



An Anthem Company

Medicare Advantage Provider Manual

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SECTION 1
HEALTHSUN HEALTH PLANS PROVIDER
MANUAL

HEALTHSUN HEALTH PLANS PROVIDER MANUAL

The HealthSun Health Plans Provider Manual was developed to assist providers in understanding HealthSun's administrative policies and procedures. The manual provides both general and specific information about HealthSun expectations, programs, reports, forms and other pertinent operational details needed to facilitate your interaction with HealthSun Health Plans, Inc.

In the event of any inconsistency between information contained in this manual and the arrangement between you and HealthSun, the terms of the agreement shall govern. Additionally, inconsistency between information contained in this manual and the provision of any state or federal statute or regulation applicable to either HealthSun or a contracted provider, the provisions of the statute or regulation shall have full force and effect. Also, please note that HealthSun may provide available information concerning an individual member'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 eligibility of any such individuals to receive benefits. In addition, all payment is subject to the terms of the contract under which the individual is eligible to receive benefits.

This manual will be updated and providers notified, as needed, to incorporate any changes to HealthSun administrative policies and procedures that impact providers.

Confidentiality of Information

Confidentiality is the responsibility of every HealthSun staff member and contracted provider. We are both "Covered Entities" under the Privacy Regulations in the 1996 Health Insurance Affordability and Accountability Act (HIPAA), even if you submit paper claims. Fortunately, all of the normal transfers of confidential patient information between us are allowed under HIPAA, within the prescribed Security limits of the Act. There is a HealthSun Corporate Policy of zero-tolerance for any infraction of the policy by HealthSun staff members. All new HealthSun staff are informed as part of their Orientation Process that they can be immediately fired for any breach of confidentiality. This policy is also highlighted in the staff member handbook. Additionally, access to all files (manual and computerized) is provided with security clearance at the time of employment with HealthSun and revoked formally at the time of termination.

Providers should comply with HealthSun policies regarding confidentiality to the extent that confidential treatment is provided for under State and Federal laws and regulations. All records and all other documents deemed confidential by law, and disclosure or transfer of confidential information will be in accordance with applicable law.

Statement of Non-Discrimination

HealthSun Health Plans subscribes to the principles of equal opportunity and affirmative action. We do not discriminate on the basis of age, race, ethnicity, religion, mental or physical disability, national origin, marital status, sexual orientation, sex, genetic deformation or source of payment in the enrollment of members, the delivery of covered services or items or the credentialing or contracting of providers. HealthSun Health Plans will not tolerate or condone employees or providers that discriminate.

HEALTHSUN HEALTH PLANS CONTACT INFORMATION

INFORMATION

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Website: www.HealthSun.com

PHONE NUMBERS

Tel: (305) 234-9292
Tel: (877) 207-4900
Fax: (305) 448-9980
Toll Free: (877) 207-4900
TDD/TTY: (877) 206-0500
E-mail: info@HealthSun.com

Authorizations/Medical Management/ Case Management

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Medical Management

Tel: (305) 969-8484
e-Fax: (305) 489-7997
Toll Free: (877) 207-4900
E-mail: Utilization_Dept@HealthSun.com

Claims

HealthSun Health Plans
P.O. Box 211154
Eagan, MN 55121
Attention: Claims Department

Claims Review Department

P.O. Box 330968
Miami, FL 33233-0967
Attention: Claims Review Department

Credentialing

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Credentialing Department

Tel: (305) 448-8100
e-Fax: (888) 415-5826
Toll Free: (877) 207-4900
E-mail: HSHPCredentialingGroup@healthsun.com

Appeals

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Appeals

Tel: (305) 447-4451
e-Fax: (877) 589-3256
Toll Free: (877) 207-4900
E-mail: Appeals_eFax@health.com

Member Services (Designated for Members only)

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Member Services

Tel: (305) 234-9292
e-Fax: (305) 448-5783
Toll Free: (877) 336-2069
E-mail: MemberServicesStaff@healthsun.com

Provider Eligibility, Benefit and Claim

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Interactive Voice Response (IVR)
Attention: Member Services

Tel: (305) 447-4459
e-Fax: (305) 448-5783
Toll Free: (877) 999-7776
(305) 448-8100
E-mail: Provider_Call_Unit@healthsun.com

Part D Services Department

HealthSun Health Plans
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Part D Services Department

Tel: (305) 460-3901
e-Fax: (305) 643-4323
Toll Free: (877) 207-4900
E-mail: PartDServices@HealthSun.com

INTRODUCTION AND BACKGROUND

We are sincerely pleased that you have agreed to participate with the HealthSun Health Plans network of providers. We look forward to working with you to offer quality health care to your patients who participate as members of HealthSun Health Plan. It is important at the outset that you are made aware of the goals and objectives that guide HealthSun in the provision of care and service to members. Equally important is your understanding of the efforts made by HealthSun to introduce an oversight committee structure that serves to monitor and provide continuous input into the operation of HealthSun.

HealthSun is organized to ensure 1) members access to quality care, 2) on-going monitoring of appropriate utilization of services, and 3) continuous evaluation and improvement in the quality of care and services delivered by participating providers to HealthSun members. **Our guiding goals** are to:

Improve and maintain member's physical and emotional status.

Promote health and early intervention and empower members to develop and maintain healthy lifestyles.

Involve members in treatment and care management decision-making.

Ensure that the care and treatment provided a member is based on accepted evidenced-based medical principles, standards, and practices.

Be accountable and responsive to member concerns and grievances.

Utilize technology and other resources efficiently and effectively for member welfare.

Ensure that appropriate care and treatment is accessible to members and provided in a timely manner.

These goals are supported by the following HealthSun **operational objectives**:

Enhancing the efficiency of resource utilization, while at the same time ensuring the delivery of high quality and accessible care and treatment.

Proactive pursuit of methods to improve care and service to members.

Provision of interventions designed to improve the overall health and productivity of members.

Providing consistency and continuity in care and service throughout the HealthSun health and mental health care delivery network.

Ensuring systematic identification and follow-up of potential quality/compliance issues.

Continuously educating and reinforcing members, physicians, hospitals, and ancillary providers about goals, objectives and structure for providing quality, cost effective, and coordinated managed health and mental health care.

Promoting open communication and interaction between providers and members.

Review individual and aggregate utilization patterns.

HealthSuns Vision and Mission

Vision

To be the Medicare Advantage plan of choice in the South Florida marketplace.

Mission

HealthSun's mission is to improve the health and well-being of our members.

Partner with our stakeholders to provide high quality, cost effective health care.

Create a rewarding and positive culture for HealthSun employees.

Values

Integrity

Consistently demonstrate high levels of integrity that earns the trust of our stakeholders.

Accountability

All employees embrace the commitments to our stakeholders by delivering superior results.

Teamwork

Promote a collaborative spirit with all stakeholders to benefit our customers.

SECTION 2
HEALTHSUN HEALTH PLANS
COMMITMENT TO PROVIDERS

HEALTHSUN HEALTH PLANS COMMITMENT TO PROVIDERS

HealthSun embraces the concept of establishing a strong partnership with our healthcare provider network. We know that this partnership requires us to continually demonstrate a willingness to communicate with and educate our provider partners about HealthSun's operations and offer our providers efficient and effective avenues for addressing provider issues and concerns. Accordingly, HealthSun is committed to:

Provider Support

- Having exceptionally trained Physician/Provider Operations Representatives available by telephone to answer questions, provide claims status, and resolve problems during regular business hours.

Prompt Claims Payment

- Plan, as applicable, shall comply with the provisions of Florida prompt payment guidelines as established in Section 641.3155, F.S. which describes the timing and procedures applicable to claims for payment and overpayment submitted by the physician/provider, as well as retroactive denials of claims due to eligibility. Further, the physician/provider shall exhaust all internal dispute resolution procedures pursuant to the Agreement as a prerequisite to the submission of a claim by the physician/provider to the resolution organization established by AHCA, pursuant to 408.7057, F.S.
- Assisting physicians/providers to submit claims for payment via electronic format (EDI) for purposes of efficiency, tracking, and improved payment turnaround; and;
- Assisting physicians /providers in posting claims to their accounts receivable through designing an easy-to-use Explanation of Benefits (EOB).

Efficient, Practical, and High Quality Medical Management

- Providing the most efficient methods to obtain referrals and authorizations, including the ability to request referrals/authorization on-line;
- Approving outpatient diagnostic services, ambulatory surgery, and non- urgent hospitalization requests within 24-hours of receipt of all necessary information and;
- Developing and implementing state-of-the-art health risk management, chronic care improvement, and wellness programs to assist our physicians/providers to provide the highest quality of care to their patients and to ensure the highest quality of life for their patients.

HealthSun Health Plans will ensure

- Provision of care and services to our members is made available through our Provider Network.
- Non-discriminatory practices for prospective and current enrollees or to enrollees with physical, mental disability and or chronic illnesses.
- To maintain current membership records for providers.
- Provider Operation staff is available to Providers and their staff.
- Training and support for Providers and their Staff.
- Provider support in the provision of language services.
- To provide changes, revisions, updates, enrollment, and disenrollment data.

- Referral support for Provider and their Staff.
- To maintain communication with providers and their staff for revisions to Policies or Procedures in accordance with Regulatory and Accreditation Agencies
- To require compliance from Providers for Site Audits, Medical Record Review, Access Audits, QI Reviews, and other requirements as determined by HealthSun.
- To notify Provider of changes, revisions, additions, deletions and other modifications to their agreements.
- To notify and forward member Health Risk Assessment Information to Provider.

CREDENTIALING/RE-CREDENTIALING PROCESS

Credentialing

Credentialing is the process by which the appropriate committee reviews documentation for each individual physician/provider to determine participation in the health plan network. Such documentation may include, but is not limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and physical and mental impairments. The credentialing process includes verification that the information obtained is accurate and complete. The physician/provider must respond to any reasonable HealthSun Health Plans, Inc. (HealthSun) request for additional information including, but not limited to, a medical record review as well as a site visit as applicable.

HealthSun recognizes the physician's/provider's right to review information submitted in support of the credentialing application to the extent permitted by law and to correct erroneous information. Physician/provider may obtain information regarding the status of their credentialing or recredentialing process by calling HealthSun.

The credentialing process generally is required by law. The fact that the physician/provider is credentialed is not intended as a guarantee or promise of any particular level of care or services.

HealthSun Credential Committee

The Credential Committee is composed of a chairperson and participating physicians. Functions of the committee include credentialing, ongoing and periodic assessment, recredentialing, and establishment of credentialing and recredentialing policies and procedures. The physician's/provider's documentation is provided to the corporate credentials committee for approval or denial for participation in the network. Notification of approval or denial of credentials is sent to the physician/provider.

Recredentialing

Recredentialing is conducted at least every three (3) years in accordance with the HealthSun credentialing and recredentialing process. The recredentialing process is conducted with the same standards as those for initial credentialing. The decision concerning re-appointment or failure to re-appoint will be conveyed to the physician/provider in writing.

Providers Site Visits

In order to ensure conformance with standards set by the Centers for Medicare and Medicaid Services for HealthSun, a structured review of contracted practitioner medical offices and of medical record keeping practices is conducted of PCPs and high volume specialist providers.

The structured site visit review assesses the physical accessibility and appearance of the office or clinic, appointment availability, adequacy of waiting and examining room space, safety, infection control, and confidentiality issues.

A copy of the Site Survey can be obtained by contacting the HealthSun Provider Operations Department—Refer to the Telephone Contact Numbers at the beginning of the Provider Manual.

DELEGATED PROVIDERS

The guidelines and responsibilities outlined in this section are applicable to all HealthSun delegated providers. The information provided is designed primarily for the provider's administrative staff responsible for the implementation or administration of certain functions that HealthSun has delegated to provider.

Downstream Education

Administrative staff of the delegated provider bears a responsibility to educate downstream physicians and health care providers, as well as any providers to whom they sub-delegate activities (who require preapproval to perform any delegated function from HealthSun), about HealthSun's policies and procedures. Explanations of any special circumstances which justify variation from the guidelines set forth in this section, should be documented, retained, and discussed with HealthSun prior to implementation. HealthSun expects to periodically review and approve all downstream educational material to confirm that all information mentioned in this appendix is referenced.

The following information should be incorporated into the delegate's business practices as it relates to the functions delegated by HealthSun.

HealthSun, Legal, Regulatory and Accreditation Requirements for Delegated Providers

Delegates are required to allow HealthSun to monitor the quality and effectiveness of any delegated function through periodic audits performed by HealthSun. HealthSun will provide advance notification of 10 days before performing an on-site review or such shorter notice as may be imposed on HealthSun by a federal or state regulatory agency or accreditation organization. The documentation for review may include, but is not limited to the following:

- Current policies and procedures
- Standard of Conduct
- Compliance of Fraud Waste and Abuse Training
- Documentation of the OIG/GSA exclusion list review
- Monitoring of delegated entities audits and corrective action plan in order to ensure compliance with all applicable laws and regulation
- Program or plan description
- Annual program work plan and evaluation
- Specified files
- Reports including analysis as specified by HealthSun for all functions delegated
- Pertinent committee meeting minutes.

In addition, the delegated provider will comply with the following requirements:

- Allow any regulatory agency to examine, at any time, information the agency deems relevant to determine the financial solvency of the delegate or to review the delegate's ability to meet its responsibilities in connection with any function delegated to delegate by HealthSun.
- Agrees that HealthSun retains the right to modify, rescind, or terminate at any time any or all delegated activities.
- Submit any material change in the performance of delegated functions to HealthSun for review and approval, prior to the effective date of the proposed changes.

- Notify HealthSun of any sanctions incurred by the delegate following review by a federal, state or accreditation organization (within 10 days of such sanction).
- Comply with the Employee Retirement Income Security Act (ERISA) requirements.
- Comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements.
- If required by state and/or federal law, rule or regulation, will obtain and maintain in good standing, a third-party administrator license/certificate and or a utilization review license or certification.
- Ensure that personnel who carry out the delegated services have appropriate training, licensure, and/or certification.
- Upon request, will submit to HealthSun financial information as proof of its continued financial solvency. Financial information submitted should include the following:
 - Recent audited financial statements (balance sheet, statement of operations, statement of cash flows, and notes to the financial statements). If the audited financial statements are over six months old, the delegate will provide current internal financials with projections (e.g., six month ended financials or quarterly reports).
 - If delegate has not been audited, delegate will provide recent internally prepared financial statements (balance sheet, statement of operations, and cash flow statement). Delegate's chief financial officer and/or owner should certify/attest to their correctness by adding his/her signature to the financial statements provided to HealthSun.
- The delegate and contracted providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary records.
- All claims shall be processed for covered services rendered to members and payments made to the delegate on a timely basis in accordance with applicable federal and state laws, rules and regulations regarding the timeliness of claims payments. For purposes of this section, a claim is approved or denied "promptly" if it is approved or denied within the time provided for by CMS and any applicable "prompt payment" state statutes.
- Ensure that under no circumstance, including without limitation, insolvency of HealthSun or delegate, or any expiration, nonrenewal or termination of performance, regardless of the cause, will delegate or any employee or contractor of delegate, inclusive of any sub-delegate, bill, seek payment or attempt to collect payment, other than authorized copayments and deductibles, for any of the delegated functions and/or activities from HealthSun members.
- Provide timely notification to HealthSun of the termination of any participating provider and ensure compliance with provider network access standards necessary to comply with any applicable state and federal laws, rules and regulations, accreditation standards applicable to HealthSun.
- Delegate and contracted providers agree to comply with Medicare laws, rules, regulations, reporting requirements, and CMS instructions. Delegate and contracted providers agree to audits and inspection by CMS and/ or its designees and to cooperate, assist and provide information as requested.
- Will ensure, when medically necessary services are available 24 hours a day, 7 days a week. Primary care physicians must have appropriate backup for absences.
- All services, clinical and nonclinical, will be provided in a skillful manner and accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

- Ensure that Medical Management decision-making is based only on appropriateness of care and service, and existence of coverage.
- Agree not to specifically reward physicians or other individuals conducting utilization review for issuing denials of coverage or service care. Agrees not to provide financial incentives for Medical Management decision makers which may result in under-utilization.
- Agree that HealthSun reserves the right to perform an on-site review with ten (10) business days notification to delegate for routine assessments or such shorter notice as may be imposed on HealthSun by a federal or state regulatory agency or accreditation organization and HIPAA regulations.
- Agree to render covered services in accordance with the rules of ethics and conduct of all applicable state and federal rules, laws and regulations. Proven misconduct may lead up to termination of the contract.

Delegated Provider Downstream Contract Content

The delegate and when applicable its subcontractors, will make available to HealthSun samples of contracts with physicians and providers and ensure compliance with the legal and regulatory contractual requirements, including HIPAA regulations. Delegate is not required to make available to HealthSun contractual provisions relating to financial arrangements with delegate's physicians and providers.

Physician and provider contract content should include, but should not be limited to the following:

- Notification of physician/specialist/specialist group's termination: The contract executed between the delegate and specialist/specialist group must state either the delegate or HealthSun will be responsible for notifying the affected members of the termination.
- Physicians/providers cooperate with quality improvement (QI) activities.
- HealthSun and delegate have access to physician/provider medical records to the extent permitted by state and federal law.
- Physicians/providers need to maintain the confidentiality of member information and records.
- Physicians/providers may freely communicate with members about their treatment regardless of benefit coverage limitations.
- A listing of all individuals or entities that are party to the written agreement.
- Definitions for termination used in the contract referenced above.
- Conditions for participation as a participating provider.
- Obligations and responsibilities of the delegate and the participating provider, including any obligations for the participating provider to participate in the delegate's management, quality improvement, complaint, or other programs.
- Events that may result in the reduction, suspension, or termination of network participation privileges.
- The specific circumstance under which the network may require access to member's medical records as part of the delegate's programs or health benefits.
- Health care services to be provided and any related restrictions.
- Requirements for claims submission and any restrictions on billing of members.
- Participating provider payment methodology and fees.
- Mechanisms for dispute resolution by participating providers. Term of the contract and procedures for terminating the contract.

- Requirements with respect to preserving the confidentiality of patient health information.
- Prohibitions regarding discrimination against members.
- Physicians and providers agree to hold members harmless and not bill more than their coinsurance/copays or indemnity balances that are the member's responsibility under his/her Plan.

Note: Health plans, first tier, and downstream entities are prohibited from employing or contracting with individuals excluded from participation in Medicare.

Systems and File Retention

The delegate will furnish any and all staffing and systems necessary to receive eligibility data from HealthSun and provide HealthSun all data as required by state and federal laws, rules and regulations, and HealthSun. The documents include without limitation claims and encounters, credentialing, utilization review/medical management, quality improvement, and other documentation records, files or data pertaining to functions delegated. The records must be maintained for a period of ten (10) years.

Appeals and Grievances

HealthSun member appeals/grievances and expedited appeals are not delegated, including an appeal made by a physician/provider on behalf of the member. HealthSun maintains all member rights and responsibility functions.

SECTION 3
PROVIDER FUNCTIONS AND
RESPONSIBILITIES

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician

All HealthSun Health Plan members will select a PCP at the time of enrollment. The PCP shall be responsible for coordinating the member's health care needs through a comprehensive network of specialty, ancillary and hospital providers.

For new members, HealthSun will provide members upon initial enrollment a form or Provider will contact each new member, two times if necessary, within 90 days of enrollment, to perform an initial health risk assessment (HRA). HRA results will help determine whether a member is at risk for catastrophic illness. All HRAs received at the health plan will be forwarded to the member's primary care physician who will assist with assuring incorporation of all necessary services including, if available, nurse care management. At the time of this assessment, the PCP will request that the member authorize the release of their medical records from prior physicians. Once a release has been signed, the physician will request records from previous care providers. Health screening for adults will meet medical community standards, such as those established by the Centers for Disease Control and the U. S. Preventive Services Task Force. When external regulating agencies impose more stringent standards the PCP will comply with those standards

The Primary Care Physician is responsible for providing medical services which may include:

- Routine and urgent physician office visits;
- History and Physicals;
- Injections and immunizations;
- Laboratory services and x-ray services per contractual arrangements with HealthSun;
- Screening EKG's ordinarily performed in a physician's office;
- Periodic health assessments;
- Education on preventive health; physician hospital care;
- Physician home care; minor office surgeries; and
- Any other routine medical care normally rendered by the physician to his/her patients.

In addition, Primary Care Physicians are responsible for:

- Coordinating all care including requesting information from other treating physicians as necessary to provide care to the patient. EXCEPTIONS: HealthSun members have direct access to any appropriate participating provider for: behavioral/mental health; influenza vaccines; chiropractic services; podiatry services routine once (1) every three (3) months in the office ; dermatologist for (5) visits per calendar year; and female enrollees have direct access to participating women's health specialists for routine and preventive gynecological services.
- Adhere to referral authorization procedures.
- Maintain the member's medical record to include documentation in compliance with HealthSun Medical Records Content and Structure Standards and Confidentiality and Privacy Standards.
- Cooperate with HealthSun Case Managers in developing Care Plans for members participating in the HealthSun Chronic Care Improvement Program.
- Adhere to HealthSun emergency care guidelines.
- Submit claims and encounter data consistent with HealthSun guidelines.

- Make, or support on the member's behalf, a request for an organizational determination or reconsideration in writing or orally, and expedite the process if he or she feels the enrollee's life, health or function is endangered – See Appeal, Grievance And Complaint Rights And Procedures For Enrollees – Appeals Section for explanation and specific guidelines.
- Adhere to HealthSun member availability and accessibility standards.
- Support continuity of care.
- Cooperate with HealthSun in satisfying Quality Improvement requirements.

PCP is responsible twenty-four (24) hours a day, seven (7) days a week for providing or arranging all covered services including prescribing, directing and authorizing all care to members who have been assigned to the PCP. The PCP is responsible for arranging coverage by a HealthSun credentialed physician in the event of the PCPs absence. All financial arrangements must be made between the PCP and covering physician. The PCP is also responsible for notifying HealthSun in writing (2 weeks prior to their absence) of the duration of the absence and the physician who will be providing the coverage. The covering physician must be credentialed by HealthSun.

All PCPs must be credentialed by HealthSun. All personnel assisting in the provision of health care services to HealthSun members are to be appropriately trained, qualified and supervised in the care provided. Any time a new physician joins a practice, that individual must be credentialed with the Plan and cannot see HealthSun members until the credentialing process is completed. Services are never to be provided by a non-credentialed physician and such services will not be covered by HealthSun. Notify your Provider Service Executive when a new physician requires credentialing. The PCP is responsible for the direct training and supervision of all employed physician extenders in the provision of care and directed according to Medicare regulations and applicable state licensure requirements.

Under the Americans with Disabilities Act (ADA), physicians' offices are considered places of public accommodation and thus are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation and unequal treatment of any person with a disability. All PCP facilities must have handicapped accessibility, adequate space, supplies, good sanitation, and fire safety procedures in operation. Furthermore, PCP's are obligated to offer translation and interpreter services to members with limited English proficiency (LEP) or low literacy proficiency, and to make reasonable efforts to accommodate Members with other sensory impairments. PCPs must furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through HEALTHSUN. PCP that are unable to arrange for **language translation services for non-English speaking or LEP HealthSun members**, may contact our Member Services Department at (877) 336-2069, and a representative will assist in locating a qualified interpreter via telephone that communicates in the Member's primary language while the member is in the office.

SPECIALTY CARE PHYSICIAN

Referral (Specialist) Physician

Upon referral from the Primary Care Physician and authorization from HealthSun, a referring physician is responsible for providing routine and emergency medical/surgical services in conformity with professionally recognized standards of health care and within the ethical principles and scope of their professional license.

The HealthSun member's Referral (Specialist) Physician must:

- Abide by HealthSun referral authorization procedures.
- Request information from other treating physicians as necessary to provide care to the patient.
- Provide Consultation Reports to the PCP reporting their findings and recommendations based on their examination. Interim and final reports must be sent to the referring PCP in a timely manner. Failure to do so may result in delay in reimbursement.
- Support continuity of care.
- Submit claims and encounter data consistent with HealthSun guidelines.
- Cooperate with HealthSun in satisfying Quality Improvement requirements.

Each HealthSun member will select a PCP at the time of enrollment. The PCP coordinates the member's health care needs through a comprehensive network of specialty, ancillary and hospital providers.

Upon examining a member, should the PCP determine that specialty referral services are medically indicated, he or she will arrange for the appointment with the Specialist by generating a referral.

