

# **Medica Prime Solution<sup>SM</sup> Regulations**

Centers for Medicare & Medicaid Services (CMS) regulations for **Medica Prime Solution**.

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## Overview of Medica Prime Solution

As providers of care for members of Medica's Competitive Medical Plan (CMP) Cost products, you need to be aware of the information in this chapter of the Medica Provider Administrative Manual.

A **cost contract** is a formal agreement with the Centers for Medicare & Medicaid Services (CMS) to arrange for the provision of health services to plan members based on reasonable cost or prudent buyer concepts. The plan receives an interim capitated amount, derived from an estimated annual budget, which may be periodically adjusted during the course of the contract to reflect actual cost experience. The plan's expenses are audited at the end of the contract to determine the final rate the plan should have been paid.

The regulatory requirements cited in this section come primarily from Chapter 42, Code of Federal Regulations, Section 417 (42 CFR 417) and the Health Maintenance Organization/Competitive Medical Plan (HMO/CMP) Manual. Other applicable federal and state laws are listed in Chapter 18, Section C, Subsection 6.

### ***Compliance responsibility***

Medica offers the CMP Cost program through its **Medica Prime Solution products**. In order to provide health services to the **Medica Prime Solution** membership, Medica, as the **Managed Care Organization (MCO)**, and you, Medica's network of contracted physicians and providers, are subject to compliance with these CMS requirements. Although many CMS regulations are included in your current Medica contract and/or Medica contract amendments, Medica has chosen to further describe some of the requirements to ensure your understanding and compliance with these requirements.

You may direct questions about these requirements and regulations to your Medica contract manager or call the Provider Service Center at 952-992-2232 or 1-800-458-5512.

### ***A definition***

In this chapter, the terms "enrollee" and "beneficiary" are used to describe any individual eligible for Medicare benefits. "Member" specifically describes an individual covered by **Medica Prime Solution** products.

## General Medica Prime Solution Requirements

As part of Medica's agreement to comply with regulations and instructions related to the provisions of the MCO contract with CMS, Medica and Medica's providers must **comply with the following CMS-defined requirements and conditions**. Actions supportive of these conditions include:

1. Enroll any individual who is entitled to benefits under both Part A and Part B of Medicare or only Part B, who lives in the geographic area served by the Comprehensive Medical Plan (CMP), and who is not enrolled in any other HMO or CMP under contract with Medicare.
2. Not disenroll any Medicare beneficiary with end-stage renal disease (ESRD) who is already enrolled.
3. Notify general public of enrollment using, among other methods, marketing materials submitted to CMS at least 45 days prior to planned distribution and provide written descriptions of rules, procedures, benefits, fees, other charges and services to any prospective enrollees.
4. Establish a CMS-compliant application form and effective system for receiving, controlling and processing applications; provide prompt written notice of acceptance or rejection including reason for denial explanation; and submit acceptance information to CMS within 30 days of application date.
5. Accept the (coverage) conversion of any individual who is enrolled in the CMP for the month before the individual is entitled to both Medicare Parts A and B or Part B only and to notify CMS in a timely manner.
6. Maintain written rules that deal with benefits, services, premiums, grievance and appeal procedures, advance directives and other CMS-prescribed matters; furnish a copy of rules to each Medicare enrollee; submit rule changes to CMS; and notify enrollees of changes at least 30 days before their effective date.
7. Make timely payment directly to Medicare enrollees for services obtained from a provider or supplier outside the CMP if those were emergency or urgently needed services, or denied services are found appropriate on appeal; comply with state-mandated benefits as appropriate, hospice care and inpatient hospitalization.
8. Accept CMS liability for payment on behalf of Medicare beneficiary on the first day of the month in which he or she is entitled to Medicare benefits and is enrolled in the CMP.
9. Collect appropriate deductibles and coinsurance, subject to CMS limitations, from enrollees.
10. Refund amounts incorrectly collected and amounts due for certain services obtained outside the CMP.
11. Recoup deductible and coinsurance amounts uncollected from previous contract periods only under specific conditions.

12. Disenroll Medicare beneficiaries only when certain conditions are met, e.g., the beneficiary fails to pay required premiums or other charges, commits fraud, moves out of the CMP's geographic range, loses entitlement to Medicare Part B benefits or dies. Give written notice of disenrollment with reasons and right to appeal.
13. Accept an enrollee's written, signed and dated request for disenrollment and notify CMS.

## Enrollee Rights

### Enrollment – Informed Decision Making

CMS provides the following information to enrollees prior to each annual election period through its "Medicare & You Handbook." This information is offered to help current and potential enrollees make informed decisions with respect to available Medicare plan choices.

