



Provider Guidebook

Medicare Advantage

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SIMPLY OVERVIEW

Simply Healthcare Plans, Inc. (Simply) corporation is wholly owned by Simply, Inc. As a leader in managed healthcare services, Simply helps its members get the care they need.

MEDICARE ADVANTAGE OVERVIEW

Simply refers to the Medicare Advantage Special Needs Plans (SNPs) and integrated Medicare Advantage Prescription Drug (MA-PD) plans we offer. All network providers are contracted with Simply through a participating provider agreement. As a participating provider in the Medicare network, your contract will have a Medicare rate sheet in addition to any rate sheets for other Simply products in which you participate. We strive to incorporate expertise available nationally into operating local community-based healthcare plans with experienced staff to complement our operations.

Simply believes hospitals, physicians and other providers play a pivotal role in managed care. Simply can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. We are committed to assisting you in providing quality healthcare and hope the information in this manual is beneficial to you and your office staff. As a participating provider, you are invited to participate in our quality improvement committees. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at the Dedicated Service Unit (DSU) at **844-405-4297** with any suggestions, comments, or questions, or if you are interested in learning more about specific policies. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.

MEDICARE MEMBER AND ENROLLMENT INFORMATION

Members have a choice of getting their Medicare healthcare services through Original Medicare or through one of the Simply plans we offer. The Centers for Medicare & Medicaid Services (CMS) mails a copy of the document *Medicare & You* to Medicare beneficiaries describing Medicare benefits and plan choices every fall.

Medicare beneficiaries can enroll in Medicare Advantage plans like Simply during certain time periods called election periods. Five important election periods are:

- **Annual Election Period (AEP):** The AEP occurs from October 15 through December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- **Initial Enrollment Period for Part D (IEP):** This is the period when an individual is first eligible to enroll in a Part D plan. An individual is eligible to enroll in a Part D plan when they are entitled to Part A or is enrolled in Part B and permanently resides in the service area of the plan. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.
- **Special Election Period:**
 - CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, there is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Medicaid program. This includes both “full benefit” dual eligible individuals as well as individuals often referred to as “partial duals” who receive cost sharing

- assistance under Medicaid (for example, QMB-only, SLMB-only) and individuals who qualify for low income subsidy, but who do not receive Medicaid benefits.
- This SEP begins the month the individual becomes dually-eligible and exists as long as they receive Medicaid benefits; however, there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:
 - January – March,
 - April – June, and
 - July – September.
 - It may not be used in the 4th quarter of the year (October – December).

After CMS confirms the enrollee’s eligibility, we send the member a letter to confirm their enrollment. A new member will also receive:

- An ID card.
- A provider directory.
- A formulary (which lists the prescription drugs we cover).
- An Evidence of Coverage (EOC) document.
- Summary of Benefits.

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. Simply follows CMS directives on member enrollment and disenrollment dates; they are not determined by the plan. If retro-activity occurs, this may have an impact on claims payments.

Members who choose to enroll in a Simply plan will receive a member identification (ID) card containing the member’s name, member number and basic information about the member’s benefits. Members enrolled in a Simply plan receive an EOC document from Simply describing the Medicare benefits and services they receive. Simply plan members should present their member ID cards when receiving services.

OUR SIMPLY PLANS

Simply is a licensed health maintenance organization. We have contracted with CMS to provide Dual-Eligible Special Needs Plans (D-SNPs), as well as traditional Medicare Advantage Prescription Drug health plans.

These plans (in other words, Medicare Advantage products) include full Medicare Part D prescription drug coverage, as well as supplemental benefits covering other healthcare services beyond those offered by traditional fee-for-service Medicare. **Not all plans are offered in all service areas or carry the same supplemental benefits.** Please see the appropriate Summary of Benefits document online at <https://provider.simplyhealthcareplans.com> for more information.

Our Simply plans are designed to:

- Address the greater incidence of chronic disease and disability in the Medicare and Medicaid dual-eligible and Medicare-only populations.
- Enhance the coordination of a member’s primary and acute care, long-term care, and prescription drug benefits through a unified case management program.

Our Simply plans provide members with the benefits of integrated case management through a holistic approach while promoting continuity of care and preserving provider choice.

To learn more about our Simply plans and the work we are doing to help our members receive quality healthcare, visit <https://provider.simplyhealthcareplans.com>, contact your local Provider Relations representative to schedule a visit, or call the Dedicated Service Unit at **844-405-4297**.

THE PROVIDER SELF-SERVICE WEBSITE

Simply provides access to a website, <https://provider.simplyhealthcareplans.com> that contains the full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
 - New user registration and activation, login help, and user name and password reset. Forms to update provider demographics and information such as tax ID or group affiliation changes
 - Provider panel reports
 - Online daily PCP quality reports:
 - Hospital/inpatient admission, transfer and discharge reports
 - Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Interactive look-up tools and reference materials, such as:
 - Provider/referral directories
 - Prior Authorization lookup tool
 - Claims status/submission tool
 - Reimbursement policies
 - Provider manuals (provider manuals are available two ways, via the provider website or through your local Provider Relations representative)

Simply also offers a dedicated Provider Services team to assist with Prior Authorization and notification, health plan network information, member eligibility, claims information, and inquiries. The team can also take any recommendations you may have for improving our processes and managed care program. Below you will find additional information we hope will assist you in your day-to-day interaction with Simply.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

QUICK REFERENCE INFORMATION

Dedicated Service Unit (DSU)	Contact the DSU at 844-405-4297 for Member Eligibility, Nurse HelpLine, and Pharmacy Services
AT&T Relay Service	For English call 800-855-2880 , for Spanish call 800-855-2884 .
Acupuncture	American Specialty Health (ASH) 800-972-4226 Provider manual Link: ashlink.com/ASH/public/Providers/Benefits/Chiropractic.aspx?pg=cpg
Behavioral Health	Carelon Behavioral Health, Inc. 877-698-7787 Provider manual link: carelonbehavioralhealth.com/providers/resources/provider-handbook
Chiropractic	American Specialty Health (ASH) 800-972-4226 Provider manual link: ashlink.com/ASH/public/Providers/Benefits/Chiropractic.aspx?pg=cpg
Dental	DentaQuest 800-936-0948 Provider manual link: https://dentaquest.com/state-plans/regions/florida/dentist-page
Dermatology	Dermatology Network Solutions (DNS) 844-222-3535 Provider manual link: providernetworksolutions.com/
Durable Medical Equipment	Integrated Home Care Services Inc. (IHCS) 844-215-4264 Provider manual link: https://ihcscorp.com/resource-center
Hearing	Hearing Care Solutions 877-583-2842 Provider manual link: https://hearingcaresolutions.com/provider-program-information
Home Health	Integrated Home Care Services Inc. (IHCS) 844-215-4264 Provider manual link: https://ihcscorp.com/resource-center
Home Infusion	Integrated Home Care Services Inc. (IHCS) 844-215-4264 Provider manual link: https://ihcscorp.com/resource-center
Podiatry	Podiatry Network Solutions (PNS) 844-222-3939 Provider manual link: providernetworksolutions.com
Specialty care	Evolent: (Only in Dade, Broward, and Palm Beach) 888-999-7713 Provider manual link: newcenturyhealth.com/provider-solutions
Therapy (PT, OT, ST)	Health Network One (HN1) 888-550-8800 Provider Manual Link: ataflorida.com/provider-resources.php

Transportation	Ride2MD 833-628-0388 Provider manual link: transportationamerica.com
Vision	ICare 855-373-7627 Provider manual link: myicarehealth.com/for-providers
Notification/prior authorization	<p>May be telephoned, submitted online, or faxed to Simply:</p> <ul style="list-style-type: none"> • Telephone: 844-405-4297 • Fax: <ul style="list-style-type: none"> ○ All in-home requests for durable medical equipment, home health, and infusion services directly to Integrated Home Care Services (IHCS): 844-215-4265 ○ Concurrent review clinical documentation and request for SNF, LTACH acute rehab: 866-811-0197 ○ Behavioral health: 800-370-1116 ○ Long-term care pending (LTC) request: 866-811-0197 ○ Initial emergent admission request: 866-959-1537 ○ Outpatient/inpatient elective prior authorization: 866-811-0143 ○ Non-in home DME/HH prior authorization: 866-811-0148 • Web: https://provider.simplyhealthcareplans.com/florida-provider • Peer-to-peer (telephone): 866-588-4760 ext. 1061213000, option 2 <p>Data required for complete notification/prior authorization:</p> <ul style="list-style-type: none"> • Member ID number • Legible name of referring provider • Legible name of individual referred to provider • Number of visits/services • Dates of service • Diagnosis • Current Procedural Terminology (CPT®) code <p>Pre-service prior authorization — Providers are required to provide notification in advance of services to allow Simply to meet CMS processing timeframes:</p> <ul style="list-style-type: none"> • Medical: <ul style="list-style-type: none"> ○ Standard — 14 Calendar Days ○ Expedited — 72 Hours • Pharmacy (Including Part B Medical injectables): <ul style="list-style-type: none"> ○ Standard — 72 Hours ○ Expedited — 24 Hours <p>ER admissions:</p> <ul style="list-style-type: none"> • Simply requires notification within one business day for all ER admissions.

	<p>Notification is required:</p> <ul style="list-style-type: none"> • 14 days in advance for standard requests • Three days for expedited requests • Within one business day for all ER admits <p>Clinical staff is available during normal business hours from 8 a.m. to 5 p.m. local time. Clinical information is required for prior authorization (the <i>Prior Authorization Request Form</i> is also available online).</p>
<p>Claims submission: paper</p>	<p>Submit paper claims to:</p> <p>Simply Healthcare Plans, Inc. P.O. Box 61010 Virginia Beach, VA 23466-1010</p>
<p>Claims submission: electronic</p>	<p>Electronic claims Payer ID: SPLY</p> <p>Please contact Availity Client Services with any questions at 800-Availity (800-282-4548).</p> <p>Timely filing is governed by the terms of the <i>Provider Agreement</i>:</p> <ul style="list-style-type: none"> • Simply provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status, and prior authorization status at Availity.com. • If you are unable to access the Internet, you may receive claims, eligibility, and prior authorization status over the telephone at any time by calling our automated Provider Services number at the DSU toll-free at 844-405-4297.
<p>National Provider Identifier</p>	<p>National Provider Identifier (NPI) — The <i>Health Insurance Portability and Accountability Act (HIPAA) of 1996</i> requires the adoption of a standard unique provider identifier for healthcare providers. All Simply participating providers must have an NPI number.</p> <p>The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers, such as the state in which they practice or their specialty.</p> <p>Providers can apply for an NPI by completing an application:</p> <ul style="list-style-type: none"> • Online at https://nppes.cms.hhs.gov (estimated time to complete the NPI application is 20 minutes). • By downloading a paper copy at https://nppes.cms.hhs.gov. • By calling 800-465-3203 and requesting an application. <p>Please send your NPI to:</p> <p>Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040</p>

<p>Medicare Advantage Participating Provider Disputes and Administrative Plea</p>	<p>Medicare Provider Payment Disputes: A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims 1010 payment determinations have already been rendered.</p> <p>Medicare Provider Administrative Plea: A formal request for review of a previous Simply decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered.</p> <p style="text-align: center;">Medicare Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466-1599</p>
<p>Medicare Advantage Participating Provider Appeals</p>	<p>Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or <i>Explanation of Payment (EOP)</i> issued to determine the correct appeals process.</p> <p>Medicare Participating Provider Standard Appeal A formal request for review of a previous Simply decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.</p> <p style="text-align: center;">Medicare Complaints, Appeals & Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040</p>
<p>Medicare Member Appeals</p>	<p>Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All Medicare member liability appeals should be sent to:</p> <p style="text-align: center;">Medicare Complaints, Appeals, and Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040</p> <p>In the event that applying the standard pre-service appeal timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, an expedited pre-service appeal can be initiated by contacting us in one of the following ways:</p> <p style="text-align: center;">Medicare Complaints, Appeals and Grievances Department Attention: Member Expedited Appeals Mailstop: OH0205-A537</p>

	<p>4361 Irwin Simpson Road Mason, Ohio 45040 Part C Appeals fax: 888-458-1406 Part D Appeals fax: 888-458-1407</p> <p>Please indicate if you are requesting an expedited appeal.</p>
Provider Service representatives	For more information, contact Provider Services at the DSU at 844-405-4297 or your local Provider Relations representative.

ONGOING PROVIDER COMMUNICATIONS AND FEEDBACK

To ensure providers are up-to-date with information required to work effectively with Simply and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.

PARTICIPATING PROVIDER INFORMATION

THE MEDICARE ADVANTAGE PROVIDER NETWORK

Our Medicare members obtain covered services by choosing a Primary Care Provider (PCP) who is part of our Medicare network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral healthcare).

Note: Some services provided by a specialist may require prior authorization or a referral. All referrals to a provider that is not within the Simply Medicare network require prior authorization. Please refer to Provider Obligations — prior authorization.

When referring a member to a specialist, it’s critical to select a participating provider within our Medicare network to maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services at the Dedicated Service Unit (DSU) at **844-405-4297**. If you believe you must refer to a provider outside of our network, you must notify Simply in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories; however it does not include urgent or emergent services. Please refer to Provider Obligations — prior authorization.

THE PRIMARY CARE PROVIDER ROLE

Members are asked to select a PCP when enrolling in a Simply plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month except in extenuating circumstances. Simply contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining prior authorization for covered services for members. Medicare participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, or geriatricians. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of their members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Any referral to a provider outside of the network will require prior authorization from Simply. Please refer to Provider Obligations — Prior Authorization.

When coordinating member care, the PCP should refer the member to a participating provider within the Simply Medicare network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require prior authorization from Simply or the services may not be covered. Contact Provider Services at the DSU at **844-405-4297** for questions or more information.

THE SPECIALIST ROLE

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Simply before performing certain procedures or when referring members to non-contracted providers. Please refer to the Summary of Benefits or Evidence of Coverage documents for those procedures requiring prior authorization. You can review prior authorization requirements online at provider.simplyhealthcareplans.com or call Provider Services at the DSU at **844-405-4297**.

After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP.
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan, and any other pertinent information.
- If the specialist needs to refer a member to another provider, the referral should be to another Simply Medicare provider. Any referral to a nonparticipating provider will require prior authorization from Simply. Please refer to Provider Obligations — Prior Authorization.

SPECIALIST AS A PCP

In some cases, a specialist, physician assistant, nurse practitioner, or certified nurse midwife under physician supervision may be a PCP. This must be authorized by the health plan. Requirements and exceptions vary by market. If you have any questions, contact the DSU. To download a copy of the *Specialist as a PCP Form*, go to provider.simplyhealthcareplans.com and select **Forms** under *Provider Resources & Documents*.

PARTICIPATING PROVIDER RESPONSIBILITIES:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting Simply standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special healthcare needs
- Participate in systems established by Simply to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements
- Make provisions to communicate in the language or fashion primarily used by their assigned members
- Provide hearing interpreter services upon request to members who are deaf or hard of hearing
- Participate in and cooperate with Simply in any reasonable internal and external quality assurance, utilization review, continuing education, annual Model of Care training, and other similar programs established by Simply
- Comply with Medicare laws, regulations, and CMS instructions; agree to audits and inspections by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years
- Participate in and cooperate with the Simply appeal and grievance procedures
- **Agree to not balance bill** members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually-eligible member covered both by Medicare and Medicaid with full cost sharing coverage or in the QMB (Qualified Medicare Beneficiary) program; federal law requires providers may bill only the member's health plan or the state Medicaid agency for copayments or other cost-sharing amounts. **Providers may not bill such members for cost sharing.**
- Continue care in progress during and after termination of a member's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act of 1990 (ADA)*
- Support, cooperate, and comply with Simply Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Inform Simply if a member objects to the provisions of any counseling, treatments, or referral services for religious reasons
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release

- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
- Participate in the interdisciplinary care team meetings when necessary and as needed collaborate with Simply Case Management and review/approve or provide feedback on care plans for Special Needs Plan (SNP) members. Simply Case Management may provide members with linkage to care, care coordination, and informal resource supports for identified members agreeing to these services.
- If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Simply Medicare provider directory to ensure the specialist is in the network. Referrals to Simply Medicare-contracted specialists do not require prior authorization, all referrals to providers outside the Simply network require prior authorization unless urgent or emergent services are needed.
- Some procedures performed by specialist physicians may require prior authorization. Please refer to the Summary of Benefits document for procedures that require prior authorization or call Provider Services at the DSU at **844-405-4297**. If you cannot locate a provider in the Simply Medicare network, you should contact Provider Services at the DSU at **844-405-4297**. You must obtain authorization from Simply before referring members to noncontracted providers. Additionally, certain services/procedures require prior authorization from Simply.
- Provide **advanced** notification to members of services that are not covered by the plan or Medicare in accordance with Medicare requirements. Please refer to Provider Obligations — Prior Authorization.

