed. The filing fee will be refunded in the event that the physician, physician group, or physician organization prevails in the Level II post-service appeal process.

Chapter 16: Member Appeal and Grievance Procedures

16.1 Member grievances and appeals

Experience Health members are encouraged to let Experience Health know if they have questions, concerns or problems related to covered services or the care they receive. Members are also encouraged to first attempt to resolve issues about treatment through his / her primary care physician. If the member's issue cannot be resolved in this manner, the member has the right to file a formal complaint with Experience Health.

16.2 What is an appeal?

An appeal is a request to change a coverage decision about what services are covered or what we will pay for a service. Appeals must be filed within sixty (60) calendar days from the date of the written denial

notice. Each denial notice will include information on the member's right to file an appeal with instructions on how to do so. Once Experience Health receives an appeal, it is handled through the mandated CMS appeal process.

16.3 Who can file an appeal?

A member or their authorized representative has the right to file an appeal through a formal process. If someone other than the member requests to file an appeal, the request is not valid until the member and the requesting party sign an appointment of representative form.

A standard appeal must be in writing. For appeals, the member's physician can file the appeal in addition to the member or their authorized representative. A fast appeal is usually filed orally or by fax.

16.4 How quickly does Experience Health handle an appeal?

CMS states that all appeals must be handled as quickly as the member's health requires. However, there are specific, maximum timeframes for handling the different types of appeals after a valid request is received. For example:

- An appeal of a medical claim denial must be handled within sixty (60) calendar days after we receive the request.
- An appeal of a medical service denial must be handled within thirty (30) calendar days after we receive the request unless an expedited or fast appeal is requested. An expedited appeal must be handled within seventy-two (72) hours.
- An appeal of a prescription drug denial must be handled within seven (7) calendar days unless an expedited or fast appeal is requested. An expedited prescription drug appeal must be handled within seventy-two (72) hours.

16.5 What is a grievance?

A grievance is a type of complaint that is made if a member is dissatisfied with any aspect of Experience Health or with service or quality of care rendered by a contracting provider.

Only the member or his / her authorized representative may file a grievance.

Experience Health will respond to a grievance within thirty (30) calendar days after we receive the grievance. Grievances from members about contracting providers may relate to a provider's compliance with Experience Health procedures, personal relations between providers and members, access to medical care, service issues with the provider's office, or potential medical quality problems. All grievances about network providers are documented and placed in the provider's file for trending and review during credentialing. Every quality of care grievance is reviewed for further investigation with the provider in question is indicated.

16.6 What involvement does a contracting physician have with an appeal?

A contracting physician can be involved in an appeal in several ways:

- If a member files an appeal, he / she may ask their physician for support by asking the physician to write a letter on their behalf.
- Experience Health may contact the physician's office to obtain additional medical records for review during the appeal process. Quick compliance with this request is necessary as Experience Health is required to handle an appeal as quickly as the member's health requires.

- If the case is forwarded to MAXIMUS CHDR, CMS’s contracted independent review entity for a decision, CHDR will ask for medical records if they do not believe all records have been submitted to them. Again, the requested records will need to be provided expeditiously.
- A physician may file an appeal on the member’s behalf. The physician can do this by calling Experience Health Customer Service, or by faxing an appeal request to 1-336-794-8836 or 1-919-287-8815

Please note that neither the mandated CMS appeals process nor the grievance process is available to providers who have a dispute with Experience Health over payment of a claim or over a contractual denial.

See Chapter 13.13, Claims reimbursement disputes for how to request a review of a claim or contractual denial for which the member has no financial liability.

Chapter 17: Member Rights and Responsibilities

17.1 Member rights

- 1) You have the right to be treated with respect, dignity and consideration for your privacy by health care providers and by Experience Health staff.
- 2) You have the right to receive information about the Plan, its services, its health care providers and your rights and responsibilities as a member of the Plan.
- 3) You have the right to private, confidential treatment of your records by plan staff and providers, and you have the right to access your medical records by contacting the provider of service.
- 4) You have the right to accessible services from the Plan and from providers of health care, regardless of your English proficiency, reading skill, cultural or ethnic background, and/or physical or mental disabilities.
- 5) You have the right to receive medically necessary services as described in your Experience Health Medicare Advantage (HMO) Certificate of Coverage agreement.
- 6) You have the right to coverage for emergency and urgently needed care without prior authorization using prudent layperson standards outlined in your Certificate of Coverage. (Refer to the Certificate of Coverage for details.)
- 7) You have the right to a second opinion if you question a contracting provider’s decision about the need for surgery. A list of contracting providers can be found in the provider directory. With authorization from either your primary care physician or the Plan a second opinion from the provider you select is covered.

If the second opinion fails to confirm the primary recommendation for a treatment plan and/or if the member so desires, a third opinion, provided by a third provider can be sought. Second and third opinions do require a referral from the PCP and should be obtained within the Experience Health contracted provider network provided that there is a qualified physician. If there is no qualified physician, the PCP will need to contact the Medical Management Department for assistance and approval to go outside of the network.

- 8) You have the right to prompt resolution of any problems or complaints regarding Experience Health Medicare Advantage (HMO) or contracting providers via the Plan’s

grievance process. You have a right to prompt resolution of any request for reconsideration or pre-service or claim denials via the Medicare appeals process. Questions about benefits, claims payment, contracting providers, plan services or the appeals and grievance procedures referenced above should be directed to an Experience Health Customer Service Professional by calling 1-833-777-7394 (TTY: 711).

- 9) You have the right to disenroll from Experience Health Medicare Advantage (HMO), within guidelines governing restriction of election changes beginning 1/1/02, by giving written notice to the Plan of your intent to do so. Coverage will end on the first day of the month following the receipt of your request. To end your coverage, you may either:
 - (a) send written notice to
Experience Health
PO Box 17509
Winston-Salem, NC 27116-7509; or
 - (b) disenroll at any Social Security Administration Office or Railroad Retirement Board Office.
- 10) You have the right to continue coverage with Experience Health Medicare Advantage (HMO), except in the following situations:
 - (a) non-payment of plan premiums,
 - (b) fraud,
 - (c) abuse of the organization's membership card,
 - (d) permanent moves outside the Experience Health Medicare Advantage (HMO) service area,
 - (e) loss of Medicare entitlement, or
 - (f) "for cause" subject to CMS approval.
- 11) You have the right to participate with providers in making decisions about your health care and to receive information on available treatment options (including no treatment) or alternative courses of care. In addition, you have the right to designate someone to make your health care decisions for you in the event you are unable to make these decisions yourself. (These are known as advance directives. For more information, ask your primary care physician.)
- 12) You have the right to receive the services of the Experience Health Medicare Advantage (HMO) primary care physician of your choice. Your choice of PCP must be reported to and recorded by the Plan. Your PCP is required to provide or arrange care twenty-four (24) hours a day, seven (7) days a week.

