Ochsner Health Plan

2024 Provider Manual

H9763_PROVMAN_2024_C

updated January 1, 2024

Ochsner Health Plan
Provider Manual

Welcome to the **Ochsner Health Plan (OHP)** network. As a participating provider, you play an important role in the delivery of healthcare services to our members, and you have our commitment to work collaboratively with you to provide your patients and our members access to excellent care and coverage.

This OHP Provider Manual is intended to be used as a guide to assist providers in delivering covered services to Ochsner Health Plan members. This manual contains policies, procedures, and general information, including the minimal standards of care, which are required of OHP providers and govern the administration of the Medicare Advantage and Prescription Drug (MA-PD) plans. This information is provided to promote an effective understanding of OHP operations and supplements the provider contract.

This manual is effective January 1, 2024. This guide is subject to change. We frequently update content in our effort to support our healthcare provider networks. Please visit www.OchsnerHealthPlan.com for the most recent version.

Ochsner Health Plan

Dear Provider Partner:

Louisiana residents eligible for Medicare in 14 parishes throughout the New Orleans and Baton Rouge areas have the opportunity to enroll in Medicare Advantage benefit plans offered by the Ochsner Health Plan. Premiums and copays start at $0 and include a wide range of cost-saving features and wellness programs not available with original Medicare, such as prescription drug coverage, fitness, dental, hearing and vision. The open enrollment period for the following year runs from October 15th to December 7th.

The coverage area for Ochsner Health Plan includes the following parishes in the Greater New Orleans and Greater Baton Rouge areas: Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafayette, Lafourche, Livingston, Orleans, St. Charles, St. John the Baptist, St. Martin, St. Tammany, and West Baton Rouge.

Ochsner Health Plan works collaboratively with our participating providers to make a healthy difference in the lives of our members by offering preventive care resources and health management services that are fully integrated with both virtual and in-person programs for chronic and complex conditions that remain highly prevalent in Louisiana — like diabetes, high blood pressure, heart failure, obesity, nicotine addiction, and more.

Why choose Ochsner Health Plan?

Ochsner Health Plan works with its parent organization and other providers to reduce barriers to healthcare and invest in the health of our communities. Our Medicare Advantage plans provide a full complement of competitively priced benefits – all backed by the quality and innovation that patients expect from Louisiana's leading healthcare provider, Ochsner Health.

Ochsner Health Plan with Medicare Advantage also bolsters Ochsner's efforts to stay ahead of the increasing demand and health needs of Louisiana's aging citizens. As the U.S. Medicare population continues to grow by 11,000 people every day, more seniors across Louisiana are seeking the best medical options available to them. Ochsner Health Plan is committed to working with our participating providers to offer the highest quality, most affordable care available for all our members health and wellness needs.

Ochsner Health Plan Medicare Advantage (MA)

As a Medicare Advantage managed care organization, Ochsner Health Plan administers coverage that includes all the benefits traditionally covered by Medicare plus added benefits identified in the Plan's coverage documents. Such additional benefits may include:

- No monthly health plan premiums with predictable co-pays for most in-network services
- Outpatient prescription drug coverage
- Routine dental, vision, over-the-counter (OTC) and hearing benefits
- Preventive care from participating providers with no co-payment

Below is a list of Ochsner Health Plan's MA products:

Health Maintenance Organization (HMO) –Traditional MA plan. All services must be provided within the Ochsner Health Plan network unless an emergency or urgent need for care arises, out of area dialysis services, or a covered service is not available in-network. Some services require prior authorization by Ochsner Health Plan, or its designee.

HMO with Point-of-Service Option (HMO-POS) – The point-of-service (POS) benefit allows members to access most Medicare-covered, Medically Necessary services from non-network providers, and they are entitled to use their POS option anywhere in the United States. However, members may pay more to access services outside the network via their POS benefit, and no guarantee can be made that non-network providers will accept Ochsner Health Plan insurance for non- emergency services.

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Section 1: Ochsner Health Plan Important Contacts

Ochsner Health Plan website: www.ochsnerhealthplan.com

Ochsner Health Plan Departments

Department	Phone Number	Fax Number	E-Mail
Claims Questions	833-674-2112	N/A	N/A
Care Management/Prior Authorizations	866-978-2029	985-898-1505	N/A
Provider Relations	833-674-2112	N/A	OHPproviderrelations@ochsner.org
Compliance & Fraud/Waste/Abuse	Toll free 833-937-3167 Local 504-754-7086	N/A	OHPCompliance@ochsner.org
Privacy Office	Toll free 833-937-3167 Local 504-754-7086	N/A	OHPPrivacy@ochsner.org

Ochsner Health Plan Appeals

Department	Phone Number	Fax Number	E-Mail
Part C – Pre-Service Appeal	866-978-2029	985-898-1505	N/A
Part C – Post-Service Appeals	866-978-2029	985-898-1505	AppealsGrievancesOHP@ochsner.org
Part D – Appeals	800-910-1837	858-790-6060	N/A
Administrative Appeals or Reconsiderations - Claim Denials or Benefit Exceptions	504-754-7087	504-754-6496	AppealsGrievancesOHP@ochsner.org

Ochsner Health Plan has contracted with certain vendors and providers to provide services to members outside of services traditionally covered by Medicare. The following information is the contact information for those vendors/providers.

Ochsner Health Plan Ancillary Vendors

Service	Vendor/ Provider	Phone Number	Fax Number	Claims Address
Routine Vision/Eyewear	Community Eye Care (CEC) a VSP Company	844-498-9518	704-426-6044	CEC, Attention: Claims 4944 Parkway Plaza Blvd. Suite 200 Charlotte, NC 28217
Ochsner Health Plan Flex Card Services	Convey/InComm	1-855-638-1420		N/A
Routine Dental	DINA Dental	877-649-3188	281-313-7154	DINA Dental 101 Parklane Blvd. Suite 301 Sugar Land, TX 77478
Fitness	SilverSneakers	888-423-4632	N/A	N/A

This Manual is available on Ochsner Health Plan's website, www.OchsnerHealthPlan.com.

In accordance with the Provider Participation Agreement, participating providers must abide by all applicable provisions contained in this manual.

Additional Resources
The following resources are at www.OchsnerHealthPlan.com. **The *Quick Reference Guide*** contains important addresses, phone/fax numbers and prior authorization requirements.

Website Resources
Ochsner Health Plan's website www.OchsnerHealthPlan.com offers a variety of tools to assist Providers and their staff.

Available resources include:

- Provider Manuals
- Quick Reference Guides
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Formulary and drug lookup
- Training materials and job aids
- Privacy Statement and Notice of Privacy Practices

Section 2: Provider and Member Administrative Guidelines

Provider Billing and Address Changes

Providers are required to give prior notice per the terms of their Agreement for any of the following changes. Please contact 833-674-2112 to report changes to your:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number
- Panel status (open/closed)

Failure to notify Ochsner Health Plan prior to these changes will result in a delay in claims processing and payment.

To maintain the integrity of Provider Directory data, Ochsner Health Plan may rely on information independently verified by a third party and may take appropriate actions to remove inaccurate provider data from the directory.

Access to Care

Access and Availability Standards

All Ochsner Health Plan network providers must use their best effort to adhere to the following standards for appointment scheduling to ensure timely access to medical care for our members. (42 CFR 422.112(a)(6)).

Adherence to member access guidelines will be monitored through office site visits and the tracking of complaints and grievances related to access and availability, and patient satisfaction surveys.

Ochsner Health Plan's standards for appointment wait times for primary care and behavioral health services are as follows:

- Urgently needed services and emergency care: immediately
- Services that are not an emergency or urgently needed, but the enrollee requires medical attention - within 7 business days; and
- Routine and preventive care: within 30 days business days.

Type of Appointment	Access Standard
PCP – Urgent	≤ 24 hours
PCP – Non-urgent	≤ 1 week
PCP – Routine	≤ 30 days
Specialist	≤ 30 days

PCPs must provide or arrange for coverage of services and consultation 24 hours per day, seven days per week.

Hours of Operations
Hours of operation must not discriminate against Ochsner Health Plan members relative to other members. All Participating providers will treat all OHP members with equal dignity and consideration as their non-Medicare patients. (42 CFR 422.112(a)(7))

After-hours access shall be provided to ensure a response to after-hours phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek Emergency Services or call 911.

Provider Roles and Responsibilities

Selecting a Primary Care Provider (PCP)
Ochsner Health Plan members select a PCP at the time of enrollment. The member's PCP will be responsible for providing, coordinating, and arranging all medically necessary services for the member. In rare cases, if the member has not identified a PCP and we cannot verify his/her choice, a PCP will be assigned. The member may select and/or change their PCP within the network without interference by contacting Ochsner Health Plan's Member Services Department at the number listed on the back of the members ID card. A PCP serves as the members total care coordinator for non-emergent care. PCPs are available to members 24 hours a day, seven days a week through regular scheduling or on-call coverage. There will always be a doctor on call to help them.

The PCP Role
As a PCP, you are responsible for providing medically necessary primary care services to Ochsner Health Plan members. You are the coordinator of our members total health care needs and should assist members to obtain prior authorizations if necessary. You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit.

- Provide the same level of care to OHP members as provided to all other patients.
- Keep a central record of the members health and health care that is complete and accurate.
- Enter into the member's health record all reports received from specialty care physicians or professional providers.
- Assume the responsibility for arranging and prior authorizing hospital admissions in which he/she is the admitting physician or delegate this responsibility to the admitting specialty care physician or professional provider
- The PCP designates backup (covering) primary care physicians/providers during the network application process.

Maximum Out-of-Pocket

- For Medicare Advantage (MA) Plans, member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a member has reached the maximum out-of-pocket amount for their benefit plan, a provider should not collect any additional out-of-pocket amounts from the member for Medicare Covered Services and should not apply or deduct any member expenses from that provider's reimbursement. Providers may determine a members accumulated out-of-pocket amount by contacting Ochsner Health Plan's provider services department. If a provider collects an out-of-pocket amount that causes a member to exceed his or her annual maximum out-of-pocket, Ochsner Health Plan will notify the provider that the amount collected from the member was in excess of the maximum out-of-pocket, and the provider shall promptly reimburse the member for that amount.

- If Ochsner Health Plan determines that the provider did not reimburse the amount in excess of the maximum out-of-pocket amount to the member, Ochsner Health Plan may pay the overage amount to the member directly and recoup the amount directly from the provider.

- If Ochsner Health Plan erroneously deducts an amount from the provider's reimbursement as a result of a members payment of a cost-share amount that does not exceed maximum out-of-pocket, Ochsner Health Plan will reimburse the provider for the amount deducted in error.

- Ochsner Health Plan may audit the providers compliance with this section and may require the provider to submit documentation to Ochsner Health Plan demonstrating that the provider reimbursed members for amounts in excess of the maximum out-of-pocket amounts.

Enrollment and Eligibility
All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency.

Annual Wellness Visit
An annual wellness visit should be completed to assess the health status of all Ochsner Health Plan MA members. The member should receive an appropriate assessment and intervention as indicated, or upon request.

Provider Network Information

Provider Panel

Closing of Provider Panel
When requesting closure of their panel to new members and/or transferring Ochsner Health Plan members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel.
- Keep the panel open for Ochsner Health Plan members who were provided services before the closing of the panel.
- Notify Ochsner Health Plan when reopening the panel and provide the effective date.

Requests may be submitted by contacting your Provider Relations Representative.

Provider Data Accuracy
To be included in Provider Directory or any other customer communications, providers must be fully credentialed and contracted. Directory specialty designations must commensurate with the education, training, board certification, and specialty(ies) verified and approved by the credentialing process. Any requests for changes or updates to the specialty information in the directory will only be approved once validated through the credentialing process.

Plan Notification Requirements for Providers
Participating providers must provide written notice to Ochsner Health Plan no less than 90 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter. The following is a list of changes that must be reported to Ochsner Health Plan by contacting Provider Relations or Customer Service:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions

Provider Quarterly Outreach
CMS requires all Medicare Advantage Organizations (MAOs) to outreach to contracted providers on a quarterly basis in order to verify providers demographic data published in the Ochsner Health Plan provider directory. CMS also requires MAOs to update the provider directories within 30 days of receipt of new or revised demographic information.

As a contracted provider you are required to comply with the outreach request and supply updated information within the allotted timeframe. The accuracy of our directories directly impacts the members we both serve, and we take this compliance requirement very seriously.

Additionally, providers should log into to the National Plan and Provider Enumeration System (NPPES: NPPES (hhs.gov)) any time demographic information changes.

Independent Physician Termination
Ochsner Health Plan is required to make good faith efforts to provide at least 30 calendar days advance written notice to impacted customers when a provider is being terminated or leaving the network. Impacted customers are those who are seen on a regular basis by the provider, have scheduled services with the provider or have recently received treatment or a service from the provider (within the past 90 calendar days). Providers must provide advanced written notice (timeframe varies based on the Provider Services Agreement) to Ochsner Health Plan prior to terming their agreement or leaving the network (retiring, office closure, moving out of area, etc.). Reference your participating provider agreement for termination notification requirements.