Note: Simply does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

DIGITAL TRANSACTIONS AND ELECTRONIC DATA EXCHANGE

Simply has developed a Provider Digital Engagement Supplement with the purpose of establishing standards for increasing the use of secure digital provider tools and applications. These tools and applications are accessible to both participating and nonparticipating providers. This supplement is applicable to commercial, Federal Employee Program, Medicaid, and Medicare. The products include medical, behavioral health, dental, and vision. To access the digital supplement, use this link:

https://provider.simplyhealthcareplans.com/docs/gpp/FLFL_SHC_CHA_CAID_DigitalProviderSupplement.pdf?v=202010232202

Admission, Discharge and Transfer messaging data

Facilities are asked to provide Simply with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer the message data segments according to the standard HL7 format, or as requested by Simply. On a “near real-time basis” means no later than twenty-four (24) hours from admission, discharge, or transfer for any member.

CARE TRANSITION PROTOCOLS AND MANAGEMENT

Assisting with the management of transitions is an important part of our case management program. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between healthcare providers and settings and includes changes in a member’s level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition.

CARE TRANSITION PROTOCOLS

Transitional care management includes a comprehensive set of protocols that include logistical arrangements, providing education to the member and caregiver, coordination between healthcare professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing healthcare management with goal of providing access to high quality, cost-effective medical care.

PERSONNEL RESPONSIBLE FOR COORDINATING CARE TRANSITION

Managing transitions in care is a responsibility of the interdisciplinary care team (ICT). The membership of the team varies based on the complexity of the member’s needs and the desires of the member and type of transition. The team consists of providers (including other case managers or social workers), the member and/or care giver, and members of our care management team.

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The primary care provider (PCP) is responsible for coordinating and arranging referrals to the appropriate care provider. The provider network includes providers who have an expertise in managing the healthcare needs of our dual-eligible and special needs members. Some of the provider types available in our network to manage the special need of this population include but are not limited to:

- Geriatricians, physical medicine, and physiatrists
- Behavioral health providers and facilities
- Skilled nursing facilities
- Ancillary providers and facilities
- Cardiologists
- Endocrinologist

- Diabetic educators
- Dialysis centers
- Social workers and nursing professionals available through home health agencies

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps:

- When a member experiences a transition in care, it is the responsibility of the transferring provider to:
 - Notify the member in advance of a planned transition.
 - Provide documentation to the provider or facility about the member to assist in providing continuity of care.
 - Communicate and follow up with the member about the transition process.
 - Communicate with the member about their health status and plan of care to prevent any gaps post transition.
 - Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- The referring physician or provider should provide the relevant patient history to the receiving provider.
- Any pertinent diagnostic results should be forwarded to the receiving provider.
- The receiving provider should communicate a treatment plan back to the referring provider.
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent how our case managers work with our providers and members to coordinate care and assist in the management of transitions:

- Communicates with the provider to discuss the member's care needs as identified during case management or model of care activities
- Assist the member in making appointments
- Coordination between Medicaid and Medicare benefits
- Perform medication reconciliation
- Arranging transportation
- Refer to external or internal programs
- Coordinate care with behavioral health
- Arrange durable medical equipment (DME) and home health services
- Coordinate and facilitate transitions to the appropriate level of care
- Provide the member with disease specific education and self-management techniques
- Contact members post discharge to reduce unnecessary readmissions
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition

ENROLLMENT AND ELIGIBILITY VERIFICATION

All healthcare providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment, and coverage by performing the following steps:

- Request the member's Simply Medicare ID card; if there are questions regarding the information, call Provider Services at the DSU at **844-405-4297** to verify eligibility, deductibles, coinsurance amounts, copayments and other benefit information or use the online provider inquiry tool at <https://provider.simplyhealthcareplans.com/florida-provider>.
- Copy both sides of the member's Simply Medicare ID card and place the copies in the member's medical record.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- If you are a PCP, check your Simply Member Panel Listing via <https://provider.simplyhealthcareplans.com/florida-provider> to ensure you are the member's doctor.
- If the patient does not have an identification card, use the online provider inquiry tool at <https://provider.simplyhealthcareplans.com/florida-provider> or call Provider Services at the DSU at **844-405-4297**.

MEMBER MISSED APPOINTMENTS

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Simply requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at the DSU at **844-405-4297** to address the situation. Simply staff will contact the member and provide more extensive education and/or case management as appropriate. Simply's goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

NONCOMPLIANT SIMPLY MEDICARE MEMBERS

Simply recognizes providers may need help in managing non-adherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at the DSU at **844-405-4297**.

A Member or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report the outcome of any counseling efforts to you.

SECOND MEDICAL OR SURGICAL OPINION

Members may request a second opinion if they:

- Dispute the reasonableness of a decision.
- Dispute the necessity of a procedure decision.
- Do not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the Simply Medicare network.
- Be responsible for the applicable copayment.

Our Dedicated Service Unit (DSU) staff at **844-405-4297** can assist members and providers with identifying a participating provider for obtaining a second opinion.

ACCESS AND AVAILABILITY

Participating Medicare providers must:

- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Medicare provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (for example, emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

ACCESS AND AVAILABILITY STANDARDS TABLE

Type of appointment (medical or behavioral)	Availability standard
Patient visit with new PCP	Within 30 calendar days
Routine follow-up or preventive care	As soon as possible but within 10 business days
Routine/symptomatic	Within seven calendar days
Nonurgent care	Within seven calendar days
Urgently needed services	Within 48 hours
Emergency	Immediately

Appointments for **urgent** medical or behavioral healthcare services shall be provided:

- Within six hours for a non-life threatening emergency.
- Within 48 hours of a request for medical or behavioral healthcare services that do not require prior authorization.

- Within 96 hours of a request for medical or behavioral healthcare services that do require prior authorization.
- Appointments for **non-urgent** care services shall be provided:
 - Within seven calendar days post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
 - Within 14 calendar days for initial outpatient behavioral health treatment.
 - Within 14 calendar days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
 - Within 30 calendar days of a request for a primary care appointment.
 - Within 60 calendar days of a request for a specialist appointment after the appropriate referral is received by the specialist.

AFTER-HOURS (ONLY PCPS)

The PCP provides, or arranges for, coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7) by a Medicaid-enrolled PCP(s). After-hours coverage must be accessible using the medical office's daytime telephone number. After-hours coverage shall consist of an answering service, call forwarding, provider call coverage, or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision within 30 minutes.

AFTER HOURS APPOINTMENT AVAILABILITY

The Plan monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing.

All providers and hospitals are expected to treat Simply plan members with the same dignity and consideration as afforded to their non-Medicare patients.

COVERING PHYSICIANS

During a provider's absence or unavailability, the provider must arrange for coverage for their members. The provider will either: (i) make arrangements with one or more Simply Medicare network providers to provide care for his or her members or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider's behalf.

REPORTING CHANGES IN ADDRESS AND/OR PRACTICE STATUS

Any changes in a provider's address and/or practice status can be updated online by logging in to <https://provider.simplyhealthcareplans.com/florida-provider> or reported to your local Simply provider Relations Representative.

SIMPLY MEDICARE PLAN-SPECIFIC TERMINATION CRITERIA

The occurrence of any of the following is grounds for termination of the Simply Medicare provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance use
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept, unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation, and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers):
 - Unfavorable inpatient- or outpatient-related indicators:
 - Severity-adjusted morbidity and mortality rates above established norms
 - Severity-adjusted length-of-stay above established norms
 - Unfavorable outpatient utilization results
 - Consistent inappropriate referrals to specialists
 - Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
 - Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
 - Unfavorable malpractice-related issues
 - Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Simply Medicare providers have 30 calendar days to appeal a termination. The Simply process is designed to comply with all state and federal regulations regarding the termination appeal process.

INCENTIVES AND PAYMENT ARRANGEMENTS

Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider's agreement with Simply. Simply may also use financial incentives to reward providers for achieving certain quality indicator levels.

Simply does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Simply approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with Medicare Advantage regulations.

LAWS REGARDING FEDERAL FUNDS

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

PROHIBITION AGAINST DISCRIMINATION

Neither Simply nor its contracted providers may deny, limit or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

PROVIDER PANEL — CLOSING A PANEL

When closing a provider panel to new Simply Medicare members or other new patients, providers must:

- Give Simply prior written notice to Provider Relations in their health plan or submission using the online provider website the provider panel is closing to new members as of a specific closing date and accept new members until that closing date (written notice only required in Tennessee).
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Simply.
- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers the practice participates with.
- Give Simply prior written notice when reopening the provider panel, including a specific reopening date.

PROVIDER PANEL — TRANSFERRING AND TERMINATING MEMBERS

Simply will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.

A provider may request termination of a member due to fraud, disruption of medical services or the member's repeated failure to make the required reimbursements for services. In such cases, the provider should contact the DSU at **844-405-4297**.

REPORTING OBLIGATIONS — COOPERATION IN MEETING CMS REQUIREMENTS

Simply is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

Simply provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Simply in its data reporting obligations by providing Simply with any information required to meet these obligations in a timely fashion.

REPORTING OBLIGATIONS — CERTIFICATION OF DIAGNOSTIC DATA

Simply is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician, or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information, and belief) the accuracy, completeness and truthfulness of the data.

CULTURAL COMPETENCY

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to their provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include but are not limited to:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward healthcare providers
- The fact that individual preferences affect traditional and nontraditional approaches to healthcare
- The fact that patients must overcome their personal biases within healthcare systems
- The fact that healthcare providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the United States healthcare system
- A fear of rejection of personal health beliefs
- The member's expectation of the healthcare provider and of the treatment

To be culturally competent, Simply expects providers serving members within their geographic locations to demonstrate the following.

Cultural awareness:

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity

Cultural knowledge:

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person's rejection or acceptance of medical advice and treatment
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

Cultural skills:

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources

- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

MARKETING

Providers may not develop or use any materials that market Simply or the Simply plans without Simply's prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Simply plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

AMERICANS WITH DISABILITIES ACT REQUIREMENTS

The Simply policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street side parking
- Street-level access

FIRST LINE OF DEFENSE AGAINST FRAUD AND ABUSE

GENERAL OBLIGATION TO PREVENT, DETECT AND DETER FRAUD, WASTE AND ABUSE

As a recipient of funds from state and federally sponsored healthcare programs, Simply has a duty to help prevent, detect and deter fraud, waste, and abuse. Simply is committed to detecting, mitigating, and preventing fraud, waste, and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Simply policies on detecting, preventing and mitigating fraud, waste, and abuse in all the federally and state funded healthcare programs in which Simply participates.

The Simply policy on fraud, waste, and abuse prevention and detection is part of the Simply Corporate Compliance Program.

Simply maintains several ways to report suspected fraud, waste, and abuse. As a Medicare Advantage provider and a participant in government-sponsored healthcare, you and your staff are obligated to report suspected fraud, waste, and abuse. To report suspected fraud, waste, or abuse to the Plan, call the Plan's Confidential Compliance and Fraud, Waste & Abuse hotline at **877-253-9251** or send an email to SIU@simplyhealthcareplans.com.

To meet the requirements under the Deficit Reduction Act, you must adopt the Simply fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Simply. If you have questions or would like more details concerning the Simply fraud, waste, and abuse detection, prevention, and mitigation program, please contact the Simply Chief Compliance Officer.

IMPORTANCE OF DETECTING, DETERRING AND PREVENTING FRAUD, WASTE AND ABUSE

Healthcare fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. In this section, Simply educates providers on how to help prevent member and provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following.

Provider fraud, waste, and abuse:

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member fraud, waste, and abuse:

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste, and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help

prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. Simply may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** a Simply Medicare member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Simply Medicare member ID card at all times, and report any lost or stolen cards to Simply as soon as possible.

Simply believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Simply Medicare ID card can help prevent fraud, waste, and abuse. Simply encourages its members and providers to report any suspected instance of fraud, waste, and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and Simply will make every effort to maintain anonymity and confidentiality.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The *Health Insurance Portability and Accountability Act (HIPAA*, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

Simply strives to ensure both Simply and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the *HIPAA* privacy regulations.

Simply recognizes its responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Simply. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Simply to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Simply, verify the receiving fax number is correct, notify the appropriate staff at Simply, and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to Simply (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Simply.

The Simply voicemail system is secure and password-protected. When leaving messages for Simply associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Simply, providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier number.

MEDICAL RECORDS REQUIREMENTS OVERVIEW

Simply Medicare providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews.
- In conformity with good professional medical practice and appropriate health management.
- Located at the primary care site for every Simply Medicare member.
- Kept in accordance with Simply and state standards as described in this manual.
- Retained for 10 years from the final date of the contract or from the date of completion of any audit.
- Accessible upon request to Simply and/or downstream entities, any state agency, and the federal government.

Simply will:

- Systematically review medical records to ensure compliance with standards. The health plan's MAC oversees and directs Simply in formalizing, adopting, and monitoring guidelines.
- Institute actions for improvement when standards are not met.
- Maintain a record keeping system that is designed to collect all pertinent medical management information for each member.
- Make information readily available to appropriate health professionals and appropriate state agencies.
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members.

MEMBER MEDICAL RECORDS STANDARDS

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided at no cost. Members or their representatives should have access to these records.

Our medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author
4. Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies — must note prominently:
 - Medication allergies
 - Adverse reactions
 - No Known Allergies (NKA)
6. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
8. Diagnostic information
9. Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
10. Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact the care.
11. All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
12. Medical information including medication and instruction to patient
13. Identification of current problems:
 - Serious illnesses
 - Medical and behavioral conditions
 - Health maintenance concerns
14. Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
15. Smoking/alcohol/substance use — notation required for patients age 12 and older and seen three or more times
16. Consultations, referrals, and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
17. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
18. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
19. Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

DOCUMENTATION STANDARDS FOR AN EPISODE OF CARE

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible

- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (for example, handwritten signatures, unique electronic identifiers, or initials)

Other documentation not directly related to the member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures, and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Simply may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Section 1833(e) of the Social Security Act, states that Medicare payment can be made only when the documentation supports the service/item.

Simply is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

PATIENT VISIT DATA RECORDS STANDARDS

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints
2. Behavioral health treatment, including at-risk factors:
 - Danger to self/others
 - Ability to care for self
 - Affect
 - Perpetual or Chronic disorders
 - Cognitive functioning
 - Significant social health
3. Admission or initial assessment must include:
 - Current support systems
 - Lack of support systems
4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
 - Decreased
 - Increased
 - Unchanged
 - A plan of treatment, including:
 - Activities
 - Therapies
 - Goals to be carried out
 - Diagnostic tests
 - Evidence of family involvement in therapy sessions and/or treatment
5. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months, or PRN
6. Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for 10 years from the date of service.

MEDICAL RECORD REVIEW

Federal regulations require Medicare managed care organizations and their agents review medical records in an effort to avoid over or under payment and verify medical record documentation support for diagnostic conditions. Medical Record Reviews are conducted under the direction of the Medical Director and the Quality Management Director. Results of the Medical Record Review are presented to the MAC and the QMC.

Simply may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under 45 CFR § 164.502 (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of healthcare operations after they have obtained the *general consent* of the member. A general consent form should be an integral part of your medical record file.

CMS MEDICARE RISK ADJUSTMENT DATA VALIDATION AUDITS

As part of the risk adjustment process, CMS performs two different types of validation audits: Contract Level RADV and Part C Improper Payment Measure (IPM) Audits. Both audits are used to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a Contract Level RADV and/or Part C IPM Audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted and for which Medicare risk adjustment payment was received.

More information related to risk adjustment can be found at [cms.gov](https://www.cms.gov).

OTHER RISK ADJUSTMENT DOCUMENTATION REVIEWS AND AUDITS

Providers may be required to submit medical records to Simply for purposes of provider documentation and coding reviews and/or audits. Simply may also engage with providers regarding education and/or remediation to support submission of diagnosis code data that is truthful, accurate, and complete based on best knowledge, information, and belief. Based on the outcome of such documentation and coding reviews and/or audits, providers will be asked and are expected to participate in education and/or remediation.

ICD-10-CM CODES

CMS requires that providers currently use the ICD-10-CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with the guidelines, it is important for providers to code all conditions that coexist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

MEDICARE RISK ADJUSTMENT PROVIDER EDUCATION

Simply maintains a library of provider education and training regarding, for example, condition-specific information (for example, congestive heart failure), Medicare Risk Adjustment (MRA) basics, MRA-related obligations, and medical record documentation and diagnosis coding guidance. Providers are encouraged to explore provider.simplyhealthcareplans.com and access available trainings. Providers should make their best effort to participate in live (in person or virtual) and/or on-demand training and education opportunities when offered.

CLINICAL PRACTICE GUIDELINES

Using nationally recognized standards of care, Simply works with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Simply in formulating, adopting, and monitoring guidelines.