All referrals must be pre-approved by the PCP and be pre-authorized/certified by HealthSun (except as agreed upon in certain areas).

The same process is followed for members who are hospitalized, even in cases when the PCP is not the admitting physician.

Under the Americans with Disabilities Act (ADA), physicians' offices are considered places of public accommodation and thus are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation and unequal treatment of any person with a disability. All Specialty Care facilities must have handicapped accessibility, adequate space, supplies, good sanitation, and fire safety procedures in operation. Furthermore, Specialty Care Physicians are obligated to offer translation and interpreter services to members with limited English proficiency (LEP) or low literacy proficiency, and to make reasonable efforts to accommodate Members with other sensory impairments. Specialty Care Physicians must furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through HealthSun. Specialty Care Physicians that are unable to arrange for **language translation services for non-English speaking or LEP HealthSun members**, may contact our Member Services Department at (877) 336-2069, and a representative will assist

in locating a qualified interpreter via telephone that communicates in the Member's primary language while the member is in the office.

CAPITATED PROVIDERS

Capitation payments are used by managed care organizations to control health care costs. Capitation payments control use of health care resources by putting the physician at financial risk for services provided to patients. At the same time, in order to ensure that patients do not receive suboptimal care through under-utilization of health care services, managed care organizations measure rates of resource utilization in physician practices.

Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. It is the responsibility of all HealthSun Health Plan Capitated Providers to supply encounter/claims data on a timely basis not less than monthly. HSHP expects the encounter claims data by the 15th of the month following the month of the services provided.

Should any Capitated Provider not be able to provide such information by the due date, the Plan, at its discretion may withhold the current month capitation check until such time as the data has been received. Continued lack of compliance with this requirement may lead to termination of the Providers contract.

PHYSICIAN RESPONSIBILITIES

The relationship between HealthSun and any participating physicians/provider, non-participating provider, or other associated institution, organization, or practitioner, hereafter "Independent Contractor(s)", is solely that of an independent contractor. Neither HealthSun nor any of its agents, servants, or staff members shall be deemed to be an agent, servant, or staff member of any such Independent Contractor, and such Independent Contractor nor any of its agents, servants, or employees shall be deemed to be an agent, servant, or employee of HealthSun. HealthSun shall not be deemed to be a health care provider with respect to any services performed or provided by any such Independent Contractor. Any decisions made by HealthSun concerning appropriateness or setting or whether any service or supply is medically necessary pursuant to an Evidence of Coverage shall be deemed to be made solely for purposes of determining whether benefits are covered and not for purposes of recommending any treatment or non-treatment. **All physicians and other providers of health care should rely on their own independent professional judgment, experience, and skill when treating their patients. HealthSun will NOT assume liability for any loss or damage arising as a result of acts or omissions of any independent contractor.**

The following requirements are the basic guidelines you have agreed to in accordance with your Provider Agreement with HealthSun Health Plans. You are responsible for the provision of care, and ensuring continuity and accessibility of care. You will be notified as to any regulatory changes that require revisions and additions/deletions to standard responsibilities.

Affiliation

All physicians/providers should contact HealthSun to update their provider file for changes in their Professional Association (PA) affiliation(s) (e.g., partnership, physician group practice).

Tax ID Change

All physicians/providers should contact HealthSun to update federal tax identification information; a W-9 form will be required. The IRS requires that we report payments made to you and that we have the correct information on the file for all physicians/providers to whom payments are made.

Advance Directive

HealthSun Health Plans, Inc. acknowledges a member's right to make an advance directive. Advance directives are written instructions, such as living wills or durable power of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provisions of health care if the patient becomes incapacitated and is unable to make those wishes known. Providers are expected to advise each HealthSun member regarding his or her future health care needs and available options. Providers may give advance directive information to the patient's family or surrogate should the patient be incapacitated at the time of enrollment. Advance Directive Forms are also available at the following website www.aafp.org

After Hours Access

Providers and/or Covering Providers are required to provide advice, consultation, and access to care appropriate for each Member's medical condition as described below:

- Availability of 24-hour answering service.
- Answering system with option to page the physician
- On call schedule. Physicians will provide advice and assess care as appropriate for each patient's medical condition. Life threatening conditions will be referred to the nearest emergency room.
- Notification to the Plan of known ER visits and ER admits

In addition, HealthSun recommends the following standards for all physicians:

- Response to urgent calls within 15 minutes; response to routine calls within 24 hours.
- After hours, response to urgent calls within 15 minutes; non urgent response in 30 minutes.
- The average wait time should not exceed 60 minutes from the scheduled appointment time. This includes time spent both in the waiting and examination room prior to being seen by the physician. In the case of an unexpected emergency, which may cause this standard to be exceeded, the member should be promptly notified and given the option of waiting or rescheduling.

By monitoring compliance with these guidelines over time, HealthSun can take action to improve member service availability and access to medical services when necessary. HealthSun may monitor compliance with the above-mentioned access standards through a variety of ways including site visits, telephone audits, member surveys and complaints.

Changes in your Information

Providers will notify HealthSun Health Plan of additions, changes, or deletions as follows:

- Name
- Address
- Phone, Fax, Pager, Cell Phone, E-mail
- Office Hours
- Coverage Procedures
- Change in Covering Physician
- Termination/Resignation/Hires of Licensed Health Care Professionals (i.e., PAs or ARNPs)
- Corporate Name
- Tax ID Number
- NPI Numbers
- DEA Number
- Specialty Change
- Permit to Practice
- Open or closed status to enrollment
- Professional Liability Insurance Coverage
- Potential conflicts of interest
- Contract Status Change
- State, Federal or Regulatory Actions
- Other information that may affect the current contracting relationship

Closing your Practice

Providers are required to provide HealthSun Health Plan prior written notice of no less than sixty (60) days if you are closing your practice or wish to close your panel to new Members.

Upon termination as a participating provider, the records of the Members that had been under your care will be made available to the next physicians at no cost to that physician or to the member, and will be made available to HealthSun Health Plans upon request.

Continuing Medical Education

Physicians and Professionals who participate in HealthSun Health Plans Network of Providers are expected to maintain and exceed the requirements for Continuing Medical Education (CME) or (CUE) as defined by the Florida Medical Association, County Medical Associations, Board of Health, Department of Professional Regulation and other appropriate Boards.

Confidentiality Statement

All providers are required to have policies on confidentiality, information regarding the patient, their health status and care, the release of information or records, electronic and fax data. Authorizations are considered confidential and should be maintained appropriately in your offices. Your staff should have instructions on your Confidentiality Standards.

Covering Physicians

Physicians must arrange for coverage of their practice 24 hours a day, seven days per week 365 days a year. The covering physician must be a HealthSun Health Plan physician or credentialed by HealthSun Health Plans

Disabled Members and CMS Requirements

There are Federal laws to protect the rights of persons with disabilities such as the Americans with Disabilities Act ("ADA"), Rehabilitation Act, and other protections. HealthSun Health Plans requires providers to meet the standards that ensure your facility is accessible and usable by persons with disabilities.

Emergency Care and Services

The provider is responsible for establishing emergency procedures in the office when necessary including CPR and contacting 911 for transportation to the nearest Emergency Room. Emergency services are necessary to screen and stabilize assigned Members without precertification or emergency services in cases where a prudent layperson, acting reasonably would have believed that an emergency existed.

Emergencies are defined as a sudden onset of a condition that may result in the member's health being seriously jeopardized, causing impairment, or dysfunction of a bodily part or organ.

Medical Emergencies include but may not be limited to: severe chest pains, uncontrolled

bleeding, broken bones, sprains, burns, poisoning, convulsions, and extended fever. Members are instructed that if they believe they have a medical emergency, they should immediately call 911 and or go to the nearest Emergency Room for treatment. Members or the responsible party are requested to contact their Primary Care Physician within 48 hours of the ER visit for follow up. Emergency Services are not required to have a prior authorization and cannot be denied retrospectively for eligible Members.

Encounter Process

Providers should verify eligibility prior to providing care to HealthSun members. Eligibility must be verified by requesting a HealthSun membership card and confirming eligibility by calling the Provider Services Help Line listed below.

Upon request by Plan, CMS or Governmental Agency, Provider shall certify the accuracy, completeness and truthfulness of encounter data submitted to Plan.

All cost sharing be collected according to information on the Plan's benefit grids or as per the information provided when checking eligibility.

All Encounters must be recorded and submitted to Plan. Electronic format is preferred. If you are not currently submitting them electronically and would like to, please contact your assigned Provider Operations Representative.

Paper Encounters should be submitted on CMS 1500 forms and sent to the following address:

HEALTHSUN HEALTH PLANS
P.O. Box 211154
Eagan, MN 55121
Attention: Claims Department

Encounters may also be submitted electronically on a HIPAA accepted 837 file format and filed electronically. HealthSun has contracted with Gateway EDI and Availity EDI for Electronic Claim Submissions. The Payor ID Number for HealthSun is HESUN. There is no enrollment required to send claims electronically, but the pay ID number must always be placed on the claim. If you need assistance with getting set up to submit claims electronically, please contact your EDI provider Availity EDI Customer Service at 800-282-4548 or Trizetto EDICustomer Service at 800-556-2231 or your HEALTHSUN Provider Operations Representative at 305-448-8100.

Hours of Operations Meet Disability Requirements

Providers are required to ensure that their hours of operation are convenient to and do not discriminate against Members in the following manner:

- Access to care after normal business hours for urgent medical events that require attention after hours.
- The operating hours of the providers sites for the provision of care to Members who are not able to take off from work to receive their care (Medicare Working Aged).
- The hours of operation do not discriminate against Medicare Members relative to other Members.

Identifying/Verifying HealthSun Members

Providers shall verify that all HealthSun patients receiving treatment in your office are either on the PCP membership list or members of the Plan. Upon signing an enrollment application, HealthSun Health plan will send the member an Acknowledgement of Enrollment Letter, to acknowledge the request for enrollment. Once the enrollment request has been approved by CMS the member will receive an Enrollment Confirmation letter, which will be accompanied by the Member Welcome letter, which includes the Member Identification (ID) Card. The Evidence of Coverage (EOC) is provided to all of our Members at the time of enrollment. The EOC educates the patient on the following subjects:

The EOC educates the patient on the following subjects:

- 1) How to schedule an appointment;
- 2) What to do in case of an Emergency;
- 3) How to contact their PCP during and after business hours; and
- 4) How to access "out-of-area services".

Each Plan Member will be identified as follows:

Each Plan member will be identified by a HealthSun Member ID card which indicates assignment to a specific PCP and cost sharing guidelines. All HealthSun Plan Members are sent an ID card which will be presented at the time of each visit. When membership eligibility cannot be determined you may contact the Provider Services Help Line for "Eligibility Verification".

Please note that possession of a card does not constitute eligibility for coverage. If a HealthSun member is unable to present his/her membership card, please call the Provider Operations Help Line to determine eligibility or access the provider portal.

Verifying eligibility does not guarantee that the patient is in fact eligible at the time the services are rendered or that payment will be issued. We provide our members several options of health plans with an array of services, deductibles and cost sharing. Payments will be made for the specific covered services provided to eligible HealthSun members after satisfaction of applicable premiums and cost sharing.

Involuntary Disenrollment

Members may not be transferred or disenrolled for pre-existing medical conditions, change in health status or periodic missed appointments. HealthSun will follow the involuntary disenrollment process set forth by the Centers for Medicare & Medicaid Services. Providers who may have a member that has displayed disruptive behavior, must clearly document in the member records the incident(s) and submit them to HealthSun' Provider Operations Department. The documentation must include attempts to bring the member into compliance. A member's failure to comply with a written corrective action plan must be documented. The member must have at least one written warning regarding the implications of his/her actions. The Plan must issue approval in order for a member to be transferred out of a physician's practice. For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file be submitted along with this request.

Disenrollment may be involuntary under the following conditions:

- Loss of Medicare entitlement to Part A and/or Part B
- Fraudulent use of ID card
- Disruptive behavior
- The plan contract is terminated
- Member moves outside the service area or is away from the service area for more than six (6) consecutive months
- Member provides fraudulent information on an election form
- Member is no longer eligible for plan (e.g., SNP plans)
- Member fails to pay their Part D Income Related Monthly Adjustment Amount (IRMAA)

Language Support Services

HealthSun Health Plans will provide support services to Providers requiring assistance in communicating with members in languages that they are not proficient in.

Licensure

Providers are required to maintain their State of Florida license current and in good standing. In addition, they must provide documentation of compliance with CEU's as required by the state Insurance Coverage as outlined in their Provider Agreement and meet State, Federal, and HealthSun Health Plan Standards as required.

Member Listing

The PCP office will receive a monthly active member listing by the end of the first week of each month. The list consists of those HealthSun members who have chosen the PCP office to provide them with PCP services. Please verify that all HealthSun patients receiving treatment in your office are on your membership listing. If you do not receive your list by the date mentioned above, please contact your assigned Provider Service Executive. If there are any questions regarding a patient's eligibility, please contact HealthSun' Provider Operations Department at the number in the Key Contact List or access the provider portal.

Member Participation

Providers will allow Members the right to participate in their decision making regarding their health care. Health Sun Health Plan encourages all providers to provide active Member participation in their treatment planning and course of care. This includes the Member's right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with Federal and State Laws. All Members have the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law. Healthcare Providers must inform the member of their treatment options in a language the member understands.

Missed Appointments

Provider will follow up with the member when an appointment has been missed. If the patient does not go to the previously scheduled appointment without prior cancellation Provider must document within the medical records.

Non Discriminatory Notice

Providers will ensure that Members are not discriminated against in the delivery of healthcare services consistent with the benefits covered in their Policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Open/Close Panel

PCP Providers may close their panel to new and/or transferring HealthSun members with at least 45 days prior written notice to the Provider Operations Department. An asterisk (*) indicating a closed panel will be placed beside your name when the provider directory is updated. Written notification to the Provider Operations Department is required if you wish to accept a new member into a closed panel or to reopen your panel to new members.

Requests for openings and closing a panel should be submitted on your letterhead to the following:

Written Requests – HealthSun Health Plans, Inc.
3250 Mary Street Suite 400
Coconut Grove, Florida 33133
Attention: Provider Operations Department
E-Fax-1-305-489-8110
E-Mail - Provider Services@ HealthSun.com

OSHA and Infection Control

Providers must maintain an environmentally safe practice facility. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and tables, examination room, and equipment are in proper working order and comply with City, State, and Federal Regulations concerning safety and public hygiene.

Providers shall be responsible for establishing an exposure control plan in compliance with OSHA standards regarding Bloodborne Pathogens. In addition, provider will make all necessary provisions to minimize sources and transmissions of infection in the office. This will include good hand-washing, the use of gloves/universal precautions, cleaning of rooms and equipment prior to and between patients, and the safe use of needles and syringes and multi-dose injectables.

Providers are to comply with CDC hand hygiene protocols that include washing hands with soap and water or an alcohol-based gel prior to putting on gloves for patient contact and after the removal of the gloves. Hand hygiene with the use of soap and water or alcohol-based gel should be used after any patient contact. Hands should be washed with soap and water when any visible matter is present on the hands.

Protocols related to the safe use of syringe and needles are adopted from CDC/HICPAC and APIC nationally and require that each needle and syringe are used only 1 time for 1 patient. The use of multi-dose vials requires compliance with USP 797 regulations. Each multi-dose vial must be labeled with a date at the time of opening and discarded within 28 days of opening unless the manufacturer's expiration date is sooner. Each vial must be wiped

using friction for 6-8 seconds with an alcohol swap prior to entering with a new needle and syringe with each use. Vials may never be spiked.

Patient care areas (e.g. exam tables, counter tops, chairs) and equipment (e.g., BP cuffs, Glucometers, EKG leads) must be wiped down after each patient use with sanitizing wipes (e.g. Cavi-wipes or Clorox wipes).

Any patient determined to have presented to the office with a communicable disease should be isolated immediately, a mask applied, and the patient either discharged or transferred immediately if the disease is a reportable one. If the patient is a HealthSun member, Provider Operations should be notified immediately. Providers are also required to compliance with public health reporting requirements.

For provider offices who conduct minor removal of lumps and bumps, processes must be in place for either the disposal of equipment or the sterilization of equipment in autoclaves. Providers are expected to monitor the functionality of autoclaves and any failures in the sterilization processes to ensure against any injections, cross-contamination, and exposure.

Part D Prescriber Enrollment

As per Section 6405(c) of the Affordable Care Act any physician or other eligible professional who prescribes Part D drugs must either enroll in the Medicare program or opt out in order to prescribe drugs to their patients with Part D prescription drug benefit plans. Medicare Part D may no longer cover drugs that are prescribed by physicians or other eligible professionals who are neither validly enrolled, nor opted out of Medicare. All prescribers should enroll before January 1, 2019 to allow for the processing of applications and to ensure enrollees get their prescriptions. Patients presenting scripts written by prescribers who do not meet either one of these requirements will not be able to fill their prescriptions through their Part D plans.

As a provider of HealthSun Health Plans you are required to be enrolled in Medicare. In order to prescribe medications for the Part D patients, the new federal rule requires physicians, including psychiatrists and other prescribers of Part D drugs, to be enrolled in Medicare in an approved status, or to formally opt out of Medicare.

Provider Compliance and Quality Reviews

Provider will comply with quality reviews conducted by HealthSun Health Plans. The reviews are conducted to ensure that the provider is in compliance when addressing Member concerns and rights. Areas of review will include site audits, Medical Record Audits, analysis of complaints and grievances, Member Satisfaction Surveys, request for Provider changes, Rapid Disenrollment Survey, Safety and Infection Control and other measureable data.

Physician/Provider Information Changes

It is important that you keep HealthSun up to date on provider demographic and affiliation changes. This ensures that the correct reimbursement amount is sent to the correct entity and address and ensures that the directory information provided to our members is accurate.

All physicians/providers should contact the HealthSun Provider Operations Department to update information in their provider file. Changes that require notice to HealthSun may include, but are not limited to the following:

- An address change to an existing office location or billing address.
- Establishment of an additional office location.
- A telephone number or fax number change.
- NPI
- Adding a provider to the practice/group
- Provider Deletions – provider no longer participating in practice/group

In adding a provider, the new provider must first be credentialed before rendering any treatment to any plan member.

Provision of Care

All providers are required to provide services in a manner consistent with professionally recognized standards of care that are time specific and updated.

Safety Requirements

Providers are required to meet Safety Standards in accordance with the Occupational Safety and Health Administration (OSHA), ADA, and regulatory requirements. They are required to develop a written safety plan that includes fire and emergency activities. It should include the following:

- Medical Emergency Procedures;
- 911 Calling;
- Obtaining emergency equipment;
- Disaster Plan and Emergency Procedures for fire, flood and other natural disasters;
- Evacuation route to be posted and reviewed with personnel;
- Evacuation plan for able Member and handicapped Members, staff and visitors.

Upon termination as a participating provider, the records of the Members that had been under your care will be made available to the next physicians at no cost to that physician or to the member, and will be made available to HealthSun Health Plans upon request.

Safety drills such as fire, CPR, and weather should be held at least quarterly with staff and documented to include an evaluation of the drill. Other required safety protocols include the compliance with a sharps injury prevention program that requires the safe disposal of syringe and needles as follows:

- Disposal of intact needles and syringes into appropriate sharps containers
- Replacement of sharps containers when the fill line is reached
- Handling and disposal of filled sharps containers to a biohazardous waste contractor

Staff must be oriented on these protocols at the time of hire and annually thereafter in conjunction with the OSHA training.

Provider offices must ensure that any cleaning or hazardous materials or liquids are stored in a safe manner and that staff have received appropriate orientation related to their use and the need for the use of personal protective equipment.

Providers should ensure on-going monitoring of information related to the recall of medications and equipment maintained in offices. Should any items be subjected to recall, processes need to be implemented to notify staff, return the recalled item, contact any effected patients, and maintain a record of such activities.

PROVIDER RESPONSIBILITIES FOR HEALTHSUN BENEFICIARIES

Maintain Accurate and Complete Medical Record Documentation

1. Quality documentation leads to correct code specificity and accurate risk adjusted payment.
2. Includes main reason for episode of care, all co-existing, acute and chronic conditions, and pertinent past conditions that impact clinical evaluation and therapeutic treatment.
3. Document co-existing conditions during a face-to-face encounter at least once during reporting period.
4. Document fully the specified type of common conditions, if known. For example, specific type of anemia, pneumonia, depression, etc.

Report Claims and Encounter Data in a Timely Manner

1. Under the HCC/risk adjustment model, providers must submit the following elements to HealthSun:
 - ICD-10CM diagnosis code
 - Service from date
 - Service through date
 - HIC# of the member

Report ICD-10CM Diagnosis Codes to the Highest Level of Specificity and Report These Codes Accurately

1. Combination codes
 - Related conditions that can be expressed with one code. (e.g. Hypertensive heart or renal conditions)
 - "Code also" instructs when more than one code are needed. (e.g. Diabetic manifestations)
2. Digit specificity or coding to the fourth or fifth digit impacts risk adjustment payment. (e.g. MI and Diabetes)
3. Do not code:
 - Symptoms that is common to the main diagnosis
 - "History of" codes that are no longer pertinent to the current problem
 - "Rule out" codes of outpatient and physician visit

Alert HealthSun of Any Erroneous Data That Has Been Submitted and Correcting the Data in a Timely Manner.

Administrators Provider Portal

Administrators are an authorized representative of a provider's organization. They **are not required** to be the provider themselves. Administrators **must** execute all required documentation prior to access being granted by HealthSun Provider Operations. Administrators are allowed to add users to their group.

Participating Providers

Participating Provider registration is now made easy via the new online self-registration process.

1. Go to <https://provider.healthsun.com>
2. Click Register on the top right
3. Select New Administrator
4. Fill out the form.
5. Once the form is submitted, Provider Operations reviews and either approves or denies the application.
6. The provider will receive an email with their approval or denial.

Non-Participating Providers

Non-participating providers are **not** allowed to use the online self-registration.

1. Go to <https://www.healthsun.com>
2. Click Providers
3. Download the paper application
4. Fill it out and submit it via email or fax to Provider Operations department
5. Provider Operations will review and approve or deny the application
6. If approved, IT will create an account for the user if they are approved, and they will receive a welcome email.

Users

Users of the provider portal have limited access granted by the administrator. They do not have administration rights for their group and are only allowed to access the functions that their administrators have granted them. Users are created by their administrators, **not** by HealthSun.

To Create a User As an Administrator:

1. Sign in as an administrator
2. Go to administration -> Admin Panel
3. Click Add User
4. Fill out the form
5. Note the username and password created
6. Click modify permissions
7. Grant the user the permissions they should have
8. The user can now sign in

An alternative method is for the user to create their account themselves. Using an access code the administrator creates on the Groups page of the admin panel, they follow this procedure:

To Allow Users to Create Their Own Accounts:

1. Go to <https://provider.healthsun.com>
2. Click register on the top right
3. Select New User
4. Put in the access code they were given. Access codes, like passwords, are case sensitive and space sensitive.
5. Fill out the application. It is fairly self-explanatory.
6. Submit the application.
7. Users will **not** be able to log in until accepted by the administrator.

Then, the administrator will then need to accept the registration as part of user self-registration:

1. Sign into the portal as an administrator
2. Go to the admin panel
3. A new, deactivated user should now be in the user list.
4. Click activate
5. Click modify permissions once the page has reloaded
6. Grant the user the permissions the user requires

The user can now sign

SECTION 4
HEALTHSUN HEALTH PLANS PROVIDER
REQUIREMENTS AND
MEMBER BENEFITS

PHYSICIAN INITIATING MEMBER TRANSFER

Reasonable efforts should always be made to establish a satisfactory provider and member relationship. The provider should provide adequate documentation in the member's medical records to support his or her efforts to develop and maintain a satisfactory provider and member relationship. If a PCP wishes to transfer a member to another PCP, the PCP must prepare a Physician Initiated Request Member Form and forward it with supporting documentation to the HealthSun Provider Operations Department or their designated Provider Operations Representative. The PCP will be notified of HealthSun's decision. If the request is approved by the Plan, the member's care remains the responsibility of the PCP requesting the transfer until the change is effective. **PCPs may not, in any way, coerce a member to transfer.** Furthermore, a PCP may not seek or request to terminate their relationship with a member or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the Plan's member. Any primary care office that violates guidelines for transferring members to another office is given a 30-day, noncompliance written notification requiring immediate corrective action. No further written notice is necessary to terminate the participation agreement if the primary care office is found in violation of established policies and procedures and is, therefore, considered to be non-compliant. Members or their power of attorney/guardians have the right to file a formal grievance.