Member Rights and Responsibilities
Ochsner Health Plan members are entitled to certain rights and services. A good partnership between the member, the health care provider, and the health plan enhances the ability to provide appropriate services with maximum benefit to the member for the services provided. Listed below is a summary of OHP member rights and responsibilities.

Provider Responsibilities Regarding Member Rights
- Treat members with fairness, dignity, and respect at all times.
- Do not discriminate against members based on race, religion, national origin, sex, age, sexual preference, type of illness or financial status.
- Provide information in a way that works for the member (in languages other than English, in braille, in large print, or other alternate formats, etc.).
- Ensure members get timely access to covered services.
- Keep members free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Present members with information regarding all appropriate and medically necessary treatment

options for their conditions, regardless of cost or benefit coverage.
- Keep members advance directives, or other information about what is to be done if they are unable to make decisions for themselves, in a prominent place in their medical record.
- Support their right to make decisions about their care including informing them about treatment options, the risks associated with them, their right to refuse care, and provide an explanation if you as their provider cannot provide the care.
- Explain information in a way that the member can understand and encourage them to ask questions to ensure comprehension.
- Allow members to make complaints without having it affect the way they are treated.
- Protect member privacy regarding their personal health and financial information and cooperate with their right to review their records and make requests to amend or correct them.
- Provide members with access to their records and notify them of how the information is shared with others.

Member Responsibilities

- Be familiar with their coverage and the rules they must follow to get covered services.
- Notify the plan and providers if they have additional health insurance coverage.
- Show their ID card before receiving health care services.
- Be considerate.
- Pay any necessary copayment at the time they receive treatment.
- Keep scheduled appointments.
- Provide information needed for their care and follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals.
- Ask their providers questions about treatment if they do not understand.
- Notify providers with any questions, concerns, problems, or suggestions they have.

OHP is committed to ensuring that enrolled members are treated in a manner that respects their rights as individuals entitled to receive health care benefits.

Non-Discrimination and Cultural Competency

Participating providers shall provide health care services to all members, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

Participating providers shall provide covered services in a culturally competent manner to all customers by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include, but are not limited to, translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

For more information on cultural competency, visit the U.S. Department of Health and Human Services website at Home - Think Cultural Health (hhs.gov).

Advance Directives
Ochsner Health Plan members have the legal right to make choices about their medical care prior to a severe illness or injury through an advance directive. Providers should provide each member with written information on state laws about advance treatment directives and patients' rights to accept or refuse treatment and encourage each member to complete an advance directive. Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. (42 CFR 422.128(b)(1)(ii)E)

Providers, including facilities, must not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. (42 CFR 422.128(b)(1)(ii)(F)).

Providers must also educate staff concerning your policies and procedures on advance directives.

In Louisiana, you can find further information, including advance directive forms, on the Office of the Attorney General State of Louisiana website at www.ag.state.la.us/.

Privacy (HIPAA)
Ochsner Health Plan continues to ensure that we conduct business in a manner that safeguards member information in accordance with the privacy guidelines enacted pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

All provider practice personnel must be trained in HIPAA Privacy and Security regulations. The practice must ensure there is a policy or procedure in place for maintaining confidentiality of members medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures must include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

To learn more about Privacy, Security & Breach Notification Rules, please see HIPAA Basics for Providers: Privacy, Security & Breach Notification Rules Booklet (cms.gov)

Termination of a Member
Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. If a provider desires to terminate his or her relationship with a member, the provider must complete a PCP Request for Transfer of Member form and attach documentation of the members non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the member effectively. The form should be faxed or emailed to Ochsner Health Plan's Compliance Officer at OHPCompliance@Ochsner.org. The Request for Transfer of Member form is at www.OchsnerHealthPlan.com.

Once the form has been submitted, the provider shall continue to provide medical care for the member until such time that written notification is received from Ochsner Health Plan confirming that the member has been successfully transferred to another Provider.

A provider may not seek or request to terminate his or her relationship with a member or transfer a member to another provider of care based on the members medical condition, amount or variety of care required or the cost of covered services required by the member.

Section 3: Credentialing

Overview

For purposes of *Section 3: Credentialing* in this manual, all Ochsner Health Plan providers are credentialed and recredentialed to review and evaluate their qualifications according to the standards defined by the National Committee for Quality Assurance (NCQA).

Practitioners are required to be credentialed prior to being listed as an Ochsner Health Plan participating network provider.

The Credentialing Department, or its designee (Kearny Consulting), is responsible for gathering all relevant information and documentation.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and Ochsner Health Plan policy and procedure requirements, and include a query to the National Practitioner Data Bank. Currently Ochsner Health Plan has delegated primary source verification to Allied Physician Services, an NCQA certified CVO.
- Ochsner Health Plan utilizes CAQH. Ochsner Health Plan strongly encourages you to maintain your information with CAQH.
- After the credentialing process has been completed and the Credentialing Committee renders a participation decision, a timely notification of the credentialing decision is forwarded to the provider. If a denial was issued, the provider is advised of their Appeal Rights in writing.

Credentialing may be done directly by Ochsner Health Plan or by an entity approved by Ochsner Health Plan for delegated credentialing. All providers or entities delegated for credentialing must meet NCQA standards.

All practitioners are afforded the right to review and correct information used during the credentialing process. The only exception is National Practitioner's Data Bank (NPDB) reports, references or recommendations which are peer review protected. If any discrepancies are found, OHP with notify provider by phone or in writing at least 10 days prior to the chart review by the Credentialing Committee.

Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in the Ochsner Health Plan network. Existing providers who get restricted from participation in any government program are subject to immediate termination in accordance with Ochsner Health Plan policy and procedure and the Agreement.

A provider who opts out of Medicare is not eligible to become a participating provider. An existing provider who opts out of Medicare is not eligible to remain as a participating provider for Ochsner Health Plan.

Site Inspection Evaluation

Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:

Office site criteria:

- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment recordkeeping criteria

SIEs are conducted for:

- Unaccredited facilities
- State-specific initial credentialing requirements
- State-specific recredentialing requirements
- When complaint is received relative to office site criteria

Covering Physicians

Primary care physicians in solo practice must have a covering physician who also participates with, or is credentialed with, Ochsner Health Plan.

Allied Health Professionals

- Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Ochsner Health Plan. AHPs include, but are not limited to the following:
    - Nurse Practitioners
    - Certified Nurse Midwives
    - Physician Assistants
    - Osteopathic Assistants
    - Social Workers
    - Physical Therapists
    - Occupational Therapists
    - Audiologists
    - Behavioral Health Providers

Recredentialing

In accordance with regulatory, accreditation, and Ochsner Health Plan policy and procedure, recredentialing is required at least once every 36 months.

Ongoing Sanction Monitoring

On a monthly basis, Ochsner Health Plan or its designee accesses the listings from the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) report of exclusions and reinstatements, for the most current available information. This information is cross-checked against Ochsner Health Plan's network of providers. If participating providers are identified as being currently excluded, such providers are subject to immediate termination, in accordance with Ochsner Health Plan policies and procedures and the Agreement.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, Ochsner Health Plan, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of Ochsner Health Plan providers. If a network provider is identified as currently under sanction, appropriate action is taken in accordance with Ochsner Health Plan policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Ochsner Health Plan policies and procedures.

If a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing Peer Review Committee. The committee determines whether the provider should continue participation or whether termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process

Ochsner Health Plan may immediately suspend, pending investigation, the participation status of a provider who, in the sole opinion of Ochsner Health Plan's Medical Director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare or safety of members.

Ochsner Health Plan has a participating provider dispute resolution peer review panel process if Ochsner Health Plan chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The provider dispute resolution peer review process has two levels. All disputes in connection with the actions listed below are referred to a first-level peer review panel consisting of at least three qualified individuals of whom at least one is a participating provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second-level peer review panel consisting of at least three qualified individuals of which at least one is a participating provider and a clinical peer of the practitioner that filed the dispute. The second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by Ochsner Health Plan entitle the practitioner affected to the provider dispute resolution peer review panel process:

- Suspension of participating provider status for reasons associated with clinical care, conduct or service
- Revocation of participating provider status for reasons associated with clinical care, conduct or service
- Non-renewal of participating provider status at time of recredentialing for reasons associated with clinical care, conduct, service, or excessive claims and/or sanction history

Notification of the adverse recommendation, together with reasons for the action, the practitioner's rights, and the process for obtaining the first- and/or second-level dispute resolution peer review panel, are provided to the practitioner.

The practitioner has 30 days from the date of Ochsner Health Plan's notice to submit a written request to Ochsner Health Plan. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, with return receipt, to invoke the dispute resolution peer review panel process.

Upon Ochsner Health Plan's timely receipt of the request, Ochsner Health Plan's Medical Director or his/her designee shall notify the practitioner of the date, time, and telephone access number for the panel hearing. Ochsner Health Plan then notifies the practitioner of the schedule for the review panel hearing.

The practitioner and Ochsner Health Plan are entitled to legal representation at the review panel hearing. The practitioner has the burden of proof by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn therefrom, are arbitrary, unreasonable, or capricious.

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. Ochsner Health Plan's Medical Director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first-level panel hearing. If the findings are positive for the practitioner, the process concludes and the action against the practitioner's network participation status does not go forward.

If the findings of the first-level panel hearing are adverse to the practitioner, the practitioner may access the second-level peer review panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level peer review panel.

Within 10 calendar days of the request for a second-level peer review panel hearing, the Medical Director or his or her designee shall notify the practitioner of the date, time, and access number for the second-level peer review panel hearing.

The second-level dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the second-level dispute resolution peer review panel hearing, shall notify the practitioner of the results of the second-level panel hearing via certified or overnight recorded delivery mail. The findings of the second-level peer review panel shall be final, except that the provider may pursue applicable dispute resolution rights, if any, in the Agreement.

A practitioner who fails to request the provider dispute resolution peer review process within the time and in the manner specified waives all rights to such review to which he or she might otherwise have been entitled. Ochsner Health Plan may terminate the practitioner and may make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable.

Section 4: Claims

Overview

The focus of Ochsner Health Plan's Claims Department is to process claims in a timely manner. Ochsner Health Plan has established toll-free telephone numbers for providers to access a representative in the member Services Department. For more information on claims submission, refer to the *Quick Reference Guides* at www.OchsnerHealthPlan.com.

Timely Claims Submission

Unless otherwise stated in the Agreement, providers must submit clean claims (initial, corrected, and voided) to Ochsner Health Plan within 180 calendar days from the date of discharge (for inpatient services) or the date of service (for all other services). The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or CMS, Ochsner Health Plan may deny payment of any claim that fails to meet Ochsner Health Plan’s submission requirements for clean claims or failure to timely submit a clean claim to Ochsner Health Plan. A provider whose claim is denied as described in this paragraph must not bill or accept payment from the member for the services in question.

The following items can be accepted as proof that a clean claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Ochsner Health Plan
- A provider’s electronic submission sheet that contains all the following identifiers:
    - Patient name
    - Provider name
    - Date of service to match Explanation of Benefits (EOB)/claim(s) in question
    - Prior submission bill dates
    - Ochsner Health Plan’s product name or line of business

The following items are examples of what is not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter
- A copy of the provider’s billing screen

Tax ID and National Provider Identifier Requirements

Ochsner Health Plan requires the provider-issued Tax Identification Number (Tax ID/TIN) and National Provider Identifier (NPI) on all claim’s submissions, with the exception of atypical providers (providers that do not provide healthcare services, and instead provide services such as home and vehicle modifications, taxi services and respite care). Atypical providers must pre-register with Ochsner Health Plan before submitting claims to avoid NPI rejections.

Ochsner Health Plan will reject claims without the Tax ID and NPI, and such claims will not qualify as Clean Claims. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996’s (HIPAA) NPI Final Rule Administrative Simplification, is available at www.cms.gov/Regulations-and-Guidance/HIPPA-Administrative-Simplification/NationalProvidentStand.

Taxonomy
To increase appropriate adjudication, providers are encouraged to submit claims with the correct taxonomy code consistent with providers specialty and services being rendered. Ochsner Health Plan may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted; in such cases, provider must not bill or accept payment from the member for the amount denied or reduced by Ochsner Health Plan.

Prior Authorization number
If an prior authorization number was obtained from Ochsner Health Plan, the provider must include this number in the appropriate data field on the claim.

National Drug Codes
Ochsner Health Plan follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit National Drug Codes as required by CMS.

Strategic National Implementation Process (SNIP)
All claims and encounter transactions submitted via paper, direct data entry (DDE), or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. If a claim is rejected for lack of compliance with Ochsner Health Plan's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits based on the date of service (those limits are described above under "Timely Claims Submission"). For more information on encounters, see the *Encounters Data* section below.