1. Benefits under original Medicare and any additional benefits offered by Managed Care Plans beyond original Medicare, including:
  - Beneficiary cost sharing, such as deductibles, coinsurance and copayment amounts.
  - Covered services.
  - Any beneficiary liability for balance billing.
2. Enrollment procedures and instructions.
3. A general description of member rights including grievance and appeal procedures under original Medicare and Managed Care Options.
4. The right to be protected against discrimination based on factors related to health status.
5. A general description of Medicare supplemental policies and Medicare Select.
6. The facts and effects of an MCO plan termination or refusal to renew its contract with CMS, and/or a reduction of the plan's service area.
7. A list of MCO plans that are or will be available to residents of the service area in the following calendar year, as well as information that aids the beneficiary in comparing the plans.
8. The extent that the enrollee can obtain out-of-network benefits.
9. The types of providers participating in the plan network and how an enrollee may select among those providers.
10. The coverage of emergency care and urgently needed services.
11. The monthly premiums for basic and/or supplementary benefits offered by Managed Care Plans.
12. The plan's service area.
13. Quality and performance indicators for benefits and how they compare to those indicators under original Medicare, including:
  - Disenrollment rates for Medicare enrollees for the two previous years (excluding those due to death or relocation outside the service area).
  - Medicare enrollee satisfaction.
  - Health outcomes.
  - Plan-level appeal data.
  - Recent record of plan compliance with MCO regulations.
14. Whether the Managed Care Plan offers mandatory or optional supplemental benefits and the premiums for those benefits.

## Enrollee Rights

### Enrollment

#### ***Hospice benefits***

New applicants may not be receiving hospice benefits at the time of their application for coverage and still enroll in **Medica Prime Solution**. No payment is made to Medica on behalf of a Medicare enrollee who has elected hospice care after enrollment. **During the time that the hospice election is in effect, all providers/suppliers should bill Medicare on a fee-for-service basis for all Medicare-covered services.** Medica will still be responsible for appropriate coinsurance and deductibles not related to the terminal illness.

#### ***Out of service area***

Members may be temporarily out of the service area for up to 90 consecutive days and remain covered through their **Medica Prime Solution** product. **After 90 days, Medica is required to disenroll the member unless the member has activated his or her Extended Absence Option.**

#### ***Extended Absence Option***

**Medica Prime Solution's** Extended Absence Option allows members to be temporarily absent from the service area for more than 90 days, but **less than nine months**. Under this option, members can use their Medicare and **Medica Prime Solution** benefits for non-emergency services with physicians and hospitals that are not part of the **Medica Prime Solution** network. **This feature can only be used outside of the service area and within the United States.** Members must carry both their Medicare and **Medica Prime Solution** ID cards to use this option and benefits will be covered exactly as if they received care from a **Medica Prime Solution** network provider, which means that **copayment and coinsurance amounts may apply**. Members must remain a permanent resident of the **Medica Prime Solution** service area, and must **call Medica to activate this option** by indicating that they will be out of the service area and for how long. If a member does not contact Medica, this feature will not be activated.

## Enrollee Rights

### Disenrollment

**Medica may disenroll members for nonpayment of premium** if a written notice has been sent to the member and it has been **30 days** past the date that the notification was sent. However, Medica and the provider are responsible to provide health services during that **30-day** period even if the premium is not received by Medica.

## **Enrollee Rights**

### Confidentiality

#### ***Access to medical records***

Each member has a right to privacy. Medica has established procedures related to maintaining the privacy of its members' medical records and other health and/or enrollment information.

Actions to comply with confidentiality include:

- Safeguard the privacy of information that identifies a specific individual member.
- Ensure that unauthorized persons are unable to get access to or alter patient records.
- Maintain the records and/or information in a timely and accurate manner.
- Ensure members timely access to their records and information.
- Release such information only to authorized persons.
- Release original medical records only in accordance with federal or state laws, court orders or subpoenas.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information.

This standard applies to the release of information to third parties and is not meant to impede the exchange of information among Medica, Medica's contracted providers and other providers as necessary to deliver care and ensure continuity and coordination of care and to carry out contractual responsibilities.

#### ***Audits and policies/procedures***

As part of the periodic audit by CMS of Medica as an MCO plan, policies and procedures related to all aspects of confidentiality of records and other health information will be included for review. CMS may visit Medica-contracted provider offices as part of the audit of Medica.

## **Enrollee Rights**

### Nondiscrimination Related to Health Status

Medica and Medica's providers **must not deny, limit, or place conditions on the coverage or furnishing of benefits on the basis of any factor that is related to the health status of individuals eligible to enroll in Medica Prime Solution.** These factors related to health status include but are not limited to:

- Medical condition, including mental as well as physical illness.
- Claim experience.
- Receipt of health care services.
- Medical history.
- Genetic information.
- Evidence of insurability, including conditions arising out of acts of domestic violence.
- Disability.