Simply selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the Medicare member population. The guidelines are reviewed and revised by the Simply Quality Improvement Council at least every two years or whenever the guidelines change.

The Simply CPGs are located online at provider.simplyhealthcareplans.com. To access the CPGs, log in to the secure site with your user name and password and select the Clinical Practice Guidelines link from the Clinical Policy and Guidelines section on the top navigation menu. A copy of the guidelines can be printed from the website.

ADVANCE DIRECTIVES

Advance directives are written instructions that:

- Give direction to healthcare providers as to the provision of healthcare
- Provide for treatment choices when a person is incapacitated
- Are recognized under state law when signed by a competent person

There are three types of advance directives:

- A durable power of attorney for healthcare (durable power) allows the member to name a patient advocate to act on behalf of the member
- A living will allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

Simply advance directive policies include:

- Respecting the rights of the member to control decisions relating to their own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CFR 489 subpart I, including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive. (42 CFR 438.3(j)(3)).
- Advising members of their right to self-determination regarding advance directives.
- Encouraging members to request an advance directive form and education from their PCP at their first appointment.
- Assisting members with questions about an advance directive; no Simply employee may serve as witness to an advance directive or as a member's authorized agent or representative.
- While members have the right to formulate an advance directive, a Simply associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law.

- Having Member Services, Health Promotion, Provider Relations and/or Healthcare Management Services staff review and update advance directive notices and education materials for members on a regular basis.
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians.
- Simply or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
 - Describes the range of medical conditions or procedures affected by the conscience objection
 - Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits.

Providers must:

- Comply with the Patient Self-Determination Act requirements.
- Make sure the first point of contact in the PCP's office asks the member if they have executed an advance directive.
- Document in the member's medical record their response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and the provider's discussion with the member, including the date when this discussion occurred, and action regarding the execution or nonexecution of an advance directive.
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact.
- Make an advance directive part of the member's medical record and put in a prominent place:
 - The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician, if applicable.
 - If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if they would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether they have executed an advance directive.

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at the following website: nrc-pad.org/content/view/41/25/.

CREDENTIALING

SIMPLY'S DISCRETION

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Simply's discretion in any way to amend, change or suspend any aspect of Simply's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Simply further retains the right to approve,

suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Simply
 - An independent relationship exists when Simply directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Simply's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
 - That are part of Simply's primary Network and include Simply Members who reside in the rental network area.
 - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Simply credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Simply credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
 - Adult Family Care/Foster Care Homes
 - Ambulatory Detox
 - Community Mental Health Centers (CMHC)
 - Crisis Stabilization Units
 - Intensive Family Intervention Services
 - Intensive Outpatient – Mental Health and/or Substance Use Disorder
 - Methadone Maintenance Clinics
 - Outpatient Mental Health Clinics
 - Outpatient Substance Use Disorder Clinics
 - Partial Hospitalization – Mental Health and/or Substance Use Disorder
 - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance) End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Simply's networks or plan programs is conducted by a peer review body, known as Simply's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Simply affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Simply medical director designee and the vice-chair must be a lead medical officer or an Simply medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels their judgment might otherwise be compromised. A committee member will also disclose if they have been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Simply's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Simply may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Simply will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Simply will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Simply will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Simply will take appropriate action to track and eliminate those practices.

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Simply when applying for initial participation in one or more of Simply's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at [CAQH.org](https://www.caqh.org).

Simply will verify those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Simply will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations <ul style="list-style-type: none"> • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

RE-CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Simply credentialing standards (“Credentialing Standards”).

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Simply for review. If the candidate meets Simply screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the “Simply Credentialing Program Standards” section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Simply may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

ONGOING SANCTION MONITORING

To support certain Credentialing Standards between the re-credentialing cycles, Simply has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (“OIG”)
- Federal Medicare/Medicaid Reports
- Office of Personnel Management (“OPM”)
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Simply departments
- Any other information received from sources deemed reliable by Simply.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

APPEALS PROCESS

Simply has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Simply’s Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Simply may wish to terminate practitioners or HDOs. Simply also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Simply’s Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Simply will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Simply’s intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one or more of Simply’s Networks or

Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Simply's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Simply takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Simply may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

SIMPLY CREDENTIALING PROGRAM STANDARDS

Eligibility criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which they will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Simply.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
 - a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
 - i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
 - ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
 - iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Simply's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
 - b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Simply education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Simply review and approval. Reports submitted by delegates to Simply must contain sufficient documentation to support the above alternatives, as determined by Simply.
5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for selecting practitioners

New applicants (credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
 - a. It can be verified that this application is pending.
 - b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
 - c. The applicant agrees to notify Simply upon receipt of the required DEA/CDS registration.
 - d. Simply will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Simply's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if **all** the following criteria are met:

- a. It can be verified that the applicant's application is pending; and
- b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
- c. The applicant agrees to notify Simply upon receipt of the required DEA registration; and
- d. Simply will verify the appropriate DEA/CDS registration via standard sources; and
- e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

- a. controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
 - b. they must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
 - c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
 12. No history of or current use of illegal drugs or history of or current substance use disorder.
 13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
 14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
 15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
 16. A minimum of the past 10 years of malpractice claims history is reviewed.
 17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Simply's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
 18. No involuntary terminations from an HMO or PPO.
 19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a. Investment or business interest in ancillary services, equipment or supplies;
 - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. Voluntary surrender of state license related to relocation or nonuse of said license;
 - d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;

- e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
- f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
- g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
- h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation criteria and exceptions for non-physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
 - a. Master or doctoral degree in social work.
 - b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
 - c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
 - b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
 - c. Practitioners with PhD training as a clinical psychologist can be reviewed.
 - d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
 - e. Licensure to practice independently or in states without licensure or certification:
 - i. Marriage & Family Therapists with a master's degree or higher:
 - Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
 - ii. Mental Health Counselors with a master's degree or higher:
 - Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
 - a. Master's or doctoral degree in a mental health discipline.
 - b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
 - c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
 - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
 - a. Valid state clinical psychologist license.
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
 - c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
 - a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
 - b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
 - c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - i. Transcript of applicable pre-doctoral training;

- ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
- iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
- iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:

- a. Applies only to practitioners in states that license psychoanalysts.
- b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Simply Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
- c. Practitioner must possess a valid psychoanalysis state license:
 - i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - ii. Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements and Verification – Nurse Practitioners:

- a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
 - i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
 - ii. American Academy of Nurse Practitioners – Certification Program;
 - iii. National Certification Corporation;

- iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
- v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
- vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review.

- f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
- g. The NP applicant will undergo the standard credentialing processes outlined in Simply's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the NP may be listed in Simply's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. NPs will be clearly identified:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Certified Nurse Midwives:

- a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
- b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force

adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

- d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All CNM applicants will be certified by either:
 - i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
 - ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

- f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
- g. The CNM applicant will undergo the standard credentialing process outlined in Simply's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
- h. Upon completion of the credentialing process, the CNM may be listed in Simply's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. CNMs will be clearly identified:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to network services and to the provider database.

10. Process, Requirements and Verifications – Physician's Assistants (PA):

- a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

- c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Simply Health Plan and submitted for individual review by the CC.
- f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
- g. The PA applicant will undergo the standard credentialing process outlined in Simply's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the PA may be listed in Simply provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. PAs will be clearly identified:
 - i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to network services and to the provider database.

11. Process, Requirements and Verifications – Acupuncturists (non MD/DO):

- a. The provider applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as an Acupuncturist and all Acupuncturists applicants must have a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM).
- c. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing

- agency does not verify education, the education will be primary source verified in accordance with policy.
- d. The license status must be that of an Acupuncturist as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - e. The provider applicant will undergo the standard credentialing process outlined in Simply's Credentialing Policies. Acupuncturists are subject to all the requirements described in these Credentialing Policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.
 - f. Upon completion of the credentialing process, the Acupuncturist may be listed in Simply's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - g. Acupuncturists will be clearly identified such:
 - i. On the credentialing file;
 - ii. At presentation to the Credentialing Committee; and
 - iii. On notification to Network Services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Simply's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Simply's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;

10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
 - a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - b. Voluntary surrender of state license related to relocation or nonuse of said license;
 - c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
 - f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Simply standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Simply may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Simply may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Simply standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or

patient safety. HDOs are re-credentialed at least every three years to assess the HDO’s continued compliance with Simply standards.

1. General Criteria for HDOs:
 - a. Valid, current, and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
 - b. Valid and current Medicare certification.
 - c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. **Note: If, once an HDO participates in Simply’s Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Simply’s other credentialed provider Networks.**
 - d. Liability insurance acceptable to Simply.
 - e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Simply’s quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND SIMPLY APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

PERFORMANCE AND TERMINATION

PERFORMANCE STANDARDS AND COMPLIANCE

All providers must meet specific performance standards and compliance obligations. When evaluating a provider’s performance and compliance, Simply reviews a number of clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to healthcare costs
- Member satisfaction — measured by the members’ reports regarding accessibility, quality of healthcare, member/provider relations and the comfort of the office setting
- Administrative requirements — measured by the provider’s methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the provider’s involvement with panels used to monitor quality of care standards

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment.
- Comply with Simply standards, including:
 - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity).
 - Federal, state, and local laws regarding professional conduct.
- Comply with Simply policies and procedures regarding the following:
 - Participating on committees and clinical task forces to improve the quality and cost of care.
 - Prenotification and/or prior authorization requirements and time frames.
 - Provider credentialing requirements.
 - Referral policies.
 - Case Management Program referrals.
 - Appropriately releasing inpatient and outpatient utilization and outcomes information.
 - Providing accessibility of member medical record information to fulfill Simply business and clinical needs.
 - Cooperating with efforts to assure appropriate levels of care.
 - Maintaining a collegial and professional relationship with Simply personnel and fellow providers.

- Providing equal access and treatment to all Medicare members.

The following types of noncompliance issues are key areas of concern:

- Unnecessary out-of-network referrals and utilization (which require prior authorization)
- Failure to provide advance notice of admissions or prior authorization of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities, or home health care services
- Member complaints and grievances filed against the provider
- Underutilization, overutilization, or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Medicare members for monies that are not their responsibility
- Nonsupportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

PHYSICIAN–PATIENT COMMUNICATIONS

Providers acting within the lawful scope of practice are encouraged to advise Simply members of the following:

- Health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits, and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Simply, the provider remains responsible for all treatment decisions related to the Simply plan member.

PROVIDER PARTICIPATION DECISIONS: APPEAL PROCESS

Upon a denial, suspension, termination or nonrenewal of a physician's participation in the provider network, Simply acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Simply
- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- Simply ensures the majority of the hearing panel members are peers of the affected physician
- Simply notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies

Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.

Simply decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. Simply notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs them of the right to appeal.

NOTIFICATION TO MEMBERS OF PROVIDER TERMINATION

Simply makes a good faith effort to provide at least 30 calendar days written notice of a provider's termination, to all members who are seen on a regular basis by that provider before the termination effective date, (or within 30 calendar days when the plan receives notification the provider terminated from the network, even when the effective termination is past) regardless of the reason for the termination. Simply may provide member notification in less than 30 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP, all members who are patients of that PCP are notified of the termination.

QUALITY MANAGEMENT

Simply maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical, and behavioral health needs of the population served. The Quality Management Program goals include, but are not limited to:

- Develop and maintain QM resources, structure and processes that support the organization's commitment to quality healthcare for our members
- Continuously improve the quality of care and service provided to members
- Improve the ability of the Plan, including all Special Needs Plans (SNP), to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner.
- Improve or maintain positive member and provider experiences through data analysis and implementing effective interventions
- Monitor and maintain full compliance with all applicable state, federal and accreditation requirements
- Implement a comprehensive Population Health Strategy that addresses:
 - Keeping Members Healthy
 - Managing Members with Emerging Risk
 - Patient Safety Outcomes Across Settings
 - Managing Chronic Illness
- Monitor for and maintain patient safety and promote safe clinical practices
- Determine if vulnerable and special needs populations have adequate access and maintain that access to appropriate care management programs, including Complex Case Management, Case Management and Condition Care and if available Long Term Services and Support (LTSS) Programs
- Maintain compliance with the Cultural and Linguistically Appropriate Services (CLAS) standards through a Health Disparities Program and the NCQA Minority Health Distinction
- Establish and maintain effective credentialing and re-credentialing processes for providers that comply with state, federal and accreditation requirements

- Provide appropriate access to care by monitoring practitioner and provider access and availability report.
- Provide oversight for all delegated activities to maintain compliance with all state, federal and accrediting organizations
- Communicate all Quality Improvement (QI) activities and outcomes through the QI process throughout the organization including the providers, Board of Directors, management, staff, members, and the community.
- Cultivate a continuous Quality Improvement (CQI) management style that is woven throughout the organization with emphasis on the member, measurement of key performance indicators, empowerment of employees, and a commitment to the improvement of healthcare and services.
- Review provider's practice methods and patterns, morbidity/mortality rates, and all grievances filed against a provider relating to medical treatment.

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Simply QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members. Practitioners and providers must allow Simply to use performance data in cooperation with our quality improvement program and activities.

CMS STAR RATINGS

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families, and caregivers for comparing MA-PD plans based on a one to five rating:

- ★ ★ ★ ★ ★ = equals excellent
- ★ ★ ★ ★ = equals very good
- ★ ★ ★ = equals good
- ★ ★ = equals fair
- ★ = equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

Staying Healthy — screening, tests, and vaccines:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Annual Flu Vaccine

- Improving and Maintaining Physical and Mental Health
- Monitoring physical activity

Managing Chronic Conditions:

- SNP Care Management
- Care for Older Adults: Medication Review, Functional Status Assessment and Pain Screening
- Osteoporosis Management in Women who had a Fracture
- Diabetes Care:
 - Diabetes Eye Exam
 - Blood Sugar
 - Cholesterol Control
- Controlling Blood Pressure
- Reducing the Risk of Falling
- Improving bladder control
- Medication Reconciliation Post-Discharge
- All-Cause Readmissions

The growing focus on quality healthcare and plan member satisfaction, CMS assesses MA plan performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Medicare beneficiaries who receive healthcare services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess their health and the care received from their primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about their access to needed healthcare services. Several questions directly correlate to a plan's CMS star rating. The survey questions ask the member to report their opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from their providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

Drug safety:

- Medication Adherence for Diabetes Medication
- Medication Adherence for Hypertension
- Medication Adherence for Cholesterol
- Statin Use for People with Diabetes

The rating system empowers consumers, families, and caregivers with information to compare MA-PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families and caregivers results to make an educated decision about their

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

healthcare needs. The ratings are posted online and may be accessed at [medicare.gov](https://www.medicare.gov). Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.

Simply encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual.
- Educating members and talking to them during each visit about their preventive healthcare needs and condition care goals.
- Ensuring providers answer any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral.
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department at the DSU and speaking to a case manager.

COMMITTEE STRUCTURE

Simply maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

MEDICARE QUALITY MANAGEMENT COMMITTEE (MQMC)

The purpose of the Corporate Medicare Quality Management Committee (CMQMC) is to provide a forum for members of the committee to review, coordinate, and direct the Medicare Quality Improvement Program. This enables interdepartmental leadership and oversight of key quality improvement activities and processes, including Medicare specific policies and procedures. This work supports improved quality of care and services, and improved member health outcomes.

Responsibilities:

- Review and approve Quality Management (QM) Trilogy Documents: Program Description, Work Plan, and Annual QI Evaluation
- Review standardized reports (at least annually) reflecting progress towards goals, actions taken, improvements
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service Quality Improvement Projects (QIP) and Chronic Care Improvement Programs (CCIP)
- Review, monitor, and evaluate program compliance against Simply, Inc., State, Federal, and CMS standards
- Oversight of the overall effectiveness of the Special Need Plan (SNP) Model of Care (MOC) goals
- Oversight and overall effectiveness of the
- MMP MOC goals
- Review overall regional and corporate quality program effectiveness including, but not limited to, member and provider satisfaction, quality of care, and accessibility and availability of care and services

QUALITY MANAGEMENT COMMITTEE

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Simply culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management Program.
- Establish processes and structure that ensures accreditation compliance.
- Review and accept corporate and local QM policies and procedures, as appropriate.
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the Plan
- Review HEDIS and CAHPS data and action plans for improvement.
- Review, monitor and evaluate program compliance against Simply, state, federal, and accreditation standards.
- Review and approve the annual quality management program description and work plan; determine and describe the program's overall effectiveness; consider the adequacy of resources, committee structure, practitioner participation, and leadership involvement in the QM program; and determine whether to restructure or change the QM program for the subsequent year based on its findings.
- Provide oversight and ensure compliance of delegated services.
- Assure inter-departmental collaboration, coordination, and communication of quality improvement activities.
- Measure compliance to medical and behavioral health practice guidelines.
- Monitor continuity of care between medical and behavioral health services.
- Monitor accessibility and availability with cultural assessment.
- Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety.
- Make information available about the QM program to members and practitioners.
- Assure the availability of Quality Management program minutes to the appropriate state regulatory agency, as applicable.
- Assure practitioner involvement through direct input from the Medical Advisory Committee or other mechanisms that allow practitioner involvement.