PROVIDER ID NUMBERS

Prior to enrollment of Medicare beneficiaries, HealthSun will supply unique provider ID numbers to each contracted provider. This 5-digit number is used by HealthSun to identify providers in all areas of interaction between the provider and HealthSun, including claims submission and payment.

Providers are reminded that these numbers should be made available to all appropriate office staff and billing services at the discretion of the provider. Additional important information about use of these numbers when submitting claims to HealthSun can be found in the "Claims Submission" section of this manual, under the topic "Provider Identification (ID) Number Requirements

MEDICAL RECORD STANDARDS

HealthSun has adopted the following standards for Medical Records. These are suggested standards for the content and structure, confidentiality and privacy of all medical records kept on HealthSun members. The standards are in compliance with state and federal requirements as established by the Florida Agency for Healthcare Administration (AHCA) and the Centers for Medicare and Medicaid Services (CMS).

Well-documented medical records are fundamental to maintaining and enhancing coordination and continuity of care, facilitating communication and promoting quality care. HealthSun requires all participating providers to maintain appropriate, accurate, complete and timely medical records for all HealthSun Members receiving medical services in a format required by Medicare laws, regulations, reporting requirements, CMS and plan instructions, as requested; and maintain records for a minimum of 10 years. Medical records **must be available** for utilization, risk management, peer review, studies, customer service inquiries, grievance and appeals processing, validation of risk adjustment data and other initiatives HealthSun may be required to conduct. To comply with accreditation and regulatory requirements, periodically HealthSun may perform a medical record documentation audit of some provider medical records.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

HealthSun reserves the right to review any member's medical record in accordance with these standards and HIPAA privacy regulations. This right is to assure that the Quality of Care and Quality of Service being delivered to our membership is well documented and medically appropriate.

Electronic medical records, like medical records, must be kept in unaltered form and authenticated by the creator. Under data protection legislation, responsibility for patient records (irrespective of the form they are kept in) is always on the healthcare provider. The physical medical records are the property of the medical provider (or facility) that prepares them. This includes films and tracings from diagnostic imaging procedures such as X-ray, CT, PET, MRI, ultrasound, etc. The patient, however, according to HIPAA, has a right to view the originals, and to obtain copies under law.

If a member changes his/her PCP for any reason, the provider must transfer the member's medical record to the member's new PCP at the request of the Plan or the member. If a provider terminates, the provider is responsible for transferring the members' medical records.

Medical Record Content and Structure Standards

Medical Record Content and Structure Standard 1:

All medical records must be complete and up to date. Each member record must identify and ensure recording of the following:

- The HealthSun member's name (or ID/chart number) and birth date. This information is to be recorded on each page of the member's medical record.

- Personal/biographical data including age, sex, address, employer, home and work telephone numbers, and marital status.
- Dates for all entries.
- Legible author identification. Author identification may be a handwritten signature, initials, stamped signature, or a unique electronic identifier.
- Prominent notation of medication allergies and adverse reactions. If the member has no known allergies or history of adverse reactions, this should be appropriately noted in the record (no known allergies = NKA).
- Past medical history must be easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Diagnostic information, consistent with findings, must be present and legibly recorded.
- Treatment plans, including medication information, be identified and legibly recorded.
- Significant illnesses, medical conditions and health maintenance concerns must be identified and legibly recorded.
- For members 12 years and over, notation concerning the use of cigarettes and alcohol use and substance abuse must be legibly recorded.
- Emergency Room discharge notes and hospital discharge summaries (hospital admissions which occur while the member is enrolled in HealthSun, and prior admissions, as necessary) must be legibly recorded.
- Evidence that preventive screening and assessment are offered in accordance with the HealthSun Preventive Health Services policies, procedures, and guidelines.
- Documentation of whether or not the individual has executed an advance directive. If the individual has executed an advance directive, the advance directive must be available in the record.

Medical Record Content and Structure Standard 2:

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- The history and physical expression of subjective and objective presenting complaints.
- Treatment plan / Plan of Care
- Laboratory and other diagnostic studies used.
- Therapies and prescribed regimens.

- Encounter forms or notes regarding follow up care, calls, or visits.
- Unresolved problems from previous visits.
- Consultation, lab, and imaging reports filed in the chart initialed by the PCP to signify review.

Medical Record Content and Structure Standard 3:

All medical records must be secured in a safe place.

Medical Record Content and Structure Standard 4:

All medical record entries must be neatly recorded, legible, complete, and concise, and written in black ink.

Medical Record Content and Structure Standard 5:

All records must be dated and recorded in a timely manner with the complete name and professional designation of the entrant.

Medical Record Content and Structure Standard 6:

No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.

Medical Record Content and Structure Standard 7:

All telephone messages and telephone consult discussions must be clearly identified and recorded.

Privacy and Confidentiality Standards

Medical Record Privacy and Confidentiality Standard 1:

All HealthSun members' individually-identifiable information whether contained in the member's medical records or otherwise is confidential. Such confidential information, whether oral or recorded in any format or medium, includes but is not limited to, a member's medical history, mental or physical condition, diagnosis, encounters, referrals, authorization, medication or treatment, which either identifies the member, or contains information which can be used to identify the member.

Medical Record Privacy and Confidentiality Standard 2:

In general, medical information regarding a HealthSun member must not be disclosed without obtaining written authorization. The authorization must come from the member, the member's guardian, or conservator. If the authorization is signed by the member, the member's medical record must not reflect mental incompetence. If the authorization is signed by a guardian or conservator, evidence such as a Power of Attorney, Court Order, etc., must be submitted to establish the authority to authorize the release of medical information.

Medical Records Privacy and Confidentiality Standard 3:

To release member medical information, a valid and completed Medical Information Disclosure Authorization Form, prepared in plain language, must be used.

The form must include the following items:

1. Name of the person or institution providing the member information.
2. Name of the person or institution authorized to receive and use the information.
3. The HealthSun member's full name, address, and date of birth.
4. Purpose or need for information and the proposed use thereof.
5. Description, extent or nature of information to be released that identifies the information in a specific and meaningful fashion, including inclusive dates of treatment.
6. Specific date or condition upon which the HealthSun member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation.
7. Date that the consent is signed, which must be later than the date of the information to be released.
8. Signature of the member or legal representative and his or her authority to act for the member.
9. HealthSun member's written acknowledgment that information used or disclosed to any recipient other than a health plan or provider may no longer be protected by law.
10. Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization.
11. A statement that the member may refuse to sign the authorization.

Medical Records Privacy and Confidentiality Standard 4:

Pursuant to laws that allow disclosure of confidential medical information in certain specific instances, such information may be released by HealthSun without prior authorization from the member, the member's guardian, or conservator for the following reasons:

- Diagnosis or treatment, including emergency situations.
- Payment or for determination of member eligibility for payment.
- Concurrent and retrospective review of services
- Claims management, claims audits, and billing and collection activities

- Adjudication or subrogation of claims
- Review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges
- Coordination of benefits
- Determination of coverage, including a pre-existing conditions investigations
- Risk management
- Quality assessment, measurement and improvement, including conducting satisfaction surveys of members
- Conducting case management and discharge planning
- Conducting preventive care programs
- Coordinating specialty care, such as Maternity Management
- Detection of health care fraud and abuse
- Developing clinical guidelines or protocols
- Reviewing the competency of health care providers and evaluating provider performance
- Preparing regulatory audits and regulatory reports
- Conducting training programs
- Auditing and compliance functions
- Resolution of grievances
- Provider contracting, certification, licensing and credentialing
- Due diligence
- Business management and general administration
- Health oversight agencies for audits, administrative or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions
- In response to court order, subpoena, warrant, summons, administrative request, or similar legal processes
- To comply with Florida law relating to workers' compensation;
- To County coroner, for death investigation;

- To public agencies, clinical investigators, healthcare researchers, and accredited non-profit educational or healthcare institutions for research, but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed;
- To organ procurement organizations or tissue banks, to aid member medical transplantation;
- To agencies authorized by law, such as the FDA;
- To State and Federal disaster relief organizations, but only basic disclosure information, such as member's name, city of residence, age, sex and general condition;
- To any chronic disease management programs provided member's treating physician authorizes the services and care.

Medical Records Privacy and Confidentiality Standard 5:

All individual HealthSun member records containing information pertaining to alcohol or drug abuse are subject to special protection under State and Federal Regulations (Confidentiality of Alcohol and Drug Abuse Member Records, Code 42 of Federal Regulation, chapter 1, Subchapter A. Part 2). An additional and specific consent form must be used prior to releasing any medical records that contain alcohol or drug abuse diagnosis.

Medical Records Privacy and Confidentiality Standard 6:

Special consent for release of information is needed for all members with HIV/AIDS and Mental Health disorders. In general, medical information for member's who exhibit HIV/AIDS and/or mental health disorders will always be reported in compliance with Florida state law. Additional information will be released regarding a member infected with the HIV virus only with an authorized consent.

Information released to authorized individuals/agencies shall be strictly limited to minimal information required to fulfill the purpose stated in the authorization. Any authorization specifying "any and all medical information" or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

Member Rights regarding their Protected Health Information (PHI)

All HealthSun Members have the right to request that HealthSun restrict the use and disclosure of their PHI for treatment payment; healthcare operations; or to a family member, other relative, or close personal friend. HealthSun does not have to agree with the restriction. If HealthSun agrees with the restriction, HealthSun may not use or disclose the members PHI in violation of the restriction, except in cases of emergency treatment or if the information is needed by HealthSun for internal operations. HealthSun may terminate its agreement to a restriction if the member agrees to such termination. In such cases, termination of the restriction is only effective for PHI HealthSun receives after HealthSun informs the member.

1. Members have the right to request communication of their PHI by alternative means or at alternative locations, if the member communicates to HealthSun that the disclosure of the PHI could endanger the member. The request must be in writing.
2. Members have the right to inspect and copy their PHI that is maintained in a designated record set (e.g., medical record). HealthSun is required to provide access within 30 days after receipt, in writing (60 days if the information is stored off-site). HealthSun is required to provide the information at a convenient time or place, or mail the information to the member. HealthSun may charge the member a reasonable fee to cover duplicating costs, including associated labor costs and postage. Members do not have the right to access psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. HealthSun may deny the member's request for access if a healthcare professional finds that it will endanger the member or another person.
3. Members have the right to request, in writing, an amendment to their PHI. HealthSun may deny the member's request if the PHI was not created by HealthSun or one or more of HealthSun contracted providers, or if the PHI is contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. HealthSun must act on the request for an amendment within 60 days (with up to a 30-day extension, if needed).
4. Members have the right to provide an authorization for other uses and disclosures of their PHI pursuant to specific written authorization signed by the member or the member's personal representative.

STANDARDS OF CARE

HealthSun is required to establish health care service accessibility and availability standards of care for all contracted providers in compliance with state and federal regulations. As a participating provider, the following standards are expected to be adhered to:

Accessibility, Availability and Service Standards

Standards: Provider Accessibility

Routine PCP appointments available within 14 calendar days.

Urgent Care appointments available within 24 hours.

Regular specialty referral appointments within 30 calendar days.

Wait time in the reception area not exceed 45 minutes

Standards: Provider Availability of Care and Treatment

Access to physician services 24 hours per day, 7 days per week.

Practice capacity not exceed: One (1) PCP; 3,000 patients and One (1) NP or PA: 1,000 patients.

Transport time to the primary care provider office not to exceed 30 minutes, except in rural areas where rural community standards apply.

Transport time to an acute care facility not to exceed 30 minutes, except in rural areas where rural community standards apply.

Transport time to commonly used services, including specialist services, not to exceed 30 minutes, except in rural areas where rural community standards apply.

Standards: Accessibility and Availability of HealthSun Services

HealthSun call answer times shall be within 30 seconds 95% of the time.

HealthSun call abandonment rates shall be less than 5%.

Translator services shall be made available for non-English speaking members.

Interpreter services and other accommodations shall be made available to the hearing impaired.

Standards: Availability of Basic HealthSun Services to Members

All HealthSun members are provided, **at a minimum**, the following services:

1. Pharmacy services
2. Ambulatory diagnostic and treatment services such as laboratory, radiology, physical therapy, and occupation therapy.
3. Coordination of inpatient care and services, with appropriate ancillary services for proper on-going evaluation and treatment.
4. Specialty referrals and coordination of care.
5. Health risk management for individuals who are at high risk for chronic disease based on their lifestyle behaviors.
6. Disease management and corresponding lifestyle management training for individuals with chronic diseases, particularly those who are diabetic, have CHF, major depression, and/or hypertension.
7. Access to skilled nursing facilities and tertiary services, when medically indicated.
8. Access to home health services, when medically indicated.
9. Health promotion/wellness services, including dietary counseling, smoking cessation education, and stress reduction counseling.

MEDICAL DIRECTOR ROLE

The HealthSun Medical Director is responsible for directing and overseeing the Medical Care Management Department. The Medical Director addresses medical necessity (referrals and authorizations), concurrent review, credentialing, pharmacy & therapeutics, and quality assessment and improvement. The Medical Director serves as the liaison between the health plan and the participating providers and other healthcare providers in the community. The Medical Director is not engaged in the practice of medicine while acting in the medical director's role of the health plan.

If a physician has a disagreement with a determination on a referral or pre-authorization request, they should initiate contact with the HealthSun Medical Director by calling the phone number shown on the "Contact Information" page in the introduction section of this Manual.

MEMBER BENEFITS

General Information

HealthSun Medicare members receive a document referred to as an Evidence of Coverage (EOC) and a Summary of Benefits which explains the Covered Benefits under the plan that they have chosen with HealthSun. The Evidence of Coverage defines the rights and responsibilities of the Member and HealthSun.

Members choose a PCP who provides and coordinates all care. HealthSun does not cover services that have not been provided or referred/authorized by the PCP except for emergencies and services exempt from PCP.

When applicable, members pay established cost sharing and/or deductible or coinsurance. There is no member cost sharing for influenza or pneumococ calvaccine; however, applicable cost sharing may apply for other services rendered at the same time. There are no pre-existing limitations for HealthSun.

Medical services identified as Covered Benefits in the HealthSun Evidence of Coverage or in the Summary of Benefits are covered if the service is:

- Required for a condition;
- Received from the member's PCP, referred by the member's PCP, or authorized by the member's PCP and HealthSun **except for Emergency Care and exempt services that allow direct access as described below.**
- Rendered while coverage under HealthSun is in force; and
- Not specifically limited or excluded under HealthSun.

Appointment Scheduling Criteria

To ensure accessibility and availability of health services to plan members, the following standards have been set forth by the Centers for Medicare & Medicaid Services (CMS):

- Urgent Care but non-emergent – within 24 hours. Urgent care should be provided for those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received or can substantially restrict a member's activity. Providers will be licensed to perform any urgent procedures in the State of Florida.
- Non-urgent, but in need of attention – within one (1) week.
- Routine and Preventive Care – within 30 days. Non-emergent complaints that do not restrict a member's activity or are chronic in nature.
- Provider agrees not to maintain hours that discriminate against Members accessibility to Provider.

MEDICARE COVERED BENEFITS

DIRECT ACCESS

The following services are covered and do not require a PCP referral. Members may directly access network providers for these services as well as providers required and as stated by statutory regulations.

Dermatology Services

Dermatology office visit does not require a referral from the PCP for the first five (5) visits per calendar year. Any other service does require a referral.

Chiropractic Services

Chiropractic services do not require a referral from the PCP. HealthSun members may directly access a HealthSun participating chiropractic physician. Chiropractic services up to 12 visits per calendar year are provided by HealthSun.

Hearing Services

Diagnostic hearing, balance evaluation and hearing aids do not require a referral from the PCP.

Podiatry Services

Up to one (1) supplemental routine podiatry visit(s) every three (3) months.

Flu Vaccine

HealthSun members may directly access a participating HealthSun provider for influenza vaccine, including pharmacies (contact Part D Services Department for listing of participating pharmacies providing influenza vaccines).

Behavioral/Mental Health

HealthSun members may directly access a HealthSun participating behavioral/mental health provider by calling our Behavioral and Mental Health Provider Concordia Behavioral Health at 1-855-541-5000.

Annual Well Woman Check-Up

HealthSun members may directly access a Healthsun participating gynecologist for a well woman check-up.

Emergency Services

Medicare defines an emergency medical condition as:

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

- (1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or unborn child.
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part."

Medicare defines emergency services as:

“Covered inpatient and outpatient services that are—

- (1) Furnished by a provider qualified to furnish emergency services and need to evaluate or stabilize an emergency medical condition.”

HealthSun covers Emergency Services. Members are encouraged, when possible, to contact and be seen by their PCP when they require medical care. If the PCP cannot see the member, the member should be directed by their PCP to a HealthSun network facility, or; when appropriate, to the nearest emergency facility. However, a member is not required to contact their PCP prior to receiving emergency services and an authorization is not required for emergency services, whether in or out of the service area.

Follow-up care must be coordinated, and, when applicable, authorized by the member's PCP.

If the Emergency services result in a hospital admission, the member should contact their PCP so that care will be coordinated. The treating physicians will decide when the member is discharged or when the member is stabilized for transfer to a network hospital.

Urgently Needed Services

Medicare defines urgently needed services as:

“Covered services provided when an enrollee is temporarily absent from the Medicare or Medicaid plan's service (or, if applicable continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization'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 services through the organization offering the Medicare plan.”

HealthSun covers urgently needed services. This usually occurs when the member is absent from the service area. The member should contact their PCP as soon as possible so that follow-up care can be coordinated.

Urgently needed services within the service area are provided or coordinated by the PCP. There may be extraordinary situations in which urgent care applies when the member is in the service area but the network is temporarily inaccessible due to an unusual event. Care that is not emergency or urgent care which is not coordinated by the PCP is non-covered and will be the member's financial responsibility.

PREVENTIVE CARE

Preventive care has the aim of preventing disease or its consequences. It includes programs aimed at warding off illnesses (e.g., immunizations), early detection of diseases and inhibiting further deterioration of the body.

HealthSun covers the following Preventive Services:

General Preventive Care and Screening Tests*

HealthSun covers and arranges for appropriate screenings such as:

- Abdominal aortic aneurysm screening
- Bone mass measurement
- Immunizations
- Mammography screening
- Pap test, pelvic exam, and clinical breast exams
- Glaucoma screening
- Colorectal screening
- Prostate cancer screening
- Cardiovascular disease testing
- Diabetes screening
- HIV Screening
- Preventive Physical Exam ("Welcome to Medicare" Physical Exam)
- Personalized Prevention Plan Services (Annual Wellness Visit)
- Comprehensive smoking cessation counseling services
- Screening and Behavioral Counseling Interventions for Primary Care to Reduce Alcohol Misuse
- Screening for Depression in Adults
- Periodic health assessments by the member's PCP
- Annual Flu Vaccine
- Pneumococcal Vaccine – usually, one per lifetime
- Hepatitis B Vaccine
- Colorectal Cancer Screening (Colonoscopy for very high risk members; annual Fecal Occult Blood Test – members age 50 and older;
- Flexible Sigmoidoscopy once every 4 years – members at high risk;
- Barium Enema can be substituted for sigmoidoscopy or colonoscopy

**Authorization rules may apply. Please contact HealthSun for additional details*

Women's Health

- Annual Screening Mammogram for female members
- Annual Pap smear and clinical breast and pelvic examination for female members.

Bone Mass Measurements

- Bone Mass Measurements – members at risk for bone mass loss.

Prostrate Screening

- For men with Medicare age 50 and older.

Self Monitoring, Training and Supplies for Diabetic Members

- Supplies for glucose monitors, test strips, lancets and self-management training must be obtained from HealthSun Providers
- Annual diabetic retinal eye exam
- Diabetes training and education
- One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). For members with diabetes who have severe diabetic foot disease coverage includes fitting.

COVERED SERVICES

Ambulance Services

Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Chiropractic and Podiatry Services

These services will be covered as follows:

Podiatry

- Treatment of injuries and diseases of the feet (such as a hammer toe or heel spurs);
- Routine foot care for members with certain medical conditions affecting the lower limb;
- Medically necessary foot care.

Chiropractic Services

- Will be covered only for manual manipulation of spine to correct subluxation that can be demonstrated by X-ray;
- Routine visits up to 12 visits per year at no charge.

Dental Services*

- Dental Benefits are described in the Summary of Benefits.
- Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

- Dental benefits under Restorative, Periodontics, Prosthodontics and Oral/Maxillofacial are subject to approval and enrollment in the plan for a minimum consecutive period of 90 days from the effective day of coverage under the health plan.

**Authorization rules may apply. Please contact HealthSun for additional details.*

Durable Medical Equipment (DME)

DME, such as oxygen equipment, wheelchairs and other Medically Necessary equipment, is covered when prescribed by a PCP or authorized physician (with a valid treatment authorization) for use in the home, provided the DME does not, in whole or part, serve as a comfort or convenience item for the member. DME must be authorized by HealthSun. *Authorization rules may apply.*

End- Stage Renal Disease

HealthSun covers dialysis services for members with ESRD either at home or at the facility. The venue for the dialysis will be determined by the provider for the member. HealthSun will also cover for renal dialysis when member is temporarily out- of -service area.

Hearing Services

Coverage for hearing service is described in the Summary of Benefits. Please refer members to the Provider Services Department for assistance.

Home Health Services

Home Health Services require Authorization.

Eligibility criteria require the Member to be (all must be met):

- Confined to the home;
- Under a plan of treatment established and periodically reviewed by a Physician; and
- In need of Intermittent Skilled Nursing Care, physical therapy, or, in certain circumstances, occupational therapy.
- Home Health Agency is a Provider and approved by the Medicare Program

Inpatient/Outpatient Hospital Services

Inpatient and outpatient hospital services are covered and must be authorized. Inpatient hospital services include all items and medically necessary services which provides appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. HealthSun shall be responsible for Part A inpatient care to members who at the time of disenrollment are under inpatient care until the time of his/her discharge. HealthSun shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. The hospital would have to bill either the member insurance carrier prior to HealthSun or Medicare directly.

Inpatient Psychiatric Service

These services will be covered for up to 190 days lifetime limit and will be provided in a Medicare-Certified facility. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when the members enroll in a Medicare Advantage Plan. Please contact Concordia Behavioral Health directly for authorizations.

Laboratory

Lab services are **ONLY** provided by Lab Corp.

Outpatient Rehabilitation Services

Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehab services, intensive cardiac rehab services, pulmonary rehab services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services. The plan will cover these services which are to be provided by licensed, independently practicing providers who are Medicare Certified.

Part B Prescription Drugs

There are drugs which are covered under Part B of Original Medicare. HealthSun Health Plans members receive coverage for the following drugs through our plan. Some limitations, restrictions, coinsurance and/or cost sharing may apply.

- Drugs which are usually not self-administered by the patient and are injected in a professional setting.
- Drugs taken using durable medical equipment (i.e., nebulizers) which were authorized by the plan.
- Clotting factors, administered through injections if member has hemophilia.
- Immunosuppressive drugs, if member was enrolled in Medicare Part A at time of organ transplant.
- Injectable osteoporosis drugs.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis.
- Intravenous Immune Globulin for the home treatment of primary immune diseases.

Part D Prescription Drugs

What is covered, what is not covered?

Covered: All plans are required to have formularies which address all medically necessary drugs. Drugs on Plan's Formulary are in Tiers. Tier 1= Preferred Generics, Tier 2= Generics, Tier 3= Preferred Brand, Tier 4= Non-Preferred Brands, Tier 5= Specialty Drugs and Tier 6= Enhanced Drugs. Six (6) drug classes of special concern have been specified in which all or substantially all drugs will be on a plan's formulary: anti-neoplastics, HIV/AIDS drugs, immunosuppressant, anti-psychotics, anti-depressants and anti-convulsants.

Not Covered: By law, there are certain types of drugs which Medicare must exclude from Part D: drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals and over-the-counter drugs. For your patients having both Medicare and Medicaid, check with Florida Medicaid program as most programs is c continuing to cover all or some of these excluded drugs.

Go to: www.cms.hhs.gov/States/EDC/list.asp#TopOfPage, to check which states cover the se excluded drugs.

*HealthSun covers some erectile dysfunction drugs. Please contact the Plan for details.