17.2 Member responsibilities

- 1) It is your responsibility to select a primary care physician and have all your medical care provided by or arranged by your PCP except for emergency or urgently needed care. Experience Health Medicare Advantage (HMO) does not cover services which you arrange on your own except for emergencies and urgently needed care or as specified in your Certificate of Coverage.
- 2) In the event of an emergency, go to the nearest emergency room or call 911 for assistance. We ask that you notify your PCP within forty-eight (48) hours or as soon as possible if you seek emergency care so that he or she can arrange for appropriate follow-up care. If you are out of the service area and require urgently needed care, we request that you, if possible, first telephone your PCP and then seek care from an appropriate local medical facility, according to your PCP's instructions. (Refer to the Certificate of Coverage for details.)

- 3) It is your responsibility to make monthly plan premium payments for your coverage on or before the first day of the month of coverage, unless your employer / retiree group makes these payments on your behalf. If the premium is not paid on time, we will send you notice of late payment, indicating that your Experience Health Medicare Advantage (HMO) coverage may be ended according to our Experience Health Medicare Advantage (HMO) payment guidelines. For more plan payment information, call Customer Service at 1-833-777-7394 (TTY: 711).
- 4) It is your responsibility to inform us of changes in name, address and telephone number, PCP selection, etc.
- 5) It is your responsibility to pay any required copayments when they are requested of you, such as copayments for office visits.
- 6) It is your responsibility to pay for any service that is not covered under the Plan. This includes services which are excluded from coverage, services obtained from a specialist without referral from your PCP (except in instances where direct access is available), and services obtained from non-plan providers without prior authorization.
- 7) It is your responsibility to notify the Plan if you move out of the Experience Health Medicare Advantage (HMO) service area. According to Medicare regulations, persons who live outside of the Experience Health Medicare Advantage (HMO) service area are not eligible to continue enrollment in Experience Health.
- 8) It is your responsibility to keep appointments or follow procedures to avoid missed appointment charges.
- 9) It is your responsibility to understand how the Plan works and follow plan procedures. This includes understanding the referral process to avoid unauthorized, non-covered services.
- 10) It is your responsibility to supply health care providers information needed to provide adequate care, and to follow treatment advice given by those providing health care services.
- 11) It is your responsibility to consult with your primary care physician in all matters regarding your health care. This includes contacting your primary care physician for instructions on care after regular office hours, except for emergency or urgently needed care. Inquiries regarding member rights and responsibilities should be directed to the Experience Health Medicare Advantage (HMO) Customer Service department at 1-833-777-7394 (TTY: 711), Monday-Friday from 8 am to 6 pm.

You may also write to:

Experience Health
 PO Box 17509
 Winston-Salem, NC 27116-7509

Chapter 18: Sanction Process

18.1 Grievance procedure / sanction process

There are times when immediate action must be taken to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician

- Actions taken by a court of law, regulatory agency or any professional organization which, if successful, would materially impair the provider’s ability to carry out the duties under the contract
- Insolvency, bankruptcy or dissolution of a practice

Upon receipt of notification of these actions the affected provider will be notified of the Plan’s intent to terminate him or her from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

18.2 Provider notice of termination for recredentialing

18.2.1 Level I appeal

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within five (5) days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than thirty (30) days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of Experience Health’s credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

Experience Health will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner involved.

A description of the formal hearing process includes, but is not limited to, the following:

If the credentialing committee’s recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a Level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within thirty (30) days from the date of the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his or her right to request a Level II appeal if the decision is unchanged.

18.2.2 Level II appeal

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within five (5) days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than thirty (30) days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of Experience Health’s credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

Experience Health will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner involved.

A description of the formal hearing process includes, but is not limited to, the following:

- Representation: The practitioner / provider and the Plan may be represented by counsel or other person of their choice.
- Court reporter: Experience Health may arrange for a court recorder to provide a record of the hearing. If Experience Health does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner / provider upon payment of a reasonable charge.
- Hearing officer’s statement of the procedure: Before evidence or testimony is presented, the hearing officer of the Level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- Presentation of evidence by Experience Health: The Plan may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner /provider or his or her representative will have the opportunity to cross-examine any witness testifying on the Plan’s behalf.
- Presentation of evidence by practitioner / provider: After the Plan submits its evidence, the practitioner / provider may present evidence to rebut or explain the situation or events described by the Plan. The Plan will have the opportunity to cross-examine any witness testifying on the practitioner’s / provider’s behalf.
- Plan rebuttal: The Plan may present additional witnesses or written evidence to rebut the practitioner’s / provider’s evidence. The practitioner / provider will have the opportunity to examine any additional witnesses testifying on the Plan’s behalf.
- Summary statements: After the parties have submitted their evidence, first the Plan and then the practitioner / provider will have the opportunity to make a brief closing statement. In addition parties will have the opportunity to submit written statements to the appeal committee. The appeals committee will establish a reasonable time for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- Examination by the appeals committee: Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner’s choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine, and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing. Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of

the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within five (5) days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) days of the receipt of the initial notification or fifteen (15) days from the receipt of the notification of the Level I appeal decision, the Plan will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to Provider Network operations to proceed with termination from all networks. Communication will be sent from Provider Network operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing complaint will be forwarded to the delegated practitioner's credentialing department for follow up. Any actions taken by the delegated practitioner as follow-up must be documented and a copy forwarded to Experience Health.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the Experience Health Medicare Advantage (HMO) network.

Chapter 19: Credentialing

19.1 Credentialing / recredentialing

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to sixty (60) days for completion from the date a completed application is received by the Plan. The credentialing department deems an application to be complete when all applicable sections of the uniform application are completed accurately, along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform application to participate as a health care practitioner
- DEA
- Sufficient comprehensive general liability and professional insurance coverage
- Medicare / Medicaid sanctions
- National Practitioner Databank (NPDB)
- Health Care Integrity Protection Databank (HIPDB)
- Hospital privileges or letter stating how patients are admitted
- Board certification*
- Other pertinent documentation
- In some instances, a letter of recommendation from the chief of staff or department chair may be required (i.e., if malpractice settlements exceeding \$200,000 and/or two (2) or more malpractice settlements)

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Full instructions by medical specialty along with a copy of the uniform application can be found online at the [Experience Health Provider Resource page](#).

All documents should be sent to the Experience Health credentialing department for verification and processing. To ensure that our quality standards are consistently maintained, providers are recredentialed every three (3) years.

We require initial credentialing of any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than thirty (30) days. Please note that this is a change from the previous timeframe of ninety (90) days.

* For physicians that are not board certified, letters of reference will be required in support of the application.