### ***Exception***

Medica may not enroll an individual who is in a hospice program or who has been determined to have end-stage renal disease (ESRD).

However, an enrollee who develops ESRD while enrolled in a **Medica Prime Solution** plan may not be disenrolled for that reason. Applicants with ESRD who have been enrolled in a Medica commercial plan prior to applying for **Medica Prime Solution** coverage are also exempt from this exception. However, the Medica commercial plan is primary for all claims relating to ESRD for the first 30 months of the members Medicare eligibility. Once an enrollee has had a successful kidney transplant, that individual is no longer considered to have ESRD.

## **Enrollee Rights**

### Federal and State Laws Affecting Enrollee Rights

Medica and its providers and subcontractors must comply with the following regulations:

- Chapter 42, Code of Federal Regulations, Section 417 (42 CFR 417).
- Federal Omnibus Budget Reconciliation Act (OBRA).
- Health Maintenance Organization/Competitive Medical Plan (HMO/CMP) Manual.
- CMS Operational Policy Letters (OPL).
- Title VI of the Civil Rights Act of 1964.
- The Social Security Act.
- Age Discrimination Act of 1975.
- Rehabilitation Act of 1973.
- The Americans with Disabilities Act.
- Executive Order 11246.
- Vietnam Era Veteran's Readjustment Assistance Act.
- HIPAA
- Other laws applicable to recipients of federal funds and all other applicable laws and rules.

## **Enrollee Rights**

### Participation in Decision Making and Treatment Planning

#### ***Treatment planning***

Medica and its providers **must promote members' understanding of their medical condition and work with members to develop mutually agreed upon treatment goals.** Special emphasis may be necessary regarding the involvement of members and their families in treatment planning related to mental health/substance abuse problems, chronic diseases and end-of-life care and decisions. State law governs who may act as a member's representative when the member is unable to exercise rational judgment or give informed consent about treatment planning.

Providers use culturally competent methods to ensure that all members have access to effective communication throughout the system to enable them to make decisions regarding treatment options.

#### ***Non-interference with health care professional advice***

Medica may not prohibit or restrict a provider from advising or advocating on behalf of his or her patient who is a member of **Medica Prime Solution** about:

- The member's health status, medical care, treatment options or alternative treatments.
- The risks, benefits and consequences of treatment or non-treatment.
- The opportunity for the member to refuse treatment and make choices about future treatment.

## Enrollee Rights

### Advance Directives

**Advance directive** is the term used by CMS to describe:

- A written document made before a person suffers from an incapacitating illness or injury, in which an individual specifies choices about health care treatment or names someone to make these treatment decisions if he or she is unable to make decisions.
- A written instruction, such as a living will or durable power of attorney for health care, that reflects the health care wishes of an individual is recognized under State Law.

**Advance directive** is interchangeable with the term **health care directive**.

- A health care directive is a written health care instruction(s) that may include a health care power of attorney identification. It is designed to enhance an incapacitated individual's control over medical treatment, and not as a means to reduce necessary care to vulnerable individuals.
- The attending physician makes the determination regarding the individual's decision-making capacity unless the individual has designated a person other than the physician to make this determination.

A **health care directive** must meet the following criteria:

- Be written and dated.
- Name the individual person who is the subject and owner of the directive.
- Be executed by the subject (if not incapacitated) or by a person authorized by the owner of the directive (any competent person age 18 or older).
- Contain verification of the subject's signature or the signature of the authorized person by a notary public or two witnesses.
- Include a health care instruction(s) or a health care power of attorney or both.
- Does not expire but should be reviewed periodically to ensure it continues to express the individual's health care wishes.

Medica **must inform members of state laws on health care directives** and does this by:

- Including information in new member packets to inform all members of their right to accept or refuse treatment and to execute a health care directive/advance directive.
- Including a sample health care directive form in the member packet as well as instructions on how to put it into effect.
- Providing education for staff, providers and the community regarding health care directives.

As a provider of health care services you need to be aware that:

- You **cannot** discriminate in the provision of care based on whether or not a patient has executed a health care directive. Providers **cannot** refuse to care for individuals because they do not have advance directives. (An individual may refuse to develop a health care initiative document).
- An individual may change or cancel a health care directive at any time by a written, signed and dated cancellation per state laws.
- A health care directive or similar document executed in another state is legal if it complies with the law of that state.