The MAC provides applicable advice and input to the corporate committee with oversight over the development and updating of clinical practice guidelines (CPGs) and identifies opportunities to improve services and clinical performance by establishing, reviewing/updating clinical practice guidelines based on review of demographic and epidemiologic information to target high volume, high cost, high risk, problem prone conditions. The MAC gives advice to the health plan administration in any aspect of the health plan policy or operation affecting network providers or members and provides oversight of the peer review process and drug utilization reviews. The MAC also provides guidance and feedback regarding technology assessment.

The MAC's responsibilities are to:

- Use ongoing peer review system to assess levels of care and quality of care provided.

- Monitor practice patterns to identify appropriateness of care and for improvement/risk prevention activities.
- Review and provide input, based upon the characteristics of the local delivery system, approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop and approve action plans/recommendations regarding clinical quality improvement studies.
- Review and provide input on clinically oriented Quality Management policies and procedures, Utilization Management policies and procedures, and Disease/Case management policies and procedures.
- Review and provide feedback regarding new technologies.
- Oversee compliance of delegated services.

PEER REVIEW COMMITTEE (PRC)

The Peer Review is responsible for evaluating the appropriateness of care rendered by the plan's contracted providers and reviewing provider's practice methods and patterns. The PRC evaluates provider performance and trends in quality of care and service issues. The PRC develops and analyzes Plan-wide audits. The PRC may also serve as the plan's provider advisory council providing input and recommendations to the plan concerning, but not limited to, the clinical guidelines adopted, QM Trilogy documents, Credentialing report, PIPS, process improvements, quality indicators, performance measures, HEDIS, and Provider Satisfaction Survey tools and results.

CREDENTIALING COMMITTEE

The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management Committee and the National Credentials Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated.

The CC's responsibilities are to:

- Consider/act in response to provider sanctions.
- Approve credentialing/recredentialing policies and procedures.
- Review practitioner and provider credentialing and recredentialing applicants for participation in Simply provider networks.
- Provide pre-delegation, ongoing oversight, and annual review of delegated entities.
- Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation.
- Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation.

HEALTHCARE MANAGEMENT SERVICES

Simply continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with Simply in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:

- Healthcare management services policies and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The healthcare delivery system is a gatekeeper model that supports the role and relationship of the Primary Care Provider (PCP). The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers as required to deliver Medicare benefits, additional benefits and Simply programs for members with complex medical needs. All contracted providers are available to Medicare members by PCP or self-referral for the services identified below. There are no sub networks that limit the choice of specialist referrals based on selection of PCP.

The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Simply works with the member, the physician and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

SELF-REFERRAL GUIDELINES

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening, and preventive women's health services, such as Pap smears)

Except for emergent or out-of-area urgent care and dialysis services, in general, Medicare members must obtain services within the Simply Medicare network or obtain a prior authorization for covered services outside the network. As a contracted provider with the plan, you are responsible for either referring within the network or obtaining prior authorization from the plan.

REFERRAL GUIDELINES

PCPs may only refer members to Simply Medicare contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, such as an HMO member and has expressed a desire to receive care from a different specialist or you believe the required specialty is not available within the contracted network, contact Provider Services at the DSU at **844-405-4297**. Provider must obtain prior authorization from Simply before referring members to nonplan providers. Referring a Medicare Member out-of-network will result in the claim denying with member liability unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained from the plan.

Providing Non-Covered Services Advanced Notification

For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that Simply authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Simply authorization protocols, Simply may decline to pay the claim in which case the physicians will be held

financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) issued guidance concerning Advance Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-For-Service (FFS) document and cannot be used for Medicare Advantage denials or notifications. Per CMS, the ABN is given to beneficiaries enrolled in the Medicare FFS program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

PRIOR AUTHORIZATION

Certain services/procedures require prior authorization from Simply for participating and nonparticipating PCPs and specialists. Please refer to the list below or the prior authorization Lookup tool online, or call Provider Services at the DSU at **844-405-4297** for more information. You can also access information concerning prior authorization requirements on our website at <https://provider.simplyhealthcareplans.com/florida-provider>.

CMS defines an expedited/urgent request as a request in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in seriously jeopardy.' Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

The following are examples of services requiring prior authorization before providing the following nonemergent or urgent care services:

- Behavioral health partial hospitalization
- Intensive Outpatient Services (IOP)
- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Referrals and services from noncontracted providers
- Durable Medical Equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Referrals outside of the Simply network
- Requests for non-covered services under the Medicare program

For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member

elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow authorization protocols, Simply may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of coverage is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact us prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare Member in the event of non-coverage. As a Contracted Provider with us, you are prevented from billing the Medicare Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

MEDICALLY NECESSARY SERVICES AND MEDICAL CRITERIA

Multiple clinical and coverage determination guidelines are utilized to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS (Centers for Medicare & Medicaid Services) National and Local Coverage and Benefit Guidelines, current editions of InterQual Level of Care, MCG™ Guidelines (formerly Milliman Care Guidelines®), Simply Medical Policies and Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Simply Behavioral Health Medical Necessity Criteria are utilized for all behavioral health services, unless superseded by state or federal requirements or regulatory guidance. The Medical Policies and Clinical Utilization Management Guidelines are developed by the Simply Medical Policy and Technology Assessment Committee (MPTAC). Criteria for review of behavioral health issues are reviewed by the National Behavioral Health Clinical Advisory Committee, a subcommittee of MPTAC. In addition to policies developed and approved through MPTAC, the Health Plan's medical reviewers use criteria developed by Carelon Medical Benefits Management, Inc. for review of selected requests in some markets.

Simply Healthcare Plans, Inc. is also collaborating with Health Network One (HN1) to conduct medical necessity reviews for physical therapy, occupational therapy, and speech therapy for our Medicare Advantage members.

Additional partners delegated for medical necessity reviews are Integrated Home Care Services (IHCS) for DME/Home Health and Home Infusion and Evolent for Cardiology, Oncology, Vascular, and Interventional Radiology services in Miami-Dade, Broward, and Palm Beach Counties. These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral healthcare based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Medical Policy and Technology Assessment Committee and updated when appropriate. Input from the medical community is solicited and utilized in developing and updating policies. Policies and procedures for application of medical necessity criteria are reviewed and approved annually by the Medical Operations Committee.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Simply Medicare Advantage members. These members rely on their healthcare professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria are made available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria, or for any inquiries, contact may be made via the Customer Services department by calling the number on the member's identification card.

HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Simply requires prior authorization of all inpatient elective admissions. The referring primary care or specialist physician is responsible for prior authorization.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Simply Health Care Management Services department.

Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Simply to verify benefits and process the prior authorization request. For services that require prior authorization, Simply makes case-by-case determinations that consider an individual's healthcare needs and medical history, in conjunction with nationally recognized standards of care.

Interactive Care Reviewer

Simply's Interactive Care Reviewer (ICR) is the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members covered by Simply plans in Florida. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR, or other online tool):

- **Initiate pre-authorization requests online**, eliminating the need to call or fax. ICR allows detailed text, photo images, and attachments to be submitted along with your request.
- **Make inquiries** on previously submitted requests via phone, fax, ICR, or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Use the dashboard** to provide a complete view of all UM Requests with real time status updates, including email notifications if requested using a valid email address.
- **Real time results** for some common procedures with immediate decisions.
- **Access ICR** under *Authorizations and Referrals* via Availity Essentials.

For an optimal experience with **Simply's Interactive Care Reviewer (ICR)** use a browser that supports 128-bit encryption. This includes Edge, Chrome, Firefox, or Safari.

Simply's Interactive Care Reviewer (ICR) is not currently available for the following:

- Transplant services
- Services administered by vendors such as Carelon Medical Benefits Management. *(For these requests, follow the same pre-authorization process that you use today.)*

Our website will be updated as additional functionality and lines of business are added throughout the year.

The hospital can confirm a prior authorization is on file using the Interactive Care Reviewer (ICR) or by calling Provider Services at the DSU at **844-405-4297** (see the Simply website and the Provider Inquiry Line section of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at the DSU at **844-405-4297**. Simply will contact the referring physician directly to resolve the issue.

Simply is available 24 hours a day, 7 days a week to accept prior authorization requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse.

The prior authorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the prior authorization nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, a Simply reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.

Member liability for inpatient admissions will be assigned only:

- When the denial is issued prior to the services being rendered.
- When the Important Message from Medicare is delivered in accordance with CMS guidelines.
- When inpatient services were rendered by a nonparticipating facility, were not precertified, and are not considered services covered under the plan.

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

EMERGENT ADMISSION NOTIFICATION REQUIREMENTS

Simply prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Simply of emergent admissions within one business day. Simply Health Care Management Services staff will verify eligibility and determine benefit coverage.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, a Simply reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Simply will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

NONEMERGENT OUTPATIENT AND ANCILLARY SERVICES — PRIOR AUTHORIZATION AND NOTIFICATION REQUIREMENTS

Simply requires prior authorization for coverage of selected non emergent outpatient and ancillary services. Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the need for the request (14 days advance notification for standard requests and three days advance for expedited)

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number, and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

Prior Authorization

Providers are required to provide notification in advance of services to allow Simply to meet CMS processing timeframes.

Medical:

- Standard — 14 Calendar Days
- Expedited — 72 Hours

Pharmacy (Including Part B medical injectables):

- Standard — 72 Hours
- Expedited — 24 Hours

NOTE: Simply requires notification within one business day for all ER admissions.

INPATIENT ADMISSION REVIEWS

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. Urgent and emergent admissions require notification within one business day by the Provider. The Simply utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. The appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are discussed with the medical director for possible coordination and referral to care management program. The request for prior authorization for a planned inpatient stay should occur as soon as the provider determines the need for the inpatient admission. Providers should submit prior authorization requests in advance of the inpatient admission to allow for CMS processing timeframes. CMS standard processing timeframe is 14 calendar days, expedited processing timeframe is 72 hours.

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Simply, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on the appropriateness of care and service and existence of coverage.
- Simply does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for Simply UM decision-makers do not encourage decisions that result in underutilization or create barriers to care or service.

DISCHARGE PLANNING

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. The Simply concurrent review nurse working with the Simply medical director will assist providers and hospitals with the discharge planning process in accordance with requirements of the Medicare Advantage program. At the time of admission and during the hospitalization, the Simply concurrent review nurse will discuss discharge planning with the provider, member, and/or member advocate.

When the provider identifies medically necessary and appropriate services for the member, Simply will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care. A case manager may be assigned to members at risk for readmission through Simply's post-discharge management (PDM) program and may collaborate with all parties in the process from discharge to home/community.

HOSPITAL-ACQUIRED CONDITIONS

A Hospital-Acquired Condition (HAC) is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. Examples of HAC include but are not limited to:

- A pattern of substandard care that is likely to result in future dangers to members
- Failure to comply with accepted ethical and professional standards of behavior
- An action that represents a clear and serious breach of accepted professional standards of care, such that the continued care of members by the provider could endanger their safety or health
- Potential quality of care issues related to underutilization or overutilization

Our Quality Management staff will review the identified or potential quality of care issue, request medical records, supporting documentation and other information as appropriate relevant to the case. The medical director will make a determination.

We review and analyze the quality of care issues quarterly for the health plan and identify opportunities for improving care and making recommendations for quality improvement actions. On an annual basis, we report quality of care issues to our corporate Quality Improvement Committee. The Credentialing department uses quality of care reports to evaluate practitioners during the recredentialing process. As appropriate and required, we will report incidents to federal, state, and contractual entities as required. Please contact your local Quality Management department when you identify potential incidents.

CONFIDENTIALITY STATEMENT

Members have the right to privacy and confidentiality regarding their healthcare records and information in accordance with the Medicare Advantage program and provisions of *HIPAA* concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, condition care, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

MISROUTED PROTECTED HEALTH INFORMATION (PHI)

Providers and facilities are required to review all member information received from Simply to ensure no misrouted PHI is included. Misrouted PHI includes information about members whom a provider or

facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report receipt of misrouted PHI.

EMERGENCY SERVICES

Simply provides a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Simply does **not** discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring Prior Authorization. Any hospital or provider calling for Prior Authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; and/or (3) serious dysfunction of any bodily organ or part. Emergency response is coordinated with community services, including the police, fire, and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Simply will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the healthcare provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Simply. If the emergency department is unable to stabilize and release the member, Simply will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Simply concurrent review nurse will implement the concurrent review process to ensure coordination of care.

POSTSTABILIZATION CARE SERVICES

Poststabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Prior authorization is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicaid network rate. Simply will adjudicate emergency and poststabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

NONEMERGENCY SERVICES

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than four to six weeks, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 48 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 45 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 14 days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

URGENT CARE

Simply requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Prior Authorization with Simply is not required for a member to access an urgent care center.

MEMBER MANAGEMENT SUPPORT

Medicare covers a diverse group of people. Most are over 65, but 15 percent (nearly 7 million) are people under 65 who have a disability. Almost half (47 percent) have modest or low incomes, and over one-third (36 percent) of the Medicare population has three or more chronic conditions. Medicare also covers many people who have a cognitive or mental impairment (29 percent of the Medicare population).

A significant portion (17 percent) of the Medicare population is also enrolled in Medicaid. These beneficiaries are known as dual-eligibles.

WELCOME CALL

As part of our member management strategy, Simply offers a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally,

Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

APPOINTMENT SCHEDULING

Simply, through its participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The Primary Care Provider (PCP) should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

NURSE HELPLINE

The Simply Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, healthcare and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The Simply Nurse HelpLine telephone number is **844-405-4297** and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare information when needed. Features of the Nurse HelpLine include:

- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to providers' offices within 24 hours of the call

INTERPRETER SERVICES

Simply provides our members with free interpreter services. Services are available 24 hours a day, 7 days a week and include over 150 languages, as well as services for members who are deaf or hard of hearing. To arrange interpreter services for a member in your care, call Provider Services at the DSU at **844-405-4297**.

HEALTH PROMOTION

Simply strives to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Simply.

Simply manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of Ameritips, the Simply health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Health education programs offered to members
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

MEMBER REWARDS FOR HEALTH PROGRAM*

Simply encourages our members to participate in their healthcare for living healthier lives. Our program rewards members for receiving preventive healthcare services and gives them the option of receiving up to a total of \$50 in gift cards per calendar year. When the member visits your office for one or more of the preventive services listed below, they will ask you to sign the Rewards for Health reply card. The member will mail the reply card and receive a gift card. The goal of the program is to increase early detection, decrease the cost of treatment and improve members' quality of life.

The preventive health services eligible for the Member Rewards for Health Program include:

- Annual wellness exam
- Depression screening
- Health risk assessment
- Colorectal cancer screening: fecal occult blood test (FOBTs) or fecal immunochemical test (FIT)
- Colorectal cancer screening: colonoscopy
- Diabetes care eye exam
- Diabetes care – hemoglobin a1c (hgba1c) test
- Diabetes care – hemoglobin a1c (hgba1c) control
- Annual flu vaccine
- Breast cancer screening (mammogram)
- Fall risk screening

* Does not apply to Simply's ESRD C-SNP plans.

CASE MANAGEMENT

The Simply Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs.

The scope of the Case Management Solutions Program includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- Member education
- Member empowerment using motivational interviewing techniques
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Provider referrals and member/caregiver self-referrals are also considered for appropriate case management programs. All members in a Special Needs Plan (SNP) have access to receive case management.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

A core feature of the Simply Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional, and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across healthcare settings, to collaborate with other healthcare team members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member's providers with the goal of facilitating access to quality, necessary, cost-effective care. The process requires member/caregiver active participation and consent.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values, and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest their own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may have access to review member care plans through and/or a copy of the

member's care plan may be sent to you for review. A case manager or designee may contact you to request any feedback or approval as part of the member's interdisciplinary team.

If you have identified a patient as a possible candidate for case management and wish to have them evaluated to see if they qualify, you can call in the referral for evaluation to **844-405-4297** or the number on the members identification card and ask for someone in the Case Management department. The case management department is available Monday-Friday from 8 a.m. to 5 p.m. EST. You may also email the Case Management referral group at: CM_DM_Referrals@simplyhealthcareplans.com

When sending an inquiry or referral please be sure to include member ID, DOB, Plan, reason for email or identified need and your contact information.