19.2 Requirements for provider credentialing and provider rights

We follow a documented process governing contracting and credentialing, do not discriminate against any classes of health care professionals, and have policies and procedures that govern the denial, suspension and termination of provider contracts. This includes requirements that providers meet Original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation.

Providers are required to meet and to continue to meet all applicable credentialing standards adopted or utilized by us during the term of their participation, including the requirement to possess and maintain a current unrestricted medical license, hospital privileges (if applicable), and DEA registration certificate (if applicable). Providers are required to notify us of subsequent changes in the status of any information relating to provider's professional credentials, including a change in the status of his / her medical license, hospital privileges, or DEA registration certificate. Providers are required to participate in and cooperate with us credentialing and recredentialing processes, and to comply with determinations made pursuant to the same.

19.3 Policy for practitioners pending credentialing

The credentialing department must deem a practitioner's credentialing complete and effective on or before providing service to an Experience Health member in order to receive the practitioners contracted reimbursement for member's covered services.

Claims for covered services provided to members by a non-participating practitioner in a participating provider group will be denied unless pre-approved. The Experience Health member will be held harmless, including any copayments, coinsurance and/or deductibles.

19.3.1 Credentialing process

Participating practitioners are encouraged to consider the time required to complete the credentialing process as you add new practitioners to your practices. To assist you in maintaining accessibility in circumstances where your practice, and/or the new practitioner, is unable to submit the credentialing application in a timely manner, we have created a standard operating procedure that will allow reimbursement for covered services provided by a non-participating practitioner who is in the process of joining an Experience Health participating practice. The following must apply:

- A credentialing application must have been submitted to Experience Health and a determination on such application is pending, and
- The new practitioner must provide covered services to Experience Health members under the direct supervision of an Experience Health-similarly licensed and credentialed practitioner at the practice who sign the medical record related to such treatment and files the claim under his or her current provider number, and

- A statement of supervision form is completed and submitted to Provider Network (the form may be obtained by contacting Provider Network, if needed).

For a copy of the new standard operating procedure outlining the details of this process, or if you have questions, please call Provider Network for further assistance (see **Chapter 2, Contacting Experience Health and general administration**).

19.4 Credentialing grievance procedure

There are times when we must take immediate action to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician
- Actions taken by a court of law, regulatory agency, or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy, or dissolution of a practice

Upon receipt of notification of these actions the affected provider will be notified of our intent to terminate him / her from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider, which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

19.4.1 Provider notice of termination for recredentialing (Level I appeal)

If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a Level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within thirty (30) days from the date of the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his / her right to request a Level II appeal if the decision is unchanged.

19.4.2 Level II appeal (formal hearing)

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within five (5) days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than thirty (30) days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of our credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

We will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner, or before a panel of plan-appointed individuals not in direct competition with the practitioner involved.

A description of the formal hearing process includes, but may not be limited to, the following:

- Representation: The practitioner / provider and the Plan may be represented by counsel or other person of their choice.
- Court reporter: The Plan may arrange for a court recorder to provide a record of the hearing. If the Plan does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner / provider upon payment of a reasonable charge.
- Hearing officer's statement of the procedure: Before evidence or testimony is present, the hearing officer of the Level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- Presentation of evidence by the Plan: The Plan may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner / provider or his / her representative will have the opportunity to cross-examine any witness testifying on the Plan's behalf.
- Presentation of evidence by practitioner / provider: After the Plan submits its evidence, the practitioner / provider may present evidence to rebut or explain the situation or events described by the Plan. The Plan will have the opportunity to cross-examine any witness testifying on the practitioner's / provider's behalf.
- the Plan rebuttal: The Plan may present additional witnesses or written evidence to rebut the practitioner's / provider's evidence. The practitioner / provider will have the opportunity to cross-examine any additional witnesses testifying on the Plan's behalf.
- Summary statements: After the parties have submitted their evidence, first the Plan and then the practitioner / provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the appeals committee. The appeals committee will establish a reasonable time for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- Examination by the appeals committee: Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine, and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing. Upon

completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within five (5) days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) days of the receipt of the initial notification or fifteen (15) days from the receipt of the notification of the Level I appeal decision, the Plan will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to Provider Network operations to proceed with termination from the network.

Communication will be sent from Provider Network operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing, Provider Network, marketing, and Customer Service.

If a request is made by the practitioner, the termination process will be suspended awaiting the outcome of the reconsideration or formal hearing.

The practitioner may be reinstated if so indicated by the outcome of the hearing. If the decision is unchanged the Plan will proceed with termination.

If the Plan identifies quality concerns related to a delegated practitioner, the complaint will be forwarded to the delegated practitioner's credentialing department for follow up. Any actions taken by the delegated practitioner as follow up must be documented and a copy forwarded to Experience Health to be placed in the subscriber file.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the Experience Health network.

Chapter 20: Marketing, Advertising and Brand Regulations

Marketing, advertising and brand regulations are the legal rules that must be followed when marketing or advertising a Medicare plan offered by Experience Health, or using the Experience Health brand, and must be consistent with applicable law and the terms of the participation agreement with Experience Health.

20.1 Marketing and advertising

The marketing and advertising of Medicare Advantage health plans and Part D prescription drug plans by health care providers is highly regulated by CMS and subject to tight restrictions. As a result, you cannot conduct any marketing or advertising activity related to any Medicare plan offered by Experience Health without prior written approval from Experience Health.

For more information regarding these restrictions, please refer to the Medicare Marketing Guidelines issued by CMS and available through www.cms.gov.

20.2 Logo usage

The Experience Health logo is available for use. Please do not alter any elements within the logo.

20.3 Approvals

All marketing pieces (excluding general / operational business letters) that are being developed for dissemination to the public must be reviewed and approved by Experience Health prior to use.

All Experience Health materials, after approval by advertising and brand marketing, along with compliance, must be submitted by Experience Health for review, acceptance and/or approval by CMS, which carries up to a forty-five (45) day mandated allowable approval time.

For questions, please contact your provider relations coordinator who can facilitate the process for you.

20.3.1 Sample Experience Health logo



Chapter 21: Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans, and employer groups.

Processes targeted for simplification include:

- Electronic transactions
- Code sets and identifiers
- Security
- Privacy

Please also reference the HIPAA companion guide available online at [the Experience Health Provider Resource page](#).

21.1 Electronic transactions

The administrative simplification provisions mandate of HIPAA requires that all payers, providers, and clearinghouses use specified standards when exchanging data electronically. Providers and payers must be able to send and receive transactions in the designated EDI format. Providers will be able to send and receive information from health plans and payers, using the following standardized formats:

- Claims
- Claims status
- Remittance
- Eligibility
- Authorizations

21.2 Code sets and identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-10 – CM
- CPT
- HCPCS
- CDT (were HCPCS dental codes, but now ADA code, prefixed with “D”)

These common code sets enable a standard process for electronic submission of claims by providers. Experience Health has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper. Code sets must be implemented by the effective date to avoid claims denials.