As a provider of health care services you can ensure your compliance by:

- Asking each patient you treat if he or she has a health care directive such as a durable power of attorney for health care or a living will.
- Documenting in a prominent part of the patient's medical record whether that individual has executed a health care directive.
- Keeping a copy of the health care directive in the front of the individual's medical record.
- Verifying with the patient that the copy is the latest version of their health care directive.
- Educating your staff regarding this policy and procedure.
- Developing a process to comply.
- Referring any complaints to Medica and/or contacting:

In Minnesota:

Health Resources Division Director  
Minnesota Department of Health  
393 North Dunlap Street  
PO Box 64900  
St. Paul, MN 55164-0900

In North Dakota:

North Dakota Senior Health Insurance  
Counseling Program  
600 East Boulevard  
Department 401  
Bismarck, ND 58505-0320

Hospitals, skilled nursing facilities, hospice providers, home health agencies and, for Medicaid, all providers of personal care services, must provide written information to patients on the state law regarding health care directives/advance directives. This information should be given to patients upon their admission to the facility or at the initiation of services.

## **Benefits**

### General Requirements for Benefits

#### ***Consistent with standards of care***

Benefits must be provided in a manner consistent with professionally recognized standards of care.

#### ***Basic and supplemental benefits***

Medica and Medica's providers must provide basic and supplemental benefits and access to benefits as required by Medicare in a manner consistent with professionally recognized standards of health care.

Medica, acting as an MCO with a Medicare CMP contract, must offer the plan:

- To all Medicare beneficiaries who meet the eligibility requirements and reside in the Medica service area.
- At a uniform premium.
- With a uniform level of cost sharing.

CMS reviews and approves the MCO to ensure the plan does not:

- Promote discrimination.
- Discourage enrollment.
- Steer specific subsets of Medicare beneficiaries to particular plans.
- Inhibit access to services.

#### **Basic benefits**

- These benefits generally include all services covered by Medicare Part A and Part B that are available in the Medica geographic service area and Medicare Part B services if the enrollee is entitled only under that program.
- When Medicare pays first, Medica will pay the appropriate deductible and coinsurance on care received from contracted providers, for out-of-network emergency and urgent services, and authorized referrals. See Chapter 18, Section J - Claim Submission, for a detailed listing of Medica vs. Medicare claim submission procedures.
- Medica must comply with CMS' national coverage decisions and with written coverage decisions of the local Medicare carrier or intermediary.
- As a reminder, you are required to comply with the same billing regulations that apply to Medicare.

#### **Supplemental benefits**

A Medicare enrollee may elect to pay for optional services that are offered by the CMP in addition to the covered Part A and Part B services. The CMP may not set health status standards for those enrollees it will accept for these optional supplemental services. Medica is also responsible for state-mandated benefits and other services not covered by Medicare.

## **Benefits**

### Specific Benefits

#### ***Influenza or pneumococcal vaccine cost sharing***

No copayments or costs may be assigned to enrollees for influenza or pneumococcal vaccine.

#### ***Continuation of member health care benefits***

Medica must provide for continuation of health care benefits to members under the following circumstances:

- For all members, the duration of the contract period for which premium payments have been made to Medica.
- For members who are hospitalized on the date Medica's contract with CMS ends or the date Medica becomes insolvent. Coverage for that hospitalization is continued through the date of hospital discharge for that member.

## Benefits

### Payments to Nonparticipating Providers

**Medica must make timely and reasonable payments to nonparticipating providers for certain services when obtained by a Medica MCO member under the specifically outlined circumstances.** Medica complies with this CMS requirement if Medica provides payment in an amount that the provider would have received under original Medicare. These services and circumstances are:

1. **Emergency care services** defined by CMS that are covered inpatient and outpatient services are:
  - Furnished by a provider qualified to furnish emergency services.
  - Needed to evaluate or stabilize an emergency medical condition.**For the definition of emergency medical condition see Chapter 18, Section E, Subsection 4.**
  
2. Urgently needed services are defined by CMS as covered services provided when such services are medically necessary and immediately required:
  - As a result of an unforeseen illness, injury or condition; **and**
  - It was not reasonable, given the circumstances, to obtain the services through Medica's provider network while in the service area, **or**
  - Under unusual and extraordinary circumstances, Medica's provider network is temporarily unavailable or inaccessible, **or**
  - Enrollee is temporarily absent from Medica's service area.**Refer also to Chapter 18, Section E, Subsection 5.**
  
3. Services that Medica denied coverage for and that are found **on appeal to be entitled to coverage.**

## **Access and Availability**

General Access

### ***Access guidelines***

**Please refer to Chapter 14, Section C, for Medica's Access Guidelines and Office Wait Time Standards.**

### ***Service availability***

Medica and its providers must make medically necessary services available 24 hours a day and seven days a week. This includes the provision of essential health care professionals during normal business hours and the availability of an after-hours telephone contact that can provide referral to an emergency facility. As part of Medica's access guidelines, a physician is expected to return a member's after-hours phone call within one hour unless the member has been directed to seek care at another facility and/or emergency services.