MODEL OF CARE (SPECIAL NEEDS PLAN)

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified The SNP model of care is designed to improve the care of our members with the following goals:
 - Improved access to affordable medical, mental health, and social services
 - Improved coordination of care through an identified point of contact or gatekeeper
 - Improved transitions of care across settings and providers
 - Improved access to preventive health services
 - Assure appropriate utilization of services
 - Improved member health outcomes
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an assigned case manager, as well as an individualized interdisciplinary care team (ICT) which at minimum is composed of the member/caregiver, nurse case manager, and primary care physician but may include others participating in the member's care as needed and appropriate. Additional ICT members may include home health nurses, specialists, social workers, pharmacists, behavioral health specialists, or other participants as determined by the member.
3. We will work to complete a telephonic health risk assessment (HRA) on each member. For new members, the goal is to complete an HRA within 90 days and annually before the anniversary of the last HRA. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional, and environmental topics and serves as the basis for the member's individualized care plan. Providers have access to the HRA results and the ICP through the provider website or may receive a copy via fax.
4. Based on the results of the health risk assessment, an individualized care plan will be developed by the case manager working directly with the member and the interdisciplinary care team to address identified needs. The care plan includes interventions designed to educate, inform, and serve as an advocate for our members to help achieve their health goals and in support of the physician

treatment plan. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid as appropriate.

5. An interdisciplinary care team is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers, and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care through additional activities as needed.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing, and educating members, performing assessments, diagnosing, and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members, and our care team. Information from our internal systems is available to you through the provider website and may assist you in managing our member's care. You can access claim information, the care plan, the health risk assessment and see other providers involved in providing care. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your patient's care team by calling the number provided to you on any correspondence from us or the number on the member's identification card. General information is available online through the provider website on our website.
8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of healthcare institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed, and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include the following measures:
 - Healthcare Effectiveness Data and Information Set (HEDIS) — used to measure performance on dimensions of care and service
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
 - Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited

to SNP members responses we use these results to assist us in the population assessment.

- CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations, and procedure frequency
- Medication therapy measurement measures
- Clinical and administrative/service quality improvement projects

10. SNP model of care training is required annually and provided to providers, employees, and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, on our provider website or through Availity.

11. Annual Program Evaluation: Each year an evaluation of the model of care occurs to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we periodically review our program to assist in early identification of any potential issues that may require actions. A summary of the findings from the Model of Care Annual Evaluation are posted on the provider website during the 2nd quarter of each year for the prior measurement year.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

MEMBER SATISFACTION

The Plan, periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Simply reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Medicare Advantage plans' HEDIS and star ratings. The Plan encourages its participating providers to encourage members to actively participate in their healthcare, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan. See the Centers for Medicare & Medicaid Services Star Ratings section of this manual.

CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

CLAIMS — BILLING AND REIMBURSEMENT

Clean claims for Medicare members are generally adjudicated within 30 calendar days from the date Simply receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Simply and the information required from the provider to adjudicate the claim. Simply produces and mails an Explanation of Payment (EOP) on a daily basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Medicare members must **not** be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Medicare members are also not held liable for non-covered services where the provider failed to provide advanced notice of non-coverage via the organization determination process. Reimbursement by Simply constitutes payment in full except for applicable copays, deductibles, and coinsurance. These amounts will be indicated on the EOP and

direction provided based on whether Simply is responsible for processing both the primary and secondary claims or not. In instances where Simply is only responsible for processing primary claims, the provider should bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for Specialty + Rx plan members. See the Billing Members section of this manual for additional details about cost sharing.

Provider must use *HIPAA*-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating provider agreement will not be required to replace such billing codes. Simply follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with *HIPAA*. Simply will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

CLAIM STATUS

Providers should access the Simply online claim status inquiry tool at provider.simplyhealthcareplans.com or call Provider Services at the DSU at **844-405-4297** to check claim status.

PROVIDER CLAIMS

Providers should submit claims to Simply as soon as possible after service is rendered. Claims should be filed using the *CMS-1500* (08-05) or *UB-04* or *CMS-1450* claim form or filed electronically.

BILLING DIFFERENCES FOR MEDICARE ADVANTAGE

***CMS-1500* (08-05)**

Box 9, 9A-D	Other Insurance, including Medicaid
Box 25	Federal Tax ID number
Box 33	State Medicaid number

Hospitals

Hospitals should submit claims to the Simply claims address as soon as possible after service is rendered, using the standard *UB-04* form or by filing electronically.

UB-04/CMS 1450

Box 5	Federal Tax ID Number
Box 51a	Simply Unique Provider ID Number
Box 51b	State Medicaid Number
Box 51c	Medicare ID Number

COORDINATION OF BENEFITS

Simply and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Simply is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Simply does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Simply will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Simply will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Simply handles the filing of liens and settlement negotiations both internally and externally via its vendors.

D-SNP Covered Services and Plan Benefit Packages

D-SNP Plan benefit package/member covered services are listed at <https://provider.simplyhealthcareplans.com/florida-provider/manuals-and-guides>.

Providers servicing the Dual-Eligible population agree to comply with:

- All applicable Medicare Advantage rules, regulations, and policies.
- AHCA's Medicaid Services Coverage and Limitations Handbooks, including professional licensure and certification standards and includes the scope of services, which can be found at the link below:
https://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/Medicare_Advantage_D-SNP_Medicaid_Covered_Services.pdf
 - May be amended from time to time by AHCA and Simply

ELECTRONIC SUBMISSION

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit [Availity.com](https://www.availity.com) > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse or billing vendor or Availity at **800-AVAILITY (800-282-4548)**.

Payer ID

Your Payer Name is Simply Healthcare and the Payer ID is SEMPLY.

Availity's Payer ID's

<https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/>

***Note:** If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.*

Useful EDI Documentation

Availity EDI Connection Service Startup Guide — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide — This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page — **Availity register page for users new to Availity.**

Washington Publishing Company - X12 code descriptions used on EDI transactions.

EDI SUBMISSION FOR CORRECTED CLAIMS

For corrected professional (837P) claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

For corrected electronic claims the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUBC website at nubc.org/FL4forWeb2_RO.pdf.

PAPER CLAIMS SUBMISSION

Providers also have the option of submitting paper claims. Simply uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Simply staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, Simply now requires the use of the new *CMS-1500 (08-05)* for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Simply now requires the use of the new *UB-04* or *CMS-1450* for the purposes of accommodating the NPI.

CMS-1500 (02-12) and *UB-04* or *CMS-1450* must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-9 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Simply provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician

- NPI of performing provider when applicable State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/Prior Authorization number or copy of authorization/Prior Authorization
- Name of referring physician
- NPI of referring physician when applicable
- CLIA Identification number when applicable (*CMS-1500* only)
- Any other state-required data

Simply cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Simply will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service.

Submit paper claims to the following address:

Simply Healthcare Plans, Inc.
 P.O. Box 61010
 Virginia Beach, VA 23466-1010

DENYING CLAIMS BY EXCLUDED AND PRECLUDED PROVIDERS

Simply monitors appropriate sanction resource lists to identify providers for whom claims should be denied for its Medicare businesses. For pharmacy providers, the PBM shall be primarily responsible for reviewing the OIG and General Services Administration (GSA) sanction lists in their entirety to ensure no excluded providers are in the pharmacy network. Monthly updates to the sanctions lists are monitored to ensure pharmacies new to the list are not included in the network. For medical providers, Simply Medicare Claims monitors the OIG website on a monthly basis to identify sanctioned providers both to prevent payment for medical claims to ineligible providers, and to support correct claim determination complying with Medicare regulations. Further, Simply Provider Data Management monitors the CMS website on a monthly basis to identify precluded providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries both to prevent payment and to support correct claims determination complying with Medicare regulations.

ENCOUNTER DATA

Medicare Advantage Organizations must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Facilities and providers who render services to Simply members are required to submit complete claim and encounter data to Simply. In addition, providers have contractually agreed to submit diagnosis code data that is accurate, complete, and truthful (based on their best knowledge, information, and belief). Data should be submitted through a compliant, electronic 837 submission or on a CMS-1500/UB-04 form, unless other arrangements are approved by Simply. Claim/Encounter submissions should follow industry standards as well as comply with all Simply and CMS requirements.

Electronic 837 industry standards are developed and maintained by the American National Standards Institute and the X12 organization. More information on formatting and compliant submission can be found here: <https://x12.org/>

Claim and Encounter data submissions are used in a variety of ways, including collecting data related to Healthcare Effectiveness Data and Information Set (HEDIS) measures and calculating risk adjustment. Risk adjustment was implemented by CMS to pay Medicare Advantage Organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. The Medicare Advantage Organization is required to submit diagnosis information collected from encounter and claim data to CMS for the purposes of risk adjustment.

CLAIMS ADJUDICATION

Simply is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT and ICD manuals. Institutional claims should be submitted using EDI submission methods or an *UB-04* or *CMS-1450* and provider claims using the *CMS-1500*.

Providers must use *HIPAA*-compliant billing codes when billing Simply. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Simply will not pay any claims submitted using noncompliant billing codes.

Simply reserves the right to use code-editing software to determine which services are considered part of incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 6 months from the date the eligibility is added and Simply is notified of the eligibility/enrollment.
- Claims submitted after the market specific timely filing deadline will be denied.

After filing a claim with Simply, review the daily *EOP*. If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Simply website at provider.simplyhealthcareplans.com or by calling Provider Services at the DSU at **844-405-4297**. If the claim is not on file with Simply, resubmit your claim within six months from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

CLEAN CLAIMS PAYMENT

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form, including a *CMS-1500* or *CMS-1450* or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment, or alteration by the provider or by a third party in to be processed and paid by Simply.

Clean claims are typically adjudicated within 30 calendar days of receipt. If Simply does not adjudicate the clean claim within the time frames specified above, Simply will pay all applicable interest as required by law.

Simply produces and mails an *EOP* on a daily basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, Simply should complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the Simply contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Simply will pay at least 95 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 calendar days of the date of receipt. Simply will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date Simply receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

PROVIDER REIMBURSEMENT

Electronic Remittance Advice (835) and Electronic Funds Transfer (EFT)

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to [Availity Essentials](#)
2. Select **My Providers**
3. Select **Enrollment Center** and select **Transaction Enrollment**

Note: *If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.*

Contact Availity

Please contact Availity Client Services with any questions at **800-Availity (800-282-4548)**.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (<https://enrollsafe.payeehub.org>) to register and manage EFT account changes.

PRIMARY CARE PROVIDER REIMBURSEMENT

Simply reimburses PCPs according to their contractual arrangement.

SPECIALIST REIMBURSEMENT

Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Simply.

Specialty care providers must obtain Simply approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or Prior Authorization, as appropriate, and receipt of the required claims and encounter information to Simply.

REIMBURSEMENT POLICIES

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Simply benefit plan.

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Simply reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however Simply strives to minimize these variations. Simply reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy at provider.simplyhealthcareplans.com.

REIMBURSEMENT HIERARCHY

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

REVIEW SCHEDULES AND UPDATES

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Simply business decision. We reserve the right to review and revise our policies when necessary. When there is an update we will publish the most current policy at provider.simplyhealthcareplans.com.

MEDICAL CODING

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Simply. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

REIMBURSEMENT BY CODE DEFINITION

Simply allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

OVERPAYMENT PROCESS

Refund notifications may be identified by two entities, Simply Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Simply, the CCU will notify the provider of the overpayment.

Upon determination that any recoupment, improper payment, or overpayment is due from a provider, provider must refund the amount within 60 days of when Simply notifies a provider. If such reimbursement is not received within the 60 days following the date of such notice, Simply shall be entitled to offset such overpayment against other amounts due and payable by Simply to a provider in accordance with regulatory requirements. Simply reserves the right to employ a third-party collection agency in the event of nonpayment.

In cases when the provider has identified the overpayment, the provider shall voluntarily refund all duplicate or erroneous claim payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, noncompliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. within the 60 days of identification of the overpayment.

The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns the Simply check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the provider website at provider.simplyhealthcareplans.com. Submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at the DSU at **844-405-4297**.

Simply uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

Recovery Look-back period for Medicare claims (when Simply Medicaid member has Medicare coverage) — To align with CMS guidelines, 42 CFR § 405.980, **405.986**, Simply recovers Medicare Advantage claim overpayments within four years of the claim payment date. In addition, CMS' Medicare Integrity Program employs Recovery Audit Contractors to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

DETERMINING DISPUTE/APPEAL PROCESS

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable.

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals and Grievance (MCAG) department. See Medicare Member Liability Appeals process.

PARTICIPATING PROVIDER STANDARD APPEALS AND ADMINISTRATIVE PLEAS

A participating provider standard appeal is a request for Simply to review a decision by Simply Health Care Management Services that medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. Participating provider standard appeals and participating provider administrative pleas follow different processes, which are described in this Provider Manual. The provider is responsible for sending in all necessary information, and a determination will be rendered based on the information provided.

PROVIDER CLAIM PAYMENT DISPUTES AND ADMINISTRATIVE PLEA PROCESS

CLAIM PAYMENT DISPUTES

PROVIDER CLAIM PAYMENT DISPUTE PROCESS

If you disagree with the outcome of a claim, you may begin the Provider Payment Dispute Process.

There are two types of submissions that are handled within the dispute process:

- **Provider Payment Dispute:** The claim has been finalized, but you disagree with the amount that you were paid.
- **Provider Administrative Plea:** The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the Provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, these are briefly defined below. They are:

- **Claim Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** When Simply requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials is in the Correspondence section of this *Provider Manual*.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Simply decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows: Upon clinical review, the services related to the Prior Authorization request were deemed not medically necessary, but services were rendered and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this *Provider Manual*.

The Simply Provider Payment Dispute Process consists of two internal steps. You will **not** be penalized for filing a Claim Payment Dispute and no action is required by the member:

1. **Claim Payment Reconsideration:** This is the first step in the Simply Provider Payment Dispute Process. The Reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the Claim Payment Reconsideration step.
2. **Claim Payment Appeal:** The second step in the Simply Provider Payment Dispute Process. If you disagree with the outcome of the Reconsideration, you may request an additional review as a Claim Payment Appeal.

A Claim Payment Dispute may be submitted for multiple reason(s) including:

- Contractual payment issues
- Disagreements over reduced claims or zero-paid claims not related to medical necessity
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

* Timely filing issues. Simply will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration

The first step in the Simply Claim Payment Dispute process is called the Reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a Reconsideration without a finalized claim on file.

We accept Reconsideration requests in writing, verbally and through our provider website within 120 calendar days from the date on the explanation of payment (*EOP*) — see below for further details on how to submit. Reconsiderations filed more than 120 days from the *EOP* will be considered to be untimely and denied unless good cause can be established.

When submitting Reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The Plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal.

If a Reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Simply professionals. The Plan will make every effort to resolve the claims payment reconsideration within 30

calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's Reconsideration request.
2. A statement of what action the Plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider's right to request a Claim Payment Appeal within 63 calendar days of the date of the Reconsideration determination letter.
6. An address to submit the Claim Payment Appeal.
7. A statement that the completion of the Claim Payment Appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment, and *EOP* will be sent separately.

Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination you may submit a Claim Payment Appeal.

We accept Claim Payment Appeals through our provider website or in writing within 63 calendar days of the date on the Reconsideration determination letter. Claim Payment Appeals received more than 63 calendar days after the explanation of payment or the claims Reconsideration determination letter, will be considered untimely and will be upheld unless good cause can be established.

When submitting a Claim Payment Appeal, please include as much information as you can to help us understand why you think the Reconsideration determination was in error. Please note, we cannot process a Claim Payment Appeal without a Reconsideration on file. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The Plan will make every effort to resolve the Claim Payment Appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a Claim Payment Dispute

We have several options when filing a Claim Payment Dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **800-454-3730**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at [Availity.com](https://www.availity.com). Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission. For appeals, your Availity Essentials user account will need the Claim Status role. To send attachments from Claim Status, you'll need the Medical Attachments role:

- Locate the claim you want to dispute on Availity Essentials using **Claim Status** from the *Claims & Payments* menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.
- **Written (Reconsideration and Claim Payment Appeal):** Written Reconsiderations and Claim Payment Appeals should be mailed, along with the Claim Payment Appeal Form or the Reconsideration Form to:
 - Provider Payment Disputes**
 - P.O. Box 61599**
 - Virginia Beach, VA 23466-1599**

Required Documentation for Claims Payment Disputes

Simply requires the following information when submitting a Claim Payment Dispute (Reconsideration or Claim Payment Appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Simply or Medicaid ID number.
 - A listing of disputed claims, which should include the Simply claim number and the date(s) of service(s).
 - All Supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an Inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the Claim Payment Dispute. In other words, once you get the answer to your claim inquiry, you may opt to being the Claim Payment Dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **800-454-3730** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim Correspondence is different from a Payment Dispute. Correspondence is when the Plan requires more information to finalize a claim. Typically, Simply makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Simply will use it to finalize the claim. The following table provides examples the most common Correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
Electronic Data Interchange (EDI) rejected claim(s)	Contact Availity Client Services at 800-AVAILITY (800-282-4548) when your claim was submitted electronically but was never paid or was rejected.
EOP requests for supporting documentation (sterilization/hysterectomy/abortion consent forms, itemized bills, and invoices)	Submit a claim correspondence form, a copy of your <i>EOP</i> , and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit a claim correspondence form, a copy of your <i>EOP</i> , and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a claim correspondence form and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Simply to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB. Availity Essentials corrected claim submission: From the Availity Essentials menu bar, select Claims & Payments > Claims > Professional Claim or Facility Claim .
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a Claim Correspondence form, a copy of your <i>EOP</i> , and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your <i>EOP</i> and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

PROVIDER PAYMENT DISPUTES PROCESS

If you believe Simply has not paid for your services according to the terms of your provider agreement, submit a request using the Appeals Form located online under Forms at provider.simplyhealthcareplans.com.