Experience Health will maintain taxonomy or specialty codes currently in use and will continue to assign these codes for new providers. The codes are determined during the credentialing and contracting process. Experience Health only accepts active codes from national code set sources such as ICD-10, CPT, and HCPCS, as part of our HIPAA compliance measures. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. Contact your Provider Network representative if you have questions.

Common identification numbers will be created for providers, payers and employers, and will be recognized by all entities when performing electronic transactions. Standards for these unique identifiers are currently under development.

21.3 Security

Experience Health maintains a comprehensive security program for safeguarding protected health information in order to meet the requirements of the HIPAA security rule and the North Carolina Customer Information Safeguards Act. HIPAA security requires a covered entity to provide administrative, technical and physical safeguards for protected health information maintained in electronic form. The North Carolina Customer Information Safeguards Act requires North Carolina insurance companies to protect customer information in all formats, whether electronic, paper or oral.

21.4 Privacy

Privacy regulations address the way in which a health plan, provider or health care clearinghouse may use and disclose individually identifiable health information, including information that is received, stored, processed or disclosed by any media, including paper, electronic, fax or voice. Regulations do allow for the sharing of information for treatment, payment and health care operations, including such plan-required functions as quality assurance, utilization review or credentialing, without patient consent. Limited sharing of information may be allowed in instances where national security may be impacted. Please read Experience Health Notice of Privacy Practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our website, ExperienceHealthNC.com, for the most current version.

21.5 Additional HIPAA information

- Experience Health has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper.
- Additional HIPAA information is available through the following organizations:

‡ Department of Health and Human Services at www.hhs.gov

‡ North Carolina Healthcare and Information and Communications Alliance at www.nchica.org

‡ Centers for Medicare and Medicaid Services at www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html or call 1-410-786-3000

Chapter 22: Privacy and Confidentiality

At Experience Health, we take very seriously our duty to safeguard the privacy and security of our members Protected Health Information (PHI), as we know you do. In connection with recent developments concerning the law of privacy and security of PHI, including the HIPAA Privacy and Security Rules and the North Carolina Customer Information Safeguards Act, we have updated our corporate privacy policies and procedures. The highlights of these policies are described below. As contracting providers, we want you to understand how we protect our members' information.

- We protect all personally identifiable information we have about our members, and disclose only the information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by Experience Health.
- Our privacy and security policies are intended to comply with current state and federal law, and the accreditation standards of the national committee for quality assurance. If these requirements and standards change, we will review and revise our policies, as appropriate. We also may change our policies (as allowed by law) as necessary to serve our members better.
- To make sure that our policies are effective, we have designated a chief privacy official and a privacy and security committee that are charged with approving and reviewing Experience Health's privacy and security policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

22.1 Our fundamental principles for protecting PHI

- We will protect the confidentiality and security of PHI, in all formats, and will not disclose any PHI to any external party except as we describe in our privacy notice or as permitted or required by law or regulation.
- Each of our employees receives training on our policies and procedures and must sign a statement when they begin work with us, acknowledging that they will abide by our policies. Only employees who have legitimate business needs to use members' PHI will have access to personal information.
- When we use outside parties (business associates) to perform work for us, as part of our insurance business, we require them to sign an agreement, stating that they will protect members' PHI and will only use it in connection with the work they are doing for us.
- We communicate our practices to our members, through our privacy notice, newsletter articles and during the enrollment process they follow when becoming an Experience Health member.
- We will disclose and use PHI only where:
 - ‡ required or permitted by law
 - ‡ we obtain the member's authorization
- We will respect and honor our members' rights to inspect and copy their PHI, request an amendment or correction to their PHI, request a restriction on use and disclosure of PHI, request confidential communications, file a privacy complaint, request an accounting of disclosures and request a copy of our Notice of Privacy Practices.

Please read Experience Health’s Notice of Privacy Practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our website, ExperienceHealthNC.com, for the most current version.

22.2 Privacy regarding services or items paid out-of-pocket

If a member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member’s wishes and not submit a claim to Experience Health for the specific services covered by the member. Under current regulations, you may bill, charge, seek compensation or remuneration or collection from the member for services or supplies that you provided to a member if the member requests that you not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Unless otherwise permitted by law or regulation, the amount that you charge the member for services or supplies paid out-of-pocket, in full, may not exceed the allowed amount for such service or supply. Additionally, you are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member for which that member paid out-of-pocket.

Chapter 23: Medicare Advantage and Part D Compliance

23.1 Medicare Advantage and Part D Compliance for participating providers and their business affiliates

Experience Health is required by the Centers for Medicare & Medicaid Services (CMS) to maintain and administer a compliance program and a program to fight Fraud, Waste and Abuse (FWA). CMS advises that the seven (7) basic elements of the compliance program include:

- Maintaining written policies and standards of conduct
- Instituting high-level oversight, led by a compliance officer
- Providing effective training and education about Medicare program requirements
- Providing effective and accessible lines of communication between the compliance officer, employees, and First Tier, Downstream, and Related Entities (FDRs)
- Ensuring that disciplinary standards are well-publicized
- Performing routine monitoring, auditing and identification of compliance risks
- Establishing procedures for prompt response to compliance issues.

Experience Health ensure that these elements are met in the following ways:

- We provide our Experience Health Code of Ethics and Business Conduct on our website at ExperienceHealthNC.com, where we maintain an electronic library of policies, including a written ethics and compliance program.
- Experience Health has a compliance officer and a formal committee structure to provide oversight responsibilities for compliance.
- Experience Health provides annual training to their employees, board of trustees, and sales agents on training topics including: Code of Conduct, Fraud, Waste and Abuse, and Medicare Compliance (as stated in Chapter 9 of the CMS issued Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual), providers, vendors, and other business partners who have met the FWA training through enrollment in Part A or B of the Medicare program, or through accreditation as a supplier of DMEPOS (Durable Medical Equipment,

Prosthetics, Orthotics, and Supplies), are deemed to have met the FWA training and education requirements for Experience Health.

- There are several options offered for employees, producers and subcontractors to report issues or ask questions, either directly or via anonymous hotlines, or related online reporting tools. If there is suspected fraud, waste or abuse, please contact the Special Investigations Unit (SIU) at 1-844-397-4584. If there are concerns about the actions of an Experience Health employee, please contact the Ethics Hotline at 1-888-247-4075.
- Consequences for Experience Health employees who violate the Code of Conduct or the [FWA policy](#) are clearly communicated through internal Code of Ethics and Business Conduct policies, and through annual employee-required training courses.
- Hotline reports are monitored for trends, claims data is analyzed to identify fraud, and key CMS compliance metrics are reviewed. We also perform risk assessments, execute audit plans, and conduct subcontractor and first tier, downstream, related entity oversight.
- Experience Health has written processes in place to investigate issues, track them to completion, and report matters to government entities when necessary.