### ***Cultural competence***

Medica and its providers must ensure that all clinical and non-clinical services are available and accessible, and provided in a **culturally competent** way to all members. This includes accounting for the needs of the entire enrolled population including those members:

- With limited English proficiency or reading skills.
- With diverse cultural and ethnic backgrounds.
- Without homes.
- With physical and mental disabilities.

## **Access and Availability**

### Nondiscrimination

**Members may not be discriminated against in the delivery or access of health services** by Medica's providers. Medica and its providers and subcontractors must ensure:

1. That any members, in need of their health services, are accepted for treatment.
2. That members receive all health services consistent with their covered policy benefits:
  - Without discrimination. Nondiscrimination relates to factors such as race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information and source of payment.
  - With consistent application of health services to all members, e.g., specialist referrals.
3. That they publicly demonstrate their commitment to nondiscriminatory behavior in conducting business with all members. Examples include posters, member handbooks, organizational mission statements and strategic plans.
4. That nondiscriminatory behavior applies to all clinical and non-clinical personnel in their dealings with each member.

## **Access and Availability**

Direct Access Services

### ***Screening mammography and influenza vaccine***

Enrollees in **Medica Prime Solution** may directly access in-network, through self-referral, the following services:

- Screening mammography.
- Influenza vaccine.

Direct access or self-referral allows a **Medica Prime Solution** member to access these services without a written referral from his or her Medica contracted provider within the **Medica Prime Solution** provider network.

### ***Women's health specialists***

Female enrollees are allowed to directly access in-network women's health specialists for routine and preventive services, defined as:

- Breast exams.
- Mammograms.
- Pap smears.

## **Access and Availability**

### Emergency Care Services

#### ***Emergency care services***

Emergency services are those inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition.

CMS defines **an emergency medical** condition as one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following:

- 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 of bodily functions.
- Serious dysfunction of any bodily organ or part.

Members should notify Medica as soon as reasonably possible after they have begun receiving emergency care (hospital admissions) at out-of-network or out-of-area hospitals. That enables case management to help coordinate the member's care and benefits appropriately.

## **Access and Availability**

### Urgently Needed Care

**Urgently needed care** is defined as medically necessary health services immediately required to treat an unforeseen illness, injury or condition that is less serious than an emergency, but that requires prompt treatment to prevent serious deterioration of the individual's health.

Urgently needed care **may be provided** while the member is:

- Temporarily out of the service area but it is not reasonable, given the circumstances, to obtain services from a Medica-contracted provider.
- In the service area, but due to unusual and extraordinary circumstances, a Medica-contracted provider is unavailable or inaccessible to the member.

While in the service area, members are encouraged to contact their primary care provider's office to receive either:

- An appointment within 24 hours.
- Triage and information that appropriately respond to the member's medical need to be seen urgently.

The member may access urgent care services without a referral and from a non-contracted provider if he or she is not able to be seen by a Medica-contracted provider within the above timelines or has not been referred to receive services at another contracted provider's office or contracted urgent care center.

## **Quality Management**

### Quality Review Program

Medica maintains an agreement with Stratis Health, the Quality Improvement Organization (QIO) designated by CMS to act as the QIO for Minnesota, and with North Dakota Health Care Review, the QIO for North Dakota. CMS expects Medica and its providers to participate and cooperate with the activities of the QIO, which acts as an independent quality review and improvement organization.

### ***Practice guidelines***

Medica must consult with contracted physicians regarding medical policy, its quality assurance program and medical management procedures to ensure practice and utilization management guidelines that are:

- Based upon reasonable medical evidence or a consensus of health care professionals in a specific field of practice.
- In consideration of the needs of the enrolled population.
- Reviewed and updated periodically.
- Developed in consultation with contracting physicians.

Medica's guidelines are communicated to providers through ***Connections, Link, the Medica Provider Administrative Manual, Medical Policy Manual***, training and educational sessions and other communications, such as letters. **Most of these communications are available at [www.medica.com](http://www.medica.com), "Provider Resources."**

Medica utilization and coverage policies and procedures must be consistently applied using its guidelines and criteria.

## **Quality Management**

### Referral Information Requirements

#### ***Continuity of care***

Medica and Medica's providers must ensure the appropriate and confidential exchange of information among providers when complying with referral information requirements to ensure continuity and coordination of care. This requires that:

- A provider making a referral transmits any necessary information to the provider receiving the referral request.
- A provider furnishing a referral service reports appropriate information back to the referring provider.
- Providers request information from other treating providers as necessary to provide care.