Prosthetic Devices and Related Supplies

HealthSun covers devices that replace body part or function. These include, but are not limited to colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses. *Authorization rules may apply for services. Contact HealthSun for details.*

Skilled Nursing Facility

Skilled Nursing Facility Care requires Authorization. Eligibility criteria (all must be met):

- The member requires and receives Skilled Nursing Care or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel;
- The member requires and receives Skilled Nursing Care on a daily basis;
- As a practical matter, considering economy and efficiency, the daily Skilled Nursing Care can be provided only on an inpatient basis in a Skilled Nursing Facility;
- The services must be furnished pursuant to a Physician order and must be Medically Necessary for the treatment of the individual's Condition, his or her particular medical needs, and accepted standards of medical practice; and

The services must be reasonable in terms of duration quality.

Vision Services

Vision services are described in the Summary of Benefits. Please refer member inquiries to HealthSun' Member Services Department.

Health and Wellness Education Programs

SilverSneakers®
Over the Counter Drugs and Supplies
Chronic Care Improvement Program

The goals of the HealthSun Chronic Care Improvement Program are to:

Reduce unnecessary disparities in the delivery of healthcare services to members with multiple chronic diseases through the adaptation and implementation of evidenced-based clinical treatment and practice guidelines;

Improve the health and quality of life of Medicare members with multiple chronic diseases/conditions through interventions that increase member's understanding of their chronic diseases/conditions, facilitate improved self- management, modify negative lifestyle behaviors, and improve interaction and communication between the member and their provider(s); and,

Measure and track the improvements yielded by the interventions through clinical and non-clinical outcome evaluations/projects based on reliable

The Chronic Care Improvement Program consists of an integrated system of assessments and interventions that seek to identify, assess, and address issues that compromise the efficient and effective delivery of healthcare services. The Program involves active participation from the member, the member's family, and healthcare providers. One of the central objectives of the program is to empower individual members with multiple chronic conditions to work collaboratively, in a partnership relationship, with primary care physicians, specialists, case managers, and their family members to modify lifestyle behaviors, and take control of their multiple chronic diseases and exhibit compliance with recommended treatment regimens.

Primary Care Providers are required to record in member's medical records all health/wellness and lifestyle management counseling and advice provided during office visits.

For more information about these services, please contact our Provider Operations Department.

Members must obtain a referral from their PCP and authorization from HealthSun for coverage of specialty physician care; exceptions are direct access exemptions, emergency care and, in some circumstances, urgently needed services.

Elective services provided by a specialist or non-contracting physician without advance approval from HealthSun or a referral from the member's PCP will be the member's financial responsibility.

PRESCRIPTION DRUG COVERAGE

Prescription drugs are covered as described in Drug Formularies Coverage for prescription drugs are provided through a pharmacy network which includes Preferred and Non-Preferred pharmacies. Prescription drugs are subject to cost sharing. Cost sharing may vary according to drug tier (such as generic, brand, non-formulary) and pharmacy network affiliation (Preferred vs. Non-Preferred).

Drug Formulary

Prescribers should refer to Drug Formularies when prescribing medication to a HealthSun member. Member will have lower drug costs if prescribed generics or allowed substitution of brand products. Some Benefit Plans offer no cost sharing for prescriptions, in certain Tiers, when a member uses a Preferred Pharmacy. For a copy of most current HealthSun Formularies or pharmacy directory, contact HealthSun's Provider Operations Department or Part D Services Department.

Generic Drug Policy

Brand name drugs, having generic equivalents, should be prescribed in generic form.

If member insists on a brand name product, which has a generic equivalent and is included in the drug formularies, member may have additional cost sharing as indicated in Member's Summary of Benefits.

For a Tier Exception, Medicare Part D Coverage Determination Form is to be used. A tiering exception should be requested to obtain a non-preferred drug at lower cost sharing terms applicable to drugs in a preferred tier. Form may be requested ~~from plan or~~ from Provider Operations Department or Part D Services Department.

Formulary Changes

HealthSun Health Plans can make changes to formularies within certain limits. Medicare drug plans may only change therapeutic categories and classes in formularies once each year, to be effective January 1st of following year.

Medicare drug plans typically may not remove drugs from their formularies at any time during the plan year. A few exceptions to this general rule exist. Part D drugs may be removed from formularies when:

- Food and Drug Administration (FDA) pronounces a Part D drug unsafe
- Manufacturer removes Part D drug from market
- Brand name drug loses patent and becomes available in generic form, brand name drug is removed and generic is added

Prior Authorizations, Quantity Limits, and Step Therapy

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** HealthSun Health Plans requires member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber to request a prior authorization for certain drugs prior to prescription being filled at a pharmacy. This means member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber will need to get approval from HealthSun Health Plans before filling prescriptions. If approval is not obtained, HealthSun Health Plans may not cover drug.
- **Quantity Limits:** For certain drugs, HealthSun Health Plans may limit quantity which will be covered.
- **Step Therapy:** In some cases, HealthSun Health Plans requires prescriber to have member first try certain formulary drugs to treat medical conditions before HealthSun Health Plans covers another formulary drug for the same condition. For example, if Drug A and Drug B both treat a medical condition, HealthSun Health Plans may not cover drug B unless Drug A is tried first. If Drug A does not work, HealthSun Health Plans will then cover Drug B.

Instructions for completing and submitting Exception Request forms

As a provider follow these steps when submitting an Exception Request form. Form may be requested from HealthSun Health Plans Part D Services Department or a proprietary form may be used as long as all required information is provided.

- Form may be completed and submitted by member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber on behalf of member. Prescribers may utilize their staff to submit requests, as long as it has been reviewed and signed by prescriber.
- Complete all required information on form. Incomplete or not properly completed forms will be returned to sender for corrections and resubmitting or additional information may be submitted verbally. Forms must be accompanied with a copy of prescription for medication being requested and progress notes which match diagnosis provided on form. Providers must submit to HealthSun Health Plans Part D Services Department required information within timeframes allowed by CMS, especially if a prescription has rejected at a pharmacy due to requiring an Exception Request or Prior Authorization.
- Scan and email completed forms and corresponding documents to: partdservices@HealthSun.com
- Fax completed form to e-fax 305-643-4323

- Mail completed forms and corresponding documents to:
HealthSun Health Plans
Part D Services Department
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
- For any questions, please call Part D Services Department at: 305-460-3901
- If request is denied and the prescriber disagrees with the plans decision, the prescriber or member/member representative can request a redetermination. All redeterminations can be submitted in any format or by using the redetermination form located on the Plans website. Please submit all request to the address or fax located below:

HealthSun Health Plans
Appeals Department
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Phone number: 305-447-4451
Fax number: 877-589-3526

Exceptions Process

There is a process for members to obtain a Part D drug which requires a Prior Authorization, Step - Therapy- have a Quantity Limitation or is not on HealthSun Health Plans' formularies. Members and Providers may request an exception under the following circumstances:

- Member is using a drug which was covered on HealthSun Health Plans formulary but has been removed during plan year for reasons other than safety;
- Member was prescribed a non-formulary drug which prescriber believes is medically necessary;
- Member is using a drug which was moved during plan year from preferred to non-preferred cost sharing tier;
- Member's prescriber prescribed a drug which is included in HealthSun Health Plans, more expensive cost sharing tier because prescriber believes the drug included in the less expensive cost sharing tier is medically ineffective for member;
- If member disagrees with amount which HealthSun Health Plans requires member to pay for a Part D prescription drug prescribed;
- If there is a requirement member try another drug before HealthSun Health Plans pays for drug prescribed, or if there is a limit on quantity (or dose) of the drug and prescriber disagrees with the requirement or dosage limitation

A "**grievance**" is a type of complaint which a member or provider makes if they have any problem with HealthSun Health Plans or a plan provider.

For more information on how to file a request for an exception, grievance, or appeal, please contact HealthSun Health Plans' Part D Services Department, Member Services or your Provider Operations Representative.

MEMBER IDENTIFICATION CARD

Member Identification (ID) Card

Members enrolled in HealthSun are issued a temporary member identification card to use until they receive their permanent member identification card. Members should present these ID cards when they are seeking services from HealthSun network providers. If the member does not have his/her Member card or enrollment form for new enrollees, the provider's office can call HealthSun Member Services Department to verify Member eligibility.

Remember that possession of a Temporary or Permanent ID card does not guarantee eligibility. Providers are encouraged to verify the effective date of benefit coverage as well as Member identity prior to rendering services to the Member. In order to avoid potential problems with identity theft or fraud, ask the member for a separate form of identification along with the member ID card, such as his/her driver's license or picture ID.

The Member ID Card contains the following information:

Member Name. The name that should be used for claims filing and preauthorization requests.

Member Number. The HealthSun member ID number of the member.

Effective Date. The initial date of eligibility.

PCP Name. Name of Primary Care Physician.

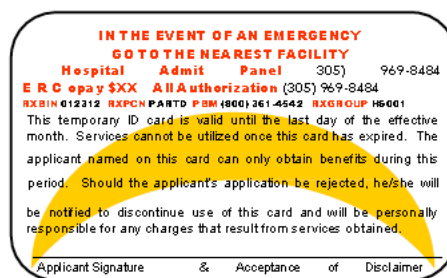
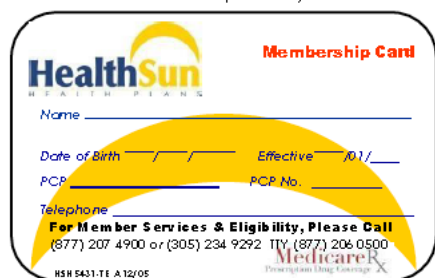
Rx Bin Number, Rx Group & Rx PCN

PBM Telephone

Member Services Telephone number

Emergency Room Co-Payment: Important notices to plan Members and Providers are indicated on the back of the card, as well as emergency phone numbers.

The Member Temporary ID card is shown below:



HEALTHSUN HEALTH PLANS COST SHARING

Members are responsible to pay applicable cost sharing at the time services are rendered. The cost sharing is collected by the provider's office; not collecting cost sharing will result in lost revenue to the provider.

Full payment for a provider's services consists of the HealthSun payment (capitation or fee for service) plus the member's cost sharing.

The PCP and specialist office cost sharing amounts are listed in the Summary of Benefits. Cost sharing amounts vary by benefit plan. Only one cost sharing should be collected at each service encounter.

Cost sharing amounts for Prescription Drugs also vary by benefit plan. If a member needs assistance with cost sharing they may contact the Plan, call the Part D Services Department to verify these cost sharing amounts.

Call the Provider Services Department to verify these cost sharing amounts. Examples of cost sharing that may apply are: Ambulance, Outpatient surgery (facility), Urgent Care, etc.

SECTION 5
PRE-AUTHORIZATION, REFERRALS
AND EMERGENCY SERVICES

PRE-AUTHORIZATION PROGRAM

Services Requiring Pre-Authorization

HealthSun defines "pre-authorization" as having received the Plan's agreement for a service to be delivered based on evaluation of medical necessity **prior to the time the service is rendered**. Services requiring pre-authorization or notification are required with respect to medical services rendered to HealthSun Members. To make these determination providers must review the preauthorization or notification list. The list will provide the medical services that require a preauthorization. Please note that Pre - Certification, Pre-Admission, Pre-Authorization and notification requirements all refer to the same process of preauthorization. Pre-Authorization or notification requirements for services may be obtained by contacting the Medical Management Department at 305-969-8484.

Physician Responsibilities for Admissions

It is ultimately the admitting physician's responsibility to obtain authorization for services specified in this section and to provide the necessary clinical and patient information to process authorization requests. Although any physician participating in an admission, either directly or through consultation, may supply pre-authorization information, ultimate accountability for this authorization falls to the physician requesting the elective admission.

Failure to obtain pre-authorization for the specified services will result in denial of payment for services rendered. Providers may not bill members for denied services.

A physician or designee should be prepared to provide clinical information regarding the requested admission (elective or emergency) when contacting the Health Plan's Pre - Authorization Department.

How to Obtain Pre-Authorization

Pre-certification requests are accepted from either a PCP or specialist. Elective services require authorization *before* delivery of the service or admission. The Medical Management Department must be contacted 48 hours prior to the elective admission.

Contact HealthSun for pre-certification by calling, e-mailing or faxing the Medical Management Department.

During the pre-authorization process the Medical Management Department will:

- Verify the current status of member eligibility and benefits;
- Verify what services will be performed, and if the services are to be performed by a participating, in-network provider;
- For inpatient admissions, determine if the admitting diagnosis, clinical information and treatment plan are presented;
- For inpatient admissions, review admission request against medical appropriateness criteria and health management guidelines; and
- For inpatient admissions, assign an estimated length of stay (ELOS).

Provision of pre-authorization by HealthSun for a specific service is not a guarantee of payment. Payment is subject to continuing member eligibility at the time the service is rendered.

Information Required for Pre-Authorization

- Member name, date of birth, HealthSun ID #
- Facility name to provide service
- Expected date of admission/procedure (if date changes, notify Health Plan)
- Diagnosis (or a clear statement of the problem)
- Procedure code number or description
- Pertinent clinical information (a clear, concise description of the work-up, pertinent lab, x-ray, or other test data, and any other pertinent information reasonably providing justification for the requested services)
- Expected length of stay
- Bed Type (In-Patient or Out-Patient)
- Anticipated discharge needs
- Treatment plan
- Other carrier information

We prefer the information be e-mailed to the Plan at: Utilization_Dept@HealthSun.com. The Pre-Authorization Form should include any and all pertinent clinical information. If faxing a Pre-Authorization Request to the Health Plan, complete the fax form and include any pertinent clinical information. The Pre-Auth Request Form should also be sent with your claim.

Elective Service Pre-Authorization Lead Time Requirements

For non-emergent elective admissions and procedures contact HealthSun at least two **(2)** working days before the planned service or admission. This will allow for enough time for the HSO staff to verify benefits and process the pre-certification request utilizing a pro-active approach in attempting to early identify potential care management needs of the member pre and post hospitalization and implement an interventional plan of care.

Failure to meet the lead times specified for elective admissions or procedures may result in HealthSun's inability to approve the procedure or admission for the original scheduled date. Late requests for authorization for elective services that do not meet the lead time requirements will not be given priority, will not be treated as emergencies, and will not be approved on a priority basis.

Emergency Admissions and Direct Admissions

It is the responsibility of the admitting facility and/or provider to contact HealthSun Medical Management Department within 24 hours or the next business day of any emergency or direct admission. When the hospital emergency department, PCP or Specialist office notifies HealthSun of an emergent hospital admission, the HSO staff will verify eligibility and determine benefit coverage. A determination to approve the admission or deny, based on clinical information, will be made in a timely manner (within two hours of notification).

If the admission is approved, an authorization number will be provided with the total number of days authorized. If the admission is not authorized, the member, requesting facility, attending provider and the PCP will be notified of the decision with the right to appeal.

Failure to contact HealthSun about an emergency or direct admission may result in delay of payment for services.

Concurrent Review of Inpatient Admissions

HealthSun will monitor the course of inpatient care services received by a member. A HealthSun Case Manager will conduct regular concurrent reviews of the hospital medical record either by on-site review at the hospital or by telephonic review to determine the authorization for continued length of stay. The facility will be notified regularly of the continued authorized length of stay. In the event additional continued stay is not authorized, the member, facility, attending provider, and the PCP will be notified by HealthSun.

The HealthSun Case Manager will review the medical information on regular intervals. If the Case Manager is onsite at the hospital they will also be responsible to work with the attending provider, the hospital case management/discharge staff, the patient and/or family, and the PCP to discuss any discharge planning needs. The Case Manager will verify that the member and/or family are aware of the member's PCPs name, address and telephone number and encourage him/her to make a post-hospitalization follow-up appointment with the PCP.

The Concurrent Review Nurse or Case Manager may also conduct any of the following:

- Review of member's chart;
- Communicate with the patient/guardian/parent;
- Discuss the case with the hospital UM staff; and/or
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and
- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the course of the review, the Concurrent Review Nurse or Case Manager determines, based on established guidelines, that the available documentation indicates the patient can be transitioned to a lower level of care, the attending physician will be contacted to discuss the justification of any continued services and possible alternatives. The Concurrent Review Nurse or Case Manager, in collaboration with the HealthSun Medical Director, may reduce the authorized level of services and notify the attending physician of same, and suggest appropriate alternatives to current services.

If the attending physician disagrees with the HealthSun determination regarding denial of continued services, he or she may request a further review by the HealthSun Medical Director (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "*Appeal Procedure for Adverse Determinations*").

Requesting Extensions to the Authorized Length of Stay

If, during the course of hospitalization or other services, the attending physician believes the approval for reimbursement of hospitalization or other services should be extended beyond what has been authorized, he or she must contact the HealthSun Medical Management Department to request an extension of the length of stay or other services.

Failure to obtain authorization for additional days of inpatient stay or other services may result in denial of payment for services.

EMERGENCY CARE NOTIFICATION

When reasonably possible, it is requested that a HealthSun Member contact their PCP for instruction prior to seeking Emergency care. In the event that such notification is not made, the Member should contact HealthSun and the PCP within 48 hours of receiving Emergency Care. If a member is seen in the emergency department and the PCP is notified, then it is the responsibility of the PCP to schedule a timely follow-up visit in his/her office.

CANCELLATION, TECHNICAL DENIALS, ADVERSE DETERMINATIONS AND CANCELLATIONS

All reasonable efforts will be made by HealthSun to obtain the necessary information from the provider and/or his/her designee required to make a timely decision related to requests for medical services. The provider and/or his/her designee may submit requests for services to the HealthSun Medical Management Department by phone, fax, or letter.

If additional information is needed in order to make a valid determination, the Medical Management Department will contact the requesting provider and indicate what additional information is required. The Medical Management Department will limit the request for additional information to only the information necessary to certify the admission, procedure, or treatment and length of stay. The request for additional information should be made as soon as possible, but in no event to exceed one working day from the receipt of the original request. The Medical Management Department will send at least two faxed letters to the provider requesting the additional information. If there is no response from the provider regarding the two faxed letters within two working days of the second faxed letter, the Medical Management Department will send a letter indicating the request has been canceled. The letter will state that processing of the request cannot be completed without the necessary information and therefore the referral has been canceled. The letter will also indicate that the processing of the request can be re-initiated once the necessary information has been received. A copy of the cancellation letter is also sent to the member. A call will be made to the requesting provider's office, informing them of the cancellation letter prior to it being sent. The cancellation process is not a denial.

Technical Denials

A technical denial is a denial of reimbursement for requested or provided services based on non-medical issues such as: member not eligible, non-covered services, benefit limits, failure to obtain pre-certification within the required time frame, and requests for out-of-plan services that are available in-plan. Technical denials are issued by the Medical Management Department. **The Healthsun Medical Management Department will notify via the US postal service. The Member will receive a notification called "Notice of Denial of Medical Coverage".**

The notification of a technical denial will include:

- the principal reason for the technical denial;
- a description or the source of any screening criteria that were utilized as guidelines in making the technical denial;
- a description of the procedure for the complaint process, including:
- notification to the member of the member's right to file a complaint related to a technical denial; and the member's right to contact the Florida Department of Financial Services Office of Insurance Regulation, including all-free telephone number and address.

Adverse Determinations (Denials Based On Lack of Medical Necessity)

Anytime HealthSun is questioning the medical necessity or appropriateness of health care services, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis with the HealthSun Medical Director.

Prior to the issuance of an adverse determination the requesting/ordering provider will be given the opportunity to discuss the plan of treatment for the patient and the clinical basis for HealthSun decision with the Medical Director. The Medical Director may call the provider directly or a Medical

Medical Management Department staff member may call the provider's office leaving information as to when the Medical Director will be available to discuss the potential adverse determination, as well as the telephone number for contacting the Medical Director. If the case results in an adverse determination, all requirements related to an adverse determination will be followed.

HealthSun will notify the member or a person acting on behalf of the member and the member's provider of record of an adverse determination made during the course of utilization review activities.

The notification of an adverse determination will include:

- the principal reason(s) for the adverse determination;
- the clinical basis for the adverse determination;
- a description or the source of the screening criteria that were utilized as guidelines in making the determination; and
- a description of the procedure for the complaint and appeal process, including:
 1. notification to the member of the member's right to appeal an adverse determination to an independent review organization;
 2. notification to the member of the procedures for appealing an adverse determination to an independent review organization;
 3. notification to a member that has a life -threatening condition of the member's right to an immediate review by an independent review organization and the procedures to obtain that review; and
 4. the member's right to contact the Florida Department of Financial Services Office of Insurance Regulation, including toll-free telephone number and address.

HealthSun will provide the notification of the adverse determination:

- Within one working day by telephone or electronic transmission to the provider of record. In the case of a patient who is hospitalized at the time of the adverse determination, to be followed by a letter notifying the provider of record of an adverse determination within three working days;

- Within three working days in writing to the provider of record and the member.
- Within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider.

VERIFICATION

Verification is a guarantee of payment for health care or medical care services if the services are rendered within the required timeframe to the patient for whom the services are proposed. Verification may include a preauthorization.

A request for verification must contain the following information:

- Member name
- Member ID number
- Member address
- Member date of birth
- Initial diagnosis
- Procedure code
- Name and address of hospital or facility, if applicable
- Proposed date of service
- Name of provider providing the proposed services
- Provider's federal tax ID number
- Place of service

The Provider may request verification via telephone, in writing, or any other means agreed to by the Provider and HealthSun. HealthSun shall respond to requests for verification within the following time periods:

- Verification requests regarding concurrent hospitalizations, HealthSun must respond without delay, within 24 hours after receipt of the request.
- Verification requested for post-stabilization care and life threatening conditions, HealthSun must respond without delay, but not later than one hour after receipt of the request.
- All other verification requests are responded to within 30 days.

HealthSun may make a request for additional information. The request for additional information must be made within one (1) day of receipt of the verification request.

A verification or declination may be delivered via telephone call or in writing. If the verification or declination is delivered via telephone call, HealthSun will, within three (3) calendar days of providing a verbal response, provide a written response which must include, at a minimum, the following:

- Member name
- Member ID number
- Requesting provider's name
- Hospital or other facility name
- A specific description, including relevant procedure codes, of the services that are verified or declined. If the services are verified, the effective period for the verification, shall not be less than 30 days from the date of verification
- If the services are verified, any applicable deductibles, cost sharing, or coinsurance for which the member is responsible.
- If the verification is declined, the specific reason for the declination

- If the request involved services for which the preauthorization is required, a decision as to whether the proposed services are medically necessary and appropriate
- Statement that the proposed services are being verified or declined

Verification confirmation is good for a period of 30 days

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SECTION 6
QUALITY/UTILIZATION MANAGEMENT
PROGRAM

QUALITY/UTILIZATION MANAGEMENT PROGRAM

QUALITY MANAGEMENT IMPROVEMENT PROGRAM (QM)

Upon request, HealthSun will make available to providers information about its quality improvement program. HealthSun Health Plans is required to maintain a health information system that collects, integrates, analyzes and reports data necessary to implement our program as required by CMS. Quality Management Activities are analyzed by the plan these activities include:

- Medical Records Review – Conducted to meet requirements of accrediting agencies and federal and state law requirements. Annually, HealthSun Health Plans may review a sample of records. HealthSun does not review all records and is not responsible for assuring the adequacy or completeness of records.
- HEDIS® - Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of performance measures that are reviewed by the plan and reported on an annual basis.
- CAHPS – Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey that includes several measures that reflect member satisfaction with the care and service provided by the physician. All providers are encouraged to have HealthSun Health Plan Members respond to the survey which is conducted annually.
- Risk Management Occurrences and Adverse Events – Unexpected occurrences and adverse events involving members are to be reported to the Quality/Utilization Management by providers, nurses and case managers. Cases are reviewed in accordance to the HealthSun Health Plan Quality Management process and as required by law and accrediting agencies.
- CMS Quality Improvement Organizations – HealthSun Health Plan is overseen by the QIO and the QIO collaborates with the plan for Quality Improvement activities.
- Analysis of Member Complaints – Member Complaints and grievances pertaining to a quality of care concern may be referred to Quality Management for review.

The Quality Management Department shall also initiate Quality Assessment and Performance Improvement (QAPI) Projects that will address those areas that have been identified as healthcare priorities for Medicare Beneficiaries.

UTILIZATION MANAGEMENT PROGRAM (UM)

The HealthSun Health Plan Utilization Management (UM) Program is designed to actively manage and oversee the utilization of healthcare resources while maintaining a high quality of patient care. The program identifies, documents and reviews all utilization issues; initiating and implementing improvement plans, as indicated, to ensure the delivery of medically necessary, appropriate cost-effective, quality healthcare.