Due to the relationships between CMS, Experience Health and its subcontractors and first tier, downstream, related entities, participating providers should be aware of several key federal rules:

- Anti-Kickback Statute – This statute imposes criminal penalties for individuals or entities who knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward business reimbursement in federal health care programs.
- False Claims Act – This act imposes liability on any person of an organization who submits a claim to the federal government that is known or should be known to be false.
- Excluded Entity Provision of Social Security Act – Medicare Part C and Part D contractors are prohibited from employing or contracting with an individual or entity who is excluded from participation in federal health care programs.

Nondiscrimination in Healthcare

On May 13, 2016, the HHS Office for Civil Rights issued the final rule implementing of Section 1557. Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex (including elements of the final rule outlining significant requirements related to transgender individuals and the treatment of gender dysphoria), age, or disability in certain health programs or activities.

Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in any health program or activity any part of which received funding from HHS, including Medicare Advantage. As a contracted provider to the Plan, you are expected to adhere to the Plan’s prohibition on discriminatory treatment, and any failure to do so could impact your network participation.

If you have questions regarding the final rule or to report an incident of discrimination or discriminatory practices, please review our [Non-Discrimination and Accessibility Notice](#) for contact information.

Chapter 24: Forms

The following forms are referenced in the preceding sections of this guide. We have included copies of the following forms for you to copy and use at your convenience.

- Provider Inquiry Form
- Level I Provider Appeal Form for Experience Health Medicare Advantage (HMO)

Note: Pharmacy forms, including drug-specific fax forms, are available for download via our website or by contacting the Provider Line at 1-877-397-4584. Some forms are updated at least once annually.

Always verify you are using the most current version by visiting us on the Web at ExperienceHealthNC.com.

Sample Provider Inquiry Form

- [Click here](#)

Sample Level I Provider Appeal Form for Experience Health

- [Click here](#)

Sample Specialist Referral Form

Access the most current Specialist Referral Form at ExperienceHealthNC.com

- [Specialist Referral Form](#)

Chapter 25: Glossary of Terms

Alphabetical listing of terms

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

A

Term	Description
Additional benefits	Health care services not covered by Medicare.
Agreement	The agreement between Experience Health and members that includes Certificate of Coverage, riders, amendments and attachments.
Annual Election Period (AEP), enrollment period	The AEP is the period of October 15 through December 7 during which Medicare beneficiaries may elect enrollment in an MA plan for the following year. This period will also be the period during which an enrollee in an MA plan may elect to return to Original Medicare or elect a different MA plan. In addition to the AEP, Experience Health will accept applications during a continuous enrollment period each month for new Medicare beneficiaries and those with eligibility for a Special Election Period unless it provides notice to CMS and the public that it has changed its continuous open enrollment policy.

B

Term	Description
Basic benefits	All health care services that are covered under the Medicare Part A and Part B programs (except hospice services), and additional services that we use Medicare funds to cover.
Benefit period	A “spell of illness” is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services and the spell of illness ends with the close of a period of sixty (60) consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a skilled nursing facility. To determine the sixty (60) consecutive day period, begin counting with the day on which the individual was discharged. Spell of illness also applies to home health.

C

Term	Description
Calendar year	A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.
Certificate of Coverage (COC)	The document which describes services and supplies provided to a member. Same as evidence of coverage.
Center for Health Dispute Resolution (CHDR)	An independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Experience Health Medicare Advantage (HMO).
CMS	Refers to the center for Medicare and Medicaid services. It is the agency responsible for administering Medicare and federal participation in Medicaid. It also oversees the provision of health care benefits to Medicare beneficiaries by CMS-approved Medicare Advantage organizations.
Coinsurance	A fixed percentage of the recognized charges for a covered service that a member is required to pay to a provider.
Coordination of Benefits (COB)	Means those provisions, which Experience Health uses to coordinate benefits for costs incurred due to an incident of sickness or accident, which may also be covered by another insurer, group service plan or group health care plan. These provisions are also known as Medicare Secondary Payer (MSP).
Copayment	Means a fixed dollar amount of payment made by a member to a provider, as their share of the cost for a medical service or supply. Copayments must be made at the time services and/or supplies are received. The schedule of copayments can be found in Chapter 4 of the member’s book.
Custodial care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets and taking medication. Custodial care is not covered by Experience Health or Original

	Medicare unless provided in conjunction with Experience Health approved skilled nursing care.
--	---

D

Term	Description
Designated provider /authorized provider	Refers to the provider appointed by Experience Health to provide a specific covered service.
Disenrollment	Means the process of ending or terminating membership in Experience Health.
Drugs	Defined as inpatient medications which require a physician’s order or outpatient medications which require a prescription. To be covered, a drug must be covered by Medicare and Experience Health using Medicare coverage guidelines.
Durable Medical Equipment (DME)	Means equipment which is: (a) designed and intended for repeated use; and/or (b) primarily and customarily used to serve a medical purpose; and (c) generally not useful to a person in the absence of disease or injury; and (d) appropriate for use in the home. Must meet Medicare guidelines for coverage. Braces and prosthetic devices as defined by Medicare are considered part of the DME benefit.

E

Term	Description
Emergency medical condition	A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.
Emergency services	Covered inpatient or outpatient services that are (1) furnished by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an emergency medical condition.
Evidence of coverage	Shall have the same meaning as Certificate of Coverage and refers to this document, which explains covered services and defines our obligations and your rights and responsibilities as a member of Experience Health.
Exclusions	Items / services, which are not covered under this Certificate of Coverage.
Experimental and/or investigational	Refers to medical, surgical, psychiatric and other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by Experience Health to be either: (a) not generally accepted or endorsed by health care professionals in the general medical community as safe and effective in treating the condition, illness or diagnosis for which their use is proposed, or (b) not proven by

	scientific evidence to be safe and effective in treating the condition, illness or diagnosis for which their use is proposed.
--	---

G

Term	Description
Grievance and appeal procedure	The method of resolving member complaints, grievances and appeals.

H

Term	Description
Home health services	Shall mean skilled nursing care or therapeutic services provided by an agency or organization licensed by the state and operating within the scope of its license. For home health services to be a covered benefit, the member must be homebound (confined to home), under a plan of treatment established and periodically reviewed and approved by a physician, and in need of intermittent skilled nursing services, physical therapy or speech therapy. (Please Note: custodial care is not included under this definition.)
Hospice	An organization or agency, certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

I

Term	Description
Indemnification, beneficiary financial protection	Ensures that the member cannot be held financially liable for payment of fees which are the legal responsibility of Experience Health. This would include the services of Experience Health contracting providers as well as non-contracting providers.