#### ***Confidentiality monitoring***

Medica monitors confidentiality procedures for the exchange of information during the referral process, the documentation and filing of such information in the patient record and the confidentiality of such information as part of the record-keeping practices. Medica conducts this monitoring as part of its clinic site survey process.

## **Utilization Management**

### Medical Necessity Decisions

Medica's policies and procedures must allow for individual medical necessity determinations. These policies include coverage rules, practice guidelines, payment and utilization management. Policies should not cause unnecessary delay or preclude the delivery of services.

Medica has established effective procedures to monitor utilization of appropriate health services and to control costs of basic and supplemental health services to achieve utilization goals.

Medica's incentive arrangements do not include any specific payment to be made directly or indirectly to a physician or physician group that will act as an inducement to withhold, limit or reduce medically necessary services to an individual enrollee.

Medical policies are based on scientific evidence with input from practicing network physicians regarding community standards of practice. These are available at [www.medica.com](http://www.medica.com), "Provider Resources," "Medical Policies," or by calling the Provider Literature Request line at 952-992-2232 or 1-800-458-5512, provider option 1, option 5, ext. 2-2355.

The needs of individual patients who may not meet the criteria must be considered and are addressed by the process in the coverage area for each policy:

- If met, the care is approved.
- If not met, the case is submitted to the medical director or external review for individual consideration.

## Utilization Management

### Denials, Appeals and Expedited Appeals

Medica establishes, maintains and follows the appeal procedures and procedures for expedited reviews and informs all enrollees in writing of the appeal procedures and procedures for expedited organization determinations.

Medica's Evidence of Coverage (EOC) properly defines and identifies organization determinations, i.e.:

- Reimbursement for emergency or urgently needed services.
- Services furnished by non-affiliated providers or suppliers that the enrollee believes are covered by the Medica contract and should have been furnished, arranged for or reimbursed by Medica.
- Services that Medica refuses to provide that the enrollee believes should be furnished or arranged for by Medica and the enrollee has not received outside Medica.
- Discontinuation or reduction of a service.

Medica makes an organization determination (Medica's decision to provide, authorize, deny, pay for a service, or the discontinuation or reduction of a service) **within 60 days (standard) or 72 hours (expedited) of the enrollee's request for the service, or within 60 days of the enrollee's request for payment of a service.** Failure to provide a notice constitutes an adverse organization determination that the enrollee may appeal (i.e., the situation is deemed adverse).

All adverse organization determinations must be in writing. Medica's decision to deny payment for claims or refusal to provide or authorize a service is an adverse organization determination. In addition, an organization determination to discontinue inpatient services, i.e., hospitals or skilled nursing facility, must be in writing if a Prime Solution enrollee disagrees with the discharge decision. (Note: Not every service reduction is adverse. Therefore, written notice is not required for reduction, unless objection is raised). A written notice of adverse organization determinations and discontinuation of inpatient services:

- Upon notification of a Prime Solution enrollee disputing an inpatient discharge, Medica will issue a Notice of Discharge and Medicare Appeal Rights (NODMAR) to the enrollee. To notify Medica, providers or enrollees may call Medica's Center for Healthy Aging at 952-992-2300 or 1-800-234-8755.
- States the specific reason for the denial.
- Informs the enrollee of his or her right to a reconsideration, including the right to an expedited reconsideration (expedited reconsideration not applicable to denied claims).
- Provides parties to the reconsideration reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing.
- Specifies who may file a reconsideration.

- Includes information explaining that physicians and other health professionals may act on behalf of an enrollee in time-sensitive situations.
- Explains the 60-day appeal process.
- Explains the 72-hour expedited appeal process for appeals not related to claims.
- Informs the beneficiary of the opportunity to present evidence.
- Suggests information to support an appeal.
- Instructs beneficiaries how to obtain help with filing an appeal.
- Describes the QIO quality complaint process.
- Describes the Medica quality complaint process.
- Informs members of the need for representative statement or waiver.

Medica develops procedures to assure that contracted providers are fully informed of appeal procedures and the providers' responsibility to provide written notice of adverse organization determinations to the enrollee when any of the following occurs:

- A service or payment is denied.
- An enrollee objects to the reduction of a service.
- Inpatient care is discontinued.

Medica monitors these procedures.

Medica accepts requests for reconsiderations and expedited reconsiderations filed **within 60 days** of the organization determination (or if good cause is shown, accepts reconsiderations filed **after 60 days**).

Medica assures that someone not involved in making the organization determination makes the reconsidered determination (first level of appeal of an adverse organization determination).

Medica either makes a fully favorable decision and issues a decision to the enrollee **within 60 days** or if Medica is unable to make a fully favorable decision, Medica forwards the case to CMS' contractor **within 60 days** from date of receipt of the reconsideration request and concurrently notifies the beneficiary of the action.