Pre-Admission Review

- Verify member eligibility and benefits for specific service.
- Evaluate the medical necessity and appropriateness of services.
- If the admission is approved, authorization is given and concurrent reviews are conducted by plan to assure the need for continued hospital stay.
- If the admission does not meet criteria or the Plan is not able to obtain information, no authorization is given. Should the physician decide to proceed with the admission

a medical review will be conducted on the next working day. If criteria are not met, the admitting physician will be contacted to obtain further clarification. The Medical Director will be advised of the case and will make a determination. The facility and physician will be advised of the determination. If denied, the facility will have the option of submitting the claim with a copy of the medical record for appeal. Additionally, if the Plan is not notified of the admission until after the patient is discharged, the medical records must be submitted for review of coverage determination and payment.

Elective Admissions

- PCP and/or Specialist will identify the need to admit the patient.
- PCP will notify HealthSun Health Plans Pre-cert Department of his/her intent to admit at least 5 days prior to the scheduled admission and will complete a pre-certification request form and send pertinent medical records. Request form will be process after received via fax or via SHMS referral.
- Pre-certification Staff will verify eligibility and determine benefit coverage.
- When the case meets criteria the request will be approved and the Precert Staff will issue an authorization number and notify the hospital.
- When the criteria are not met, the case will be referred to HealthSun Health Plans' Medical Director.
- If the Medical Director approves the request the Precert Staff will issue an authorization number and notify the hospital.
- Concurrent Review will be conducted by Plan's Utilization Review Staff.
- When the Medical Director determines that the Provider's documentation does not meet the established criteria for inpatient admission, the requesting physician will be notified according to CMS regulations.
- A denial letter with the appeal information will be generated and sent to the Physician, Hospital and member.

Reviews

On site reviews will be conducted by the Plan's utilization review department.

Admission to Non-Participating Hospitals

No notification is required by CMS or the Plan for emergent admission. Health plans are required to pay for emergent services. Continue stay will be subject to concurrent review guidelines.

HealthSun Health Plan will contact the PCP and ER Physician to facilitate the patient's transfer only when the patient can safely be transferred to a participating facility.

Concurrent Reviews

- A case manager will perform concurrent review either on site or by telephone.
- Authorizations given for particular treatment/procedures are for those treatment/procedures only. Any additional procedures that are determined to be medically necessary need to be authorized by the Plan. For example: if Plan

authorizes chemotherapy plan of thirty (30) days, and the provider decides to perform a CT scan or MRI to determine the patients response, authorization must be obtained prior to rendering these additional services.

Procedures

- If the admission is at a facility not visited by on-site reviewers, the hospital UR Department will be contacted to request pertinent information.
- If adequate information cannot be obtained through the on-site medical record review or after the Hospital's UR department review, the admitting physician will be contacted.
- When the admission meets criteria, continued stay authorization will be given and a subsequent review date will be set. If at any time a potential quality issue is identified through the review process, an appropriate referral will be made to HealthSun Health Plans Quality Management Department.
- When the admission or continued hospital stay does not meet guidelines, the Case Manager will contact the attending physician for additional information.

The attending physician will be contacted if:

1. Guidelines are not met and review is performed before the patient is hospitalized for 24 hours.
2. Guidelines are not met and the patient is hospitalized for more than 24 hours.
3. Special Unit appropriateness is not met.
4. Appropriateness for clinical support services is not met.
5. The Medical Record lacks sufficient information to make a decision.
6. Physician consultations, laboratory or radiology tests are not performed within one day of a specified request.
7. The patient is admitted more than 24 hours pre-operatively in the absence of medical necessity
8. The elective surgical procedure planned is on the same-day surgery list and there is no documentation of the clinical rationale for the patient to be admitted to the hospital to have the procedure performed.
9. A treatment and/or discharge plan is needed for the purpose of effective discharge planning and/or case management.
10. If the attending physician provides additional information so that guidelines are met, the Case Manager will approve the request at the time of the review and assign the next review date.

11. If after review of the case, the request for continued stay is denied, the Case Manager will notify the attending physician of the decision and the appeals process. If the attending physician does not wish to appeal, the "Denial Letter" will be issued. If the attending physician wishes to appeal, the Case Manager will facilitate a telephone conference with the attending physician and HealthSun Health Plan.

Discharge Planning:

The objectives of discharge planning are to coordinate hospital discharge to facilitate continuity of care, care plan development and individual case management. All hospitalized HealthSun members will be reviewed by a Case Manager within 24 hours of admission notification.

Procedure

- The Case Manager will review hospital medical records to determine discharge planning needs during initial review of the concurrent review process.
- The patient's psychosocial, and medical history, current treatment plan, and prognosis will be assessed to determine the need for post discharge care, including Home Health Care, DME, Rehabilitative Services, short or long term placement in a Skilled Nursing Facility.
- The Attending Physician will be contacted to formulate discharge plan and post discharge healthcare service needs will be continually assessed and re-evaluated throughout concurrent review of hospital stay. The PCP will be notified of the admission and discharge of the member from the hospital or any healthcare facility.
- The Case Manager will also arrange and authorize post discharge ancillary services (HHC, DME) to have visits scheduled and equipment delivered prior to the member's discharge and coordinate with the ancillary provider to assure member and family receive education and training about post discharge care at home.
- Any post discharge follow-up appointment and transportation will be coordinated with the cooperation of the PCP office.
- Once the process is completed, copies of the authorization for discharge services will be auto-faxed to the PCP.

Denial of Inpatient Length of Stay Extension:

Case Managers will refer all decisions to deny length of stay extensions to the HealthSun Medical Director. The Case Manager will attempt to reach an agreement with the attending provider regarding appropriate course of action for member's Length of Stay (LOS) extension.

If the attending provider agrees the review will be continued as needed. If attending physician disagrees, the case will be discussed with the Medical Director. The Medical

Director will contact the attending provider for clarification of any questions necessary for making LOS denial determination and inform Case Manager of the decision to deny LOS extension.

The Case Manager will immediately notify the attending Provider (or member of the Provider's office staff), member, and hospital by telephone of the denial determination at least 48 hours prior to discharge, explaining the right to appeal and the appeal process and forward written notice of the denial determination to the attending provider and PCP (if not the attending provider, detailing the provider's and member's right to appeal and the appropriate procedure to follow. A written notice of denial determination will be delivered to the member in person or via mail if the member is out-of-area/out-of-network and a written confirmation of denial determination will be sent to the hospital and PCP.

Chronic Care Improvement Program

The UM program is responsible for identifying the needs of its members with regard to the potential value of a member with any chronic disease in benefiting from participation in the HealthSun Chronic Care Improvement Program.

Medical Management Activities and Provider Advocacy

HealthSun Medical Management Department activities are designed so that they do not provide incentives, financial or otherwise, for the denial, limitation, or discontinuation of authorized services by HealthSun staff or network providers. Furthermore, HealthSun does not prohibit network providers from advocating on behalf of members within the Medical Management process, and does not prohibit network providers from advising or advocating on behalf of a patient. Without interference from HealthSun, providers may give information to their patients about:

- Their health status, medical care or treatment options (including alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The opportunity for the member to refuse treatment and to express preferences about future treatment decisions.

The Medical Director, Medical Management Department, Quality Management Department, Quality Management Steering Committee, and Board of Directors are responsible for oversight and implementation of the HealthSun Medical Care Management program. Through their ongoing review and approval of Medical Management Department Policies and Procedures, any possible policy or procedure that could provide inappropriate incentive or interfere with a provider's ability to advocate on behalf of a member will be immediately addressed and rectified.

The Quality Management Steering Committee will monitor provider complaints in order to identify any potential patterns that indicate inappropriate incentives or interference with a provider's role as patient advocate. Members are apprised of this policy via the HealthSun Evidence of Coverage.

SECTION 7
MEMBER RIGHTS AND
RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

Members Initiating PCP Transfer

In order to maintain continuity of care, HealthSun encourages its members to remain with their PCP. However, a member or power of attorney/guardian may request to change the PCP by contacting HealthSun' Member Services Department or submitting a written request.

The effective date of the change will be the first day of the following month. Special circumstances may provide for a mid-month PCP change. The current process for handling retroactive PCP change requests does not include an outbound call to either the new or former PCP's office.

The primary care office must send his/her medical records to the newly selected primary care office. If they do not agree with the transfer, refer to the "Involuntary Disenrollments" for additional information.

Member Disenrollment Procedure

A member may only disenroll from HealthSun during a valid election period. Some members may have special circumstances. For disenrollment procedures, please refer members to the Member Services Department for assistance. HealthSun is committed to providing quality health care coverage at a reasonable cost while maintaining the dignity and integrity of our Members. Consistent with our commitment and with the recognition that Contracting Providers are independent contractors and not the agents of HealthSun; the following statement of Members' Rights and Responsibilities has been adopted. Healthsun ask that any written disenrollment letter received, be treated with the highest importance and immediately submitted to the Enrollments Department.

Member Rights

Providers are required to post the member rights and responsibilities document in the waiting area of your offices. The rights and responsibilities are as follows:

As a member, you or your representative has the right:

1. To be provided with information about HealthSun, its benefits and the choice of independent Contracting Providers providing care.
2. To access medical care and treatment from providers who have met the credentialing standards of HealthSun.
3. To expect health care providers who participate with Physicians to:
 - a. Discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
 - b. Permit you to participate in the major decisions about your health care and treatment options, consistent with legal, ethical, and relevant patient-provider relationship requirements.

4. To expect health care providers who participate with HealthSun to provide treatment, and relevant information about your treatment, with courtesy, respect, and concern for your dignity and privacy regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age religion, or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care.
5. To appeal unfavorable medical or administrative decisions by following the established appeals process or grievance procedures found in this Agreement or other procedures adopted by HealthSun for such purposes.
6. To inform health care providers who participate with HealthSun that you refuse treatment, and to expect to have such providers honor your decision, if you chose to accept the responsibility and the consequences of such decisions.
 - a. Complete an Advance Directive, living will or other directive and provide it to your Contracting Medical Providers.
7. To access your medical records, any information that pertains to them, and to have confidentiality of these records maintained, in accordance with applicable law and HealthSun rules. Written permission from you or your authorized representative shall be obtained before medical records can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.
8. As a Member, you have the right to request information on the following:
 - a. General coverage and comparative plan information
 - b. Utilization control procedures
 - b. Statistical data on Grievances and Appeals
 - d. The financial condition of HealthSun
 - c. e. Quality Assurance Program
 - d. f. Summary of Provider compensation arrangements that can affect the use of referrals and other services that you might need
9. To receive Emergency Services when you, as a prudent layperson, acting reasonable would have believed that an Emergency Medical Condition existed and payment will not be withheld in cases where you are seen for Emergency Services.
10. To receive urgently needed services when traveling outside the Plan's service area or in the Plan's service area when unusual or extenuating circumstances prevent you from obtaining care from your Primary Care Physician.

Responsibilities As a member, you or your representative has the responsibility:

1. To seek all non-emergency care through your assigned Primary Care Physician (PCP), to obtain a referral from your PCP for specialist care, and to cooperate with all persons providing your care and treatment.
2. To be respectful of the rights, property, comfort, environment, and privacy of other patients and not be disruptive.
3. To be responsible for understanding and following instructions concerning your treatment and to ask questions if you do not understand or need an explanation.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To be financially responsible for any Cost sharing and to provide current information concerning your HealthSun Membership status to any HealthSun affiliated provider.
6. To follow established procedures for filing an appeal or grievance concerning medical or administrative decisions that you feel are in error.
7. To request your medical records in accordance with HealthSun rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in your Member Handbook, or Evidence of Coverage.

SUMMARY OF THE FLORIDA PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Florida Law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the part of the patient. All providers are required to post this summary in their offices. You may request a copy of the full text of this law from your healthcare provider or healthcare facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.
- A patient has the right to know what rules and regulations apply to his conduct.
- A patient has the right to be given, by his healthcare provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- A patient has the right to confidential handling of medical records and, except when required by law, patients are given the opportunity to approve or refuse their release.
- A patient has the right to express grievances regarding any violation of his rights, as stated in Florida Law, through the grievance procedure of the healthcare provider or healthcare facility which served him and to the appropriate state licensing agency.
- A patient is responsible for providing to his healthcare provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to his health.
- A patient is responsible for reporting unexpected changes in his condition to his healthcare provider.
- A patient is responsible for reporting to his healthcare provider whether he comprehends a contemplated course of action and what is expected of him.

- A patient is responsible for following the treatment plan recommended by his healthcare provider.
- A patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- A patient is responsible for his actions if he refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

SECTION 8

CLAIMS AND ENCOUNTERS

FILING A CLAIM

General Claims Information

A major goal of HealthSun is to provide prompt processing of claims. We follow prompt payment laws currently and from time to time implemented and modified by The Centers for Medicare and Medicaid Services. Clean claims, as currently defined by law, are to be processed within 30 days of date received.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the Contractor's Medicare operation on a prepayment basis.

Invalid or incomplete electronic claims will be returned as unprocessable. Notification of rejection is provided by the Clearinghouse.

Resubmission of rejected claims is subject to timely filing requirements.

Clean Claim Definition

To meet the HealthSun definition of a "clean claim" a claim must:

- Complete all required fields with accurate and valid information on a CMS 1500; or UB-04 or as required for electronic submission in accordance to the Medicare claims processing manual.
- Include any additional data elements (i.e. copy of the Referral Form, Pre-Certification Form, medical documentation) required by HealthSun as specified in this manual or other official notices from HealthSun issued from time to time only for paper claims.
- Include any primary payer's Explanation of Payment (EOP) or payment voucher showing the amount paid by the third party if the member is covered by another insurance or HMO carrier other than HealthSun.
- Indicate services which are provided consistent with any referrals or authorizations necessary as directed by HealthSun.
- The claim must not involve an investigation for coordination of benefits (COB), or member eligibility
- Be filed in a timely fashion in accordance with the provider contract;
- Provider must maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to payment for service. HEALTHSUN reserves the right to review the original signed assignment document at any time.
- Separate charges must be itemized on separate lines. Medical records documentation must validate the scope of services provided and billed.

*** An “unclean claim” is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider. If you submit incomplete or inaccurate information, we may reject the claim, delay processing or make a payment determination (e.g., denial, reduced payment) that may be adjusted later when complete information is obtained.***

Provider acknowledges and agrees that no reimbursement is due for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. Furthermore, provider acknowledges and agrees that at no time shall members be responsible for any payments to provider except for applicable copayments, coinsurance, deductibles, and non-covered services provided to such members. Notification that a service is not a covered benefit must be provided to the Member prior to the service and be consistent with HealthSun policy, in order for the Member to be held financially responsible. HealthSun policy requires that the notification include the date and description of the service, name and signature of the Member, name and signature of the Provider, and be in at least 12 point font. Documentation of that pre-service notification shall be provided to HealthSun or its designee upon request, and including timely to substantiate Member appeals. In addition, consistent with current Medicare policy for non-covered services, HealthSun will not issue payment for a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure but on the wrong patient. HealthSun will also not cover hospitalizations and other services related to these non-covered procedures.

Overpayments include, but are not limited to, situations in which a Provider has been overpaid by HealthSun due to an error in processing, incorrectly submitted claims, an incorrect determination that the services were Covered, a determination that the Covered Individual was not eligible for services at the time services were rendered or another entity is primarily responsible for payment of the claim. In the event of an overpayment, HealthSun will notify the Provider of the refund amount due in writing via mail. The Provider is responsible for immediately refunding to HealthSun the overpayment amount according to the instructions stated in the written notification. If a refund is not issued, HealthSun may recoup the monies due from any future payments.

Claims must be submitted to the correct address. For information on where to send your claims, please refer to the “Key Contact List” at the beginning of this manual. The member's HealthSun ID card will also list the claims address. **Submitting claims to the incorrect address will result in delay of processing.** All claims for payment, whether electronic or non-electronic must be submitted within the timeframe stipulated in the HealthSun agreement.

If notice of payment or denial of submitted claims is not received within forty (40) days, please contact the HealthSun Claims Status Telephone Queue or your assigned PRR. The HealthSun Claims Status Telephone Queue is dedicated to answering inquiries related to billing, status and payment of claims. To ensure short wait times the HealthSun Claims

representatives will review three (3) accounts per inquiry. The hours of operation are Monday through Friday between 8:00 am and 5:30 pm. See Portal Access Section page 36 to register for Claims Review.

Providers are encouraged to submit claims and/or encounters electronically. If you are not currently submitting electronically, contact your PRR or the Provider Service Help Line at (305) 447-4459 OR (877) 999-7776.

Optical Character Recognition (OCR)

HealthSun utilizes optical character recognition of paper claims to improve the accuracy and efficiency of processing the claims. Providers are encouraged to file claims that meet the elements required to enable scanning. Failure to do so results in delays in claims processing.

Do's and Don'ts pertaining to the quality of paper claims submission.

Paper Claim Submission Do's	Don'ts
Use original claim forms	Don't - Submit a copy of the original Form. Do print a new claim on an original claim form.
Use black ink for data entered on the claim form	Don't - Use red ink - this ink color cannot be "read" by the OCR system
Print/type data on claims	Don't - Use mixed fonts on the same form
Make sure data prints within the defined Boxes on the claim form.	Don't- Use dashes or slashes in date Fields. Do use the eight-digit date format (mmddyy)
Select a standard font with clear Characters. Times Roman font works well	Don't - Use italics or script fonts
Ensure print on claim/attachment is dark, clear, and legible. Photocopies and faxed copies with small print are often blurry and unreadable. Do circle information on attachments to identify critical criteria.	Don't - Highlight information on the claim-highlighting is not visible to the OCR system.
Use all capital letters	Don't - use correction fluid
Use a laser printer for best results. Characters printed by dot matrix or impact printer may be difficult to "read" by OCR	Don't - Use proportional fonts (Courier is a good example of a font that is not proportional)
Use white correction tape for corrections	Don't - Put notes on the top or bottom of the claim form
Submit notes on 8 "x 11" paper	
Use a six-digit date format (010210)	Don't Submit more than six lines on the CMS 1500 claim form

Paper Claim Submission Do's	Don'ts
Replace printer toner often	Don't print slashes over the zeroes
	Don't submit handwritten forms

ELECTRONIC CLAIMS SUBMISSION

Advantages to Electronic Claim Filing

HealthSun encourages filing claims electronically. Benefits of filing via electronic media include:

- Decrease in turnaround time for payment
- Streamlines the billing process
- Reduction in Costs for Filing (i.e. postage costs, forms cost, printing costs, labor);
- Confirmation of Receipt;
- Prompt Identification of omitted/incorrect information;
- Ability for Provider to quickly track number of rejected versus accepted claims.

Claims Clearinghouse:

HealthSun has contracted with Trizzetto and Availity EDI for Electronic Claim Submissions (EDI). The Payor ID Number for HealthSun is HESUN. There is no enrollment required to send claims electronically, but the pay ID number (HESUN) must always be placed on the claim. If you need assistance with getting set up to submit claims electronically, please contact your EDI provider Trizzetto EDI Customer Service at 800-556-2231 or Availity 1-800-282-4548. Also, your HEALTHSUN Provider Operations representative can assist you by calling 305-448-8100.

Validating Electronic Claims and Notices of Receipt

The contracted clearinghouse edits electronic claims received for file format and required fields only. The clearinghouse performs validation of the Provider's claim information. The clearinghouse will send the provider a rejection notice for the claim or the batch indicating whether the claim or batch was rejected.

Rejected claims and/or batches are the responsibility of the provider to correct and resubmit. The clearinghouse confirmation notices will not serve to support any claims appeals to HealthSun should one become necessary (i.e. for filing deadlines).

Each claim will either be accepted or rejected in its entirety, not on a line-by-line basis, based upon information provided in the service lines. HealthSun will provide a confirmation report to the clearinghouse of both accepted and rejected claims.

Claims for services filed electronically should not also be filed on paper. This creates a duplicate claim. Disputes to previously processed electronic claims should be submitted to the Claims Review Department on paper; not submitted electronically as a new claim.

Transmission Frequency

Electronic claims can be transmitted daily; however, claims transmitted on Saturday and Sunday are not downloaded into HealthSun claims processing system until the following business day.

The unique HealthSun Provider ID number is required on electronically (and paper) submitted claims. Contact your Provider Operations Representative if you need to verify your assigned HealthSun Provider ID.

Provider Identification (ID) Number Requirements

The nine (9) digit Federal Tax ID number and your NPI number will be required on all claims submitted to HealthSun.

Failure to place the Tax ID number or your NPI number on a claim or submitting a claim with a wrong number will cause the claim to be denied or to be considered deficient and to be returned. Resubmission with a Tax Id and NPI number will be required for claims processing.

PAPER CLAIMS SUBMISSION

General Requirements

HealthSun requires paper claims to be filed on a CMS-1500 or UB- 04 form with accurate and valid information. All required sections of the CMS -1500 or UB- 04 must be completed. Paper claims received on non-standard claim forms will be returned to the provider for resubmission on the appropriate claim form.

HealthSun will not accept super-bills or similar submissions as valid claims. **Preferably claims should be computer generated or typed.**

Claim Signature Requirements

When filing a paper claim, the physician or provider's handwritten signature (or signature stamp) must be in the appropriate block of the claim form (box 31).

Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

Initials are only acceptable for first and middle names for corrected claims that were previously signed off by the physician. The last name must be spelled out.

Claims prepared by computer billing services or office-based computers may have "Signature on File" in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Where to Submit Paper Claims

For paper claims from physician and ancillary providers, mail to:
HealthSun Health Plans, Inc.
Attention: Claims Department
P.O. Box 211154
Eagan, MN 55121

Claims submission via email or fax is not acceptable.

If a provider wishes to have proof of receipt by individual claim, the provider must request this and must include a list of the exact claims enclosed in the package. The list should include the following information:

- Member Name;
- Member ID;
- Date(s) of Service; and
- Billed Amount Total

HealthSun will verify that the specifically listed claims are enclosed in the package and return confirmation to the provider via mail.

Providers will be responsible for completing the information on the CMS 1500 form within the time frame specified in their contract. The claims should include the following:

- Patient name (Box 2)
- Patient ID number (Box 1A)
- Patient DOB (Box 3)
- Patient address and telephone number (Box 5)
- Other insurance information (Box 9)
 - Insured name
 - Insurance name
 - Policy/ Group number
- Attach other insurance EOP's to show payment or denial
- If patient's condition is related to: (Box 10)
 - Employment (Worker's Compensation)
 - Auto Accident
 - Other Accident
- Insured's Policy Group (Box 11)
- Patient Signature (Box 12 & 13)
- Date of current illness (Box 14)
- Dates of Patient unable to work (Box 16)
- Name of referring provider (Box 17)
- Referring Provider NPI# (Box 17B)
- Hospitalization dates (Box 18)
- ICD-10 Diagnosis Code(s) (Box 21)
- Authorization number (Box 23)
- Date(s) of Service (Box 24A)
- Place of Service (Box 24B)
- CPT and HCPC Codes. Modifiers when applicable (Box 24 D)
- Diagnosis code pointer (Box 24 E)
- Charges (Box 24F)
- Days or Units (Box 24G)
- Rendering Provider NPI (Box 24J)
- Federal TID number (Box 25)
- Patients account number-Optional (Box 26)
- Accept assignment- Y or N (Box 27)
- Total charge (Box 28)
- Amount paid (Box 29)
- Signature of Physician or supplier of service (Box 31)
- Service Facility location information (Box 32)
- Service Location NPI (Box 32A)
- Billing Provider Information (Box 33)
- Billing Providers NPI # (Box 33A)

COORDINATION OF BENEFITS AND SUBROGATION

As a participating provider with HealthSun we require that you notify the Plan of any third party information you may have received and that you assist the Plan in complying with the Medicare Secondary Payer rules. In addition, if you are notified of a Medicare Set- Aside Plan please notify the Plan immediately. You can contact the Plans Provider Services Department at (305) 447-4459.

HealthSun is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. Medicare Advantage Organizations are allowed four (4) provisions in which Medicare is considered a secondary payer.