L

Term	Description
Lifetime	Means any period of time throughout the member's life when member is covered by Experience Health.
"Lock in"	Means, as a member, all of your necessary health care treatment and services (other than emergency medical condition, urgently needed services, out of area renal dialysis and required post-stabilization care), must be provided by a contracting provider, or authorized by Experience Health.

M

Term	Description
MA	Refers to the term, Medicare Advantage organization, formerly Medicare+Choice. Provisions of the program are defined under Medicare Part C.

<p>Medically necessary</p>	<p>Refers to the medical need for diagnosis and care of treatment of a member. Medically necessary supplies and services are supplies and services that are:</p> <ul style="list-style-type: none"> (a) provided for the diagnosis, treatment, cure or relief of a condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes; (b) necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms; (c) within generally accepted standards of medical care in the community; and (d) not solely for the convenience of the member, member’s family or the provider. Plan may compare the cost-effectiveness of the alternative services or supplies when determining which of the services or supplies will be covered. <p>Experience Health shall have the full power and discretionary authority to determine whether any care, service or treatment is medically necessary, subject only to a member’s right of grievance and appeal defined in the Certificate of Coverage, and Experience Health may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.</p>
<p>Medicare Part A</p>	<p>Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.</p>
<p>Medicare Part B</p>	<p>Medical insurance that is optional and requires a monthly premium. This called the Medicare Part B premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.</p>
<p>Medicare Part C</p>	<p>A federal program with a primary goal of providing Medicare beneficiaries with a range of health plan choices through which to obtain their Medicare benefits. CMS contracts with private organizations offering a variety of private health plan options for Medicare beneficiaries, including both traditional managed care plans, such as HMOs, and new options that were not previously authorized. Originally known as the Medicare+Choice program, it was renamed by CMS and is now known as the Medicare Advantage program.</p>
<p>Medicare Part D</p>	<p>Effective January 1, 2006, this is a new federal program offering prescription drug benefits to Medicare beneficiaries. This benefit can be offered by private organizations including pharmacies and private health plans.</p>
<p>Medicare, Original Medicare</p>	<p>The federal government health insurance program established by Title XVIII of the Social Security Act.</p>
<p>Medicare Advantage organization</p>	<p>A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting MA requirements. MA organizations can offer one (1) or more MA plans. Experience Health is a Medicare Advantage organization. There are three (3) types of M+COs, (1) coordinated care plans, like Experience Health, which include a network of providers that are under contract or arrangement with the MA to deliver the services approved by CMS, (2) Medicare Advantage</p>

	Medical Savings Accounts (MSA) and (3) Medicare Advantage private fee-for-service plans.
Member	Refers to the Medicare beneficiary, entitled to receive health care services under the terms of the Experience Health Certificate of Coverage, who has voluntarily elected to enroll and whose enrollment in the Experience Health Medicare Advantage Plan has been confirmed by CMS.

N

Term	Description
National coverage decisions	Refer to coverage issues mandated by Medicare.
Non-contracting medical provider or facility	Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by nor under contract with Experience Health to deliver covered services. (These providers differ from contracting providers who affiliate with Experience Health to provide care for plan members.)
Non-covered services	Those medical services and supplies described in the member's Certificate of Coverage as not covered by Experience Health.

O

Term	Description
Optional supplemental benefits	Those benefits not covered by Medicare which are purchased for an additional plan premium at the option of the Medicare beneficiary. The existence or availability of optional supplemental benefits may vary by county. Experience Health does not offer any optional supplemental benefits.
Out-of-area service	Refers to those services and supplies provided outside the Experience Health Medicare Advantage (HMO) service area.

P

Term	Description
Post-service appeal	Shall have the meaning assigned to that term in Section 7.11(c)(ii)(A) of the Thomas / Love Settlement Agreement.
Post-stabilization care	Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition, as specified by CMS.
Primary Care	A contracting physician selected by an Experience Health member and is responsible for providing or arranging for medical and hospital services covered under this

Physician (PCP)	Certificate of Coverage. Note: A person who has acquired the requisite qualifications for licensure and is licensed in the practice of medicine.
Prior authorization	A system whereby a provider must receive approval from Experience Health before the member is eligible to receive coverage for certain health care services.
Provider	A hospital, non-hospital facility, doctor, or other provider, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification.

Q

Term	Description
Quality Improvement Organization (QIO)	An independent contractor paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the QIO also reviews hospital discharges for appropriateness and quality of care complaints.

R

Term	Description
Recognized charge(s)	Means the charge for a covered service which is the lower of (a) the provider's usual charge for furnishing it; or (b) the charge Experience Health determines to be the recognized charge made for that service or supply. In determining the recognized charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Experience Health may take into account factors such as: the complexity; degree of skill needed; type or specialty of the provider; range of services provided by a facility and the prevailing charge in other areas.

S

Term	Description
Service area	The geographic area approved by CMS within which an eligible Medicare beneficiary may enroll in a particular Medicare Advantage Plan offered by Experience Health. A listing of the approved service area can be found in Chapter 4 of this manual.
Skilled nursing facility	A facility certified by Medicare which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term skilled nursing facility does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.
Spell of illness	See benefit period.
Supplemental benefits	Those benefits not covered by Medicare for which the MA organization may charge the enrollee an additional plan premium. These benefits are offered as an option for

	the Medicare enrollee to select (optional supplemental benefits) or as a requirement for enrollment (mandatory supplemental benefits). Experience Health does not offer any optional supplement benefits.
--	---

T

Term	Description
Termination date	The date that coverage no longer is effective, (i.e., at 12:00 midnight on the last day coverage is effective). Also referred to as disenrollment date. Coverage typically ends on the last day of the month.

U

Term	Description
Urgent care facility	A health care facility whose primary purpose is the provision of immediate, short-term medical care for non-life-threatening urgently needed services.
Urgently needed services	Means covered services, that are not emergency services, provided when you are temporarily absent from the Experience Health service area (or, under unusual and extraordinary circumstances, provided when you are in the service area but your PCP is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition, and (2) it is not reasonable given the circumstances to obtain the services through your PCP.

V

Term	Description
Urgently needed services	Means covered services, that are not emergency services, provided when you are temporarily absent from the Experience Health service area (or, under unusual and extraordinary circumstances, provided when you are in the service area but your PCP is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition, and (2) it is not reasonable given the circumstances to obtain the services through your PCP.

^{A1} This [Addendum to the Supplement Guide \(June 2015\)](#) applies to the Experience Health Provider Administrative Manual as well.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Experience Health is an independent licensee of the Blue Cross and Blue Shield Association, serving North Carolina.