If the reconsidered determination is to hold Medica liable, then Medica provides or pays for the service **within 60 days** from the date of the reconsidered determination.

Medica conducts an expedited review when either a contracting or a non-contracting physician requests an expedited organization determination or expedited reconsideration (Physician must be appointed as a representative to request reconsideration).

Medica makes its appeal decision **within 72 hours unless a 10-day extension** is permitted or Medica is waiting for medical records from non-contracting providers. If the decision is not fully favorable to the beneficiary, Medica sends the appeal case to CMS' contractor **within 24 hours**.

Medica complies with the reversal of the adverse organization determination, as medically indicated, **but no later than 30 days**.

## **Provider Network**

Providers That Opt Out of Medicare and Sanctioned Providers

### ***Providers that opt out of Medicare***

Medica is not permitted to reimburse contracted providers for services provided to Medicare-eligible patients, if those physicians or providers have filed an affidavit with CMS indicating that they will only provide health services to Medicare beneficiaries through private contracts.

### ***Sanctioned providers***

Neither Medica nor its contracted providers will employ or contract with persons who have been convicted of criminal offenses related to their involvement with Medicare or Medicaid. Medica includes this check as part of its credentialing and recredentialing processes. Also, Medica cannot make payment for any services delivered after the provider became sanctioned.

## **Provider Network**

Provider Agreement Termination

### ***Termination of provider***

Medica provides written termination notice to a **participating provider** that includes:

- The reasons for the action.
- The provider's right to appeal, the appeal process and time frame.

### ***Termination without cause***

Medica and its **participating providers** will provide a minimum of **60 days written notice** to each other before a case of termination without cause.

## **Payment**

### ***Receipt of federal funds***

Payments to Medica, Medica's contracted providers and subcontracted providers for Medica MCO members are, in whole or part, from federal funds. Individuals and entities receiving federal funds are subject to certain laws. These include statutes related to the filing of "false claims."

### ***"Hold harmless"***

As a managed care organization, Medica must have arrangements to protect members from incurring liability for payments that are the legal obligation of Medica. To meet this requirement Medica must:

- Ensure that all contractual or other written arrangements with providers prohibit the provider from holding any beneficiary/enrollee liable for payment of any amount that is Medica's liability.
- Indemnify the beneficiary/enrollee for payment of any fees that are the legal obligation of Medica, when the services are furnished by Medica non-contracted providers.

### ***Prompt payment***

Medica has agreed to pay or deny 95 percent of clean claims **within 30 days of receipt** and 100 percent **within 60 days** for all providers.

A "clean claim" is defined by the state of Minnesota "as a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim."

## **Claim Submission**

Under a cost contract like **Medica Prime Solution**, CMS has specific claim submission requirements. The list below outlines where you should send your claims. Any questions you have can be directed to the Medica Provider Service Center at 952-992-2232 or 1-800-458-5512.

### **Providers should bill Medicare first for:**

- Hospital services, both inpatient and outpatient (If billed by the hospital on a UB-92 claim form).
- Emergency and urgent services from non-contracted providers.
- Skilled nursing facility.
- Hospital-based ambulatory surgical centers.
- Hospice.
- Home health care.
- Independent physical therapy\*\*.
- Ambulance (If billed by the hospital on a UB-92 or a non-contracted provider).
- Outpatient blood transfusions.
- Dialysis facility for dialysis and related services.
- Claims from physicians for dialysis and related services provided through an approved dialysis facility.

### **Providers should bill Medica first for:**

*Please note: Medica uses current Medicare criteria for determining claim eligibility except for preventive and state-mandated benefits. You are also required to comply with the same billing regulations that apply to Medicare.*

- Physician services.
- Free-standing ambulatory surgical centers.
- Ambulance (If billed by an independent contracted provider on a CMS-1500, formerly HCFA-1500, claim form).
- Durable medical equipment.
- Orthotics & prosthetics.
- Occupational therapy.
- Speech therapy.
- Mental health.
- Emergency and urgent care (If billed by a contracted provider on a CMS-1500).
- Chiropractic care.
- State-mandated benefits.
- Preventive services.
- Radiology.
- Laboratory services including hospital reference labs.
- Diagnostic testing.
- Non-independent physical therapy\*\*.

**Additional information for physical therapy providers:**

\*\* For claims submission, please use the following criteria to determine where you should send your claims:

- You should submit claims to Medica if you are employed by or affiliated with a physician group or a free-standing therapy clinic.
- You should submit claims to Medicare if you are in individual practice or a partnership and maintain a private office space for the purposes of providing physical therapy services.
- In addition, an individual whose practice is in an unincorporated solo practice or unincorporated partnership would be considered a "private practice," which in effect is the same as an "independent practice."