1. Employer Group Health Plans (EGHP) and Large Group Health Plans (LGHP)
2. Liability Insurance Plans
3. No-fault Insurance Plans
4. Workers' Compensation Plans (WC)

Employer Group Health Plans (EGHP)

Policy: Coverage under a health plan offered by an employer in which a Medicare beneficiary is covered as:

1. An employee (age 65+) or
2. As a dependent under another subscriber (of any change) covered under such plan

NOTE: Medicare is the secondary payer for beneficiaries assigned to Medicare under the ESRD benefit for up to 30 months beginning when the individual becomes eligible for Medicare if the beneficiary was not otherwise eligible due to age or disability

Liability Insurance and No-Fault Insurance

Policy: Types of liability include, but are not limited to automobile liability, malpractice, homeowner's liability, product liability, and general casualty insurance. Medicare is considered the secondary payer to all liability and no-fault insurance providers.

Workers' Compensation (WC)

Policy: Medicare does not coordinate benefits with Workers Compensation payers. Workers' Compensation assumes full liability for the payment of items and services related to a claim meeting their coverage requirements.

When a Member has coverage, other than with HealthSun, which requires or permits coordination of benefits from a third party payor in addition to HealthSun, HealthSun will coordinate its benefits with such other payor(s). In all cases, HealthSun will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, HealthSun will pay the lesser of: (i) the amount due under the prevailing agreement; (ii) the amount due under the prevailing

agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between allowed billed charges and the amount paid by the other payor(s). In no event, however, will HealthSun, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in the prevailing agreement; provided, however, if Medicare is the primary payer, HealthSun will, to the extent required by applicable law, regulation or Center for Medicare/Medicaid Services (CMS) Office of Inspector General (OIG) guidance, pay Provider an amount up to the amount HealthSun would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

Recovery: Provider and HealthSun agree to use reasonable efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by HealthSun and Provider to facilitate coordination of such other benefits. Upon request by HealthSun, Provider will provide HealthSun with a copy of any standard Provider forms used to obtain the necessary coordination of benefits information.

Payment Adjustment: Provider and HealthSun agree that retroactive adjustment to the payment including but not limited to claims payment errors, data entry and incorrectly submitted claims shall be submitted to Recovery of Over/Under Payment process.

CODING

HealthSun requires use of standard CPT, ICD-10 and HCPCS coding, unless otherwise directed by HealthSun as outlined in this Manual or Participating Provider contract.

Diagnosis codes should be billed with the highest degree of specificity. Use fourth and fifth digits whenever applicable. If a diagnosis code requires a fourth or fifth digit, and is not coded as such, the claim will be denied.

New and Deleted Codes

Providers must bill for services using current CPT, ICD-10 (as applicable) and HCPCS codes and modifiers that are appropriate for the service provided. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listings of valid codes, HealthSun policy will be the following:

- New codes are accepted upon implementation date.
- Deleted codes are accepted up to the effectiveness in accordance to coding guidelines.
- HealthSun will only accept HIPAA approved code sets.

Unlisted Codes

HealthSun will accept a provider's use of an unlisted code only when the physician/provider's contract with HealthSun specifically requires use of the unlisted code.

For unlisted supplies (e.g., HCPCS code E1399), the claim should include a detailed description of the supply. The description can be written in detail on the claim form or provided as an attachment (i.e. a copy of the supply invoice) and the validated medical documentation.

If billing for an unlisted drug, physician/provider must include a detailed description, medical documentation and the dosage given.

If a claim is filed using an unlisted code and a valid code is available, unless specifically allowed by physician/provider contract, HealthSun will deny the service or supply and the claim for that service or supply will need to be re-filed by the physician or provider.

Accurate Coding

To code accurately, it is necessary to have a working knowledge of medical terminology and to understand the characteristics, terminology and conventions of ICD-10. Transforming descriptions of diseases, injuries, conditions and procedures into numerical designations (coding) is a complex activity and should not be undertaken without proper training.

Originally, coding allowed retrieval of medical information by diagnoses and operations for medical research, education and administration. Coding today is used to describe the medical necessity of a procedure and facilitate payment of health services, to evaluate utilization patterns and to study the appropriateness of health care costs. Coding provides

the basis for epidemiological studies and research into the quality of health care. Incorrect or inaccurate coding can lead to investigations of fraud and abuse. Therefore, coding must be performed correctly and consistently to produce meaningful statistics to aid in planning for the health needs of the nation.

Follow the steps below to code correctly:

1. Identify the reason for the visit. (e.g., sign, symptom, diagnosis, conditions to be coded).
2. Always consult the Alphabetic Index, Volume 2, before turning to the Tabular List.
3. Locate the main entry term.
4. Read and interpret any notes listed with the main term.
5. Review entries for modifiers.
6. Interpret abbreviations, cross-references, symbols and brackets.
7. Choose a tentative code and locate it in the Tabular List.
8. Determine whether the code is at the highest level of specificity.
9. Consult the color coding and reimbursement prompts, including the age and sex edits.
10. Assign the code.

Service Location Codes

HealthSun accepts valid CMS place of service codes. Consultations and professional services rendered in a hospital setting will be processed according to the level of care authorized and in accordance to the Medicare Guidelines. Improper coding, including procedure and location coding may result in denial of the claim.

Reimbursement will also be made based on the applicable locality where service was rendered in accordance to Medicare Guidelines. For example, Miami Dade County, Broward County, other)

MEMBERS ENROLLED IN HOSPICE

It is important that your staff and/or billing company understands the process required to bill the Fiscal Intermediary for CMS for members of our Plan that are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.

What is Hospice?

Hospice is a program of care and support for people who are terminally ill. It is available as a benefit under Medicare Hospital Insurance (Part A). The focus of hospice is on care, not treatment or curing an illness. Emphasis is placed on helping people who are terminally ill live comfortably by providing comfort and relief from pain. Some important facts about hospice are:

- A specially trained team of professionals and caregivers provide care for the “whole person”, including his or her physical, emotional, social and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s).
- Care is generally provided in the home.
- Hospice isn't only for people with cancer.
- Family caregivers can get support.

When all the requirements are met, the Medicare hospice benefit includes:

- Physician and nursing services
- Medical equipment and supplies
- Outpatient drugs or biological for pain relief and symptom management
- Hospice aide and homemaker services
- Physical, occupational and speech-language pathology therapy services
- Short term inpatient and respite care
- Social worker services
- Grief and loss counseling for the member and his or her family

When a member/patient enrolled in hospice receives care from your practice or facility, it is very important that all of the care be coordinated with their hospice physician. Once a Member is enrolled in hospice, HealthSun is only responsible for services that are not related to hospice diagnosis, as long as the service provided is a Medicare covered benefit. HealthSun enrolls Hospice members into a new group effective the 1st of the month, following election of hospice, and removes them from the group at the end of the month, if the Member terminates or revokes the hospice benefit. The Plan will continue to assist in coordination of the member's care to the best of its ability, however, the payment process to provider's changes.

For Hospice diagnosis related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, providers need to bill the Fiscal Intermediary for CMS directly. If a Member's hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. HealthSun is only responsible for additional benefits not covered by Medicare, i.e. the

transportation benefit. Any claims received by HealthSun for Medicare- covered services that are not additional plan benefits, will be denied by the Plan.

Note: A member who has elected hospice and requires medical treatment for a non-hospice condition and do one of the following:

(1) Use plan providers and services. In such a case, the member only pays plan allowed cost-sharing, and the provider would directly bill FFS for (Parts A and B services); or

(2) Use non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the member would pay the total FFS allowed cost-sharing.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan's system, the Member is sent a new enrollment card reflecting a new group number beginning with RH*. This process may take time, depending on when the Hospice Form is received by CMS and when their system is updated.

Contact Information for the Fiscal Intermediary is as follows:

First Coast Service Options, Inc.

Medicare Part A: Provider Contact Center - (888) 664-4112

IVR System - (877) 602-8816

Medicare Part B: Provider Contact Center - (866) 454- 9007

IVR System - (877) 847-4992

CLAIMS FILING DEADLINES

Initial Claim Filing

Initial claims must be submitted within 30 to 180 days as stipulated in the HealthSun Provider agreement following the date on which the Covered Health Services were rendered, or for continuous Covered Health Services, for which one charge will be made. Claims not received at HealthSun within the time frame stipulated in the Provider agreement will be denied and are to be considered waived by the physician. These services are not to be billed to the member for payment.

Hospitals should provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to HealthSun in a timely manner.

Initial Claim Filing When There is Another Insurance

HealthSun payment as a secondary payer will not exceed the amount specified according to contract, less the primary payer's payment amount.

Exceptions to the Filing Deadline

Providers who fail to meet the filing deadline may request reconsideration of their claim through the claims review process. HealthSun recognizes there are instances where extenuating circumstances may result in missing the filing deadline (e.g. theft or destruction of Physician's records, death or disability of Physician, complete system failure). In these instances, providers must submit a written dispute to the HealthSun Claims Review Unit. HealthSun may waive the filing deadlines at its sole discretion. Provider will need to evidence that the claim was filed within the allowable time.

NOTE: If an exception to the filing deadline is granted by HealthSun and multiple claims are involved; the physician/provider should submit all claims as a batch to the Claims Department/Appeals Unit. At that time an adjustment will be done to the original submission. All request for adjustments or appeals on contracts are to be submitted 120 days from the date of receipt of denial and or underpayments.

Claims Dispute

If you believe the Plan has not paid your services according to the terms of your provider agreement, or has denied payment (without member liability) for services already rendered, you may file a written dispute for review within 90 calendar days of the Plan's notification date. Please submit all documentation to support why the claim should be reprocessed (e.g. explanation of payment, copy of claim, medical records). A copy of the Dispute Form is available on the HealthSun Health Plan's website: www.healthsun.com/providers.

A resolution will be rendered and communicated to the provider within 60 calendar days of your dispute receipt date. To submit a Dispute, please send the request to the Claims Review Department:

Claims Review Department

P.O Box 330968
Miami, FL 33233-0967

CLAIMS AUDITS

HealthSun Health Plans reserves the right to audit all claims, itemized bills, and applicable medical records documentation for billing appropriateness and accuracy.

Within the timeframes allowed by the applicable governing agency (AHCA, CMS or DFS), HealthSun Health Plans may audit a claim and itemized for appropriateness of charges and compliance with billing procedures for the approved care of the Member. Per Florida Statute 641.315 (5), HealthSun Health Plans has the right to dispute certain charges. The claim will either be (i) processed for undisputed charges; or (ii) denied requesting additional information within the time period required by the applicable regulatory agency. In the case of any disputed charges, HealthSun Health Plans will follow the payment with a certified letter to the Director of Business Office or designee explaining the reason for the dispute of the individual charges.

All providers have the right to dispute HealthSun Health Plans payment and request additional information. Such dispute must be received in writing within 35 days of receipt of HealthSun Health Plans certified audit letter. Please mail your disputes to:

HealthSun Health Plans, Inc.
Claims Department
PO Box 330968
Miami, Florida 33133

HealthSun Health Plans will then coordinate efforts with the Provider to schedule an appointment to audit the disputed claim.

Upon completion of the audit, the claim will be reprocessed, if necessary, with mutual consent of HealthSun Health Plans and Provider.

As already specified in your Agreement or in this Provider Manual in cases where a payment has already been made and it is determined after the audit that provider has been overpaid, HealthSun Health Plans will request a refund for such payments. Provider must reimburse Plan or dispute refund request within 35 days of receipt of such request. Any payments or disputes should be mailed to the address above.

If Provider agrees to coordinate joint audits with HealthSun Health Plans prior to any payment, HealthSun Health Plans will schedule such audits. Since claims must be processed within strict timeframes, this would require that the Provider allow joint audits within 3 days of the request.

Interim Bills

Interim bills will not be accepted for DRG or APC Claims. In order to properly adjudicate a claim paid on a Medicare Allowable basis, the patient must be discharged.

Itemized Statements

HealthSun Health Plans may require itemized statements as deemed necessary and appropriate.

Charge Audit

Auditors shall conduct both pre-payment and post-payment claim reviews to ensure correct reimbursement and contract compliance. Our Audit Team will conduct the following types of pre-payment claim reviews: (1) claims that fall into an APC or DRG outlier status, (2) claims that will pay to a percentage of charges, and (3) Principle Diagnosis Code or DRG discrepancies (4) CPT unbundling.

Auditors will review claims for accuracy of charges and description of services, overpayments and underpayments. Line-by-line charge audits will also focus on: (1) unbundling or bundling of charges, (2) charging for an item or service that is considered non-covered for payment, (3) high-volume items and (4) high-cost services and supplies. The following parameters will be used during an audit:

1. Non-allowable charges, including but are not limited to the following:
 - Re-usable equipment and surgical instruments.
 - Routine supplies that are included in the cost of the room where services were provided. Examples: surgical drapes, gowns, gloves, masks, irrigation solutions, sterile saline solutions, IV tubing, oxygen masks, oxygen supplies, and syringes.
 - Added fees charged for non-routine handling of laboratory specimens processed within the facility (e.g., STAT fees).
2. Room and board, including but not limited to the following services and supplies:
 - All nursing staff services including, but not limited to: coordinating the delivery of care, patient education and supervising the performance of other staff members to whom they have delegated patient care activities.
 - Room and complete linen service.
 - Dietary service including all meals, therapeutic diets, required nourishment, dietary supplements and dietary consultation.
 - Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and other similar items used in the examination of patients.
 - Routine supplies provided as part of routine care including, but not limited to: wipes, swabs, bibs, scales, body lotion, bed pan, bedside commode, water pitcher, patient gown, breast pump, nursing pads, petroleum jelly, hydrogen peroxide, and diapers (baby or adult).
 - Administration of medications including IV's.
 - Postpartum services.
 - Recreation therapy.
 - Interpretation, rental or reading of patient monitoring equipment in the OR, ICU, L&D, and ER. (e.g., pulse oximetry, fetal monitoring).
3. Incremental nursing charges (ER, OB, nursery, critical care, OR, etc.) are included in the room charge.
4. Critical care room charges include, in addition to the above, all standard equipment such as monitors, suction devices, feeding pumps, IV poles, transducers, and IV pumps.

Such items will be disputed and total charges will be reduced by these amounts prior to payment.

**SECTION 9
PHYSICIAN OR PROVIDER
TERMINATION**

TERMINATION OF PROVIDER CONTRACT

HealthSun Health Plans may exercise termination of a Provider Contract with or without cause. Termination may be due to changes in networks and the necessity of membership needs, organizational business plan, or other adjustments in our network.

Termination may be due to but not limited to the following:

- Failure of Provider to comply with the medical community standards of medical practice
- Failure of Provider to meet credentialing or re-credentialing standards
- Material breach of the terms and conditions of the Provider Agreement with the Plan
- The commission of an act of fraud or theft
- The involuntary bankruptcy or insolvency of the provider not dismissed within sixty (60) days after filing.
- Physician does not meet criteria for any of the following:
 - Re-Credentialing non-renewal due to not meeting criteria
 - Provider has been indicted or convicted of a felony
 - Repeated and documented non-compliance to adequate on-call and after hours coverage
 - Recommendation through HEALTHSUN Medical Standards process
 - Provider has been sanctioned, by Review Boards, governmental agency, or other similarly body

Before terminating a contract with physician, provider or Network, a written explanation of the reason(s) must be provided. Notice is given to the physician, provider/ Network at least 60 days before the termination date, without cause as stipulated in the physician agreement. Nonetheless, HealthSun may immediately suspend or terminate a provider for cause by written notice under circumstances including, but not limited to the following:

- Termination, suspension, limitation, voluntary surrender or restriction of professional license or other government certification/licensure;
- Conviction of a felony or any other criminal charge;
- Any disciplinary action taken by the Drug Enforcement Agency (DEA); or
- Any other legal, government or other action or event which may materially impair the ability to perform any duties or obligations under the provider's agreement with HealthSun.

Physicians terminated by HealthSun are entitled to an advisory panel hearing. However, the right to request a review is not applicable when a provider fails to maintain professional licensure or any governmental authorization required to provide services under the terms and provisions set forth in the provider agreement.

Please note the following:

- Denials of participation in HealthSun are not subject to an advisory hearing review.
- The hearing review applies only to terminations initiated by HealthSun.
- The physician must submit his/her request in writing to HealthSun if they opt for an advisory hearing review.
- The request, along with supporting written documents must be dated and post marked not more than fifteen (15) calendar days following the date of the termination notice. If the request is not received within the fifteen (15) calendar day time frame, the physician's right to review is waived.
- An Advisory Panel Review will consist of three (3) physicians who are peers of the physician. However, at least two (2) members of the Advisory Panel must be present at the review to constitute a quorum.
- The Advisory Panel will base its recommendation on the written information presented by the physician and HealthSun, along with any additional information requested by the Panel.
- The review will occur prior to the effective date of the termination decision, and in most cases, within 15 business days of HealthSun's receipt of the physician's request for the review.
- A Provider Operations representative shall send a notification letter via certified or registered mail to the Provider(s) within two (2) weeks of receipt of the Advisory Panel's decision.

Members will be given reasonable advance notice of the impending termination of any provider. Members currently under treatment with a Specialty Care Physician may be able to continue to receive care for a limited time. Continuity of care determinations will be made on a case-by-case basis by the Plan. However, please note that continuity of care will not offered to members if a provider is terminated for violations of medical competence or professional behavior, de-credentialed, relocated outside of the Plan's service area or retires.

IMPORTANT: In the event of a provider termination, the terminated provider is responsible for transferring the members' medical records.

If your name appears in the current Office of the Inspector General's (OIG) sanctioned provider listing, your contract with HealthSun will be terminated and not subject to a hearing. If you have been reinstated into a federal health care program(s), contact HealthSun immediately.

Analysis review of the Physician's utilization patterns demonstrate difficulty in maintaining utilization rates that are comparable to those of like peers and in the current medical community, and does not improve after a specified period of time with a correction action in place.

**SECTION 10
COMPLAINTS, GRIEVANCES
AND APPEALS**

PROVIDER COMPLAINTS AND GRIEVANCE PROCEDURES

Participating providers may submit an informal complaint to HealthSun Health Plans, Inc., (HealthSun) to express dissatisfaction with the plan. This usually involves a denied claim, but may include other complaints such as contractual dispute, fee schedule issues or other general plan dissatisfactions.

If a provider has a grievance, complaint or other situation regarding any aspect of HealthSun operations, the provider should first contact their designated Provider Service Executive to discuss the matter. In the event a provider wishes to submit a formal grievance regarding any issue described above, the provider must document in writing the circumstances and forward to their designated Provider Service at:

HEALTHSUN HEALTH PLANS, INC.
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133
Attention: Provider Operations Department

The letter will be reviewed by the Provider Operations Department and other plan departments as required in order to make a determination. A response will be sent within 60 days after receipt of the letter. The response will provide the appropriate next steps should the resolution not be favorable to the provider.

Initial Grievance

Any Provider who has a grievance against HealthSun Health Plans may call the Provider Operations Department Monday through Friday, 8:00 a.m. to 5:00 p.m. They will assist the Provider in taking the information and collecting all the necessary documents to resolve the grievance.

These grievance procedures will not apply to the cases submitted by agencies like the Department of Insurance (DOI) since the deadlines given by such agencies will be followed.

Formal Grievance Procedures

1. Formal grievances shall be handled by the Provider Operations Department with the cooperation of other departments involved with complainant's concerns.
2. All medical issues shall be reviewed confidentially by the HealthSun Health Plans Medical Department (Medical Records are secured either in the Utilization Management Department or with the Provider Operations Department and are only available to appropriate HealthSun Health Plans staff). For medically related grievances, at least one other physician shall be included.
3. A resolution to the Provider's grievance shall be due within the 60-day period from the receipt of the Formal Grievance, except when information needed by non-par Providers or Providers outside of the HealthSun Health Plans service area. In such cases, this period may be extended by another 30 days, if necessary. The complainant shall be advised in writing of such 30-day extension. The time limitations requiring completion of the grievance process within 60 days shall be tolled after HealthSun Health Plans has notified

the complainant in writing that additional information is required in order to properly complete review of the complaint. Upon receipt of the additional information required, the time for completion of the grievance process shall resume. HealthSun Health Plans will communicate with the complainant during the formal grievance process.

4. A resolution letter including Formal Grievance decision and Provider's next level of rights (Committee Hearing Rights) will be sent to the Provider via certified mail. The complainant always has the right to appeal to the Agency and the Statewide Provider and Subscriber Assistance Panel. HealthSun Health Plans shall provide to the complainant written notice of the right to appeal upon completion of the full grievance procedure and supply the Agency with a copy of the final decision letter. If HealthSun Health Plans is unable to resolve the grievance to the complainant's satisfaction, the complainant is provided written notice of his/her rights to appeal HealthSun grievance decision to AHCA/Bureau of Managed Health Care, P.O. Box 12800, Tallahassee, Florida 32317-2800, and the Statewide Provider and Subscriber Assistance Panel for further review.
5. All grievance cases opened/closed are secured with the Provider Operations Department.
6. A Provider has 10 days from the receipt of the Formal Grievance Decision Letter to request a Grievance Committee Hearing if not satisfied with the Formal Grievance Decision.
7. Grievance Hearing Request is acknowledged in writing to the complainant within 5 calendar days of receipt via certified mail. A tentative date and time are agreed upon with the complainant.
8. Grievance Committee meets on an as-needed basis and discusses unresolved grievances.
9. If a grievance involves a medical issue requiring medical records from out of the service area or information from a non-contracted Provider, a 30-day extension is automatically granted to gather the necessary information. The Provider is notified promptly of this extension.
10. The Grievance Committee shall meet prior to the scheduled hearing to discuss their findings and resolution. If the grievance involves a mental health issue, appropriate staff from Psych/Care, Inc. will be in attendance at the Committee Hearing. Medically related grievances will include at least one other physician.
11. Committee and Provider shall meet at scheduled hearing time to discuss their concerns regarding the case. Meeting notes shall be taken by the Provider Operations Department. Provider shall be advised that HealthSun Health Plans will issue a formal written response via certified mail.
12. After the Committee arrives at a decision the Provider/complainant shall be notified of the decision via a formal written response. Provider shall be offered the next level of rights (Address of the Agency for Health Care Administration will be given to the Provider if he/she chooses to appeal the Committee's decision).

13. HealthSun Health Plans shall maintain an accurate record of each formal grievance. Each record shall include the following:
- I.
 - a. A complete description of the grievance
 - b. Complainant's name and address
 - c. HealthSun Health Plans' address
 - II.
 - a. A complete description of factual findings and conclusions after the completion of the full formal grievance process.
 - b. A complete description of the Plan's conclusions pertaining to the grievance as well as the Plan's final disposition of the grievance.
 - c. A statement is sent to the member regarding the current level of grievance and the remaining levels of appeal available to the Provider.

Please address all Formal Grievances to:

HEALTHSUN HEALTH PLANS, INC.
3250 Mary Street
Suite 400
Coconut Grove, Florida 33133
Attn: Provider Operations Grievance Department

These grievance procedures will not apply to the cases submitted by agencies like the Department of Insurance (DOI) since the deadlines given by such agencies will be followed.

MEMBER COMPLAINT, GRIEVANCES AND APPEALS

Participating Providers must respond to the HealthSun Grievance and Appeals Department expeditiously with submission of the required medical records to comply with timeframes established by CMS and/or the State Department of Insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. To be compliant with HIPAA, Providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information. Furthermore, Providers are also required to comply with final determination made by the Plan, CMS, local Independent Review Organization (IRE), or other governmental agency according to the timeframe set forth by CMS.

Member Grievance Process

HealthSun members have 60 calendar days from the date of occurrence to file a formal grievance to the health plan.

Any Member who has a grievance against HealthSun or its providers for any matter may submit an oral or a written statement of the grievance to HealthSun. A grievance form may be requested from the Member Services or the Grievance and Appeals Department.

The written statement or Grievance Form must be forwarded to the HealthSun Grievance and Appeals Department to the following address or fax number:

HEALTHSUN HEALTH PLANS, INC.
Attn: Grievance Department
3250 Mary Street
Suite 400
Coconut Grove, Florida 33133

Grievances will be resolved in accordance with the Medicare Managed Care Manual mandated by CMS.

HealthSun members will be referred to KEPRO, Florida's Quality Improvement Organization (QIO), should the grievance be relating to the quality of care or service from the plan or its providers. HealthSun member's may also send inquiries or call KEPRO directly at the following:

KEPRO
5201 West Kennedy Blvd., Suite 900
Tampa, Florida 33609 (800) 455-8708

Medicare Reconsideration (Appeals)

A Reconsideration (Appeal) is a written or verbal request by a member, his/her legal guardian, authorized representative, or power of attorney; requesting the review of a service previously denied by the plan. A physician who is providing treatment to a member, upon providing notice to the member, may request an expedited or standard pre-service reconsideration on the member's behalf without having been appointed as the member's authorized representative.