Claims Submission Requirements
Providers using electronic submission shall submit Clean Claims to Ochsner Health Plan or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/UB-04 (or their successors), as applicable. Claims shall include the providers NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement or compensation is due for a Covered Service, and no claim is complete for a Covered Service, unless performance of that Covered Service is fully and accurately documented in the members medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses or non-covered services, including cases in which payment is denied or reduced because of providers failure to follow the requirements set forth in this manual.

For more information on paper submission of claims for Covered Services, see the "Paper Claims Submissions" subsection below.

Electronic Claims Submissions
Ochsner Health Plan accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Ochsner Health Plan must be in the ANSI ASCX12N format, version 5010A, or its successor. For more information on EDI implementation with Ochsner Health Plan, refer to Ochsner Health Plan's *Companion Guides* at www.OchsnerHealthPlan.com.

Ochsner Health Plan's Payer ID: A5236

Providers should work with their existing clearinghouse, or the clearinghouses Ochsner Health Plan uses, to establish EDI with Ochsner Health Plan. For a list of clearinghouses Ochsner Health Plan uses, contact Ochsner Health Plan's PR team.

275 Claim Attachment Transactions via EDI

Effective September 1, 2020, providers may submit unsolicited attachments (related to pre-adjudicated claims). In addition, the Plan may solicit claims attachments via 275 transactions through the clearinghouse to the billers that use the clearinghouse. At this time, electronic attachments (275 transactions) are not intended to be used for appeals or disputes.

What are Acceptable Electronic Data Interchange Healthcare Claim Attachment 275 Transactions?

Electronic attachments (275 transactions) are supplemental documents providing additional patient medical information to the payer that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries and operative reports to support a healthcare claim adjudication. The 275 transaction is not intended to initiate provider or member appeals, grievances, or payment disputes.

For more information on EDI implementation with Ochsner Health Plan, refer to the *Ochsner Health Plan Companion Guides* at www.OchsnerHealthPlan.com.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as Ochsner Health Plan, as well as providers engaging in one or more of the identified transactions, to be able to send and receive all standard electronic transactions using the HIPAA-designated content and format.

To promote consistency and efficiency for all claims and encounter submissions to Ochsner Health Plan, it is Ochsner Health Plan's policy that these requirements apply to all paper and DDE transactions.

All providers must submit HIPAA-compliant diagnosis codes (ICD-10-CM). Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code- lookup.aspx for specific codes.

Paper Claims Submissions

Providers are encouraged to submit claims to Ochsner Health Plan electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact Ochsner Health Plan's EDI team by referring to the *Quick Reference Guides* at www.OchsnerHealthPlan.com. Please submit paper claims to:

Ochsner Health Plan Claims
P.O. Box 4318
Scranton, PA 18505

If permitted under the Agreement and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- All paper claims must be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for clean claims submission:
    - The information must be aligned within the data fields and must be:
        - On an original red-ink-on-white paper claim form
        - Typed. Do not print, handwrite, or stamp any extraneous data on the form
        - In black ink
        - In large, dark font such as, PICA or ARIAL, and 10-, 11- or 12-point font
        - In capital letters
    - The typed information must not have:
        - Broken characters
        - Script, italics, or stylized font
        - Red ink
        - Mini font
        - Dot matrix font

For additional information published by CMS, see the CMS UB-04 Fact Sheet:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

CMS-1500 Fact Sheet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

Claims Processing

Readmission

Ochsner Health Plan may choose to review claims as it deems appropriate, based on data analysis. Ochsner Health Plan may review hospital admissions on a specific member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider), Ochsner Health Plan will apply its readmission policy and make all appropriate adjustments to the claim, including recovery of payments which are not supported by the medical record.

Pre-Admission Services Payment Policy

Ochsner Health Plan will not reimburse outpatient services provided within the three calendar days prior to an inpatient admission (including, but not limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services and other preadmission services). Ochsner Health Plan will apply this policy regardless of the status of the outpatient provider/facility, including (but not limited to) cases in which preadmission services were performed by an outpatient provider/facility that (i) is the same as the inpatient provider/facility; (ii) is an affiliate of the inpatient provider/facility; (iii) bills under the same tax identification number as the inpatient provider/facility; (iv) is part of the same hospital system/facility as the inpatient provider; or (v) is owned by the same corporate parent as the inpatient provider/facility.

Disclosure of Coding Edits

Ochsner Health Plan uses claims editing software programs to assist in determining proper coding for provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association(AMA) and Specialty Society correct coding guidelines. These software programs may result in claim edits for specific procedure code combinations. These claim edits may also result in adjustments to the provider's claims payment or a request for review of medical records, prior to or subsequent to payment, that relate to the claim. providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to Ochsner Health Plan. A reduction in payment as a result of claim policies and/or processing procedures is not an indication that the service provided is a non-covered service, and thus providers must not bill or collect payment from members for such reductions in payment.

Rate Updates

Ochsner Health Plan implements and prospectively applies changes to its fee schedules and CMS changes to Medicare fee schedules as of the later of:

- The effective date of the change; or
- 30 days from the date CMS publishes the change on its website.

Ochsner Health Plan will not retrospectively apply increases or decreases in rates to claims that have already been processed.

Coordination of Benefits (COB)

Ochsner Health Plan shall coordinate payment for covered services in accordance with the terms of a members benefit plan, applicable state and federal laws, and applicable CMS guidance. If Ochsner Health Plan is the secondary insurer, providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Ochsner Health Plan. Any balance due after receipt of payment from the primary payer should be submitted to Ochsner Health Plan for consideration and the claim must include information verifying the payment amount received from the primary payer. COB information can be submitted to Ochsner Health Plan by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the primary insurer's explanation of benefits.

Ochsner Health Plan may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Members under the Medicare Advantage line of business may be covered under more than one insurance policy at a time. If:

- A claim is submitted for payment consideration secondary to primary insurance carrier. Other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. Ochsner Health Plan has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the Quick Reference Guide at www.OchsnerHealthPlan.com.
- Ochsner Health Plan has information on file to suggest the member has other insurance primary to Ochsner Health Plan, Ochsner Health Plan may deny the claim.
- The primary insurance has terminated, the provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the

provider is responsible for submitting the initial claim with proof payment has been returned to the primary insurance carrier.

- Benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds Ochsner Health Plan's liability, no additional payment will be made.

Unless the applicable benefit plans (the benefit plan issued by Ochsner Health Plan and the benefit document issued by the other payer) or applicable law provide otherwise, the Order of Benefit Determination grid below for MA Members outlines when Ochsner Health Plan would be the primary or secondary payer:

Order of Benefit Determination

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age	Employer has 20 or more employees	Other Coverage	Ochsner Health Plan
Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age	Employer has fewer than 20 employees	Ochsner Health Plan	Other Coverage
Age 65 or older and covered by a group health plan after retirement	Has Medicare Coverage	Ochsner Health Plan	Other Coverage
Disabled and covered by a large group health plan from work or from a family member working	Employer has 100 or more employees	Other Coverage	Ochsner Health Plan
Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Other Coverage	Ochsner Health Plan
Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)	After 30 months	Ochsner Health Plan	Other Coverage

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
Has end-stage renal disease (ESRD) and group health plan coverage and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	Other Coverage	Ochsner Health Plan
In an accident where no-fault or liability insurance is involved	Entitled to Medicare	Other Coverage	Ochsner Health Plan
Workers' compensation/Job-related illness or injury	Entitled to Medicare	Other Coverage	Non-Covered Medicare service
Veteran with Veteran benefits	Entitled to Medicare and Veterans' benefits	Other Coverage	Non-Covered Medicare service
Covered under TRICARE	Service from a military hospital or other federal provider	Other Coverage	Non-Covered Medicare service
Covered under TRICARE	Covered Medicare services not provided by a military hospital or other federal provider	Ochsner Health Plan	Other Coverage
Black lung disease and covered under the Federal Black Lung Program	Entitled to Medicare and Federal Black Lung Program	Other Coverage	Ochsner Health Plan
Age 65 or over or disabled and covered by Medicare and COBRA	Entitled to Medicare	Ochsner Health Plan	Other Coverage

Encounters Data

Overview

Ochsner Health Plan requires all delegated vendors, delegated providers, and capitated providers to submit encounter data to Ochsner Health Plan, even if they are reimbursed through a capitated arrangement.

This section is intended to give providers necessary information to allow them to submit encounter data to Ochsner Health Plan. If encounter data does not meet the requirements set forth in Ochsner Health Plan's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (for example, CMS) have the ability to impose significant financial sanctions on Ochsner Health Plan.

Timely and Complete Encounters Submission

Unless otherwise stated in the Agreement, vendors and providers must submit complete and accurate encounter files to Ochsner Health Plan as follows:

- On a weekly basis
- Capitated entities will submit within 10 calendar days of service date
- Non-capitated entities will submit within 10 calendar days of the paid date

The above apply to both corrected claims (error correction encounters) and capitation-priced encounters.

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP levels 1-5 shall be maintained. Once Ochsner Health Plan receives a providers encounters, the encounters are loaded into Ochsner Health Plan's encounters system and processed. The encounters are subjected to a series of SNIP Edits to ensure that the encounter has all the required information, and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI™) SNIP Edits, refer to the *Transaction Compliance and Certification* white paper at www.wedi.org. For more information on submitting encounters electronically, refer to the *Companion Guides* at www.OchsnerHealthPlan.com.

Vendors are required to comply with any additional encounters validations as defined by CMS.

Submitting Encounters Using SFTP Process (*Preferred Method*)

Ochsner Health Plan accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using Ochsner Health Plan's SFTP process. Refer to Ochsner Health Plan's ANSI ASC X12 837I, 837P, and 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with Ochsner Health Plan, go to www.OchsnerHealthPlan.com.

Encounters Data Types

There are four encounter types for which delegated vendors and providers are required to submit encounter records to Ochsner Health Plan. Encounter records must be submitted using the HIPAA standard transactions for the appropriate service type. The four encounter types are:

- Dental – 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

Encounters submitted to Ochsner Health Plan from a delegated provider can be a new, voided or replaced /overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter – An encounter that has never been submitted to Ochsner Health Plan previously
- Voided Encounter – An encounter that Ochsner Health Plan deletes from the encounter file and is not submitted to the applicable regulatory agency

- Replaced or Overlaid Encounter – An encounter that is updated or corrected within the system

Balance Billing

Providers shall accept payment from Ochsner Health Plan for covered services provided to Ochsner Health Plan members in accordance with the reimbursement terms outlined in the Agreement. Payment from Ochsner Health Plan for covered services constitutes payment in full, with the exception of applicable member expenses. For covered services, providers shall not balance-bill members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of Ochsner Health Plan's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for covered services.

Providers may not bill members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the provider fails to notify Ochsner Health Plan of a service that required prior authorization
- Covered services for which payment was reduced as a result of claim editing as described in this manual
- Covered services that were not medically necessary, in the judgment of Ochsner Health Plan, unless prior to rendering the service the provider obtains the members informed written consent and the member receives information that he or she will be financially responsible for the specific services
- Any other instance in which payment for a covered service is denied or reduced, in accordance with the Agreement or this manual, as a result of a provider not complying with the requirements set forth in the Agreement or manual

Member Expenses and Maximum Out-of-Pocket

The provider is responsible for collecting member expenses. Providers are not to bill members for missed appointments, administrative fees, or other similar type fees. If a provider collects member expenses determined by Ochsner Health Plan to exceed the correct amount of member expenses, the provider must promptly reimburse the member the excess amount. The provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For MA Benefit Plans, member expenses are limited by a maximum out-of-pocket amount. For more information on maximum out-of-pocket amounts, and the responsibilities of a provider to a member, refer to *Section 2 of this manual: Provider and Member Administrative Guidelines.*

Provider-Preventable Conditions

Ochsner Health Plan follows CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html and include such events as an air embolism, falls and catheter-associated urinary tract infection.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition which

the practitioner erroneously performs. Examples include:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure on the wrong patient

CMS updates the Never Events list of procedures annually and Ochsner Health Plan adjusts accordingly.

Providers may not bill, attempt to collect from, or accept any payment from Ochsner Health Plan or the member for PPCs or hospitalizations and other services related to PPCs.

Reopening and Revising Determinations

A reopening is a remedial action to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening.

All decisions to grant reopening are at the discretion of Ochsner Health Plan. See the *Medicare Claims Processing Manual*, Chapter 34, for Reopening and Revision of Claim Determinations and Decisions Guidelines. Reopenings are distinct from the provider appeal and dispute processes.

Claims Payment Disputes

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Ochsner Health Plan in writing within 90 calendar days of the date of denial set forth in the EOP.

When submitting a dispute, the provider must provide the following information:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN
- Total billed charges
- The providers statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

To initiate the process, please refer to the *Quick Reference Guides* at www.OchsnerHealthPlan.com.