A practitioner must meet **all** of the following requirements to be considered an "independent practitioner":

1. The therapist is not employed by a physician, hospital, institution or agency.
2. The therapist must have their own patients.
3. The therapist collects fees for the services he or she provides.
4. The therapist provides physical therapy on a regular basis (need not be full-time).
5. The therapist must maintain a separately designated office space used for the purpose of operating the practice.
6. If the therapist provides services in private office space, that space must be owned, leased or rented by the practice and used for the exclusive purpose of operating the practice.
7. The therapist must maintain hours of frequency and duration so that the patients can receive the services needed.

**Please note:** As of Jan. 1, 2002, the **Medica Prime Solution** basic option has copayments for some services. The most common copayments are listed on the front of the Medica member ID card. The **Medica Prime Solution** enhanced option does not have any copayments, but some coinsurance amounts may still apply.

Also, please refer to Chapters 11 (Claim Submission – Professional Services) and 12 (Claim Submission – Facilities) for detailed information on timely submission of claims.

## **Delegation**

### ***Accountability and oversight***

Medica may only delegate activities or functions to a provider, related entity, contractor or subcontractor in a manner consistent with and compliant with Medica's contractual obligations with CMS as an MCO. Medica is accountable for and is to provide oversight of any functions or responsibilities delegated to a provider.

### ***Requirements***

If Medica, under its contract with CMS, delegates any activities or responsibilities to other parties, the following requirements apply to those delegated entities and must be in written arrangements:

- Medica must specify delegated activities and reporting responsibilities.
- Remedies for improvement or revocation of delegation activities must be in writing in instances where CMS or Medica determine that such parties have performed delegation responsibilities unsatisfactorily.
- Medica monitors performance of the parties on an ongoing basis.
- All contracts or written arrangements must specify that delegated contracted providers or subcontractors must comply with all applicable Medicare laws, regulations and CMS instructions.
- If Medica delegates the selection of providers, contractors or subcontractors to another organization, Medica's written arrangements with that organization must state that Medica has the right to approve, suspend or terminate contracted arrangements as well as subcontracted provider arrangements with contracted Medica providers.

## **Other Regulations**

### CMS Audits

#### ***CMS right to audit***

Health and Human Services (HHS) or its designee may audit, evaluate or inspect any books, contracts, medical record, patient care documentation and other records that pertain to:

- Any aspect of services performed.
- Reconciliation of benefit liabilities.
- Determination of amounts payable under the contract.
- Any factors HHS may deem necessary to enforce the contract.

HHS or its designee may evaluate through inspection or other means:

- The quality, appropriateness and timeliness of services furnished to Medicare enrollees.
- The facilities of Medica and Medica's contracted and subcontracted providers.
- The enrollment and disenrollment records.

#### ***CMS audits and retention of records***

The HHS right to audit, inspect or evaluate extends through **six years** from the final date of the contract period or completion of the audit, whichever is later, unless:

- CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Medica and/or Medica's providers at least **30 days** before the normal return date.
- CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate or audit Medica or Medica's contracted or subcontracted providers at any time.
- Retention may be extended to **six years** from the date of any final resolution of the termination, dispute or fraud.

## **Other Regulations**

Physician Incentive Plan (PIP)

### ***Incentive arrangements prohibited that induce limitation of services***

Under federal regulations, Medica, through its contracts with CMS and the Minnesota Department of Human Services (DHS) to service Medicare and Medicaid enrollees, is prohibited from having incentive arrangements with physicians that act as inducements to physicians to withhold or limit medically necessary services to specific enrollees.

### ***CMS use of data***

PIP requirements relate to CMS' assurance that enrollees have access to medically necessary referral services. CMS uses the required PIP data to monitor compliance with federal statutes and supporting regulations governing physician incentives through Medicare and Medicaid managed care organizations.

### ***Substantial financial risk***

PIP arrangements may be in place directly through the contract Medica holds with the clinic or indirectly through subcontracts (physician compensation plans with their affiliated clinic). Under the PIP regulations, if physicians are put at "substantial financial risk" by any incentive arrangements the clinic may have with them, there must be adequate stop-loss protection. Medica is also required to conduct member satisfaction surveys and supply these results to regulators and members upon their request.

### ***PIP disclosure***

The detailed worksheets include the following information that is required to be submitted by you to Medica, which in turn is required to submit this information to CMS in the prescribed manner:

- Whether referral services are covered by PIP.
- Type of incentive arrangements (e.g., withhold, bonus, capitation).
- Percent of total income at risk for referrals.
- Amount and type of stop-loss protection.
- Panel size and whether enrollees were pooled in order to achieve the panel size.