To reconsider the Plan's Initial Determination to authorize a service, a request for reconsideration must be received within sixty (60) calendar days from the date of the initial determination. A decision for a reconsideration will be reviewed as expeditiously as the member's health condition requires, but no later than 72 hours (when applying the standard timeframe could seriously jeopardize the member's life, health or ability to regain maximum function); and thirty (30) calendar days for standard pre-service requests.

Participating Providers Dispute Rights

If you believe, the Plan has not paid your services according to the terms of your provider agreement, or has denied payment (without member liability) for services already rendered, you may file a written dispute for review within 90 calendar days of the Plan's notification date. Please submit all documentation to support why the claim should be reprocessed (e.g. explanation of payment, copy of claim, medical records). A copy of the Dispute Form is available on the HealthSun Health Plan's website:
www.healthsun.com/providers.

A resolution will be rendered and communicated to the provider within 60 calendar days of your dispute receipt date. To submit a Dispute, please send the request to the Claims Review Department:

Claims Review Department
P.O Box 330968
Miami, FL 33233-0967

MEMBER QUALITY OF CARE INVESTIGATIONS

The Grievance and Appeals (G&A) department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care (QOC) concerns or sentinel events involving HSHP member's. This includes cases reviewed as the result of a grievance submitted by a member's and potential quality issues (PQI) reviewed as the result of a referral received from a HSHP clinical associate. The Potential Quality issues are received through the intranet at the Risk Management Department and then forwarded to the clinical personnel for review to determine the level of severity. All HSHP associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of Care Grievances: A complaint where a member perceives that their health is adversely affected as a result of the omission, commission, breach or violation in standard of care or not satisfied with the quality of care received by a physician, facility, healthcare provider, or a Medicare health plan. The member or member representative can file this complaint through the health plan's grievance process or through the QIO. The QIO must determine if the quality of services (including both inpatient and outpatient services) provided by the Medicare health plan, physicians, or facility meets the appropriate standards.

QOC Classification and Point System: The point system below will be used to determine trends, patterns and also be used in the re-credentialing process.

Quality of Care		
Level	Points Assigned	Description
C-0	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern. No quality of care issue found to exist. (example, unexpected adverse reaction to a medication)
C-1	5	The issue is identified as a quality of care (QOC) issue but there was no realized adverse impact on the member based on the omission, commission, breach in medical care or administrative procedures not associated with standards of care, or an error. C1-P*) Recognized Medical or Surgical complication that may occur in the absence of negligence and without QOC concern. C1-A**) Communication, administrative, or documentation issue that adversely affected the care rendered.
C-2	10	The grievance found to be a quality of care (QOC) issue where the member had an unexpected outcome as a result of the omission, commission, breach in medical care or administrative procedures not associated with the standards of care, or an error where there was a significant chance of a serious adverse outcome but there was no lasting or permanent effect.

Quality of Care		
Level	Points Assigned	Description
C-3	25	The grievance is determined to be a quality of care (QOC) where the member had an unexpected outcome or sentinel events involving as the result of the omission, commission, or error and there was death or serious physical injury or illness, including loss of limb or function, not related to the natural course of the member's illness or underlying condition or permanent and/or lasting effect.
C-D**	20	Failure of a practitioner/provider to respond to a member Grievance regarding a clinical issue despite two requests per internal guidelines or failure to submit the Action Plan requested as a result of a confirmed QOC issue.

*P-Provider. **A-Administrative. ***D-Documentation.

Quality of Care and Service Trend Parameters

The following accumulation of QOC cases with severity levels and points, or any combination of cases totaling 20 points or more during any 12 months will be subject to trend analysis:

- 10 cases with a leveling of C-0
- 4 cases with a leveling of C-1
- 2 cases with a leveling of C-2
- 1 case with a leveling of C-3(automatic referral to the applicable Peer Review Committee)
- 2 Cases with a leveling of D

A 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

The Quality Improvement Department and the Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.

PART D COVERAGE DETERMINATION, EXCEPTIONS AND APPEALS PROCESS

Short Decision Making Timeframes

CMS has directed every prescription drug plan to respond to requests without delay. Plans must communicate decisions on initial coverage determinations no later than 24 hours after receiving an expedited request, or 72 hours after receiving a standard request. If a physician or other prescriber requests coverage determination on behalf of an enrollee, the physician will receive notice of the plan's decision. If the plan fails to meet the timeframe, the case goes to an Independent Review Entity (IRE) under contract with CMS for a decision on the case. The independent review entity is commonly referred to as the Part D qualified independent contractor (Part D QIC).

Requests Made by Physicians or other Prescribers

As indicated in §10.5, an enrollee's prescribing physician or other prescriber may request a coverage determination, redetermination or *IRE reconsideration* on an enrollee's behalf, *but* is prohibited from requesting a higher appeal without being the enrollee's representative. If the IRE issues an adverse decision, the enrollee's physician or other prescriber must become the enrollee's representative, as indicated in §10.4, to file any further appeal on the enrollee's behalf (i.e., the physician or other prescriber would be responsible for becoming the enrollee's representative and submitting the proper representation documentation with the appeal request).

Physicians or other Prescribers Supporting Statements

Prescribing physicians or other prescribers have an important role in the exceptions process. Whenever an enrollee requests a Prior Authorization for a drug, prescribing physician or other prescriber must provide Part D Services Department with an oral or written statement to support exception request. Plan's timeframe for making a decision on an exception request does not begin until prescribing physician's supporting statement is received by plan.

Enrollee' s Appeal Rights

If a member does not agree with initial coverage determination decision made by plan, enrollee has the right to appeal. As indicated in §10.5, an enrollee's prescribing physician or other prescriber may request a redetermination or *IRE reconsideration* on an enrollee's behalf without providing form of representation. However, the Plan will require the prescribing physician or other prescriber to submit a representation form for redetermination payment appeals. In addition, if a request is received by someone other than the enrollee that does not include the prescribing physician or other prescriber, then the plan will require a representation form.

The enrollee, prescribing physician, other prescriber or legal representative may request any of the following types of appeals:

- 72 hour - Expedited Appeal
- 7 calendar days - Benefit Appeal
- 7 calendar days - Payment Appeal

If a plan issues an adverse redetermination, the member will receive a notice which includes information on how to request reconsideration by the Part D QIC. Detailed information can be found in the members Evidence of Coverage. All appeal inquiries may be made to the Appeals Department at (305) 448-8100 or via fax at (877) 589-3256.

SECTION 11
ENROLLMENT OPTIONS AND PERIODS

ENROLLMENT OPTIONS AND PERIODS

Enrollment Options

Medicare Beneficiaries have the option to enroll in the following:

- 1) Enroll in a Medicare Advantage Plan that has prescription drug coverage;
- 2) Enroll in a standalone Prescription Drug Plan (PDP) for the prescription drug coverage, and receive health care coverage from traditional Medicare;
- 3) Enroll in a Medicare Advantage Plan that doesn't have prescription drug coverage.

There are five types of Election Periods during which individuals may make enrollment changes for MA plans:

- 1) The Annual Election Period (AEP);
- 2) The Initial Coverage Election Period (ICEP);
- 3) The Open Enrollment Period for Institutionalized Individuals (OEPI);
- 4) All Special Election Periods (SEP); and
- 5) The Medicare Advantage Disenrollment Period (MADP)

People who are new to Medicare have an Initial Coverage Election Period (ICEP) that is similar to the Initial Enrollment Period for Part B. This period begins three (3) months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of 1) the last day of the month preceding entitlement to both Part A and Part B, or 2) The last day of the individual's Part B initial enrollment period.

The AEP is from October 15th through December 7th of each year. During the AEP the member may enroll or disenroll from an MA plan. Changes made would take effect January 1st of the following year.

The MADP is from January 1st through February 14th of every year. During the MADP, MA plan enrollees may prospectively disenroll from any MA plan and return to Original Medicare.

Special Enrollment Periods (SEP)

- 1) Change in Residence
- 2) MA contract violation
- 3) MA Non-renewal or Terminations
- 4) SEPs for Exceptional Conditions
- 5) Employer/Group Health Plan
- 6) Individuals who disenroll if CMS sanctions an MA plan
- 7) Individuals enrolled in Cost Plans that are Non-renewing their contracts
- 8) Individuals in the Program of All-Inclusive Care for the Elderly (PACE)
- 9) Dual-Eligible individual(s) or individuals who lose their dual-eligibility
- 10) Individuals who dropped a Medigap Policy when they are enrolled for the first time in an MA plan, and who are still in a "trial period"
- 11) Individuals with ESRD whose entitlement determination is made retroactively
- 12) Individuals whose Medicare entitlement determination is made retroactively
- 13) MA SEPs to Coordinate with Part D Enrollment Periods

- 14) Individuals who has an involuntary loss of creditable coverage, not including a loss due to failure to pay plan premiums
- 15) Individuals who lose Special Needs Status

Enrollment Options and Periods

- 1) Individuals who belong to a Qualified State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility
- 2) Non-Dual Eligible Individuals with LIS and Individuals who lose LIS
- 3) Enrollment into a Chronic Care SNP and Individuals Found Ineligible for a Chronic Care SNP
- 4) Disenrollment from Part D to Enroll in or Maintain other Creditable Coverage
- 5) Enrollment in an MA plan or PDP with a Plan Performance Rating of five (5) stars
- 6) SEPs for Beneficiaries Age 65
- 7) Individuals entering, residing or leaving a long term care facility

Note: Unless they show proof of "creditable coverage", people with Medicare who do not enroll in a drug plan when they are first eligible will likely have to pay a penalty if they choose to enroll in a drug plan later.

SECTION 12
CMS REQUIREMENTS
AND STATUTORY COMPLIANCE

CMS HIERARCHY OF CONDITIONS AND RISK ADJUSTMENTS

The HealthSun Health Plan HCC Analyst/Coders purpose

The HealthSun Health Plan has established a team of HCC analyst/ coders to review medical records and assist the provider with information in order to capture the quality and care of service documentation for the HealthSun Health Plan members. All Providers must maintain the encounter data current.

Medicare Risk Adjustment (MRA)

The CMS-Hierarchy of Condition Category (HCCs)/Risk Adjustment model strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage Organizations, such as HealthSun Health Plans based on the health status of their Members. Accurate payments to Medicare Advantage Organizations help to ensure that providers are paid appropriately for the services rendered to Members and provide incentives to enroll and treat less than healthy individuals.

HCC/Risk Adjustment Data Validation

Risk adjustment data validation is the process of verifying that a diagnosis code submitted by HealthSun to CMS is supported by medical record documentation. CMS validates medical records to ensure payment integrity and accuracy.

Steps in the Data Validation Process:

1. CMS selects a sample of HealthSun Members and requests medical records from the health plan.
2. HealthSun requests Member medical records from providers.
3. HealthSun sends the requested medical records to the CMS validation contractor for validation.

Provider Responsibilities:

1. Consistently follow general principles of medical record documentation.
2. Ensure all documentation to support a reported diagnosis on a given date or range of dates is provided.
3. Include supporting documents referred to in the encounter notes, such as test results or problem lists.
4. Respond quickly and send all records in an organized, secure and confidential manner.

CMS payment methodology to the MA plans changed in 2004 prior to HEALTHSUN becoming a plan. As a result all MA and MAPD plans receive adequate compensation for more complex and less healthy members through a change in payment methodology from CMS-known as the HCC system.

Yearly the reimbursement from CMS is based on predicted cost of care rather than demographics. The input from the previous year's diagnoses codes drives the subsequent

Year cost prediction and health plans receive payment based on the risk adjustment score. This is what is referred to as the HCC system – Hierarchical Condition Category.

The physician providers play a very important role in documenting chronic diseases on the face to face encounter (office visit). The physicians' medical documentation is of the essence with regards to the documentation of chronic disease.

While procedure codes are important for provider reimbursement of services to fee-for-service Medicare beneficiaries, the HCC/risk adjustment payment model relies on ICD- 9CM or ICD-10 diagnosis code specificity.

CMS SPECIFIC GUIDANCE ABOUT PROVIDER PROMOTIONAL ACTIVITIES

Refer to the Chapter 3: Medicare Marketing Guidelines, §70.12 to §70.12.7 for more detailed information.

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

CMS is concerned with the provider activities for the following reasons:

- 1) Providers may not be fully aware of all plan benefits and costs; and
- 2) Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan vs. acting as the beneficiary's provider.

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

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

Following are requirements associated with provider activities. HealthSun requires that any provider contracted with the plan (and its subcontractors) comply with these requirements:

1. Provider Activities and Materials in the Health Care Setting – Beneficiaries often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patient seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications). However, providers cannot accept enrollment applications. Providers also cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

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

The "Medicare and You" Handbook or "Medicare Compare Options" (from <http://www.Medicare.gov>), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise contracted providers of the provisions of these rules.

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

Plans are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients

Primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, pharmacy counter areas and dialysis center treatment areas (where patients interact with their clinical team and receive treatment).

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

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

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

4. SNP Provider Affiliation Information – Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and include specific information about the SNP. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

5. Comparative and Descriptive Plan Information – Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials. CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers.

6. Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party – Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party (e.g., SHIPs, State agency or independent research organizations that conduct studies). For more information on non-benefit/service providing third party providers (See § 40.14.6, “Non-Benefit/Service-Providing Third Party Marketing Materials” of the Medicare Marketing Guidelines – Chapter 3)

7. Providers/Provider Group Web Sites – Provider websites may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center (OEC).

NOTE: SNPs have the option to use the links, and the SNP should notify the provider that they may use the OEC link if they choose to but it is not required.

8. Leads from Providers – Plans and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes.

This obligation includes compliance with the provisions of the HIPPA privacy rule and its specific rules regarding uses and disclosures of beneficiary information. In addition, plans are subject to sanction for engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (i.e., health screening or “cherry picking”).

NOTE: *A provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider. All payments that plans make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the Federal and any State anti-kickback statute. For enrollment and disenrollment issues related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application) please refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.*

Sample Can/Cannot List for Provider Interactions with Potential Plan Enrollees:

Providers contracted with plans (and their subcontractors) **can**:

- 1) Provide the names of plans with which they contract and/or participate (See "Provider Affiliation Information" for additional information on affiliation).
- 2) Provide information and assistance in applying for the Low Income Subsidy (LIS).
- 3) Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as the providers offer the option of making available and/or distributing marketing materials to all plans with which they participate.
- 4) Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
- 5) Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.
- 6) Make available and/or distribute PDP enrollment applications, but no MA or MA-PD enrollment applications, for all plans with which the provider participates.
- 7) Refer their patients to other sources of information, such as SHIPs, plan marketing Representatives, their State Medicaid Office, local Social Security Administration Offices, CMS's Web site at <http://www.medicare.gov/>, or calling 1-800-MEDICARE.
- 8) Print out and share information with patients from CMS's Web site.

Providers contracted with plans (and their contractors) cannot:

- 1) Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor).
- 2) Mail marketing materials on behalf of plan sponsors.
- 3) Accept/collect enrollment applications.
- 4) Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- 5) Health screenings is a prohibited marketing activity.
- 6) Offer anything of value to induce plan enrollees to select them as their provider.
- 7) Expect compensation in consideration for the enrollment of a beneficiary.
- 8) Expect compensation directly or indirectly from the plan for beneficiary enrollment activities.
- 9) Offer sales/appointment forms.
- 10) Distribute materials/applications within an exam room setting
- 11) Advertise services such as computer classes, citizenship assistance, English classes, and other non-health-related services to Medicare beneficiaries to be paid with Medicare dollars. CMS regulations at 42 C.F.R. §422.2268 specifically prohibit engaging in activities that could mislead or confuse Medicare beneficiaries and the marketing of non-health care related products to prospective members.

In addition, MA organizations may not advertise non-health related items or services as plan benefits and are responsible for ensuring that their downstream entities also adhere to this prohibition. Advertisements for non-health related items or services by an MA organization, or one of its contracted clinics, to MA plan enrollees could be construed as inappropriate steerage to particular clinics and, ultimately, into a specific MA plan that contracts with that clinic. For more information please refer to 42CFR 422.2268

COMPLIANCE FRAUD AND ABUSE

Compliance and Fraud and Abuse

HealthSun Health Plans, Inc. is committed to the highest possible standards of openness, probity, and accountability in all its affairs. It is determined to maintain a culture of honesty and opposition to fraud and corruption.

In line with that commitment, HealthSun Health Plans, Inc. Anti-Fraud Policy outlines the principles we are committed to in relation to preventing, reporting, and managing fraud and corruption. This will be accomplished through education and training.

1. Florida Statute 626.9891 applies the 1995 law to HMOs, requiring the establishment of special investigative units and the filing of anti-fraud plans.
2. "*corrupt conduct*" means where an employee, provider or other has corruptly acted or corruptly failed to act in the performance of functions of his or her employment; or contractual duties and has benefited for corruptly taken advantage of his or her office or employment as a public officer to obtain any benefit for himself or herself or for another person.
3. "*criminal conduct*" means when an employee, provider or other has committed a scheduled offense while acting or purporting to act in his or her capacity; or
4. "*criminal involvement*" means where another person has been involved in criminal conduct engaged in a manner that the other person could be regarded, as having taken part in committing an offence, or as having committed an offence or as having been an accessory after the fact to an offence.
5. "serious improper conduct" means where an employee, provider or other has engaged in conduct (other than corrupt conduct or criminal conduct that adversely affects, or could adversely affect, directly or indirectly, the honest or impartial performance of the functions of the staff or of HealthSun Health Plans, Inc. or involves the misuse of information or material that the employee has acquired in connection with his or her employment or affiliation with HealthSun Health Plans, Inc. whether the misuse is for the benefit of themselves or another person

COMPLIANCE FRAUD AND ABUSE TRAINING FOR FDR'S

Starting January 1, 2016, to comply with training requirements sponsors must accept from FDRs certificates of completion of CMS' training located on the Medicare Learning Network (MLN).

CMS developed web-based compliance training to ensure the requirement is met and to reduce the largely duplicative training required of FDRs by the multiple organizations with whom they contract. The compliance and FWA training topics include:

- Relevant laws and regulations related to Medicare Parts C and D FWA.
- An overview of compliance expectations, how to ask compliance questions, request compliance clarification, hotline reporting.
- Types of non-compliance and FWA that can occur in the settings in which sponsor and FDR employees work.
- Processes for Sponsors and FDR employees to report suspected Medicare program non-compliance and FWA to the sponsor.
- Case examples and resources

Plans will have two (2) options for ensuring its FDRs (including the FDR's employees) have satisfied the general compliance and FWA training requirement that must be completed 90 days after initial hire/contracting and annually thereafter as described in the regulations and sub-regulatory guidelines.

- 1) FDRs and its employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once the individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be accepted by all Sponsors.
- 2) FDRs may download, view or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance training materials/systems. The CMS training content **cannot** be modified to ensure the integrity and completeness of the training. However, an organization can add to the CMS training to cover topics specific to their organization. Training materials are available at the following path:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

HealthSun has also placed the standardized training in our website: <http://HealthSun.com>

Confirmation of the training will be sent to the Provider Operations Department for additional guidance on this mandatory training please contact your Provider Representation.

FRAUD POLICY NOTICE

The corporate policy of HealthSun Health Plans, Inc. is to report cases of fraud to the law enforcement authorities for potential prosecution. HealthSun Health Plans, Inc. and its employees are committed to all State and Federal requirements to identify and report suspected fraud.

HealthSun Health Plans, Inc. has “zero tolerance” regarding any fraudulent act. Fraud is defined as “*Inducing a course of action by deceit or other dishonest conduct, involving acts or omissions or the making of false statements, orally or in writing, with the object of obtaining money or other benefits*”. HealthSun Health Plans, Inc. maintains both internal and external control procedures to identify investigate and report suspected fraudulent activities.

All employees of HealthSun Health Plans, Inc., members, vendors, and providers who suspect fraud are encouraged to call the HealthSun Health Plans anti-fraud hotline to report any possible fraudulent activities, over billing by providers and/or other matters, which they deem suspicious.

HealthSun Health Plans, Inc. maintains an easily accessible, toll-free Compliance Hotline number along with several other reporting methods, all of which are available 24 hours a day, seven days a week. Issues can be reported using the following methods:

- Website: www.lighthouse-services.com/healthsun
- Telephone:
 - English speaking USA and Canada: 844-420-0080 (not available from Mexico)
 - Spanish speaking North America: 800-216-1288 (from Mexico user must dial 01- 800-681-5340)
- E-mail: reports@lighthouse-services.com (must include company name with report)
- Fax: (215) 689-3885 (must include company name with report).

HealthSun Health Plans, Inc. and its employees are committed to work closely within the State and Federal Authorities in their investigation of such fraud cases.

Health Insurance Portability and Accountability Act (HIPAA)

We anticipate that you may have questions about whether the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule permits you to disclose your patients' (our members') medical information to us for these activities without written authorization from your patients.

Section 164.506(c) (4) of the Privacy Rule explicitly permits you to make this type of disclosure to HealthSun without a written authorization. Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) has also made this point clear. It wrote in its December 3, 2002, Guidance on the Privacy Rule that: "A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality-related health care operations activity." 2

145CFR §164.506(c) (4). The full text of the Privacy Rule is available at <http://www.hhs.gov/policies/index.html> Section 164.506(c) is on page 13 of this document.

2 The full text of the Office of Civil Rights December 3, 2003 Guidance is available at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index>. Section 164.506(c) guidance begins on page 20 of this document.

As the Privacy Rule and the Office of Civil Rights have made clear, you do not need a written authorization from your patients, who are or have been members of HealthSun, to disclose their medical information to us for HEDIS and other quality improvement, accreditation or regulatory activities.

RISK MANAGEMENT

HealthSun Health Plans Risk Management Program is designed to identify, investigate, track, and analyze adverse incidents. It is also intended to prevent the occurrence of incidents or accidents throughout HealthSun and its contracted Providers.

Under Florida Law it is the duty of all healthcare providers to report all adverse incidents, whether actual or potential, to the Plans HealthCare Risk Manager. The providers will use HealthSun Health Plans Incident Report. Please contact your Provider Operations Representative to request a form. The incident report must be completed and filed with the Plan's Risk Manger within three (3) business days of the incident or accident.

Serious incidents should be reported immediately to the Plan's Risk Manager at (305) 234-9292 since these incidents need to be reported to the Agency for Health Care Administration (AHCA) within twenty four (24) hours. Examples of these serious Incidents include;

- Death of a patient;
- Brain or spinal damage to a patient;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure; or
- Performance of a wrong surgical procedure

Incident Reports

The Incident Report is confidential. The Incident Report SHOULD NOT be copied. Provider's area prohibited from keeping a copy of the Incident Report in a member's medical record and from making a notation in the member's medical record that an Incident Report was completed. The Plan's Risk Manager shall review the Original Incident Report and shall evaluate the Incident in order to determine whether it meets the requirements for filing with the applicable State Agencies.

When completing the report the individual should refrain from documenting personal opinions or subjective information. This is not to be included in the report. The individual involved in the incident, or who observed or discovered the incident should complete the report. The report shall contain only the facts available at the time of the occurrence.

SPECIAL INVESTIGATION UNIT

HealthSun Health Plans Special Investigations Unit (SIU) is working to safeguard Medicare funds, through its commitment to detect, correct, and prevent fraud, waste, and abuse and utilizes various data mining techniques and reports to help identify questionable coding and billing patterns within Part B and D data. The department also receives referrals of possible FWA from CMS, our members, providers, and internally through various departments. All leads are investigated by the SIU team.

Depending on the type of case and allegation, the SIU investigation process will vary; however, investigational steps often include contacting members and providers in order to obtain attestations and medical records in reference to services received and provided. The SIU does this to validate that services billed are supported by documentation. If your practice receives notice from the SIU team requesting medical records or a written attestation of services rendered, please cooperate with the notice and any other instructions provided. Receiving a notice does not indicate that your practice is under investigation.

SECTION 13
HEALTHSUN HEALTH PLANS
INFORMATION TECHNOLOGY

PROVIDER IT ACCESS

HealthSun Health Plans will provide IT Access to those Providers who have met the criteria. Prior to having access to our system all Providers will be required to complete our Provider IT Access Request Form. At that time all of the individuals that will need to have access to the HEALTHSUN system shall sign the IT Agreement.