Corrected or Voided Claims

Corrected and/or voided claims are subject to timely claims submission, that is, timely filing guidelines.

How to submit a corrected or voided claim electronically:

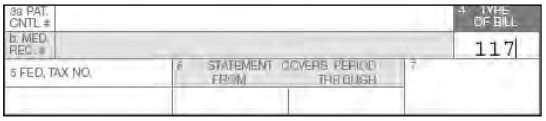
- Loop 2300 Segment CLM composite element CLM05-3 should be ‘7’ or ‘8’ – indicating to replace ‘7’ or void ‘8’
- Loop 2300 Segment REF element REF01 should be ‘F8’ indicating the following number is the control number assigned to the original bill (original claim reference number)

- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim you intended to replace.)
- Example: REF✻F8✻Ochsner Health Plan Claim number here~

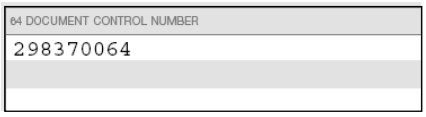
These codes are not intended for use for original claim submission or rejected claims.To submit a corrected or voided claim via paper:

- For Institutional claims, the provider must include Ochsner Health Plan's original claim number or claim number the provider is requesting be voided and bill the frequency code per industry standards.

  Example:
  Box 4 – Type of Bill: the third character represents the "Frequency Code"



  Box 64 – Place the claim number in Box 64



- For professional claims, the provider must include Ochsner Health Plan's original claim number or the claim number the provider is requesting be voided and bill the frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left-justified in the left-hand side of Box 22.

  Example:

Any missing, incomplete, or invalid information in any field may cause the claim to be rejected.

Please note: If "corrected claim" or "voided claim" is handwritten, stamped, or typed on the claim form without the appropriate Frequency Code "7" or "8" on either Institutional or professional claims along with the reference number as indicated above, the claim will be considered an original first-time claim submission.

The correction or void process involves two transactions:

1. The original or claim number the provider is requesting to be voided will be negated – paid or zero payment (zero net amount due to a co-payment, coinsurance, or deductible) – and noted "*Payment lost/voided/missed*." This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted "*Adjusted per corrected bill*." This process will pay out the newly calculatedamount on this

corrected or voided claim with a new claim number.

The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

Reimbursement

Ochsner Health Plan applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

Non-Participating Provider Reimbursement

All services rendered by non-participating providers and facilities require authorization with the exception of family planning education and counseling, in-office visits for family planning, childhood immunization administration, and emergency transportation and services. Non- participating providers are reimbursed at 100% of the Medicare rate in effect on the date of service.

Surgical Payments

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications** – A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by Ochsner Health Plan's Medical Director regarding whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges** – Charges for follow-up surgery visits are considered to be included in the surgical service charge, and providers should not submit a claim for such visits and providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures** – Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon** – Payment for an assistant surgeon and/or a non-physician practitioner to assistant surgery is based on current CMS percentages methodologies.Ochsner Health Plan uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.
- **Co-Surgeon** – Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct, operative work by adding the appropriate modifier to the procedure code and any associated add- on code(s) for that procedure as long as both surgeons continue to work together as primary

surgeons. Each surgeon should report the co-surgery only once using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the appropriate modifier following Coding Guidelines.

Modifiers

Ochsner Health Plan follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Allied Health Providers

Ochsner Health Plan follows CMS reimbursement guidelines regarding Allied Health Professionals.

Telemedicine

To the extent provided in the applicable benefit plan, telemedicine is a covered plan benefit, subject to limitations and administrative guidelines.

Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located, for the purpose of evaluation, diagnosis, or treatment. Telemedicine services provide the member with enhanced healthcare services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable.

Ochsner Health Plan follows current CMS guidelines for telemedicine. For telemedicine claims to be processed correctly provider shall follow all applicable Coding Guidelines, Rules & Regulations set forth by CMS, AMA, and/or other respectable medical billing and coding organizations.

When telemedicine is a covered plan benefit, Ochsner Health Plan reimburses for:

- Practitioners providing telemedicine services licensed within their scope of practice to perform the service.
- Telemedicine services using interactive telecommunications equipment to communicate between a recipient and a practitioner.

Ochsner Health Plan does not reimburse for:

- Standard phone calls, chart review(s), faxes, or email; in combination or individually, these are not considered telemedicine services unless certain special circumstances and/or exemptions are indicated by CMS
- Equipment required to provide telemedicine services

Overpayment Recovery

Ochsner Health Plan strives for 100% payment quality but recognizes that a small percentage of financial overpayments will occur. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s), and other reasons.

Ochsner Health Plan will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Ochsner Health Plan will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three years from the last payment date, unless a different approach is required by the Agreement. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by, or

initiated at the request of a state or federal government program or coverage that is provided by a state or a municipality thereof to its respective employees, retirees, or members.

In all cases, Ochsner Health Plan, or its designee, will provide a written notice to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the member. The notice will also provide the carrier address Ochsner Health Plan has on file but recognizes that the provider may use the carrier address it has on file. The standard request notification provides 45 calendar days for the provider to send in the refund, request further information or dispute the overpayment. For more information on the CMS RAC, refer to the CMS website at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html.

Failure of the provider to respond within the above time frames will constitute acceptance of the terms in the letter and will result in offsets to future payments. The provider will receive an Explanation of Payment (EOP) indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months, the provider may be contacted by Ochsner Health Plan, or its designee, to arrange payment.

If the provider independently identifies an overpayment, it can send a corrected claim (refer to the corrected claim section of this manual); contact Provider Services to arrange an offset against future payments; or send a refund and explanation of the overpayment to:

Ochsner Health Plan
Attn: Corrected Claims
P.O. Box 4318
Scranton, PA 18505

For more information on contacting Provider Services, refer to the *Quick Reference Guides* at www.OchsnerHealthPlan.com.

Benefits During Disaster and Catastrophic Events

In the event of a presidential emergency declaration, a presidential (major) disaster declaration, a declaration of emergency or disaster by a governor, or an announcement of a public health emergency by the Secretary of the U.S. Department of Health and Human Services – but absent an 1135 waiver by the Secretary – Ochsner Health Plan will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare-certified facilities).
- Temporarily reduce Ochsner Health Plan approved, out-of-network cost-sharing to in-network cost-sharing amounts.
- Waive the 30-calendar-day notification requirement to members as long as all thechanges (such as reduction of cost sharing and waiving authorization) benefit the member.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed 30 calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, Ochsner Health

Plan will resume normal operations 30 calendar days from the initial declaration, unless it communicates via its website or other means that the disaster or emergency provisions will be extended.

Disaster and Catastrophic Events Claims Modifiers

Type of Claim	Modifier
An Institutional claim	*Condition Code* will be DR or Modifier CR
A Professional claim	*Modifier* will be CR Code

Audits

Quality healthcare is based on accurate and complete medical record documentation. Ochsner Health Plan's Compliance Department will facilitate medical record audits as part of our audit and investigation process. Medical records are requested from the provider. Auditors perform a comprehensive review that includes how the claim was billed and whether the documentation meets basic billing and coding requirements, as well as documentation requirements as established by the Centers for Medicaid & Medicare Services (CMS) and the applicable state guidelines. Ochsner Health Plan's reviews incorporate Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), CMS guidelines, federal guidelines and regulations determined by each state.

Section 5: Prior Authorizations and Reconsiderations

Part C Utilization Management

Requesting Prior Authorization

- Members, members authorized representatives, and members providers have the right to ask OHP to provide or pay for items or services they think should be covered, provided, or continued. The decision by the plan is called an "organization determination" or "prior authorization."
- Members, members authorized representatives, and members providers can request a prior authorization from OHP in advance to make sure that services are covered. If OHP denies coverage or payment after the member receives services, that denial is the organization determination that can be appealed.
- If OHP will not cover the items or services you asked for, you will get a written notice explaining why OHP fully or partially denied your request and instructions on how to appeal OHP's decision by requesting a reconsideration. If you appeal the plan's decision, you may want to ask for a copy of the file containing medical and other information about your case. OHP may charge you for this copy.
- Covered acute inpatient admissions require prior authorization. Emergent inpatient admissions require notification to OHP within 48 hours.
- All post-acute stays require prior authorization, including, but not limited to, LTAC (long term acute care), SNF (skilled nursing facility care), AIR (acute inpatient rehabilitation).
- Referrals are not required between providers.

Process for requesting a prior authorization

Department	Phone Number	Fax Number	E-Mail
Claims Status	833-674-2112	N/A	N/A
Care Management	866-978-2029	985-898-1505	
Provider Relations	833-674-2112	N/A	OHPproviderrelations@ochsner.org
Part C – Prior Auth*	1-800-643-4416	985-898-1505	**umfax@healthcomp.com** **Online: https://hchealthbenefits.com/**
Part C – Appeals	504-754-7087	504-754-6496	AppealsGrievancesOHP@ochsner.org
Part D – Prior Auth	800-910-1837	858-790-7100	N/A
Part D – Appeals	800-910-1837	858-790-6060	N/A

*Medically Necessary coverage determination

Services requiring Prior Authorization:

1. Inpatient Admissions
    a. Covered Acute Inpatient Care
    b. All post-acute care Admissions, including, but not limited to, LTAC (long term acute care), SNF (skilled nursing facility care), AIR (acute inpatient rehabilitation).
2. All emergent inpatient admissions require notification within 48 hours.
3. Outpatient Services: (Below listing is not an inclusive listing of items)
    a. Non-emergency Ambulance/Transportation Services
    b. Ambulatory Procedures (e.g., custom-fabricated prosthetics)
    c. Hyperbaric oxygen under pressure, full body chamber therapy.
    d. High cost injectables and other drugs
    e. Home Infusion Treatment
    f. Radiation Oncology
    g. Chemotherapy
    h. All home health care, including provider in-home visits
    i. MOHS Surgery
    j. Watchmen Procedures
4. DME Supplies – only on those items for which CMS requires a Certificate of Necessity (e.g., (1) motorized wheelchairs; (2) Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds, ultra-lightweight wheelchair, Heavy Duty wheelchair, group 2 heavy duty patient weight capacity 451-600 pounds).
5. Select surgeries (e.g., (1) cosmetic surgeries; (2) dermabrasion; total face.
6. Advanced imaging/radiology:
    a. MRI
    b. MRA
    c. PET
    d. 3-D Rendering
    e. Nuclear Medicine
7. Transplants
8. Genetic testing
9. Nursing facilities, behavior health facilities, home health
10. CAT III - emerging technology, services, and procedures (e.g., (1) Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density; (2) Scalp cooling, mechanical; initial measurement and calibration of cap.)
11. Cart-T cell therapy
12. The Part D Formulary Utilization Management applies to all prescribers.
13. Hypoglossal Nerve Stimulation
14. Monoclonal Antibodies Alzheimer's disease
15. All Out-of-Network services must be reviewed for medical necessity

Note:
Doctors or other prescribers (for prescription drug appeals) can request this level of appeal for members, without members appointing them as their representative.

What If I Disagree with the Organization Determination (Prior Authorization Decision)?

If a member, members authorized representatives, or the members provider disagrees with OHP's initial decision, they can file an appeal. The appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

- Level 1: Reconsideration from your plan
- Level 2: Review by an Independent Review Entity (IRE)
- Level 3: Decision by the Office of Medicare Hearings and Appeals (OMHA)
- Level 4: Review by the Medicare Appeals Council (Appeals Council)
- Level 5: Judicial review by a federal district court

Ochsner Health Plan Appeals - Level 1: Reconsideration

If a member, members authorized representatives, or a members provider disagrees with the initial decision from OHP (also known as the organization determination), they can ask for a reconsideration (a second look or review). You must ask for a reconsideration within 60 days of the date of the organization determination. If your appeal is for a service, you have not received yet, a member's doctor can ask for a reconsideration on the member's behalf and must notify the member about it.

Members' authorized representatives, and Members' providers must file a written standard or expedited (fast) request.

Note:
Doctors or other prescribers (for prescription drug appeals) can request this level of appeal for members, without members appointing them as their representative. Include this information in your written reconsideration request:

- The member's name, address, and the member number on the member's ID card.
- The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
- If the member has appointed a representative, include the name of the representative and proof of representation.