Attachment A

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>																																																																																																																																																																																																																																																																																																																																																																																																					
HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05</small>																																																																																																																																																																																																																																																																																																																																																																																																					
<input type="checkbox"/> PICA PICA <input type="checkbox"/>																																																																																																																																																																																																																																																																																																																																																																																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="3"> 1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member/ID) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BOX (UNIG) <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/> </td> <td colspan="3">1a. INSURED'S I.D. NUMBER (For Program in Item 1)</td> <td colspan="3"></td> <td colspan="3"></td> </tr> <tr> <td colspan="4">2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td> <td colspan="2">3. PATIENT'S BIRTH DATE MM DD YY</td> <td colspan="2">SEX M <input type="checkbox"/> F <input type="checkbox"/></td> <td colspan="4">4. INSURED'S NAME (Last Name, First Name, Middle Initial)</td> </tr> <tr> <td colspan="4">5. PATIENT'S ADDRESS (No., Street)</td> <td colspan="4">6. PATIENT RELATIONSHIP TO INSURED Delr <input type="checkbox"/> O spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> </td> <td colspan="4">7. INSURED'S ADDRESS (No., Street)</td> </tr> <tr> <td colspan="2">CITY</td> <td colspan="2">STATE</td> <td colspan="2">8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> </td> <td colspan="2">CITY</td> <td colspan="2">STATE</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">ZIP CODE</td> <td colspan="2">TELEPHONE (Include Area Code)</td> <td colspan="2">Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></td> <td colspan="2">ZIP CODE</td> <td colspan="2">TELEPHONE (Include Area Code)</td> <td colspan="2"></td> </tr> <tr> <td colspan="4">9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td> <td colspan="4">10. IS PATIENT'S CONDITION RELATED TO:</td> <td colspan="4">11. INSURED'S POLICY GROUP OR FECA NUMBER</td> </tr> <tr> <td colspan="4">a. OTHER INSURED'S POLICY OR GROUP NUMBER</td> <td colspan="4">a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO </td> <td colspan="4">a. INSURED'S DATE OF BIRTH MM DD YY</td> </tr> <tr> <td colspan="4">b. OTHER INSURED'S DATE OF BIRTH MM DD YY</td> <td colspan="4">b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="4">b. EMPLOYER'S NAME OR SCHOOL NAME</td> </tr> <tr> <td colspan="4">c. EMPLOYER'S NAME OR SCHOOL NAME</td> <td colspan="4">c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="4">c. INSURANCE PLAN NAME OR PROGRAM NAME</td> </tr> <tr> <td colspan="4">d. INSURANCE PLAN NAME OR PROGRAM NAME</td> <td colspan="4">10a. RESERVED FOR LOCAL USE</td> <td colspan="4">d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, return to and complete items 9 a-d.</small> </td> </tr> <tr> <td colspan="12" style="text-align: center;"> READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. </td> </tr> <tr> <td colspan="6">12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</td> <td colspan="6">13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</td> </tr> <tr> <td colspan="6">SIGNED _____</td> <td colspan="6">SIGNED _____</td> </tr> <tr> <td colspan="6">DATE _____</td> <td colspan="6">DATE _____</td> </tr> <tr> <td colspan="3">14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY</td> <td colspan="3">15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY</td> <td colspan="6">16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="3">17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td> <td colspan="3">17a. _____</td> <td colspan="6">18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</td> </tr> <tr> <td colspan="3">19. RESERVED FOR LOCAL USE</td> <td colspan="3">17b. NPI _____</td> <td colspan="6">20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____</td> </tr> <tr> <td colspan="6">21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)</td> <td colspan="6">22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</td> </tr> <tr> <td colspan="6">1. _____</td> <td colspan="6">22. PRIOR AUTHORIZATION NUMBER _____</td> </tr> <tr> <td colspan="6">2. _____</td> <td colspan="6"></td> </tr> <tr> <td colspan="6">3. _____</td> <td colspan="6"></td> </tr> <tr> <td colspan="6">4. _____</td> <td colspan="6"></td> </tr> <tr> <td colspan="2">24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</td> <td colspan="1">B. PLACE OF SERVICE</td> <td colspan="1">C. EMG</td> <td colspan="2">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</td> <td colspan="1">E. DIAGNOSIS POINTER</td> <td colspan="1">F. \$ CHARGES</td> <td colspan="1">G. DAYS ON UNITS</td> <td colspan="1">H. SPECI. FEE#</td> <td colspan="1">I. ID. DUAL</td> <td colspan="1">J. RENDERING PROVIDER ID #</td> </tr> <tr> <td colspan="2">1</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">2</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">3</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">4</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">5</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">6</td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="2"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1"></td> <td colspan="1">NPI</td> </tr> <tr> <td colspan="2">25. FEDERAL TAX I.D. NUMBER</td> <td colspan="2">SSN EIN</td> <td colspan="2">26. PATIENT'S ACCOUNT NO.</td> <td colspan="2">27. ACCEPT ASSIGNMENT? (For gen. contract only) <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td colspan="2">28. TOTAL CHARGE \$</td> <td colspan="2">29. AMOUNT PAID \$</td> </tr> <tr> <td colspan="2">30. BALANCE DUE \$</td> <td colspan="6">31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td> <td colspan="4">32. SERVICE FACILITY LOCATION INFORMATION</td> </tr> <tr> <td colspan="2">SIGNED _____</td> <td colspan="2">DATE _____</td> <td colspan="2">a. NPI _____</td> <td colspan="2">b. _____</td> <td colspan="2">c. NPI _____</td> <td colspan="2">d. _____</td> </tr> </table>												1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member/ID) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BOX (UNIG) <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (For Program in Item 1)									2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Delr <input type="checkbox"/> O spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)				CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE				ZIP CODE		TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY				b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME				c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME				d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, return to and complete items 9 a-d.</small>				READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						SIGNED _____						SIGNED _____						DATE _____						DATE _____						14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						19. RESERVED FOR LOCAL USE			17b. NPI _____			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						1. _____						22. PRIOR AUTHORIZATION NUMBER _____						2. _____												3. _____												4. _____												24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS ON UNITS	H. SPECI. FEE#	I. ID. DUAL	J. RENDERING PROVIDER ID #	1										NPI	2										NPI	3										NPI	4										NPI	5										NPI	6										NPI	25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gen. contract only) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION				SIGNED _____		DATE _____		a. NPI _____		b. _____		c. NPI _____		d. _____	
1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member/ID) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BOX (UNIG) <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																																																																																																																																																																																																																																																																																																																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																																																																																																																																																																													
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Delr <input type="checkbox"/> O spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																																																																																																																																																																																													
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE																																																																																																																																																																																																																																																																																																																																																																																													
ZIP CODE		TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code)																																																																																																																																																																																																																																																																																																																																																																																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																																																																																																																																																																																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY																																																																																																																																																																																																																																																																																																																																																																																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																																																																																																																																																																																													
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																																																																																																																																																																																													
d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, return to and complete items 9 a-d.</small>																																																																																																																																																																																																																																																																																																																																																																																													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																																																																																																																																																																																																																																					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																																																																																																																																																																																																																																																																															
SIGNED _____						SIGNED _____																																																																																																																																																																																																																																																																																																																																																																																															
DATE _____						DATE _____																																																																																																																																																																																																																																																																																																																																																																																															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																																																																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																																																																																																																															
19. RESERVED FOR LOCAL USE			17b. NPI _____			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																																																																																																																																																																																																																																																																																																																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																																																																																																																																																																															
1. _____						22. PRIOR AUTHORIZATION NUMBER _____																																																																																																																																																																																																																																																																																																																																																																																															
2. _____																																																																																																																																																																																																																																																																																																																																																																																																					
3. _____																																																																																																																																																																																																																																																																																																																																																																																																					
4. _____																																																																																																																																																																																																																																																																																																																																																																																																					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS ON UNITS	H. SPECI. FEE#	I. ID. DUAL	J. RENDERING PROVIDER ID #																																																																																																																																																																																																																																																																																																																																																																																										
1										NPI																																																																																																																																																																																																																																																																																																																																																																																											
2										NPI																																																																																																																																																																																																																																																																																																																																																																																											
3										NPI																																																																																																																																																																																																																																																																																																																																																																																											
4										NPI																																																																																																																																																																																																																																																																																																																																																																																											
5										NPI																																																																																																																																																																																																																																																																																																																																																																																											
6										NPI																																																																																																																																																																																																																																																																																																																																																																																											
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gen. contract only) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$																																																																																																																																																																																																																																																																																																																																																																																											
30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION																																																																																																																																																																																																																																																																																																																																																																																													
SIGNED _____		DATE _____		a. NPI _____		b. _____		c. NPI _____		d. _____																																																																																																																																																																																																																																																																																																																																																																																											
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)																																																																																																																																																																																																																																																																																																																																																																																																					