Providers will not be penalized for filing an appeal or payment dispute. Submit provider liability appeals/payment disputes to:
Medicare Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

The Provider Disputes Unit will receive, distribute, and coordinate all payment disputes.

1. Submit a written request with supporting documentation, such as an *EOP*, and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when Simply notice of initial determination was generated or we will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.
2. The Simply Claims department conducts the review, and/or the health plan medical director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.
3. An internal review is conducted and results communicated in a written decision to the provider within 60 calendar days; the written decision includes:
 - A statement of the provider's dispute
 - The reviewer's decision along with a detailed explanation of the contractual and/or medical basis for such decision
 - A description of the evidence or document that supports the decision

COORDINATION OF BENEFITS

Simply and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Simply is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Simply does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Simply will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Simply will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Simply handles the filing of liens and settlement negotiations both internally and externally via its subrogation vendor, Optum.

Simply requires members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied, or pended claims should be directed to Provider Services at the DSU at **844-405-4297**.

Provider Obligations — denial notification and Member complaints, appeals AND grievances Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Simply requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans.

SKILLED NURSING FACILITIES, CORFs AND HOME HEALTH AGENCIES

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility (CORF) or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued to a Medicare member at least two days prior to when covered services are ending or in advance of the last two covered visits. This notice informs the member their stay or visits no longer meet coverage criteria and coverage will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and Simply is required to ensure proper delivery and that the member's signature is obtained.

The member's signature acknowledges receipt of the notice and is not an agreement with the denial. In the event the member is in need of an authorized representative to acknowledge/sign the NOMNC, and the SNF is unable to deliver it to the authorized representative, the SNF should telephone the representative the same day the NOMNC is issued, to advise him/her when the member's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the staff person initiating the contact, the name of the member representative contacted by telephone, the date and time of the telephone contact, and the telephone number called.

If agreed by both parties, the notice can then be emailed or faxed (in accordance with HIPAA privacy and security requirements). Otherwise, the annotated NOMNC must be mailed on the same day. A copy of the annotated NOMNC should be retained in the member's medical record. If a member (or representative) elects to exercise their right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO within the time frame indicated on the request.

HOSPITALS

The Important Message from Medicare (IM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer

any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted.

If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise them of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). Otherwise, the notice must be mailed the same day. In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider their rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise their right to an immediate review, they must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

PROVIDER OBLIGATIONS — IN-OFFICE DENIALS

In the event a member disagrees with the provider's decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by the Plan or Medicare. At each patient encounter with a Medicare member, the provider must notify the member of their right to receive, upon request, a detailed written notice from Simply regarding the member's services. The provider must request us to provide a detailed notice of a provider's decision to deny a service in whole or part; in turn, we must give the member advanced written notice of the determination, by following the Prior Authorization process (outlined below).

For services that require Prior Authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that Simply authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Simply authorization protocols, Simply may decline to pay the claim in which case the provider will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) issued guidance concerning Advance Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-For-Service (FFS) document and cannot be used for Medicare Advantage denials or notifications. Per CMS, the ABN is given to beneficiaries enrolled in the Medicare FFS program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied and the member cannot be held financially responsible. Therefore, your failure to obtain an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact Simply prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare Member in the event of non-coverage. As a Contracted Provider with Simply, you are prevented from billing the Medicare Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

PROVIDER OBLIGATIONS — PRIOR AUTHORIZATION

Providers are responsible for obtaining prior authorization from Simply before performing certain procedures, when rendering non-covered services or when referring members to noncontracted providers. Please refer to the Summary of Benefits document for those procedures that require prior authorization or call Provider Services at the DSU at **844-405-4297**. Simply will render a determination on the request within the appropriate timeframe and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Simply and the provider will not generate a member denial letter:

- An initial *organization* determination is any determination (for example, an approval or denial) made by Simply for coverage of medical services (Part B-covered services).
- An initial *coverage* determination is any determination (for example, an approval or denial) made by Simply for coverage of prescription drugs (Part D-covered services).

SIMPLY MEDICARE ADVANTAGE COMPLAINTS, APPEALS, GRIEVANCES AND DISPUTES

DISTINGUISHING BETWEEN PROVIDER AND MEDICARE ADVANTAGE MEMBER COMPLAINTS, APPEALS & GRIEVANCES

Simply has separate and distinct processes for requests to reconsider a Simply decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare Member liability denials are subject to the Medicare Complaint, Appeal & Grievance (MCAG) process as outlined in the Member Appeals and Grievances section. Disputes between the Health Plan and the Provider that do not involve an adverse determination or liability for the Medicare Member would follow the Simply Medicare Advantage Participating Provider Appeals and Dispute or Non-Participating Provider Payment Dispute processes.

Providers must cooperate with Simply and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in to allow Simply to make an expedited decision. Your participation in, along with the member's election of the Medicare Advantage plan, are an indication of consent to release those records as part of the healthcare operations.

Medicare Member Liability — Simply has determined that a Medicare Member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare Member cost-share. Any time a member liability denial letter is issued, the Member Appeals process should be followed and NOT the Provider Appeals process. Medicare Member liability is assigned when:

- The Integrated Denial Notice (IDN) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with subsequent review by the Independent Review Entity (IRE).
- Notice of Medicare Non-Coverage (NOMNC) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*
- An *Explanation of Benefits (EOB)* indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment (EOP)* indicates there is member responsibility assigned to a claim processed.

NOTE: Members who are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance, and copayment amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the Balanced Budget Act of 1997. Providers that service dual eligible beneficiaries must accept the amounts paid by Medicare as payments in full, as well as any payment under the State Medicaid processing guidelines. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as ‘private pay’ to bill the patient directly and Providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to the Centers for Medicare & Medicaid Services (CMS) for further action/investigation.

Participating Provider Liability — Simply has determined that the Participating Provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating Providers are prohibited from billing a Medicare Member for services unless the plan has determined Member liability and issued the appropriate notices as above.

Non-Participating Provider Liability — Simply has determined that the Non-Participating Provider with the plan has failed to follow Medicare processing guidelines Non-Participating Providers are prohibited from billing a Medicare Member for services unless the plan has determined Member liability and issued the appropriate notices as above and has procedures for Non-Participating Provider to follow.

SIMPLY MEDICARE ADVANTAGE PARTICIPATING PROVIDER STANDARD APPEALS

Simply participating providers may initiate provider appeals under the Provider Appeal Procedures.

Simply typically determines provider appeals within 60 days when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal

A formal request for review of a previous Simply decision where medical necessity was not established where Provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility All requests must be:

- Submitted in writing
- Submitted within *180 days from the Simply decision letter date
- Include a cover letter with:
 - Member Identifiable information
 - Date(s) of service in question
 - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Simply's original decision
- Include necessary attachments:
 - Copy of the original Simply decision
 - All applicable medical records

NOTE: Simply will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:

Simply

Attention: Medical Necessity Provider Appeals

Mailstop: OH0205-A537

4361 Irwin Simpson Road

Mason, Ohio 45040

Providing the above information will enable Simply's Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirements.

SIMPLY MEDICARE ADVANTAGE NON-PARTICIPATING PROVIDER PAYMENT DISPUTES

NON-PARTICIPATING PROVIDER PAYMENT DISPUTES

If, after a claim has been adjudicated, a non-participating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the Non-Participating Provider Payment Dispute Resolution Process can be utilized. Notification will be provided to the Non-Participating Provider at each step of the process. For more information regarding the disputes process, please see the appropriate section within this manual.

SIMPLY MEDICARE ADVANTAGE NON-PARTICIPATING PROVIDER APPEALS RIGHTS

If a claim is partially or fully denied for payment with member liability (see original decision letter), the non-participating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed Waiver of Liability statement must be included. To obtain this form, visit [cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip).

The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the non-participating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address:

Simply
Medicare Complaints, Appeals, and Grievances
Attention: Non-Contracted Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

SIMPLY MEDICARE MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility, or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare Member **appeals** process and Medicare Member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

MEDICARE MEMBER LIABILITY APPEALS

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Simply to reconsider and change an initial coverage/organization determination (by Simply or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Simply will reimburse for a service, benefit, or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Simply denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Simply or a provider concerning authorization for or termination of coverage of a healthcare service
- An adverse initial organization determination by Simply concerning reimbursement for a healthcare service
- An adverse initial organization determination by Simply concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Simply or a provider concerning authorization or payment for prescription drugs

Appeals should be sent to: Simply
Medicare Complaints, Appeals, and Grievances
Attention: Member Appeals Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare Member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

PARTICIPATING PROVIDER RESPONSIBILITIES IN THE MEDICARE MEMBER

APPEALS PROCESS:

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an Appointment of Representative Form may be required. The Appointment of Representative Form can be found online and downloaded at cms.hhs.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.
- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process

APPEAL TIMEFRAMES

- Members or their Authorized Representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug, must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe:
 - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are resolved within 72 hours unless it is in the member's interest to extend this time period.

- A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
 - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
 - Part D payment appeals must be resolved within 14 days from the date the request was received.
 - Part D appeals timeframes cannot be extended.

FURTHER APPEAL RIGHTS

If Simply is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Simply will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
 - Within 72 hours if expedited.
 - Within 30 days if the appeal is related to authorization for healthcare that is not a Part B drug.
 - Within seven days if the appeal is related to authorization of a Part B drug.
 - Within 60 days if the appeal involves reimbursement for care.
 - Part D prescription drug appeals are not forwarded to the IRO by Simply but may be requested by the member or representative; information will be provided on this process during the Simply Medicare member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

HOSPITAL DISCHARGE APPEALS AND QIO REVIEW PROCESS

Hospital discharges are subject to an expedited member appeal process. The Centers for Medicare Medicaid Services (CMS) has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in

the hospital, Simply continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.

If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then they may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

MEDICARE MEMBER GRIEVANCES

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Simply or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Simply must accept grievances from members orally or in writing within 60 days of the event. Simply must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Simply has 24 hours to respond. An expedited grievance can only be initiated if Simply refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Simply can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

RESOLVING MEDICARE MEMBER GRIEVANCES

If a Medicare member has a grievance about Simply, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Simply
Medicare Complaints, Appeals and Grievances
Attention: Member Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

BILLING MEMBERS & BALANCE BILLING

COST SHARING

An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost-sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan Summary of Benefits.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare non-participating provider (hereinafter referred to as a non-participating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS 5010 claims form; in such a case, no balance billing is permitted.

Federal law prohibits providers from charging dually eligible members with full cost sharing coverage under a Medicare Savings Program and members who are in the Qualified Medicare Beneficiary (QMB) program for Medicare cost sharing for covered Part A and Part B services.

Simply processes the claim for reimbursement when Simply has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Simply does not have an arrangement with the state Medicaid agency. In states where Simply pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Simply does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Simply. Please check your EOP upon claims adjudication.

Providers servicing DSNP members must agree to accept Simply's Medicare reimbursement as payments in full for services rendered to DSNP Members, or to bill AHCA if Plan has not assumed AHCA's financial responsibility under the DSNP Agreement between Plan and AHCA. Providers are prohibited from filing additional claims for Medicaid deductibles or co-payment reimbursement. Providers must not also file claims for Medicaid reimbursement to the Medicaid Fiscal Agent for its DSNP Members covered under this DSNP Agreement as identified in the Medicare Managed Care Manual Chapter 16b and applicable laws and regulations.

To the extent Provider provides Services to or for the benefit of DSNP Members, DSNP members will not be held liable for payment of any fees that are the legal obligation of the MA organization. 42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i). Without limiting the generality of the foregoing, provider agrees that in no event, including but not limited to (1) non-payment by Simply of any amounts that are Plan's legal obligation, (2) insolvency of Simply, or (3) Simply's breach of the Agreement, will provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any DSNP member or person acting on behalf of the DSNP Member for Services provided pursuant to the DSNP agreement. 42 C.F.R. §§422.504(g) and (i) and MMCM Ch. 11 §§100.3 and 100.4 (4) Provider will not impose cost-sharing requirements on DSNP members in excess of the amounts allowed under the Florida Medicaid State Plan. 42 CFR 422.504(g)(1)(iii)

COST-SHARING RESPONSIBILITY FOR SPECIAL NEEDS PLAN MEMBERS

The rules governing balance billing as well as the rules governing the MA payment of MA plan, non-contracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider — There is no balance billing paid by either the plan or the enrollee.

Non-contracting, Original Medicare, participating provider — There is no balance billing paid by either the plan or the enrollee.

Non-contracting, non-(Medicare)-participating provider — The MAO owes the non-contracting, non-participating (non-par) provider the difference between the member’s cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.

MA-plan, non-contracting, non-participating DME supplier — The MAO owes the non-contracting non-participating (non-par) DME supplier the difference between the member’s cost-sharing and the DME supplier’s bill; the enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in MA Payment Guide for Out-of-network Payments [cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf).

MA plans must clearly communicate to enrollees through the Evidence of Coverage (EOC) and Summary of Benefits (SB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a non-contracting non-participating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

LOSS OF MEDICAID COVERAGE FOR SPECIAL NEEDS PLAN MEMBERS

Simply Dual Coordination (HMO SNP) members are eligible for both Medicare and Medicaid; however, they may have different levels of Medicare cost sharing assistance based on their Medicare Savings Program. DSNP members who temporarily lose their Medicaid coverage may be required to pay cost sharing and copayments for services until their Medicaid coverage is re-established. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary’s loss of coverage, the member will be responsible for the extended Length of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

SIMPLY SELF-SERVICE WEBSITE AND THE PROVIDER INQUIRY LINE

The Simply self-service website at provider.simplyhealthcareplans.com provides a host of online resources, such as our **Online Provider Inquiry Tool** for real-time claim status, eligibility verification and Prior Authorization status. You can also submit a claim or prior authorization request, print referral forms or directories or obtain a member roster. Detailed instructions for use of the Online Provider Inquiry Tool can be found on our website.

TOLL-FREE AUTOMATED PROVIDER SERVICES AT THE DSU

To support our providers and members, we have established the Dedicated Service Unit (DSU) to assist with questions and concerns about the Simply plans. The DSU is comprised of Medicare subject matter experts and specializes in first-call resolution for provider and member inquiries. Our DSU representatives can help:

- Resolve payment disputes, appeals and other claims issues.
- Verify claims status, member eligibility, preauthorization requirements, and the status of healthcare services.
- Identify participating Simply providers for referring members to specialty services.
- Refer members to our Condition Care for interpreter services, transitions, care coordination, transfers, and terminations.
- Support noncompliant members (for example, members who repeatedly miss appointments, members who are noncompliant with their treatment plans).

The DSU is available Monday through Friday from 8 a.m. until 10 p.m. Eastern time toll free at **844-405-4297**. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in case/care management.

MEMBER RIGHTS AND RESPONSIBILITIES

Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Simply requirements concerning issuing letters and notices.

Simply members have the right to timely quality care and treatment with dignity and respect. Each member receives a copy of the Explanation of Coverage which outlines the member's rights and responsibilities. Providers must respect the rights of all Simply members.

Members have the right to:

- Be treated with dignity, respect, and fairness at all times.
- Receive information about the health plan, services, practitioners, providers and member rights and responsibilities.
- Receive information in a way that works for them (in languages other than English spoken in the plan service area, in Braille, large print or other alternate formats).
- Ensure the privacy of their medical records and personal health information.
- Choose a plan provider.
- Receive care from a women's healthcare provider.
- Have timely access to their providers and to receive services from specialists when appropriate.
- Obtain information from providers and be advised about all medically appropriate or necessary treatment options available for their condition, regardless of cost or benefit coverage.
- Participate fully in decisions about their healthcare and be informed about any risks involved in their care.
- Refuse treatment, leave a hospital or medical facility, or stop taking medications; the member must accept responsibility and the consequences of their decision.
- Complete an advance directive (living will or power of attorney) to help them with decisions related to their healthcare if they are unable.
- Voice complaints or appeals about the health plan or the care provided.
- Make recommendations regarding the health plan's member rights and responsibilities policy.

- Receive information about the appeals and grievances members have filed against Simply in the past.
- Receive information about the Medicare Advantage plan, plan providers, drugs, healthcare coverage and costs, including an explanation about any bills received for services or drugs not covered.
- Request information regarding provider compensation by Simply.
- Receive a written or binding advance-coverage determination for healthcare services, even if the care is requested from a nonparticipating provider.