Include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

How long your plan has to respond to your request depends on the type of request:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

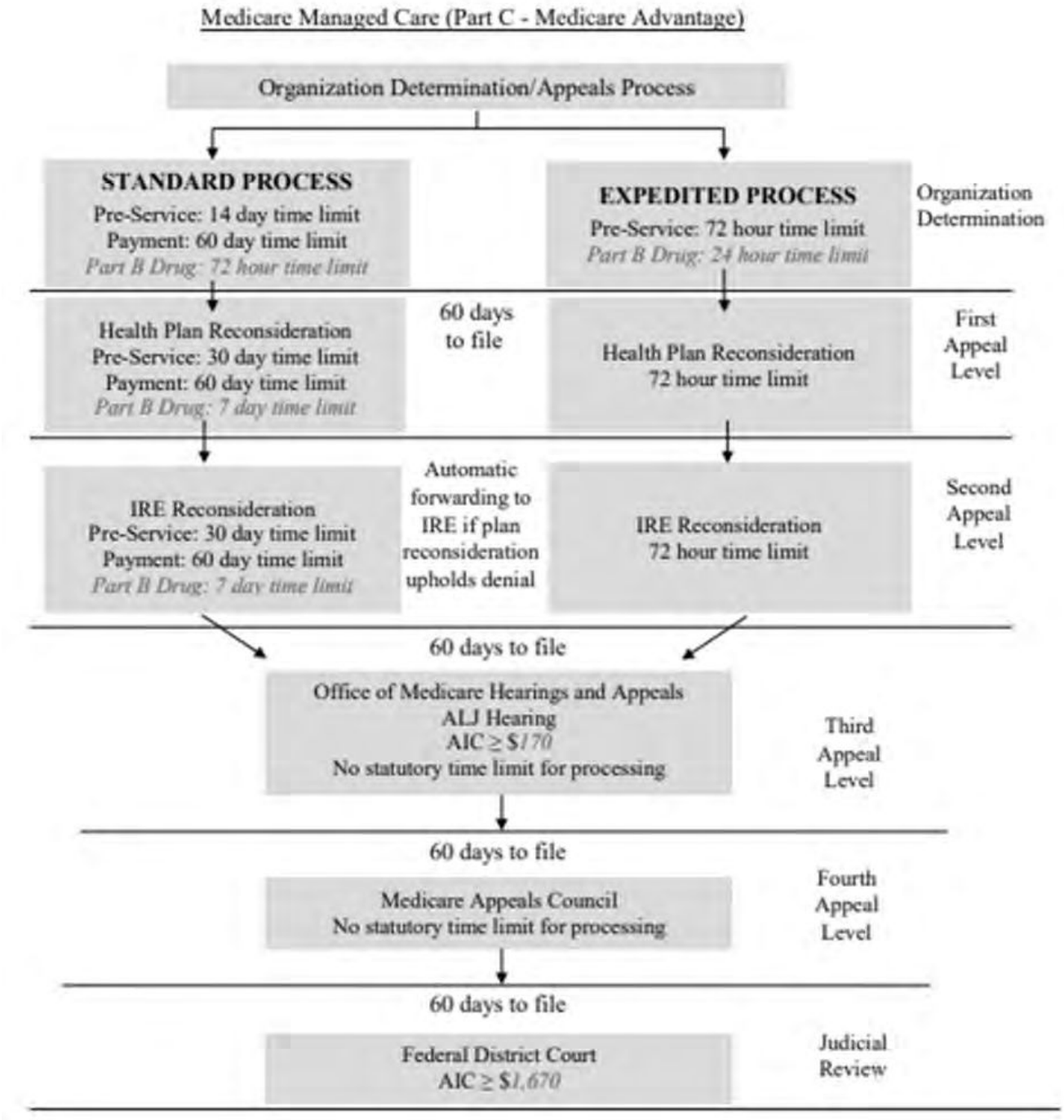
You'll get a fast request if OHP determines (or the members doctor tells OHP) that waiting for a standard service decision may seriously jeopardize your:

- Life
- Health
- Ability to regain maximum function

The time to complete standard and fast service requests may be extended by up to 14 days in some cases. For example, if OHP needs more information from a non-contract provider to make a decision about the case, and the extension is in your best interest. OHP will notify you in writing if an extension is warranted. OHP will tell you the reasons for the delay and inform you of your right to file an

expedited (fast) request if you disagree with the plan's decision to take an extension. If the plan decides against you (fully or partially), your appeal is automatically sent to Level 2.

Medicare Managed Care (Part C) Appeals Process Overview



Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-866-978-2029 Calls to this number are free. Hours are 8:00 a.m. to 5:00 p.m. Central Standard Time Monday through Friday.
TTY	711 Calls to this number are free. Hours are 8:00 a.m. to 5:00 p.m. Central Standard Time Monday through Friday.
WRITE	MedCom Care Management 2100 Covington Ctr. Suite B Covington, LA 70433
FAX	1-985-898-1505
WEBSITE	www.ochsnerhealthplan.com

Method	Appeals for Medical Care – Contact Information
CALL	1-866-978-2029 Calls to this number are free. Hours are 8:00 a.m. to 5:00 p.m. Central Standard Time Monday through Friday.
TTY	711 Calls to this number are free. Hours are 8:00 a.m. to 5:00 p.m. Central Standard Time Monday through Friday.
WRITE	MedCom Care Management 2100 Covington Ctr. Suite B Covington, LA 70433
WEBSITE	www.ochsnerhealthplan.com

Participating Provider Request for Reconsideration

Provider Retrospective Reconsideration Overview

Section 7 applies to provider issues concerning the provider's dissatisfaction with denial of payment, where a denial has been issued for reasons such as: no prior authorization, benefits exhausted, service exceeds authorization, days billed exceed authorization, payment error/not authorized, authorization denied, authorization expired, requires authorization or lack of medical information.

A provider may request a claim payment dispute (post-service) or utilization review (pre-service) denial on his or her own behalf by mailing, emailing or faxing Ochsner Health Plan a letter of claim payment dispute or a claims dispute form with supporting documentation such as medical records.

There are several ways to submit your claim payment dispute to Ochsner Health Plan. You may send your request via secure e-mail, fax, or mail. If using email to submit a claims payment dispute, ensure that it is sent securely.

Providers have 60 calendar days from Ochsner Health Plan's original utilization management review decision or claim denial to file a provider appeal. Appeals after that time will be denied for untimely filing. If the provider feels that the appeal was filed within the appropriate time frame, the provider may submit documentation showing proof of timely filing. Examples of acceptable proof include, but are not limited to, registered postal receipt signed by a representative of Ochsner Health Plan, or a similar receipt from other commercial delivery services or fax submission confirmation.

Upon receipt of all required documentation, Ochsner Health Plan has up to 60 calendar days to review the appeal for medical necessity and/or conformity to Ochsner Health Plan guidelines and to render a decision to reverse or affirm. Required documentation includes the members name and/or identification number, date of service(s) and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the provider is requesting a medical necessity review, medical records should be submitted. If the provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by Ochsner Health Plan due to lack of information. If the provider believes that he/she has adequate medical documentation to support the request for appeal, it is the responsibility of the provider to provide the requested documentation within 60 calendar days of the lack of medical information denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of Ochsner Health Plan or appropriate regulatory agencies when required for appeals. The provider is not allowed to charge Ochsner Health Plan or the member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the provider has complied with Ochsner Health Plan protocols and that the appealed services were medically necessary, the initial denial will be reversed. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied as a result of the now-reversed denial will be adjusted for payment.

Affirmation of Initial Denial

If it is determined during the review that the provider did not comply with Ochsner Health Plan protocols and/or medical necessity was not established, the initial denial will be upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member Reconsideration Process

Overview

A member reconsideration, also known as an appeal, is a formal request from a member for a review of an action taken by Ochsner Health Plan. With the members written consent, a reconsideration may also be filed on the members behalf by an authorized representative, or by a physician who has or is currently treating the member. All appeal rights described in *Section 7* of this manual that apply to members will also apply to the member's authorized representative or a provider acting on behalf of the member with the members consent.

To request an appeal of a decision made by Ochsner Health Plan, a member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action.

Examples of actions that can be appealed include, but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by CMS

Ochsner Health Plan gives members reasonable assistance in completing forms and other procedural steps for a reconsideration, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY and interpreter capability.

Ochsner Health Plan will assign decisionmakers who were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be healthcare professionals with clinical expertise in treating the members condition/disease or will seek advice from professionals with expertise in the field of medicine related to the request.

Ochsner Health Plan will not retaliate against any provider acting on behalf of or in support of a member requesting a reconsideration or an expedited reconsideration.

Appointment of Representative

If the member wishes to use a representative, he or she must complete a *Medicare Appointment of Representative* (AOR) form. The member and the person who will be representing the member must sign the AOR form. The form is at www.OchsnerHealthPlan.com.

Types of Appeals

A member may request a standard pre-service, retrospective, or expedited appeal.

Standard pre-service appeals are requests for coverage of services that Ochsner Health Plan has determined are not covered services, are not medically necessary or are otherwise outside of the members benefit plan. A pre-service appeal must be filed before the member has received the service.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for

an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals are eligible to be processed as expedited appeals.

Appeal Decision Time Frames

Ochsner Health Plan will issue a decision to the member or the members representative within the following time frames:

- Standard Pre-Service Request: **30 calendar days 7 calendar days for Pharmacy Appeals)**
- Retrospective Request: **60 calendar days (14 calendar days for Pharmacy Appeals)**
- Expedited Request: **72 hours (Part C)**
- Expedited Request: **72 hours (Part D)**

Standard Pre-Service and Retrospective Reconsiderations

A member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting the Member Services Department.

A member may also present his or her appeal in person (as used here, "in person" also includes appeals conducted via telephone). To do so, the member must call Ochsner Health Plan Member Services to advise that the member would like to present the reconsideration in person. If the member would like to present his or her appeal in person, Ochsner Health Plan will arrange a time and date that works best for the member and Ochsner Health Plan. A member of the management team and an Ochsner Health Plan Medical Director will participate in the in-person appeal.

After the member presents the information, Ochsner Health Plan will mail the decision to the member within the time frame specified above, based on the type of appeal.

If the members request for reconsideration is submitted after 60 calendar days, then good cause must be shown for Ochsner Health Plan to accept the late request. Examples of good cause include but are not limited to:

- The member did not personally receive the adverse organization determination notice or received it late.
- The member was seriously ill, which prevented a timely appeal.
- There was a death or serious illness in the members immediate family.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The member had incorrect or incomplete information concerning the reconsiderationprocess.

Expedited Reconsiderations

To request an expedited reconsideration, a member, or a provider (regardless of whether the provider participates in Ochsner Health Plan's network) must submit a verbal or written request directly to Ochsner Health Plan. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the members life, heath, or ability to regain maximum function, including cases in which Ochsner Health Plan makes a less than fully favorable decision to the member.

A request for payment of a service already provided to a member is not eligible to be reviewed as an

expedited reconsideration.

If a reconsideration is expedited, Ochsner Health Plan will complete the expedited reconsideration and give the member (and the provider involved, as appropriate) notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Ochsner Health Plan denies the request to expedite a reconsideration, Ochsner Health Plan will provide the member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Ochsner Health Plan will mail a letter to the member explaining:

- That Ochsner Health Plan will automatically process the request using the 30-calendar-day timeframe for standard reconsiderations;
- The members right to file an expedited grievance if he/she disagrees with Ochsner Health Plan's decision not to expedite the reconsideration, and providing instructions about the expedited grievance process and its time frames; and
- The members right to resubmit a request for an expedited reconsideration, and that if the member gets any providers support indicating that applying the standard timeframe for making a determination could seriously jeopardize the members life, health, or ability to regain maximum function, the request will be expedited automatically.

Member Reconsideration Decisions

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Ochsner Health Plan
2. Reconsideration of adverse organization determination by the independent review entity (IRE)
3. Hearing by an administrative law judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met
4. Medicare appeals council (MAC) review
5. Judicial review if the appropriate threshold requirements have been met

Standard Pre-Service or Retrospective Reconsideration Decisions

If Ochsner Health Plan reverses its initial decision, Ochsner Health Plan will either issue an authorization for the pre-service request or send payment if the service has already been provided.

If Ochsner Health Plan affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard appeals, the IRE has 30 days from receipt of the appeal to issue a final determination.

Once a final determination has been made, the IRE will notify the member and Ochsner Health Plan. If the IRE agrees with Ochsner Health Plan, the IRE will provide the member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the member or representative in writing of the decision. Ochsner Health Plan will also notify the member or members representative in writing that the services are approved along with an authorization number.

Expedited Reconsideration Decisions

If Ochsner Health Plan reverses its initial action and/or the denial, it will notify the member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Ochsner Health Plan affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination.
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and Ochsner Health Plan. If the IRE agrees with Ochsner Health Plan, the IRE will provide the member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the member or representative in writing of the decision.

Member Grievances

Provider

Per CMS guidance, providers acting on their own behalf are not entitled to file a grievance.

Member Grievance Overview

The member may file a grievance. With the members written consent, a grievance may also be filed on the member's behalf by an authorized representative (which may include a provider). All grievance rights described in *Section 7* of this manual that apply to members will also apply to the members authorized representative (including a provider acting on behalf of the member with the members consent). If the member wishes to use a representative, then she or he must complete a *Medicare Appointment of Representative* (AOR) form. The Member and the person who will be representing the Member must sign the AOR form. The form is at www.OchsnerHealthPlan.com.