It is understood that all of the information that the Provider and their staff members will have access to is considered Privileged and confidential. As such information transmitted by, received from, or stored in this system is the property of HealthSun Health Plans and the use of any software or business equipment is only to be used for job-related purposes. Further, Providers and staff are not permitted to use a code, access a file, or retrieve, copy download or use any stored communication unless authorized to do so in writing by HealthSun Health Plans. All pass codes are the property of HealthSun Health Plans.

Computer Information Security

It is a violation of Florida law to disclose computer passwords; penalties range from a Class B misdemeanor to a felony depending on the related monetary damage. Computer passwords should be considered highly confidential. Providers and staff should never disclose computer passwords to anyone other than those individuals in the HealthSun organization that have official capacity.

Computer Software

Staff who uses software licensed to HealthSun or an entity owned by HealthSun must abide by applicable software license agreements and may copy licensed software only as permitted by the license. Unauthorized duplication of copyrighted software is a violation of federal copyright law. Provider and their staff should direct any questions about applicable software license agreements to HealthSun Health Plans IT Department.

Confidential Information

Providers and staff may use confidential information in the performance of their official duties, that information must not be shared with others. No violation of HIPAA guidelines will be tolerated, all confidential information will be kept in compliance with applicable laws, regulations, policies, and procedures. Confidential information includes personnel data, member information, research data, financial data, strategic plans, marketing strategies, membership lists and data, supplier and subcontractor information, and proprietary computer software. When HealthSun collects information from individuals, such as members, it is required to disclose to the individual their rights under federal regulations.

HITECH Legislation Impacts Health Care Providers

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposes new privacy and security obligations on physicians and other health care providers, as well as companies currently regulated as HIPAA-covered entities, such as health plans and clearinghouses. It also expands the definition of HIPAA-covered entities to include vendors who provide third-party services to health care providers, such as billing companies, customer service centers, accounting firms, and others.

In addition, health care providers and all HIPAA-covered entities are now required to develop plans for responding to security breaches of Protected Health Information (PHI), notifying affected individuals and the Department of Health and Human Services (HHS) within 60 days of a breach. HITECH also strengthens enforcement strategies for HIPAA and HITECH violations, and increases fines for many violations.

The security breach provisions of HITECH took effect in September 2009; however, HHS will not impose sanctions for breaches discovered before February 22, 2010. The other provisions of HITECH that affect PHI, such as business associate liability; new limitations on the sale of protected health information, marketing, and fundraising communications; and stronger individual rights to access electronic medical records, took effect on Feb. 17, 2010.

Physicians should be aware of this legislation and the effect it may have on their practices. All health care providers are affected by HITECH, even those who are not currently using an electronic health records system. Practices using electronic billing, clearinghouses or a third-party billing service are subject to HITECH's provisions, and need to discuss its implementation with the providers of those services to ensure compliance.

HITECH, ARRA and HIPAA are complex pieces of legislation. HealthSun encourages physicians to seek legal and professional advice from experts, such as attorneys and local and national medical associations. The following national medical associations both have valuable information about HITECH available on their websites:

- American Medical Association

(<http://www.ama-assn.org/ama1/pub/upload/mm/368/hipaa-guidance.pdf>)

- American Academy of Family Physicians

(http://www.aafp.org/online/en/home/publications/news/news-now/government_medicine/20090318hipaa-security-rules.html)

SECTION 14
HEALTHSUN HEALTH PLANS MEMBER
ASSISTANCE AND PROGRAMS

MEMBER ASSISTANCE

State & Federal Assistance Programs

Helping HealthSun Health Plans Members Attain Public Assistance Benefits through State and Federal Cost-Sharing Programs.

HealthSun Health Plans maintains a specially trained Member Assistance Department that offers a variety of services designed to help members apply for public assistance through the Medicaid programs and the Extra Help. HealthSun has been assisting health plan members attain dual eligibility status, navigate application processes and securing financial assistance through Florida's Medicaid cost-sharing programs.

On January 1, 2006, prescription drug coverage for dual eligible members shifted from state-funded Medicaid to federally-funded Medicare Part D plans. As a result, Medicare beneficiaries who qualify as a Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) and Qualified Individuals – 1 (QI1) or any full Medicaid program are now automatically eligible for the Extra Help also known as Low Income Subsidy (LIS) a federal program that assists members with the cost of prescription drug coverage. If a member is not automatically eligible to receive the LIS and, since the eligibility standards are higher than the ones for Medicaid, a separate application can be filed at the Social Security Administration.

Attaining Dual Eligibility Status Can Help Those Most in Need of Financial Aid.

Dual eligible members are individuals that qualify for federally administered Medicare programs as well as the state administered Medicaid programs because of their low- income and assets, age and/or disability status. These Medicaid programs are:

- Supplemental Security Income (SSI) is a cash assistance program administered by the Social Security Administrations. Members automatically receive Medicaid which pays for the Medicare premiums (Part A and B), Medicare Deductibles and Medicare coinsurance within the prescribed limits and automatically qualify for LIS.
- Qualified Medicare Beneficiaries (QMB) is a Medicaid program which pays for the Medicare premiums (Part A and B), Medicare Deductibles and Medicare coinsurance within the prescribed limits. QMB members automatically qualify for LIS.
- Special Low-Income Medicare Beneficiary (SLMB) is a Medicaid program which pays for the Medicare Part B premium and members are automatically eligible for LIS.
- Qualifying Individuals 1 (QI1) is a Medicaid program which pays for the Medicare Part B premium and members are automatically eligible for LIS.

The HealthSun Member Assistance Department assists members to obtain Medicaid and with the periodic renewal process of Medicaid, through a variety of eligibility pathways. These services are offered, at no additional cost, to all HealthSun Medicare Advantage health plan members. Dual eligible members are also allowed to take advantage of special election periods that may not be available to other Medicare Advantage members, and can enroll in a HealthSun Chronic Care Diabetes Special Needs Plan (SNP) at any time during the 2014 calendar year.

To be eligible for dual eligibility status, a Medicare beneficiary must:

- Have Medicare Part A (Hospital Insurance)
- Be a Florida resident
- Be a U.S. citizen or a qualified alien
- Have monthly income range and type as specified by program.*
- Have assets value and types as specified by program.*

*Amounts may vary. Please check current year's dual-eligibility thresholds.

Non Dual Eligible Members May Still Qualify for Extra Help with Medicare Prescription Drug Plan Cost.

While prescriptions may be covered by Medicaid for certain people, Medicaid does not cover the costs of prescription drugs for Medicare beneficiaries. Social Security Administration offers a program known as The Extra Help or Low Income Subsidy (LIS) and is a federal assistance with the cost of Medicare prescription drug plan.

The LIS provides:

- Payment of all or most of the annual deductible.
- Coverage during the "doughnut hole" or gap period.
- Payment of monthly plan premiums up to the base amount.

Medicare beneficiaries MUST enroll in a Medicare prescription drug plan to obtain prescription drug coverage even if they qualify for the Extra Help. With the Extra Help, individuals who enroll in a Medicare Prescription Drug Plan have the benefit of full prescription coverage similar to prescription coverage provided by Medicaid. Individuals are responsible for small cost sharing for each prescription.

Low Income Subsidy members are also allowed to take advantage of special election periods that may not be available to other Medicare Advantage members and can switch plans at any time during the calendar year.

To be eligible for the Low Income Subsidy, a Medicare beneficiary must:

- Have monthly income range and type as specified by program.**
- Have assets value and types as specified by program.**
- Reside in the United States.

**Amounts may vary. Please check current year's LIS eligibility standards.

HealthSun is Committed to Helping Members Maximize Health Benefits through their Medicare Dual Eligibility Outreach Program.

HealthSun has partnership status as an ACCESS/Florida Assisted Facility through the Florida Department of Children and Families (DCF). The Member Assistants routinely performs the following services for health plan members:

- Assist members in understanding what verifications are necessary in order for the DCF to determine eligibility for the State program;
- Assist members in verifying case status and eligibility;
- Assist members in understanding the availability of public assistance benefits and services administered by the DCF; including Food Stamps and Cash assistance as well as the different Medicaid programs.
- Ascertain the status of a member's Medicaid coverage; and
- Notify the DCF if HealthSun has case information in possession, custody or control concerning a member that is inconsistent with DCF member-specific information.

As an ACCESS/Florida Assisted Facility, Member Assistants have undergone special training by DCF in the following areas:

- Use or disclosure of confidential case file information, including information governed by the Health Insurance Portability and Accountability Act (HIPPA) of 1996;
- The availability of public assistance benefits and services administered by the DCF;
- The application process for public assistance programs;
- ACCESS Florida initiative and Community Partner's role in the initiative; and
- DCF Security Awareness training – available only to Assisted Facility ACCESS Community Partners.

If you have questions and would like additional information, please contact our Member Services Department.

MEDICATION THERAPY MANAGEMENT PROGRAM (MTMP)

All members are automatically enrolled in the MTMP, upon meeting program criteria. However, members may choose to opt-out of the program or portions of the program. For example, members may opt-out of the Comprehensive Medical Review (CMR) component of the MTMP, but remain eligible for the Targeted Medication Review and associated follow-up.

Should a member desire to permanently opt-out of the plan's MTMP, plan *should* honor request and not re-target member in future contract years; however, if ~~the~~ member actively seeks enrollment into the MTMP at a later time, perhaps due to a level of care change, plan must allow member to participate as long as they meet the necessary MTMP requirements.

Within 60-days of becoming eligible for the MTMP, member will receive an offer by mail to complete a telephonic Comprehensive Medication Review (CMR) with a qualified health care provider. In addition, member will receive by mail, a quarterly list of updated prescription medications taken during previous quarter. Members will be instructed to take this list to each prescriber and pharmacy visit. Prescriber will be able to review therapy and make any necessary adjustments.

Communication to members may contain diet and exercise tips, information specific to their disease states, Frequently Asked Questions (FAQ) about their disease states, and tips about compliance. In addition, they will be directed to an online website where various other electronic tools will be available (health tracker, personal monthly calendar, and glossary of health terms).

Prescribers may be mailed quarterly Targeted Medication Reviews (TMR) conducted systematically if any drug-drug interactions or other medication concerns are identified.

Purpose of the MTM Program:

- To optimize therapeutic outcomes for individual members
- Optimize drug therapies.
- Improve medication use.
- Reduce risk of adverse events and drug interactions.
- Increase member adherence and compliance with prescription drugs.
- Identify interventions which provide improved care to members.
- Interventions should result in health benefits and cost effectiveness for members.

HealthSun MTMP Eligibility:

- Member must have 3 or more of the following chronic diseases:
 - Bone disease-arthritis-osteoarthritis
 - Bone disease-arthritis-osteoporosis
 - Bone disease-arthritis-rheumatoid arthritis
 - Chronic heart failure (CHF)
 - Diabetes
 - Dyslipidemia
 - Hypertension
 - Mental health-depression

- Respiratory disease-chronic obstructive - Chronic Obstructive Pulmonary Disease (COPD)
 - Opioid overutilization
-
- Member must have filled 8 or more covered Part D drugs.
 - Are likely to incur annual costs for covered Part D drugs which exceed \$3,967 as specified by the Medicare.

**SECTION 15
QUALITY AND
PERFORMANCE RATINGS**

QUALITY AND PERFORMANCE RATINGS

HealthSun Health Plans would like Providers to understand the Measures and Rating System for the Quality and Performance Ratings. Below please find a brief explanation of this Program. HealthSun is strongly committed to providing high-quality care, benefits and programs that meet or exceed all CMS quality benchmarks. The structure and operations of the CMS star rating system ensures that pay-for-performance funding is used to protect or, in some cases, to increase benefits and to keep member premiums low.

The ratings are captured in the following areas:

- HEDIS
- HOS (Health Outcome Survey)
- CAHPS (Consumer Assessment of Health Care Provider and System)
- CMS Part C Measures
- CMS Part D Measures

We encourage our Providers to assist in meeting these goals by committing to the following:

- Encourage the member to obtain preventive screenings annually or when recommended.
- Identify noncompliant patients at the time of their appointment.
- Make sure that all encounters and claims are correct and with appropriate codes.
- Submit clinical data to HealthSun .
- Communicate clearly with the member and document the communication in the chart.
- Understand the measures you

1. **CMS STAR RATINGS**

The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business:

- Health Maintenance Organization (HMO),
- Preferred Provider Organization (PPO),
- Private Fee-for-Service (PFFS) and
- Prescription drug plans (PDP).

The scale ranges from one to five stars, where a rating of one star represents "poor" quality and five stars represents "excellent" quality. The program is a key component in financing health care benefits for MA plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

CMS Goals for the Five-star Rating System

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

How Are Star Ratings Derived?

A health plan's rating is based on measures in five categories:

- Members' compliance with preventive care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

Benefits to Providers

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

Benefits to Members

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer service
- Greater focus on preventive services for peace of mind, early detection and health care that matches their individual needs

For More Information

To learn more about the CMS five-star quality rating system, visit http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp

2. Healthcare Effectiveness Data and Information Set (HEDIS)[®]

HEDIS is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, HealthSun collects data from a randomly selected sample of members' medical records for HEDIS[®]. Medicare Advantage Plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA, CMS and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

HEDIS[®] – Healthcare Effectiveness Data and Information Set

HEDIS contains 76 measures across 8 “domains” of care:

- Effectiveness of care (Quality)
- Access/availability of care
- Use of services
- Cost of care
- Health Plan descriptive information
- Health Plan stability
- Informed health care choice
- Satisfaction with the experience of care

As a primary care physician, certain measures are indicative of your practice for preventive care and chronic condition management.

Preventive Screening Measures

- **Adult BMI Assessment (new measure)**- Members 18-74 years of age who had an outpatient visit and who had body mass index (BMI) documented during the measurement year or the year prior to the measurement year
- **Breast Cancer Screening** - Female members 40-69 years old who had a mammogram during the measurement year or prior year
- **Colorectal Cancer Screening** –Members 50-75 years old who had an appropriate screening for colorectal cancer. Documentation must include one of the following:
- **Fecal Occult Blood Testing** (either guaiac or immunochemical) testing during measurement year
- **Flexible sigmoidoscopy** during the measurement year or 4 years prior to the measurement year
- **Colonoscopy** during the measurement year or nine years prior to the measurement year.
- **Glaucoma Screening in Older Adults** – Members 65 years old and older, without a prior diagnosis of glaucoma suspect, who received a glaucoma eye exam by and eye care professional for early identification of glaucomatous conditions

Respiratory Condition Measures

- **Use of Spirometry Testing in the Assessment & Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)** – Members 40 years old and older with a new diagnosis or newly active COPD disease who received appropriate spirometry testing to confirm the diagnosis.
- **Pharmacotherapy Management of COPD Exacerbation** – The percentage of COPD exacerbations for members 40 years and older who had an acute inpatient discharge or ED encounter and were dispensed appropriate medications (systemic corticosteroid within 14 days of event or bronchodilator within 30 days of event)

Cardiovascular Measures

- **Cholesterol Management for patients with Cardiovascular Conditions** – The percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous trans luminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, **or** who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year.
- **LDL –C Screening performed**
- **LDL-C controlled** (<100mg/dl)
- **Controlling High Blood Pressure** – Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year .
- **Persistence of Beta-Blocker Treatment after a Heart Attack** - The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of Acute Myocardial Infarction (AMI) and who received persistent beta-blocker treatment for 6 months after discharge.

Diabetes Measures

- **Comprehensive Diabetes Care** – Members 18-75 years of age, with a diagnosis of diabetes (type 1 or type 2) who had each of the following :
 - o HbA1c testing performed during the measurement year
 - o HbA1c poorly controlled (>9.0%) performed during the measurement year
 - o HbA1c Good Control (<8.0%)
 - o Eye exam (retinal or dilated) by an eye care professional (optometrist or ophthalmologist) performed during the measurement year **or** a negative retinal (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year
 - o LDL-C screening performed during the measurement year
 - o LCL-C controlled (<100mg/dl) performed during the measurement year

- Monitoring for Diabetic Nephropathy during the measurement year
- Blood pressure (BP) monitoring: Well controlled: Two rates are reported: (a) Members who had Blood Pressure Control (<140/90mm Hg)
- (b) Members who had Blood Pressure Control (<130/80 mm Hg)

Musculoskeletal Measures

- **Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis** – (DMARD) Members diagnosed with rheumatoid arthritis who have had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug
- **Osteoporosis Management in Women who had a Fracture** – Female members 67 years and older who suffered a fracture and who had either a bone mineral density test (BMD) or Rx to treat or prevent osteoporosis in the 6 months after the fracture.

Behavioral Health Measures

- **Follow up care After Hospitalization for Mental Illness**-Members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:
 - Follow up within 30 days of discharge
 - Follow up within 7 days of discharge
- **Antidepressant Medication Management** – Assesses the different facets of the successful pharmacological management of depression for members 18 years and older who were diagnosed with a new episode of major depression
 - Acute Phase 12 week treatment phase
 - Continuation Phase remained on an antidepressant for at least six months

Medication Management Measures

- **Annual Monitoring for Patients on Persistent Medications** – Members 18 years and older who received at least a 180 day supply of ambulatory medication therapy for the selected therapeutic agent during the measurement year. These medications include:
 -
 - ACE inhibitors or ARB
 - Digoxin
 - Diuretics
 - Anticonvulsants
- **Potentially Harmful Drug-Disease Interactions in the Elderly** – The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition, or health concern, and who were dispensed an ambulatory

prescription for a contraindicated medication concurrent with or after the diagnosis. For all three indicators a lower rate represents better performance:

- A history of falls and a prescription for a Tricyclic RX anti psychotics or sleep agents
 - Dementia and a prescription for a Tricyclic anti- depressant or anticholinergic agents
 - Chronic Renal Failure and a prescription for non-aspirin NSAIDS of COX-2
 - Selective NSAIDS
- **Use of High Risk Medications in the Elderly**– Members 65 years old or older who received at least one high risk medication, and the percentage who received at least two different high risk medications which include specific prescription drugs in the following categories: Antianxiety, Antiemetic, Analgesic, Antihistamines, Antipsychotic, Amphetamines, Barbiturates, Long-acting benzodiazepines, Calcium channel blockers, Gastrointestinal antispasmodics, Belladonna alkaloids, Skeletal muscle relaxants and Oral Estrogen.

Access/Availability of Care Measures

- **Adults' Access to Preventive/Ambulatory Health Services** – ambulatory or preventive care visit during the measurement year during the measurement year

3. CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEM SURVEY (CAHPS)

Overview

The CAHPS survey is conducted annually by the Centers for Medicare & Medicaid Services (CMS) to assess the experiences of beneficiaries in Medicare Advantage plans.

The survey is typically conducted in early spring of the reporting year by mail, with Telephonic follow-up for non-responders. The CAHPS survey measures members' experiences with the plan over the previous six months. The survey sample is drawn from all individuals who had been members of a plan for at least six months. Although beneficiaries provide ratings of their "plans," the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. HealthSun contracts with a CMS-approved Medicare vendor to conduct the survey. Results are produced annually and compared to national benchmarks.

The survey has approximately 70 questions with the results reported in composites. Some questions apply to member satisfaction related to the service provided by the health plan and some reflect the member's perception of the patient-physician relationship or communication.

Getting Needed Care: Getting Appointments With Specialists

Question: In the last 6 months, how often was it easy to get appointments with specialists?

Getting Needed Care: Getting Needed Care, Tests, or Treatment

Question: In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

Getting Care Quickly: Getting Care Needed Right Away

Question In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? [Scored only for those who needed care right away in the last six months.]

Getting Care Quickly: Getting Appointments

Question: In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? [Scored only for those who needed an appointment for health care in the last six months.]

Getting Care Quickly: Getting Seen Within 15 Minutes of Your Appointment

Question: In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? **[Scored only for those who went to a doctor's office or clinic for care in the last six months.]**

Doctors Who Communicate Well: Providing Clear Explanations

Question: In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

Doctors Who Communicate Well: Listening Carefully

Question: In the last 6 months, how often did your personal doctor listen carefully to you?

Doctors Who Communicate Well: Showing Respect for What Patients Have to Say

Question: In the last 6 months, how often did your personal doctor show respect for what you had to say?

Doctors Who Communicate Well: Spending Enough Time With Patients

Question: In the last 6 months, how often did your personal doctor spend enough time with you?

Overall Rating of Specialist

Question : We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Overall Rating of Health Plan

Question: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Overall Rating of Care Received

Question: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Medicare-Specific and HEDIS Measures: Influenza Vaccination

Question: Have you had a flu shot since September 1, 2009?

Medicare Specific and HEDIS Measures: Pneumonia Shot

Question: Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

4. Health Outcome Survey (HOS)

What is HOS?

The Health Outcomes Survey (HOS) is a Centers for Medicare & Medicaid Services (CMS) survey that gathers meaningful health status data from people with Medicare. Like the CMS Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), HOS is part of an integrated system for use in quality improvement activities and to establish accountability in managed care. All managed care plans with Medicare Advantage (MA) contracts, including HealthSun Health Plans, Inc., must participate.

How does HOS affect HealthSun Members your patients?

HOS may be of interest to physicians as they could receive questions about the survey from their Medicare patients.

Survey questions pertain to patient-physician relationships and help identify areas for improving member health outcomes. Members are asked questions about overall physical and mental health status. They also are asked if they had a discussion about or received counseling or intervention from their physician on the following topics:

- **Management of urinary incontinence**
- **Physical activity in older adults**
- **Fall risk management**
- **Osteoporosis testing in older women**

HealthSun -participating physicians are encouraged to provide assessment and counseling for members in these particular areas.

How does HOS work?

A random sample of Medicare beneficiaries receives a baseline survey in the spring. Two years later, the same respondents will be surveyed for follow-up measurement. Survey completion is voluntary. The difference in the scores for the two-year period will show if members' physical and mental health status are categorized as better, the same or worse than expected. After the study is completed, member responses will be shared with HealthSun to use in quality improvement initiatives.

Who conducts the survey?

A CMS-approved Medicare survey vendor conducts the survey.

For more information about HOS, please contact your Provider Operations Representative.

SECTION 16

DEFINITIONS

DEFINITIONS

Appeal

Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or any amounts the enrollee must pay for a service as defined in 42 CFR 422.566 (b). These procedures include reconsideration by the Health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJ's), review by the Medicare Appeals Council (MAC), and judicial review.

Appeals (Redetermination)

The process by which an enrollee may challenge a plan's coverage determination. There are five (5) levels in the appeals process: redetermination by the plan, reconsideration by the Part D QIC (an independent review entity), an ALJ hearing, review by the Medicare Appeals Council and review by a federal district court. We expect most appeals to be resolved at the first two levels

Coverage Determinations

The first decision made by a plan regarding the prescription drug benefits a member may be entitled to receive, including the decision not to provide or pay for a Part D drug, a decision concerning an exception request or a decision on the amount of cost sharing for a drug.

Exceptions

A type of coverage determination request. Through the exceptions process a member can request an off-formulary drug; an exception to the plan's tiered cost sharing structure and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or prior authorization requirement).

Informal Complaint

Any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provision of services, which related to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is part of the informal steps of a grievance procedure unless it is a grievance as described below.

Initial determination (Organization Determination)

A member must ask for a standard organization determination by making a request with the Plan, or if applicable, the entity responsible for making the determination (as directed by the Plan), in accordance with the following: the request may be made orally or in writing, except where the request is for payment. [42 CFR 422.568(a) (1) and (2)].

An organization determination is any determination made by the Plan with respect to any of the following:

- 1) Payment for temporarily out of the area renal services, emergency services, post-stabilization care or urgently needed services. [42 CFR 422.566 (b)(1)];
- 2) Payment for any other health services furnished by a provider or supplier other than HealthSun, that the Member or former Member believes are covered under Medicare; or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by HealthSun. [42 CFR 422.566(b)(2)(i)(ii)];
- 3) A refusal by HealthSun to provide or pay for services in whole or in part, including the type or level of services that the Member believes should be furnished or arranged for by HealthSun. [42 CFR 422.566 (b)(3)];
- 4) Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment. [42 CFR 422.566(b)(4)];
- 5) Failure of HealthSun to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee. [42 CFR 422.566(b)(5)].

Grievance

Any complaint or dispute, other than one involving an organization/coverage determination, expressing dissatisfaction with the manner in which HealthSun or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to HealthSun, provider or facility. An expedited grievance may also include a complaint that HealthSun refused to expedite an organization/coverage determination, reconsideration or redetermination; invoked an extension to an organization/coverage determination or reconsideration/redetermination time frame or in life threatening situations.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Quality Improvement Organization (QIO)

Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient department, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and CORFs.

Reconsideration

A member's first step in the appeals process after an adverse organization determination; the health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