Members have the responsibility to:

- Be familiar with their coverage and the rules they must follow to obtain healthcare.
- Notify Simply if they have additional health insurance coverage.
- Notify providers when seeking care that they are Medicare members and present their Simply Medicare member ID cards.
- Provide the health plan, doctors, and practitioners with accurate information to render care and follow the treatment plans and instructions they agreed to with the provider.
- Understand their health problems and participate in identifying mutually agreed-upon treatment goals to the extent possible.
- Treat their doctor, their doctor's staff, and Simply employees with respect and dignity.
- Not be disruptive in the doctor's office.
- Pay their copayment for covered services.
- Notify Simply if they have questions, concerns, problems, or suggestions. Members may call Member Services at the DSU at **844-405-4297** and TTY users should call **800-855-2880**.

BENEFITS

SUMMARY OF BENEFITS TABLES

Simply Medicare member benefits are summarized in the Summary of Benefits at <https://provider.simplyhealthcareplans.com/florida-provider/manuals-and-guides>.

Notations regarding some benefit categories are listed below. Please note availability and limitations of Medicare Advantage supplemental benefits may vary by product and market. Please refer to the appropriate Summary of Benefits documents listed above for detailed information.

Prior authorization requirements are described in later sections and in detail on the Medicare Advantage provider website. All services from noncontracted providers with the exceptions of urgent and emergent care and out-of-area dialysis require prior authorization.

The medical benefits are further explained in the following sections.

EMERGENCY CARE

An emergency medical condition is 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:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part

Simply covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services.
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard.

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency hospital. Prior authorization for an emergency medical condition is not required.

URGENTLY NEEDED CARE

Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. However, prior authorization is not required.

Urgently needed services are defined as those that are covered but are not emergent services and are provided:

- When the member is temporarily absent from the Simply service area and such services are medically necessary and immediately required.
- As a result of an unforeseen illness, injury, or condition.
- If it is not reasonable given the circumstances to obtain the services through a Simply network provider.

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the Simply provider network is temporarily unavailable or inaccessible.

OUT-OF-AREA DIALYSIS SERVICES

Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Simply service area and cannot reasonably access contracted Simply dialysis providers. Members can obtain dialysis services without Prior Authorization or notification when outside of the Simply service area.

We suggest members advise Simply if they will temporarily be out of the service area, so a qualified dialysis provider may be recommended.

HOSPITAL SERVICES

There are two types of admissions:

- Elective inpatient admissions — prior authorization is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

The Health Care Management Services, in coordination with admitting physicians and hospital-based physicians, is in charge of:

- Coordinating and conducting continued-stay coverage reviews
- Providing appropriate referrals for extended-care facilities

- Coordinating coverage of all services required for adequate discharge

Simply case managers assist in coordinating all needed services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

PREVENTIVE SERVICES

The following preventive services are offered to members with no member copayment or cost sharing:

- Preventive visit:
 - Annual physical examination (in addition to the Medicare preventive visits)
 - Annual physical examination (in addition to the Medicare preventive visits)
You may bill for one routine annual visit per year (for example, 99385–99387, 99395–99397) with diagnosis code V70.0
 - Welcome to Medicare exam
 - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap smear, pelvic exams, and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screenings
- COVID-19 vaccine
- Medical nutrition therapy services
- Pneumococcal shots
- Smoking cessation (counseling to stop smoking)
- Depression screening
- Diabetes Prevention Program
- Obesity screening
- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screenings for sexually transmitted infections
- Glaucoma screening

DOMESTIC VIOLENCE SERVICES

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.

Report suspected child abuse or neglect immediately.

Report suspected elder or partner abuse immediately to the appropriate state agency or Adult Protective Services office. An individual can access the National Domestic Violence Hotline number by calling **800-799-7233**. For text telephone assistance, call **800-787-3224**.

DOMESTIC VIOLENCE SCREENING TOOLS

Domestic Violence — Framing Statements:

1. Because violence is so common in many people’s lives, I have begun to ask all my members about it.
2. I’m concerned that someone hurting you may have caused your symptoms.
3. I don’t know if this is a problem for you, but many of the people I see as members are dealing with abusive relationships.

Domestic Violence — Direct Verbal Questions:

1. Are you in a relationship with a person who physically hurts or threatens you?
2. Did someone cause these injuries? Was it your partner or spouse?
3. Has your partner or ex-partner ever hit you or physically hurt you? Have they ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
6. Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence – New Member

Option 1:

1. Have you ever been hurt or threatened by your friend, spouse, or partner?
2. Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner?
3. Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner during this pregnancy?
4. Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

1. Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?

Option 3:

1. Have you ever been forced or pressured to have sex when you did not want to?
2. Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner?

SEXUAL ABUSE

It is required that each provider contact the appropriate local or state agency when sex abuse is suspected. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Simply Member Services at **844-405-4297** for a list of the specialty centers near them.

SUPPLEMENTAL BENEFITS

Supplemental benefits are benefits in addition to the basic Medicare services offered through Medicare Part A and B, they are not benefits offered under the Federal Medicare program. Simply offers limited supplemental benefits to covered members as outlined in the Summary of Benefits documents. Please refer to the applicable Summary of Benefits for specific supplemental benefits being offered for each plan, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under Simply. Members cannot be billed for non-covered services unless notified in advance. See Provider Obligations — In-office Denials.

Supplemental benefits vary by plan, product, and state. Below is a list of supplemental benefits we may choose to offer each calendar year in certain states and plans. Please refer to the Summary of Benefits documents for details on which plans cover certain supplemental benefits:

- Routine foot and nail care
- Routine eye examinations and eyeglasses
- Routine hearing examinations and hearing aids
- Dental examinations and cleanings
- Coverage of Over-The-Counter (OTC) items
- Generic drugs covered in the Part D coverage gap with the applicable generic prescription
- Nonemergency transportation
- Personal Emergency Response Systems (PERS) coverage for the service and monitoring equipment but not the actual telephone line
- Routine acupuncture services
- Fitness program through Silver Sneakers within their network of centers
- All plans have a Maximum Out-of-Pocket (MOOP) limit for medical services. The MOOP does include out-of-pocket costs for Part B drugs but does **not** include Part D (pharmacy prescriptions) cost-sharing amounts. Once a member reaches his or her MOOP limit, all covered medical services will be covered at 100 percent for the remainder of the year.
- Telemonitoring is available in all plans. See telemonitoring section for more details.
- Out-of-country emergency care
- Live Health Online

Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the vendor network** to render such a benefit, please note you will only be reimbursed or able to bill a member for non-covered services if you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's MA plan.

This will ensure that the member will receive a denial of payment and accompanying appeal rights. As per the Medicare Advantage HMO & PPO Provider Guidebook CMS has stated that the use of an Advanced Beneficiary Notice or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

Note: Not all supplemental benefits are available in all plans, and some limitations and restrictions apply. Some supplemental benefits must be rendered by the delegated Vendor to be covered.

Dental Services

Some of our plans include preventive dental services that are covered by Simply through a contracted dental vendor, except for dental services covered as emergency services. The Simply managed care programs and dental health benefits complement one another because both emphasize prevention, quality, and cost-effectiveness. Simply works with contracted dental providers to ensure access to the full range of preventive, primary and specialty oral health services. Please see the Summary of Benefits documents for more information on dental benefits.

OPTOMETRY AND AUDIOLOGY SERVICES

Some of our plans include coverage of routine vision and hearing services, including:

- Routine yearly visual exams
- Screening for glaucoma
- Hearing screening

Contracted network providers, assisted by the Simply Case Management Program, coordinate benefits for lenses and hearing aid devices when covered by the plan. Please see the Summary of Benefits documents for more information on vision and hearing benefits.

OVER-THE-COUNTER ITEMS

Some of our plans include coverage of OTC items and health-related supplies. For those plans that include this benefit, members are provided with a monthly or quarterly allowance to obtain the items and supplies. For plans with a quarterly allowance, the benefit replenishes at the beginning of each quarter and carries across quarters, but any unused portion of the benefit does not carry over to the next year. For plans with a monthly allowance, the benefit replenishes at the beginning of each month, but any unused portion does not carry over to the next month. OTC products are described in a printed catalogue available to members.

NONEMERGENT TRANSPORTATION

In many markets and benefit plans, Simply provides nonemergent transportation through a contracted vendor. In other markets, these services must be arranged through the Simply Case Management Program. See the Summary of Benefits documents for more information. Some plans have coverage of trips to obtain the following preventive services:

- Preventive visits
 - Annual physical examination (in addition to the Medicare preventive visits)
 - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
 - Welcome to Medicare exam
 - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training

- Cardiovascular disease testing
- Mammography screening
- Pap smear, pelvic exams and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Medical nutrition therapy services
- Pneumococcal shot
- Smoking cessation (counseling to stop smoking)
- Depression screening

PRESCRIPTION DRUG COVERAGE

All Simply plans (Dual Coordination (HMO SNP), Classic HMO and ESRD (HMO-POS SNP) plans) include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

PART D PRESCRIPTION DRUGS

In general, Medicare Part D covers drugs that are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Part D prescription drugs covered by Simply are listed in the Simply Medicare five-tier formulary. Medically Accepted Indication for purposes of Part D is an FDA labeled indication or an indication supported by citation in either the American Hospital Formulary System (AHFS), or *DRUGDEX*[®]. *Exceptions may be possible when used as part of an anti-cancer chemotherapeutic regimen.* The formulary includes most generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Simply website at

<https://provider.simplyhealthcareplans.com/florida-provider> or request a copy from the Provider Relations department. Some of these drugs may require Prior Authorization, or have step-therapy requirements, or have quantity limits. Providers may request a coverage determination, which can include prior authorization, tiering exception (request for drug to be covered at a lower cost), or for a drug that not on the formulary by contacting the Provider Services at the DSU at **844-405-4297**. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician's prescription.

Please refer to the formulary when prescribing for Simply Medicare members. The formulary will tell you if the drug requires prior authorization or has a quantity limit, and, if it is not listed, then it is considered non-formulary and will require a coverage determination. For Simply Part B, contact Provider Services department **844-405-4297, option 5**, from 8 a.m. to 8 p.m. local time, Monday through Friday. For Simply Part D, call the Carelon Rx, Inc. pharmacy services phone number on the back of the member ID card.

PRESCRIPTION DRUGS BY MAIL ORDER

Members can use the mail-order service to fill prescriptions for maintenance drugs (in other words, drugs taken on a regular basis for a chronic or long-term medical condition). Mail-order is not allowed on ISNP and IESNP plans. For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 30-, 60-, 90- or 100-day supply. Not every drug or tier is available through mail-order. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the DSU at **844-405-4297**. They will assist with obtaining an emergency supply of the member's medication until they receive the new mail-order supply.

Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Simply network to obtain their maintenance medications.

Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician's service require Prior Authorization from Simply. Please call the DSU for additional information.

COVERED VACCINES

CMS and Simply, through the Simply plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D and those covered under either Medicare Part B or Part D coverage.

VACCINES AND VACCINE ADMINISTRATION COVERAGE UNDER MEDICARE PART B (MEDICAL) BENEFITS

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine

Claims for Medicare Part B benefits should be submitted to Simply for processing and reimbursement at:

Attn: Claims Department
Simply Healthcare Plans, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

VACCINES AND VACCINE ADMINISTRATION COVERAGE UNDER MEDICARE PART D (PHARMACY) BENEFITS

Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the Simply Medicare Formulary located online at <https://provider.simplyhealthcareplans.com/florida-provider>. Providers who do not have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.

Providers who have a supply and administer the vaccine in their office should collect the member's copay at the time of service and submit the claim for the vaccine and administration on a *CMS 1500* form to:

Attn: Claims Department
Simply Healthcare Plans, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

To streamline your claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX, a clearinghouse for claims submission.

To use TransactRX, please contact the clearinghouse at the web site (transactrx.com) or call Customer Service at **866-522-3386**. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of \$2.50 for check payments on claims.

For member copayment information, please contact the DSU at **844-405-4297**.

VACCINES COVERED UNDER EITHER PART B (MEDICAL) OR PART D (PHARMACY) BENEFIT COVERAGE

These vaccines may require a coverage determination to determine appropriate coverage. Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Hepatitis B coverage depends on the risk of contracting hepatitis B. Low risk is Part D and moderate or high risk is Part B. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Anthrax vaccine

- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) and risk of contracting hepatitis B on a *CMS 1500* claims form and submit to:

Simply Healthcare Plans, Inc.
 P.O. Box 61010
 Virginia Beach, VA 23466-1010

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at cms.hhs.gov/MLNGenInfo.

COVERAGE DETERMINATIONS FOR PART D PRESCRIPTION DRUG BENEFITS

Coverage determinations: The first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

A coverage determination is any decision Simply makes regarding:

- A decision about whether to provide or pay for a Part D drug, including a decision not to pay because the drug is not on the plan's formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or we determine the drug is otherwise excluded, but the member believes it may be covered by the plan
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member's health
- A decision concerning a tiering exception request
- A decision concerning a formulary exception request
- A decision on the amount of cost sharing for a drug
- A decision on whether a member has satisfied a Prior Authorization or other utilization management requirement

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

An expedited decision can only be requested if the member or any physician believes waiting for a standard decision could jeopardize the member's life, health, or ability to regain maximum function. This is called the expedited criteria.

The member or a physician can request an expedited decision. If a physician requests an expedited decision or supports a member in asking for one and if the physician indicates the situation meets the expedited criteria, Simply will automatically provide an expedited decision within 24 hours from the initial request.

FORMULARY EXCEPTIONS

If a prescription drug is not listed in the Simply formulary, please check the updated formulary on the Simply website. The website formulary is updated frequently with any changes. In addition, providers may contact the Simply Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Simply to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests an exception Simply approves, Simply will reimburse the member. If the exception is not approved, the member may appeal the plan's denial. See the Medicare Member Liability Appeals section for more information on requesting exceptions and appeals.

In some cases, Simply will contact a member who is taking a drug that is not on the formulary. Simply will give the member the names of covered drugs used to treat their condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined a Simply plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Simply formulary.

New members in Simply Medicare plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as Prior Authorization or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Simply covers or request a formulary exception to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Simply may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in an Simply plan. For current members affected by a formulary change from one year to the next, Simply will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Simply provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), Simply will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, Simply generally will not pay for these drugs again as part of the transition policy. Simply will provide the member and the provider with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Simply will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, Simply will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Simply will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Medicare members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 30 days, unless the prescription is written for fewer days.

Please note the Simply transition policy applies only to those prescription drugs that are Part D drugs.

MEDICATION THERAPY MANAGEMENT

The [Medicare Modernization Act of 2003](#) requires [Medicare Part D](#) prescription drug plans to include medication therapy management services delivered by a qualified healthcare professional, including pharmacists. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure), take multiple medications or are likely to incur annual costs above a predetermined level. Simply supports Medicare MTM in a variety of ways:

- Medication Management Services (Simply Members)
- In-House Consults by Simply Pharmacists

REIMBURSEMENT POLICIES

Reimbursement Policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Simply benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Simply reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however Simply strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payment must meet all of aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payments conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefit coverage, medical necessity, authorization, or

stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Reimbursement policies undergo reviews for updates to state contracts, federal or Centers for Medicare & Medicaid Services (CMS) requirements. Additionally, updates may be made at any time if we are notified of a mandate change or due to a Simply business decision. Simply reserves the right to review and revise its policies when necessary. When there is an update, we will publish the most current policy to provider.simplyhealthcareplans.com.

Medical Coding

The Medical Coding Department ensures that correct coding guidelines have been applied consistently throughout Simply. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

Simply allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under a particular Current Procedure Terminology (CPT) category section, unless otherwise noted by State or provider contracts, or State, Federal or CMS requirements. There are eight CPT sections:

- Evaluation and Management
- Anesthesia
- Surgery
- Radiology (Nuclear Medicine and Diagnostic Imaging)
- Pathology and Laboratory
- Medicine
- Category II codes: supplemental tracking codes that can be used for performance measurement
- Category III codes: temporary codes for emerging technology, services or procedures

FRAUD, WASTE AND ABUSE DETECTION

Simply is committed to protecting the integrity of Simply's healthcare programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness:

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card to ensure that the individual seeking services is the same as the member listed on the card. It is the first line of defense against possible fraud. Learn more at fighthhealthcarefraud.com.

Reporting Fraud, Waste and Abuse

If someone suspects any member or provider (a person who receives benefits) has committed fraud, waste, or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

Report concerns by:

- Visiting provider.simplyhealthcareplans.com, scroll to the bottom footer and select **Health Care Fraud Prevention** to be directed to the [fighthhealthcarefraud](https://fighthhealthcarefraud.com) education site; at the top of the page, select **Report it** and complete the *Report Waste, Fraud and Abuse* form.
- Calling Provider Solutions.