To obtain information relative to grievances concerns, members should call Member Services at 1-833-673-2112 (option 3).

Ochsner Health Plan will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review time frame or extend a review time frame does not jeopardize the members health.

Ochsner Health Plan will contact the member or the members representative via telephone with the determination and will mail the resolution letter to the member or the members representative within

three business days after the determination is made. The resolution will also be documented in the members record.

Section 6: Quality Improvement

Medicare Quality Improvement Program

Overview

Ochsner Health Plan (OHP) must have an ongoing Quality Improvement (QI) program for each of its plans. The purpose of a QI program is to ensure that OHP has the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis.

For each plan, OHP must:

- Develop and implement a chronic care improvement program (CCIP).
- Develop and maintain a health information system.
- Encourage providers to participate in CMS and HHS QI initiatives.
- Implement a program review process for formal evaluation of the impact and effectiveness of the QI Program at least annually.
- Correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms.
- Contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS®) vendor to conduct the Medicare CAHPS® satisfaction survey.
- Contract with an approved HEDIS vendor to conduct annual HEDIS surveys.
- Measure performance under the plan using standard measures required by CMS and report its performance to CMS.
- Develop, compile, evaluate, and report certain measures and other information to CMS, its enrollees, and the general public. Responsible for safeguarding the confidentiality of the doctor-patient relationship and report to CMS in the manner required for cost of operations, patterns of utilizations of services, and availability, accessibility, and acceptability of Medicare approved and covered services. Perform quality of care and quality of service reviews as deemed appropriate.

Chronic Care Improvement Program (CCIP) As required by regulation, OHP must develop and implement a CCIP and QIP as part of its required QI Program. OHP must conduct the same CCIP and QIP for all its coordinated care plans offered under a specified contract.

The quality improvement model adopted by CMS for the CCIP is based on The Plan-Do-Study-Act (PDSA) quality improvement model. PDSA is an iterative, problem-solving model used for improving a process or carrying out change. The four steps of the PDSA cycle provide a systematic, step-by-step, ongoing approach for quality improvement initiatives. Components of the PDSA are as follows:

- Plan: Describes the processes, specifications, and output objectives used to establish the CCIP.
- Do: Describes the progress of the implementation and the data collection plan.
- Study: Describes the analysis of data to determine what impact the program has had on members.
- Act: Summarizes action plan(s) based on findings; describes, in particular, the differences between actual and anticipated results, and describes specific actions or steps taken or planned based on current results.

Chronic Care Improvement Program (CCIP)

An initiative with a clinical focus that includes interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and includes patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support services providers, and patient self-management techniques. Beginning CY 2012, CMS required that each MA plan conduct, over a 5-year period, a CCIP focused on reducing and/or preventing cardiovascular disease.

CCIP Plan Section Description

The CCIP Plan section describes all aspects of the proposed CCIP initiative including, but not limited to, the opportunity for improvement, target goal, what specific interventions will be introduced to achieve the identified goal, members targeted for receipt of the intervention(s), and the expected results.

Below is a general summary of the required components of the CCIP Plan.

- Basis for Selection - An overall description of the CCIP and rationale for selection that includes impact on the member, anticipated outcomes, and rationale for selection.
- Program Design - Outlines the process used to identify the target population, risk stratification, and enrollment method.
- Evidence-Based Medicine - Includes the clinical practice guidelines and standards of care to be employed.
- Care Coordination Approach - Describes the expected collaboration and communication among a multidisciplinary team that may include providers, OHP staff and the targeted member.
- Education - The method of education and the topics that will be addressed, includes education directed to applicable providers and/or targeted members.
- Outcome Measures and Interventions - Setting objectives in measurable terms, identifying the appropriate data source(s) to measure, and the methodology used to analyze the data to determine whether the initiative impacted the health status of the targeted population.
- Communication Sources - Methods used to inform patients, physicians, and other providers on what is occurring in the CCIP and any changes necessary over time.

Standard MAO Reporting Requirements for HEDIS®, HOS, and CAHPS®

This section provides information regarding the annual Medicare HEDIS®, HOS, and CAHPS® reporting requirements. Performance measures that are derived largely from the MA plan and beneficiary information form the basis of the CMS Star Ratings used to assess the quality of MA plans.

Healthcare Effectiveness Data and Information Set (HEDIS®)

A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

All Medicare Advantage plans must submit audited summary level HEDIS® data to NCQA, and this includes cost contracts with closed enrollment. Patient level data must be reported to the CMS's designated patient level data contractor.

Because of the critical importance of ensuring accurate data, CMS continues to require an external audit of the HEDIS® measures before public reporting. MAOs and §1876 cost contracts are responsible for submitting audited data, according to the audit methodology outlined in Volume 5: HEDIS® Compliance Audit: Standards, Policies and Procedures.

Health Outcomes Survey (HOS)

This is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each MAO health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

Medicare HOS Requirements: HOS reporting requirements specify that MAOs with Medicare contracts in effect on or before January 1 of the preceding year report the Baseline HOS, provided they have a minimum enrollment of 500 members as of February 1 of the current year. In addition, all continuing MAOs that participated in the Baseline survey two years prior are required to administer a follow-up survey regardless of whether they meet the current year's enrollment threshold.

Medicare CAHPS® Requirements

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

The following organization types of MAOs are included in the CAHPS® survey administration, provided that they have a minimum enrollment of 600 eligible members as of July 1st of the previous year:

- All MA organizations, including all coordinated care contracts, PFFS, and MSA contracts
- §1876 cost contracts even if they are closed for enrollment
- Employer/union only contracts

Section 7: Care Management and Disease Management

For the appropriate contact information, refer to the *Quick Reference Guide* on www.OchsnerHealthPlan.com. All forms are on www.OchsnerHealthPlan.com.

Care Management Program

Overview

Ochsner Health Plan offers comprehensive Care Management services to facilitate patient assessment, planning, and advocacy to improve health outcomes for patients. Providers must help coordinate the placement and cost-effective treatment of patients who are eligible for Ochsner Health Plan's Care Management Programs.

Ochsner Health Plan's Care Management teams are led by specially trained registered nurses and licensed clinical social worker care managers who assess the members risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes, and evaluate the outcome for possible revisions of the care plan.

The care managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

Ochsner Health Plan's Care Management teams also serve in a support capacity to the PCP and assist in actively linking the member to providers, medical services, residential, social, and other support services, as needed. Providers may request care management services for any member.

The care management process begins with member identification and follows the member untildischarge from the program. Members may be identified for care management in various ways, including:

- A referral from a members PCP
- Self-referral
- Referral from a family member
- Referral from Ochsner Health Plan's internal departments
- After completing a health risk assessment
- Data mining for members with high utilization

Care managers work closely with the provider regarding when to discharge the member from the Care Management Program. A member may be discharged from the Care Management Program if he or she:

- Is meeting primary care plan goals
- Declined additional care management services
- Disenrolled from Ochsner Health Plan
- Is unable to be contacted by Ochsner Health Plan

Section 8: Compliance

Compliance Overview

Ochsner Health Plan is committed to acting with integrity and making decisions based on the highest standards of ethical behavior, including complying with applicable laws and regulations.

To provide quality health care services in compliance with these laws, Ochsner Health Plan has developed a Compliance Program and Code of Conduct that articulate our expectations of our employees, contractors, providers, and business partners. You are required to read these documents and abide by them.

Medicare Compliance Expectations and Requirements

As a Medicare Advantage Organization (MAO) with an established contract with the CMS, Ochsner Health Plan is required to communicate its Compliance and FWA Program requirements to its providers and ensure compliance with these requirements. Providers contracted with Ochsner Health Plan to provide covered administrative or health care services to our members are required (1) to comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions, as well as all other applicable federal, state and local laws, rules and regulations; (2) to cooperate with Ochsner Health Plan in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and (3) to ensure that all healthcare professionals employed or under contract to render health care services to Ochsner Health Plan members, including covering physicians, facilities and ancillary providers, as well as downstream entities, comply with these provisions.

Compliance Education and Training

Providers are expected to have an effective compliance program, which includes the following training and education to address FWA and compliance knowledge. Please document and retain proof of training records for a period of ten years.

Standards of Conduct Awareness

1) Provide a copy of your own code of conduct, or the Ochsner Health Plan's (OHP's) Code of Conduct. Provide the materials annually, and within 90 days of hire for new employees.
    a) Note: If you use your own code of conduct or compliance policies, you must include a process for reporting all compliance and FWA issues that impact Ochsner Health Plan to the OHP Compliance Officer.

Fraud, Waste, and Abuse and General Compliance Training

Provide FWA and General Compliance training to employees and contractors providing administrative or health care services to Ochsner Health Plan members. Administer FWA and General Compliance training within 90 days of hire for new employees and annually thereafter.

Although you may use and complete your own version of general compliance and FWA training, CMS has training available for your use, which would satisfy this requirement.

- Medicare Parts C and D General Compliance
- Combating Medicare Parts C and D Fraud, Waste and Abuse

Conflicts of Interest

Providers must require any manager, officer, director, or employee associated with the administration or delivery of covered health care services to members to sign a conflict-of-interest statement, attestation, or certification at the time of hire and annually thereafter certifying the individual is free from any conflict of interest. Providers must ensure that any downstream entities are also free from conflicts of interest. Providers must supply attestation or certification to OHP upon request.

Exclusion checks

Ochsner Health Plan will not contract with or pay claims to providers who have been sanctioned or excluded from participating in Medicare programs, or who have opted-out of the Medicare program. Providers have compliance responsibility for routinely verifying that no employees or contracted entities that perform administrative or healthcare service functions relating to Ochsner Health Plan (i.e., downstream entities) are excluded by the OIG/GSA.

What you need to do

- Make sure potential employees or downstream entities are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, use the following links:
    - Department of Health and Human Services – Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) at https://oig.hhs.gov
    - General Services Administration (GSA) System for Award Management (SAM) at https://sam.gov
- Review the exclusion lists every month and disclose to Ochsner Health Plan Compliance Officer immediately any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on Federal health care programs. Failure to disclose may result in appropriate corrective actions, up to and including termination of contract.
- Maintain a record of exclusion checks for 10 years. OHP, or CMS, may request documentation of the exclusion checks to verify they were completed.

Preclusion List Policy

The CMS has a Preclusion List effective for claims with dates of service on or after April 1, 2019. The Preclusion List applies to MAPD Plans. The Preclusion List is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program; or
- Have been convicted of a felony under federal or state law within the previous 10 years and

that CMS deems detrimental to the best interests of the Medicare program.

Providers receive a letter from CMS notifying them of their placement on the Preclusion List. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Ochsner Health Plan. CMS updates the Preclusion List monthly and notifies MAPD plans of the claim rejection date, the date upon which we reject or deny a care providers claims due to precluded status. Once the claim rejection date is effective, a precluded care providers claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Ochsner Health Plan network and removed from the provider directory. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection date.

As contracted care providers of Ochsner Health Plan, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or downstream entities.

For more information on the Preclusion List, visit www.cms.gov.

Annual Compliance Attestation

You must keep evidence of your compliance with these requirements for no fewer than 10 years. This evidence may include employee training records and completed exclusion list screenings. Training records must include employee names, dates of completion, and passing scores (if captured).

Ochsner Health Plan Compliance Department performs various compliance reviews each year to test compliance with the compliance program requirements outlined in this provider manual and may require written attestation of such compliance from randomly selected First Tier, Downstream, and Related Entities (FDRs), including providers. Upon request, your attestation of compliance must be completed within 30 days of notification. If you're sent an attestation, it must be signed by someone in your organization who has responsibility, directly or indirectly, for all:

- Employees
- Contracted personnel
- Providers and practitioners
- Vendors that provide health care and/or administrative services for our Medicare plans

The signee could be your Compliance Officer, Chief Medical Officer, Practice Manager or Administrator, an Executive Officer, or someone else in a similar position.

Reporting Compliance Concerns

Providers must ensure that employees or contracted entities that perform administrative or healthcare service functions relating to Ochsner Health Plan are aware of our expectations of reporting and its policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns. Information about how to report compliance concerns can be found below and should be publicized or otherwise made available throughout your facilities.

Fraud, Waste and Abuse

Ochsner Health Plan is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory, and contractual requirements.

Ochsner Health Plan defines fraud, waste and abuse as follows:

- Fraud is the knowing and willful deception, misrepresentation, or reckless disregard of the facts with the intent to receive an unauthorized payment.
- Waste is the overuse of services that, directly or indirectly, results in unnecessary costs.
- Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss to the plan. Abuse usually does not involve a willful intent to deceive.