Attachment B

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				3b MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION	14 TYPE	15 SRC	16 DHR	17 STAT
18 CONDITION CODES		19		20		21	
22		23		24		25	
26		27		28		29 ADOT	
						30 STATE	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE	
35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE		38 OCCURRENCE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42 VALUE CODES	
CODE		CODE		CODE		CODE	
AMOUNT		AMOUNT		AMOUNT		AMOUNT	
43		44		45		46	
47		48		49		50	
51		52		53		54	
55		56		57		58	
59		60		61		62	
63		64		65		66	
67		68		69		70	
71		72		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		100		101		102	
103		104		105		106	
107		108		109		110	
111		112		113		114	
115		116		117		118	
119		120		121		122	
123		124		125		126	
127		128		129		130	
131		132		133		134	
135		136		137		138	
139		140		141		142	
143		144		145		146	
147		148		149		150	
151		152		153		154	
155		156		157		158	
159		160		161		162	
163		164		165		166	
167		168		169		170	
171		172		173		174	
175		176		177		178	
179		180		181		182	
183		184		185		186	
187		188		189		190	
191		192		193		194	
195		196		197		198	
199		200		201		202	
203		204		205		206	
207		208		209		210	
211		212		213		214	
215		216		217		218	
219		220		221		222	
223		224		225		226	
227		228		229		230	
231		232		233		234	
235		236		237		238	
239		240		241		242	
243		244		245		246	
247		248		249		250	
251		252		253		254	
255		256		257		258	
259		260		261		262	
263		264		265		266	
267		268		269		270	
271		272		273		274	
275		276		277		278	
279		280		281		282	
283		284		285		286	
287		288		289		290	
291		292		293		294	
295		296		297		298	
299		300		301		302	
303		304		305		306	
307		308		309		310	
311		312		313		314	
315		316		317		318	
319		320		321		322	
323		324		325		326	
327		328		329		330	
331		332		333		334	
335		336		337		338	
339		340		341		342	
343		344		345		346	
347		348		349		350	
351		352		353		354	
355		356		357		358	
359		360		361		362	
363		364		365		366	
367		368		369		370	
371		372		373		374	
375		376		377		378	
379		380		381		382	
383		384		385		386	
387		388		389		390	
391		392		393		394	
395		396		397		398	
399		400		401		402	
403		404		405		406	
407		408		409		410	
411		412		413		414	
415		416		417		418	
419		420		421		422	
423		424		425		426	
427		428		429		430	
431		432		433		434	
435		436		437		438	
439		440		441		442	
443		444		445		446	
447		448		449		450	
451		452		453		454	
455		456		457		458	
459		460		461		462	
463		464		465		466	
467		468		469		470	
471		472		473		474	
475		476		477		478	
479		480		481		482	
483		484		485		486	
487		488		489		490	
491		492		493		494	
495		496		497		498	
499		500		501		502	
503		504		505		506	
507		508		509		510	
511		512		513		514	
515		516		517		518	
519		520		521		522	

Attachment C



Experience Health: A New Medicare Advantage HMO Health Plan

- Health Plan Services will be available January 1, 2020
- Visit www.experiencehealthnc.com

naviHealth Responsibilities:

naviHealth (nH) has been delegated for certain utilization management responsibilities on behalf of Experience Health for patients seeking care in Skilled Nursing Facilities starting January 1, 2020.

- naviHealth will provide support for Experience Health Members through the Preservice Authorization Process (applying CMS Chapter 8 criteria), Continued Stay Reviews, drafting NOMNCs and responding to QIO appeals. Note that claims are processed and paid by the health plan; naviHealth supports the provider in billing the appropriate HIPPS code through participation in weekly Interdisciplinary Team meetings and during provider Triple Check meetings.

SNF admissions are expected to have a Preservice Authorization.

- naviHealth Hours of Operation: Monday-Friday 8 am- 5 pm EST
- Authorization during off hours may occur from the ER, MD office, or Home.
- Admission without authorization should only occur during off hours and authorization requests must be received on the first business day following the transition.
- naviHealth will conduct a review for medical necessity; denials are possible.

Contact naviHealth for UM Services:

For Preservice Referrals to SNF Phone: 833-257-4305 Fax: 855-533-9364	For Discharge Summary and Service Logs Fax: 855-222-4172
For Continued Stay Reviews in SNF Phone: 833-257-4305 Fax: 877-869-9154	Important Provider Links naviHealth.com/PDPM

Topic	Name	Title	Email	Phone
Clinical	Julia Taylor	Director of Clinical Operations	julia.taylor@navihealth.com	470-420-5967
Operations	Gerd Peters	Executive Director	gerd.peters@navihealth.com	615-593-8886
Provider Network Escalations	Jenifer Robins	Director of Provider Engagement	jrobins@navihealth.com	336-247-6373
Provider Network	Chris Weston	Network Manager	christopher.weston@navihealth.com	336-473-3848