Any incident of fraud, waste, or abuse may be reported to Simply anonymously; however, Simply's ability to investigate an anonymously reported matter may be limited if Simply doesn't have enough information. Simply encourages providers and facilities to give as much information as possible. Simply appreciates referrals for suspected fraud but be advised that Simply do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of member fraud, waste, and abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else's ID card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, member ID, or case number if available
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Examples of provider fraud, waste, and abuse:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about healthcare fraud and how to aid in the prevention on it, visit fighthealthcarefraud.com.

Investigation Process

The Special Investigations Unit (SIU) investigates suspected incidents of FWA for all types of services. Simply may take corrective action with a provider or facility, which may include, but is not limited to:

- *Written warning and/or education:* Simply sends letters to the provider or facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment or may advise of further action.
- *Medical record review:* Simply reviews medical records to investigate allegations or validate the appropriateness of claims submissions.
- *Edits:* A certified professional coder or investigator evaluates claims and places payment or system edits in Simply's claims processing system. This type of review prevents automatic claims payments in specific situations.
- *Recoveries:* Simply recovers overpayments directly from the provider or facility. Failure of the provider or facility to return the overpayment may result in reduced payment for future claims, termination from our network, or legal action.

Prepayment Review

One method Simply uses to detect FWA is through prepayment claim review. Through a variety of means, certain providers or facilities, or certain claims submitted by providers or facilities, may come to Simply's attention for behavior that might be identified as unusual for coding, documentation, and/or billing issues, or claims activity that indicates the provider or facility is an outlier compared to his/her/its peers.

Once a claim, or a provider or facility, is identified as an outlier or has otherwise come to Simply's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the provider's or facility's actions may involve FWA, unless exigent circumstances exist, the provider or facility is notified of their placement on prepayment review and given an opportunity to respond.

When a provider or facility is on prepayment review, the provider or facility will be required to submit medical records and any other supporting documentation with each claim so Simply can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Simply in accordance with this requirement will result in a

denial of the claim under review. The provider or facility will be given the opportunity to request a discussion of their/its prepayment review status.

Under the prepayment review program, Simply may review coding, documentation, and other billing issues. In addition, Simply may use one or more clinical utilization management guidelines in the review of claims submitted by the provider or facility, even if those guidelines are not used for all providers or facilities delivering services to Plan members.

The provider or facility will remain subject to the prepayment review process until Simply is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider or facility could face corrective measures, up to and including termination from our network.

Finally, providers and facilities are prohibited from billing a member for services Simply has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

In addition to the previously mentioned actions, Simply may refer suspected criminal activity committed by a member, provider or facility to the appropriate regulatory and/or law enforcement agencies

Recoupment/Offset/Adjustment for Overpayments

Simply shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Simply to provider or facility (“Overpayment Amount”) against any payments due and payable by Simply or any affiliate to provider or facility with respect to any Health Benefit Plan under this Agreement or under any Agreement between provider and an affiliate regardless of the cause. Provider or facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Simply that an Overpayment Amount is due from provider or facility, provider or facility must refund the Overpayment Amount to Simply within sixty (60) calendar days of the date of the overpayment refund notice from Simply to the provider or facility. If the Overpayment Amount is not received by Simply within the sixty (60) calendar days following the date of such notice letter, Simply shall be entitled to offset the unpaid portion of the Overpayment Amount against other claims payments due and payable by Simply or an affiliate to provider or facility under any Health Benefit Plan in accordance with regulatory requirements. In such event, provider or facility agrees that all future claim payments, including affiliate claim payments, applied to satisfy provider’s or facility’s repayment obligation shall be deemed to have been legally paid to provider or facility in full for all purposes, including affiliates and/or regulatory requirements as defined by the Provider or Facility Agreement. Should provider or facility disagree with any determination by Simply or a Plan that provider or facility has received an overpayment or improper payment, provider or facility shall have the right to appeal such determination under Simply’s procedures set forth in the *Provider Manual*, provided that such appeal shall not suspend Simply’s right to recoup the Overpayment Amount during the appeal

process unless required by Regulatory Requirements. Simply reserves the right to employ a third party collection agency in the event of non-payment.

GLOSSARY OF TERMS

Appeal: As defined by the CMS Parts C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance, the procedures that deal with the review of initial determinations made by the plan on healthcare services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services or drug coverage (when a delay would adversely affect the health of the enrollee) or any amounts the enrollee must pay for a service or drug as defined in 42 C.F.R. §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medical Appeals Council and judicial review. This process is separate from the participating provider appeals/dispute process.

Basic benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all healthcare services covered under Medicare Part A and B programs, except for hospice services. Simply Medicare also provides supplemental benefits not covered by fee-for-service Medicare.

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.

Contracting hospital: a hospital that has a contract to provide services and/or supplies to Medicare members.

Contracting medical group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members.

Contracting pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the Simply contract.

Coverage determination — As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, a determination made by a Part D plan sponsor or its delegated entity with respect to the following:

- A decision about whether to provide or pay for a drug that an enrollee believes may be covered by the plan sponsor, including a decision related to a Part D drug that is: not on the plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded under Federal law if applied to Medicare Part D;
- A decision on the amount of cost sharing for a drug;
- Failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member;
- A decision about a tiering exception request; or
- A decision about a formulary exception request.

Covered services: those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by Simply or its providers

- Emergency services and urgently needed services that may be provided by nonproviders
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Dual-eligible: a Medicare enrollee who is eligible for Medical Assistance from the state and for whom the state has a responsibility for payment of Medicare cost-sharing obligations under the state plan. Dual-eligibles are limited to the following categories of recipients: Qualified Medicare Beneficiary (QMB) Only, MB Plus, Specified Low-income Medicare Beneficiary (SLMB) Plus and other Full Benefit Dual-Eligible (FBDE) recipients.

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

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard.

Experimental procedures and items: procedures and items determined by Simply and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Simply will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare. Section 1862(a)(1)(E) of the Social Security Act, prohibits payment for procedures that are deemed experimental and/or investigational in nature.

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Simply tiered cost-sharing structure or an exception to the application of a cost utilization management tool (for example, step therapy requirement, dose restriction or prior authorization requirement).

Fee-for-service Medicare: Medicare coverage managed by the federal government and not through a CMS contracted private health plan (also known as traditional and/or original Medicare).

Full Benefit Dual-Eligible (FBDE): an individual who is eligible for both Medicare Part A and/or Part B and for state benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan.

Grievance: As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

Home health agency: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by their primary care physician.

Hospice: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Hospital: a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Hospitalist: a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key member of the healthcare team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's primary care physician during the member's inpatient stay.

Independent practice association: a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

Medicaid: the federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

Medically necessary: medical services or hospital services determined by Simply to be:

- Rendered for the diagnosis or treatment of an injury or illness
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Simply. Section 1862(a)(1)(A) of the Social Security Act, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.

Medicare: the federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement

systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.

Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B premium: a monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by private healthcare plans. The health plan must provide all Part A and B services in its plan and may offer additional benefits to the beneficiary. Also known as Medicare Advantage.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. Simply offers MA-PD plans in specific markets.

Medicare Advantage (MA) agreement: the agreement between Simply and the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Part C and other health plan services to Simply members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Simply plan is a kind of MA plan.

Member: a Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Simply plan and whose enrollment has been confirmed by CMS.

Noncontracting medical provider or facility: any professional person, organization, health facility, hospital or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish healthcare services; and that is neither employed, owned, operated by nor under contract with Simply to deliver covered services to Medicare members.

Provider: any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish healthcare services. This individual or organization has a contract directly or indirectly with Simply to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.

Provider liability appeal: a request for Simply to review a decision by the Simply Health Care Management department to deny payment without member liability for services already rendered.

Provider payment dispute: a formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered. The claim has been finalized but the provider disagrees with the amount paid.

Primary Care Provider (PCP): a provider physician selected by a member to coordinate the member's healthcare. The PCP is responsible for providing covered services for Medicare members and coordinating care, referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Qualified Medicare Beneficiary (QMB): an individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL, and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments (except for Medicare Part D). Collectively these benefits (services) are called QMB Medicaid benefits (services). Categories of QMBs are as follows:

- QMB Only — QMB who is not otherwise eligible for full Medicaid
- QMB Plus — QMB who also meets the criteria for full Medicaid coverage and is entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients

Specified Low-income Medicare Beneficiary (SLMB) without other Medicaid (SLMB only): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the Federal Poverty Level (FPL) but less than 120 percent of the FPL, and their resources do not exceed twice the limit for Supplement Security Income (SSI) eligibility and who is not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-income Medicare Beneficiary with full Medicaid (SLMB Plus): an individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the FPL but less than 120 percent of the FPL, and their resources do not exceed twice the limit for SSI eligibility and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Service area: a geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Special Needs Plan (SNP): a type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of the Simple SNP, the special class of members is comprised of persons who are both Medicare and Medicaid eligible. Plans offering SNPs receive special approval from CMS. A SNP also provides Medicare Part D drug coverage.

Urgently needed services: those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

PROVIDER DIGITAL ENGAGEMENT

PURPOSE

The purpose of this provider digital engagement chapter is to establish the standards to increase utilization of secure digital provider tools and applications that are accessible to participating and non-participating providers to improve efficiencies for providers and Simply. This chapter is applicable medical, dental, and vision services.

In support of this digital supplement, the following efficiencies have been documented as industry averages per the annual CAQH CORE Efficiency Index study:

Transaction	Method	Average Time Providers Spend per Transaction (minutes)	Min Time Providers Spend per Transaction (minutes)	Max Time Providers Spend per Transaction (minutes)	Potential Average Time Saving (minutes)
Eligibility and Benefit Verification	Manual	10	3	30	8
	Partial	5	1	15	3
	Electronic	2	<1	10	
Prior Authorization	Manual	21	3	45	17
	Partial	8	1	20	4
	Electronic	4	<1	18	
Claim Submission	Manual	6	1	25	4
	Electronic	2	<1	6	
Attachments	Manual	11	1	30	6
	Electronic	5	1	10	
Claim Status Inquiry	Manual	12	1	20	8
	Partial	4	1	10	0
	Electronic	4	<1	11	
Claim Payment	Manual	5	<1	11	2
	Electronic	3	<1	10	
Remittance Advice	Manual	7	<1	19	5
	Partial	4	<1	10	2
	Electronic	2	<1	10	
Total Potential Time Savings (Manual)					50
Total Potential Time Savings (Partial)					9

SUPPLEMENT STATEMENT

This Supplement outlines the digital tools Simply has available to providers who serve its members, whether par or non-par. It is Simply's expectation that providers will utilize these digital tools unless mandated by law or other legal requirement no later than January 1, 2021. The electronic tools and applications include the secure Provider Platform, Electronic Data Interchange (EDI) Transaction Gateway and available Business-to-Business Application Programming Interfaces (B2B APIs) — all hosted via Availity Essentials. This Supplement addresses the following processes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, attachments, and authorization status
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred, that in markets where these tools are currently available, these digital alternatives are used:

- Disputes
- Grievances and Appeals
- Demographic updates
- Pharmacy Prior Authorization drug requests
- Services through Simply affiliates, Carelon Medical Benefits Management and Carelon Behavioral Health
- Provider Enrollment

Simply expects that all providers seeking any functions and processes above will use available electronic self-service tools including EDI X12 transactions, the secure Provider Platform or direct desktop integration via B2B APIs in lieu of manual channels (paper, mail, fax, call, etc.). Availity provides access to all Simply self-service tools across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all Simply digital tools and capabilities is available on the secure Provider Platform via [Availity.com](https://www.availity.com). Please access Availity Essentials to learn more about available EDI, Provider Platform, and B2B API options. Administration Simplification standard transaction requirements: hhs.gov/hipaa/for-professionals/other-administration-simplification-rules/index.html

ACCEPTANCE OF DIGITAL ID CARDS

As Simply's members transition to using electronic member identification cards, providers may need to implement changes in their processes to accept this new format. Simply expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card. If providers require a copy of a physical member identification card, members can fax or email a copy of the electronic member identification card from their phone/app, or providers can access it directly from the secure Provider Platform through Availity Essentials.

ELIGIBILITY AND BENEFIT INQUIRY AND RESPONSE

Providers may leverage any of the following Availity-hosted channels for electronic Eligibility & Benefit inquiry and response:

- EDI Transaction: X12 270/271 Eligibility Inquiry and Response (version 5010):

- Simply supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- Secure Provider Platform via Availity Essentials:
 - Eligibility and Benefit verification utility – This utility allows a provider to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
 - Simply has also enabled real-time access to Eligibility and Benefit verification APIs that can be directly integrated within participating vendors’ practice management software, revenue cycle management software, and some electronic medical records software. Contact Availity for available vendor integration opportunities.

AUTHORIZATIONS

Prior Authorization Submission, Attachment and Status

Providers may leverage any of the following channels for prior authorization submission, status inquiries, and submission of electronic attachments (solicited or unsolicited) on the secure Provider Platform via Availity Essentials:

- EDI Transaction: X12 278 Prior Authorization and Referral (version 5010):
 - Simply supports the industry standard X12 278 transaction for prior auth submission and status inquiry as mandated per *HIPAA*.
- EDI Transaction: X12 275 Patient Information including HL7 payload (version 5010) for authorization attachments:
 - Simply supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Secure Provider Platform via Availity Essentials:
 - Interactive Care Reviewer (ICR) – The authorization ICR utility allows a provider to key a prior authorization request including an attachment or status inquiry directly into an online form.
 - Additionally, providers can use ICR to make inquiries on previously submitted requests regardless of how the original prior authorization was submitted (phone, fax, eReview, secure email, etc.).
- Provider desktop integration via B2B APIs:
 - Simply has also enabled real-time access to Prior Authorization APIs that can be directly integrated within participating vendors’ practice management software, revenue cycle management software, and some electronic medical records software. Contact Availity for available vendor integration.

CLAIMS: SUBMISSIONS, ATTACHMENTS AND STATUS

Providers may leverage any of the following channels for electronic claim submission, attachments (for both pre and post payment), and status on the secure Provider Platform via Availity Essentials:

- EDI Transaction: X12 837 Professional, Institutional and Dental Claim submission (version 5010):
 - Simply supports the industry standard X12 837 transactions for all Fee-For-Service and Encounter billing as mandated per *HIPAA*.
- EDI Transaction: X12 275 Patient Information including HL7 payload attachment (version 5010):
 - Simply supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records via the HL7 payload.
- EDI Transaction: X12 276/277 Claim status Inquiry and Response (version 5010):

- Simply supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by *HIPAA*.
- Secure Provider Platform via Availity: Direct Data Entry (DDE) — The claim DDE utility provider allows a provider to key a claim directly into an online claim form and also upload supporting documentation for a defined claim (solicited or unsolicited)
- 837 Claim batch upload — The claim batch upload utility allows a provider to upload an entire batch/file of claims (must be in X12 837 standard format).
- Claim Status Inquiry utility — This utility allows a provider to key an inquiry directly into an online claim status form with real-time responses.
- Provider desktop integration via B2B APIs:
 - Simply has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor’s practice management software, revenue cycle management software, and some electronic medical records software. Contact Availity for available vendor integration.

REMITTANCES & PAYMENTS ELECTRONIC FUNDS TRANSFER (EFT)

Like the payroll direct deposit service that most businesses offer their employees, Electronic Funds Transfer (EFT) uses the Automated Clearing House (ACH) Network to transmit healthcare payments from a health plan to a healthcare provider’s bank account. Health plans can use a provider’s banking information only to deposit funds, not to withdraw funds. Simply expects providers to accept payment via Electronic Funds Transfer (EFT) in lieu of paper checks. Providers can register or manage account changes for EFT via the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called [EnrollHub](#). This tool will help eliminate the need for paper registration, reduce administrative time and costs and allows physicians and facilities to register with multiple payers at one time. EFT payments are deposited faster and are generally the lowest cost payment method.

To facilitate quicker reimbursement for providers who have not enrolled for EFT, Simply may move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Using the same Trace Identifier Segment (TRN) helps to match the payment to the correct remittance advice, a process called reassociation. Health plans are required to input the X12 835 TRN Segment into Field 3 of the Addenda Record of the CCD+Addenda. The TRN Segment in the Addenda Record of the CCD+Addenda should be the same as the TRN Segment in the associated ERA that describes the payment.

Electronic Remittance Advice (ERA)

Providers may leverage any of the following channels for Electronic Remittance Advice on the secure Provider Platform via Availity Essentials:

- EDI Transaction: X12 835 Electronic Remittance Advice (version 5010):
 - Simply supports the industry standard X12 835 transaction as mandated per *HIPAA*.
- Secure Provider Platform via Availity Essentials — Remittance Inquiry:
 - The Remittance Inquiry application provides a digital version (PDF) of paper payment remittance that can be downloaded.

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.



Simply Healthcare Plans, Inc. is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.