Examples of fraud, waste and abuse include, but are not limited to, the following:

- Billing for procedures not performed;
- Physician kickbacks for referrals;
- Authorizing and/or billing for services not medically necessary (i.e., acute inpatient instead of observation, advance life support ambulance services instead of basic life support ambulance services, etc.);
- Certifying terminal illness when criteria is not met;
- Obtaining benefits without medical necessity (i.e., glucose test strips, incontinence supplies, or enterals, etc.) and reselling;
- Billing for services that do not meet CPT/revenue code descriptions;
- Falsifying information in a medical record / claim;
- Improper bundling/coding of charges;
- Misrepresentation by a member/provider to seek benefits;
- Unsupported risk adjustment data (including encounter data) submitted to CMS;
- Inaccurate Prescription Drug Event (PDE) and Direct/Indirect Remuneration (DIR);
- Incorrect Low Income Premium Subsidy for Employer Group Waiver Plans;
- Improper Opioid Prescription/Dispensing; and
- Incorrect enrollment into MA plans, Part D plans, and other government programs.

Federal laws governing Medicare FWA include:

- Anti-kickback statute (31 U.S.C. §§ 3729-3733)
- Criminal code (18 U.S.C. Section 1347)
- False Claims Act (31 U.S.C. §§ 3729-3733)
- Social Security Act (42 U.S.C. chapter 7)
- Stark law (42 USC § 1395nn)

These laws state the criminal, civil and administrative remedies the federal government may impose when FWA is committed. Violating these laws may result in:

- Nonpayment of claims
- Civil money penalties
- Exclusion from all federal health care programs
- Criminal and civil liability

To learn more from CMS about fraud, waste and abuse, please see Medicare Fraud & Abuse: Prevent, Detect, Report (cms.gov).

In order to meet regulatory requirements, providers are required to **immediately report** known or suspected fraud, waste and abuse that affects OHP members using one of the methods listed below. Providers may also report directly to the Federal Department of Health and Human Services (HHS) or the Office of the Inspector General (OIG) by visiting https://oig.hhs.gov/fraud/report-fraud/.

Compliance and FWA Hotline

Ochsner Health Plan has implemented a Compliance Hotline for our members, employees, first-tier, downstream, and related entities (FDRs), and other contractors and agents. The Compliance Hotline provides a mechanism for callers to report activity related to known or suspected fraud, waste, and abuse (FWA), potential health privacy violation, and unethical behavior/misconduct, including non-compliance with Ochsner Health Plan's Compliance program, policies and procedures, Code of Conduct, or any Federal, State, or local laws and regulations.

All calls to the Compliance Hotline will be treated as confidential and private to the fullest extent possible.

Compliance and FWA Hotline: 1-833-937-3167 (toll free)

If you are not comfortable or able to make a report via the Compliance Hotline, you may send a written report by mail, email, or fax to:

Ochsner Health Plan Compliance Officer
Ochsner Health Plan
1450 Poydras #56
New Orleans, LA 70112
Email: OHPcompliance@Ochsner.com
Fax: (504) 754-6492

Whether reporting by telephone or in writing, please provide as much detail as possible including, but not limited to, names, dates, times, locations, and the specific conduct you feel may violate the law or Ochsner Health Plan policy.

No individual making a good faith report of a suspected violation shall be retaliated against. However, any individual who knowingly makes a false allegation shall be subject to disciplinary action in accordance with Ochsner Health Plan policy.

Confidentiality and Accuracy of Member Records (42 CFR § 422.118)

Provider agrees to comply with the confidentiality and enrollee record accuracy requirements including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

Record Retention and Data

Provider agrees to maintain books, records, documents, and other evidence of accounting procedures and practices for ten years for the purpose of CMS inspection and audit.

Provider agrees to comply with state and federal government auditing, inspection, and evaluation requirements, including maintenance of record, access to facilities and records, and record retention guidelines pursuant to 42 CFR §422.504(d)(e).

Monitoring and Auditing

Ochsner Health Plan maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, and all applicable federal, state, and local laws, including Medicare laws, regulations, reporting requirements, and CMS instruction.

Provider Performance Monitoring and Auditing

Provider acknowledges that Ochsner Health Plan must oversee and monitor providers performance on an ongoing basis. To ensure compliance, Ochsner Health Plan routinely performs monitoring and auditing activities of our delegated entities, including providers. This helps us ensure compliant administration of our CMS contracts, and it ensures compliance with applicable laws and regulations. Each provider must take part in these monitoring and auditing activities. If you do your own audits, we may ask for the results affecting our Medicare business.

Monitoring And Auditing of Subcontracted Delegates or Downstream Entities

Delegates who subcontract the administrative or health benefit services performed for Ochsner Health Plan to a subcontractor, or downstream entity, have an obligation to ensure the downstream entity complies with all same applicable federal and state laws, regulations and requirements through contract language, compliance oversight, monitoring, and auditing activities.

Records of such activities must be maintained for a minimum of 10 years and be available for review by CMS, state regulators or our organization upon request.

Compliance with CMS Medicare Communications and Marketing Guidelines

Marketing Medicare Advantage Plans

Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Parts 422, 423, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMG) including, without limitation, materials governing “Provider-Initiated Activities” in Section 60.1. Providers must adhere to all applicable laws, regulations, andCMS guidelines regarding MA plan marketing including, without limitation, 42 CFR Parts 422, 423, Subpart V and the MCMG.

CMS holds plan sponsors such as Ochsner Health Plan responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers are not authorized to engage in any marketing activity on behalf of Ochsner Health Plan without the prior express written consent of Ochsner Health Plan, and then only in strict accordance with such consent.

Guidelines for Providers When Discussing Medicare Advantage

Healthcare providers and their staff must remain neutral parties when discussing Medicare coverage options with their patients.

Healthcare providers and their staff **must not**:

- Accept or collect Medicare Advantage scope of appointment forms from Medicare beneficiaries.
- Accept enrollment applications for Medicare Advantage plans.

- Make phone calls to direct, urge or attempt to persuade Medicare beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mail marketing materials to Medicare beneficiaries on behalf of Medicare plan sponsors.
- Offer inducements to persuade their patients to enroll in a particular plan or organization
- Conduct health screenings as a marketing activity.
- Distribute marketing materials/applications in areas where care is being delivered.
- Offer anything of value to induce enrollees to select them as their provider.
- Perform health screenings in direct or indirect connection with the sharing of information about Medicare coverage options.
- Accept compensation directly or indirectly from a Medicare Advantage and/or Medicare Part D plan for beneficiary enrollment activities.
- Conduct or facilitate sales activities in patient service areas (i.e., exam rooms, waiting rooms).

Healthcare providers and their staff **are permitted** to:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from www.medicare.gov) including in areas where care is delivered.
- Provide the names of all plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS).
- Refer patients to plan marketing materials available in common areas.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered.
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, Plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS website at www.medicare.gov, or 1-800-MEDICARE

The information contained in this section should not be construed as legal advice. Providers should consult the Medicare Communication and Marketing Guidelines published by CMS to learn more about CMS's requirements regarding provider outreach or contact OHP VP, Sales and Marketing for assistance via email at OHPproviderrelations@ochsner.org.

Specific Medicare Advantage Plan Requirements

Ochsner Health Plan is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures that apply to providers and suppliers that constitute the MA organization's health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations which is available on the U.S. Government Printing Office website (ecfr.gov)

If you participate in the network for our MA products, you must comply with the following additional requirements for services you provide to our MA members.

Summary of CMS Requirements	CFR 42 (Section)
You must safeguard privacy and maintain records accurately and timely	422.118
You may not discriminate against members in any way based on health status.	422.110(a)

You must allow members direct access to screening mammography and influenza vaccination services.	422.100(g)(1)
You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.	422.100(g)(2)
You must make sure members have adequate access to covered health services.	422.112(a)(1)
You must provide female members with direct access to a women's health specialist for routine and preventive health care services.	422.112(a)(3)
You must make sure your hours of operation are convenient to members, and you must make sure medically necessary services are available to members 24 hours a day, 7 days a week. Primary care providers must have backups for absences.	422.112(a)(7)
You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.	422.80(a), (b), (c)
You must provide services to members in a culturally competent manner considering adjustments for members who use English as a second language, hearing or vision impairment, and diverse cultural and ethnic backgrounds.	422.112(a)(8)
You must maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
You must document in a prominent part of the member's medical record whether they have executed an advance directive.	422.128(b)(1)(ii)(E)
You must provide covered health services in a manner consistent with professionally recognized standards of health care.	422.504(a)(3)(iii)
You must make sure any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.	422.208
You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)
You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.	422.64(a): 422.504(a)(4) 422.504(f)(2)
You must make good faith effort to notify all affected members of the termination of a provider contract 30 days before the termination by plan or provider.	422.111(e)

You must submit all *Risk Adjustment Data*, and other MA program related information we may request, within the time frames specified and in a form that meets MA program requirements as well as state and federal commercial insurance requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information, and belief.	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
You must comply with our MA policy guidelines, coverage summaries, quality improvement programs, and medical management procedures.	422.202(b); 422.504(a)(5)
You must cooperate with us in fulfilling our responsibility to disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years.	422.504(f)(2)(iv)(A)
You must cooperate with us in fulfilling our responsibility to disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction.	422.504(f)(2)(iv)(B)
You must cooperate with us in fulfilling our responsibility to disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes.	422.504(f)(2)(iv)(C)
You must make sure employees or downstream entities are not excluded from participating in federal health care programs.	422.752(a)(8)
You must adhere to OHP appeals and grievance procedures. This includes, but is not limited to, providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.	422.562(a)

Section 9: Pharmacy

Ochsner Health Plan Part D (*Prescription Drug*) Benefit

Since **January 1, 2022**, Ochsner Health Plan has worked with MedImpact, our Prescription Benefits Manager, to manage its Medicare Advantage prescription drug benefits. With the rising cost of prescription drugs, our goal is to make it as easy and affordable as possible for members to receive the medication they need.

MedImpact can be reached 24/365 at 1-800-910-1837

Information for Processing and Writing Prescriptions
For all Ochsner Health Plan benefit plans that include Part D prescription drug coverage, Rx information is printed on their ID cards for processing Part D prescription fills:

RxBin Number: 015574
RxPCN Number: ASPROD1
Rx Group Number: OHP01

Send e-prescriptions to pharmacies using this information.

The Ochsner Health Plan formulary and other pharmacy benefits information may be searched or downloaded from our website at www.ochsnerhealthplan.com/resources.

Pharmacy Directory
This directory provides a list of Ochsner Health Plan's in-network pharmacies available in Louisiana, updated as of Sept 1,, 2023.

- Pharmacy Directory (PDF)

Formulary
- Partial List of Covered Drugs (PDF)
- Full List of Covered Drugs (PDF)
- Search the full formulary

In addition, you can download a list of drugs that require Prior Authorization or a list of drugs that require Step Therapy.

Additional Information About Prescription Drugs
- Prior Authorization (PDF)
- Step Therapy (PDF)

The Ochsner Health Plan searchable Formulary can be accessed from our website.

Results

Brand Name *generic name*	Therapeutic Class *Sub-Class*	Dose/Strength	Status	Notes & Restrictions
atorvastatin oral tablet 10 mg G	Cardiovascular Agents *Dyslipidemics*	TABLET 10 mg	T1	QL Quantity Limit, GAP Gap Coverage

The drug search for Formulary drugs will also provide the restriction legend as follows:

Icon	Restriction	Definition
AL Age Limit	Age Limit	AGE (Max 64 Years), Age is older than x
GAP Gap Coverage	Gap Coverage	We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.
G	Generic Indicator	Generic Indicator
LA Limited Access	Limited Access	Limited Access
NO MAIL	No Mail Order (NM)	No Mail Order
NEDS	Non-Extended Day Supply	Plans can elect to limit specific drugs to a 30-day supply.
PA Prior Auth	Prior Authorization	You (or your physician) are required to get prior authorization from Ochsner Health Plan before you fill your prescription for this drug. Without prior approval, Ochsner Health Plan may not cover this drug.
PAns New Starts	Prior Authorization - New Starts	A member new to a drug therapy. The first time a member has taken that specific drug with utilization management (UM) that specifies a process that requires members to obtain advanced approval from the plan before a service is rendered or a prescription is filled.
QL Quantity Limit	Quantity Limit	A form of utilization management (UM) that specifies quantity limitations or restrictions on prescriptions over time. Quantity limitations can take on various forms, the most typical being daily and monthly restrictions on the quantity issuance or re-issuance of a prescription.
	Reference Brand Name	Reference Brand Name

	Step Therapy	Before Ochsner Health Plan provides coverage for this drug, you must first try another drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you

Prior Authorization/Step Therapy/Quantity Limit/Formulary and Tier Exceptions

OHP has engaged MedImpact (available 24/7, 365 days a year) as our health plan Pharmacy Benefit Manager (PBM) for Part D Pharmacy Services. Most information regarding prescription coverage and the UM process can be found at: www.ochsnerhealthplan.com/resources.

If a drug requires a **Prior Authorization** or **Formulary Exception**: please see below for contact information:

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-910-1837 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
WRITE	Prior Authorization Department MedImpact Healthcare Systems, Inc. 10181 Scripps Gateway Ct. San Diego, CA 92131
WEBSITE	www.ochsnerhealthplan.com

If you want to **Appeal** a previously denied request, please use the information below:

Method	Appeals Part D Prescription Drugs – Contact Information
CALL	1-800-910-1837 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
WRITE	Appeals and Grievances Department MedImpact Healthcare Systems, Inc. 10181 Scripps Gateway Ct. San Diego, CA 92131
WEBSITE	www.ochsnerhealthplan.com

Getting a 30-day supply:

Members may get a 30-day outpatient prescription drug at one of 65,000 participating retail pharmacies.

With Ochsner Health Plan, members may get a 90-day supply of drugs on Tier One and Tier Two at no cost.

Getting a 90-day supply:

There are two ways to get a 90-day supply:

1. Members may get a 90-day outpatient prescription drug by using our contracted mail order pharmacy.
2. Also, members can get a 90-day outpatient prescription drug through many retail pharmacies with the same member cost-sharing as mail order. This way members don't have to worry about waiting for medications to arrive, tracking down lost packages, packages containing medications being stolen, medication getting too hot (insulin), medication getting too cold in the winter, etc. In addition, many retail pharmacies offer free drive-through, curbside, or home delivery services.

Prescription Drug Copays

Under our new pharmacy program, copayments are based on a five-tier formulary structure. Every drug on the Ochsner Health Plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher cost share members pay for the drug:

- Tier 1 includes preferred generic drugs (this is the lowest tier)
- Tier 2 includes generic drugs
- Tier 3 includes preferred brand drugs
- Tier 4 includes brand drugs
- Tier 5 includes specialty drugs (this is the highest tier and limited to a maximum of 30-day supply at a time

Remember, Ochsner Health Plan members may get a 90-day supply of drugs on Tier One and Tier Two at no cost

2024 Prescription Drug Benefits

Prescription drug benefits do not vary between plans. *Heroes HMO-POS plan does not include Part D coverage.

Prescription Drugs			
Stage 1: Annual Prescription Deductible	Since you have no deductible for Part D drugs, this payment stage doesn't apply.		
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail 30-day supply**	**90-day supply**	**Mail Order 90-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay
Tier 2: Generic Drugs[1]	$10 copay	$25 copay	$25 copay
Tier 3: Preferred Brand Drugs	$45 copay	$135 copay	$135 copay
Covered Insulin Drugs[1]	$35 copay	$105 copay	$105 copay
Tier 4: Non-Preferred Brand Drugs	$100 copay	$300 copay	$300 copay
Tier 5: Specialty Tier Drugs[2]	33% coinsurance	N/A[3]	N/A[3]
Stage 3: Coverage Gap Stage	Tier 1 and Tier 2 Drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $5,030, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap.		

Prescription Drugs	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0 or 0% of the costs.

Other Limitations May Apply

1. Tier includes enhanced drug coverage.

2. You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

3. Limited to a 30-day supply.

Remember, *Heroes HMO-POS plan does not include Part D coverage.

Prior Authorization/Step Therapy/Quantity Limit/Formulary and Tier Exceptions

OHP has engaged MedImpact (available 24/7, 365 days a year) as our health plan Pharmacy Benefit Manager (PBM) for Part D Pharmacy Services. Most information regarding prescription coverage and the UM process can be found at: www.ochsnerhealthplan.com/resources.

A coverage determination is a decision we make about members benefits and coverage or about what OHP will pay for members drugs. If you feel the member may qualify for an exception because of unique medical needs, members, members authorized representatives, and members providers should contact us and ask for a coverage determination.

Please note: If a pharmacy tells members that their prescription cannot be filled as written, members will get a written notice explaining how to contact OHP to ask for a coverage decision.

Below are examples of coverage decisions members, members authorized representatives, and members providers may ask OHP to make about Part D drugs:

- Members, members authorized representatives, and members providers may ask us to make an exception, including:

    - Asking us to cover a Part D drug that is not on the plan's formulary.
    - Asking us to waive restriction on the plan's coverage for a drug (such as limits on the amount of the drug members can get).
    - Asking to pay a lower cost-sharing amount for a covered non-preferred drug.
- Members, members authorized representatives, and members providers may ask us whether a drug is covered and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's formulary, but we require members, members authorized representatives, and members providers to get approval from us before we will cover it.)
- Members, members authorized representatives, and members providers may ask us to pay for a prescription drug that members have already paid for. This is a request for a coverage decision about payment.

If a member, members authorized representatives, and members providers disagree with a coverage decision we have made, they can appeal our decision.

Requesting a Coverage Determination

For Part D Drugs, OHP delegates responsibility for making coverage determinations to the Pharmacy Benefits Manager (PBM), MedImpact. Members, members authorized representatives, and members providers may request a coverage determination. Members, members authorized representatives, and members providers must ask us to make a coverage decision about the drug(s) or payment you need. If the member's health requires a quick response, you must ask us to make a "fast coverage decision".

Appeals

If a member, members authorized representatives, and/or the members providers are unsatisfied with the outcome of a coverage determination request, they can ask for an appeal. When they make an appeal, OHP or the OHP PBM for Part D drugs will review your unfavorable coverage determination or organization determination.

The first level of appeal for a Part D drug is called a redetermination. Members, members authorized representatives, and members providers may file for a Part D redetermination if you want OHP to reconsider a decision regarding payment or benefits to which you believe you are entitled. There are five levels of appeals. Details of all levels can be found in the Evidence of Coverage (Chapter 9, sections 8 and 9). To locate this document and more, visit our website: www.Ochsnerhealthplan.com.

Appeals must be filed within 60 calendar days of the date included on the notice of the OHP/MedImpact coverage determination. More time may be granted depending on circumstances.

If your first appeal is denied or if you disagree with any part of our appeal (redetermination or reconsideration) decision, you can request further appeal levels. Complete details on all appeal levels can be found in the Evidence of Coverage.

Request Status

For questions regarding the process or status of a coverage determination, organization determination, redetermination or reconsideration request, members, members authorized representatives, and members providers should call MedImpact Pharmacy Help Desk. 1-800-910-1837 24 hours a day/365 days a year.

When your complaint is about quality of care, you can make your complaint to the Quality Improvement Organization (QIO). To find the name, address, and phone number of the QIO for your state, look in

the Evidence of Coverage (Chapter 2, section 4). This document and others are available on our Plan Documents page.

You can also submit feedback directly to Medicare by using the Medicare Complaint Form. You can also call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

Appointing a Representative

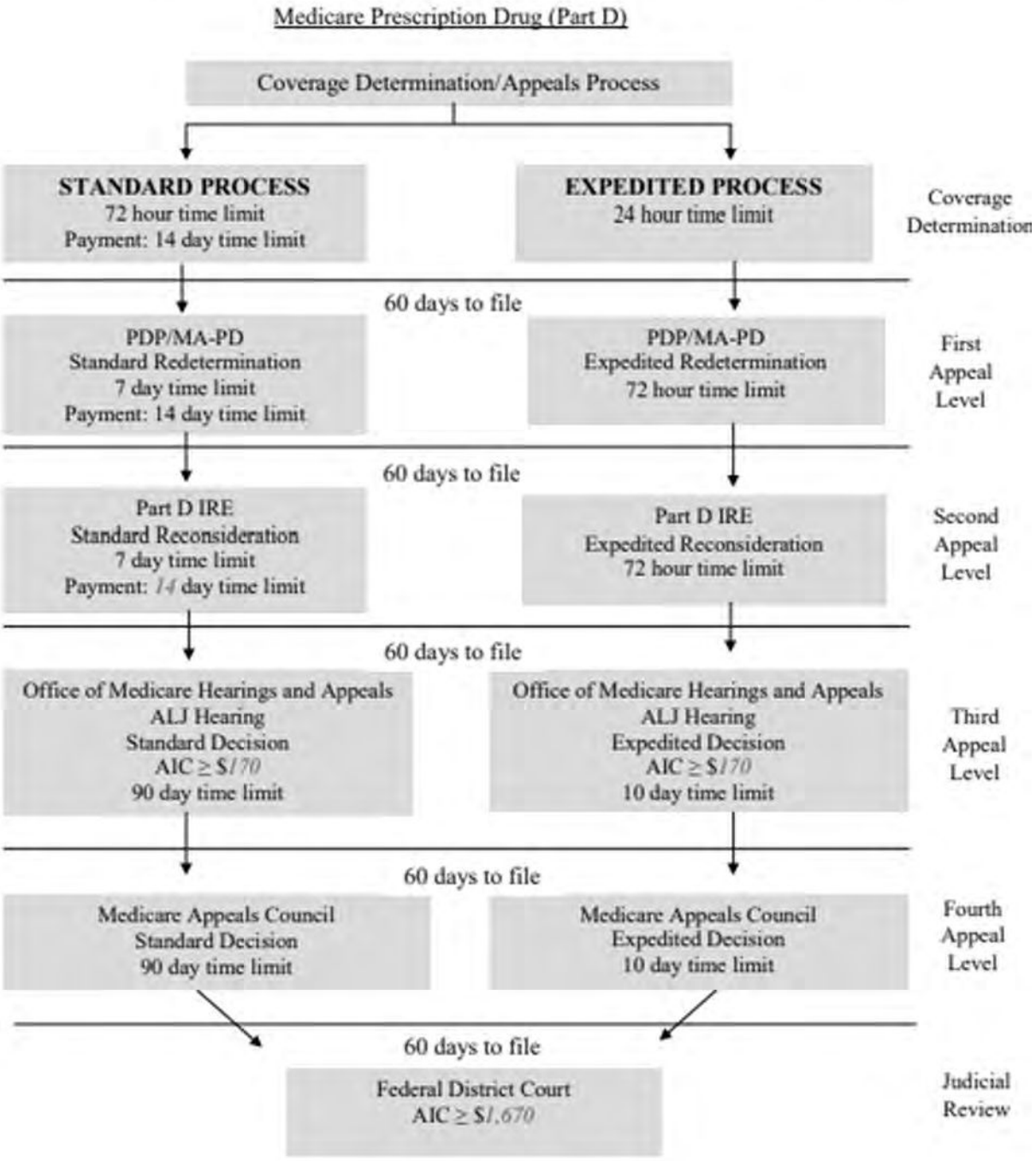
An appointed representative is a relative, friend, advocate, doctor, or other person authorized to act on the members behalf in filing a grievance, coverage determination or appeal.

Those not authorized under state law to act for you will need to sign an **Appointment of Representative Form** and mail it to MedImpact at the address at the end of this section.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits and/or copayments/coinsurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Note: You can find lists of Part D drugs that require prior authorization or step therapy on our website: www.ochsnerhealthplan.com/resources.

Medicare Prescription Drug (Part D) Appeals Process Overview



Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-910-1837 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
WRITE	Prior Authorization Department MedImpact Healthcare Systems, Inc. 10181 Scripps Gateway Ct. San Diego, CA 92131
WEBSITE	www.ochsnerhealthplan.com

Method	Appeals Part D Prescription Drugs – Contact Information
CALL	1-800-910-1837 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
WRITE	Appeals and Grievances Department MedImpact Healthcare Systems, Inc. 10181 Scripps Gateway Ct. San Diego, CA 92131
WEBSITE	www.ochsnerhealthplan.com

Opioid Overutilization

Opioid Overdose Risk Factors

There have been over 200,000 prescription opioid overdose deaths from 1999 to 2016 in the U.S.[2] According to the CDC, most fatal overdoses can be identified retrospectively on the basis of two pieces of information, multiple prescribers, and high total daily opioid dosage.[3] Morphine milligram equivalents (MMEs) of 100 or higher can increase overdose risk two to nine times. Other high risk prescribing practices include combining CNS depressants. For instance, a third of opioid overdoses involve benzodiazepine concurrent use.[4] This especially lethal combination is associated with a four times higher risk for overdose death than opioids alone.[3]

The CDC advocates that clinicians offer naloxone when factors that increase risk for opioid overdose are present.[3] Timely naloxone administration can prevent or reduce complications caused by prolonged lack of oxygen (e.g., kidney failure, debilitating nerve/muscle/brain damage and/ or death).[5, 6] A naloxone distribution program in Massachusetts reduced opioid overdose deaths by an estimated 11% in the nineteen communities that implemented it without increasing opioid use.[6]

Through the implementation of a combined retrospective DUR and case management approach, CMS reported a 61% decrease in the number of beneficiaries that met criteria for high-risk opioid use from

2011 and 2016.[7]

Opioid Drug Management Plans are mandatory for all Part D sponsors starting in 2022, consistent with section 2004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (SUPPORT Act).

Ochsner Health Plan's Opioid Overutilization and Safety Controls Program.

Working to Prevent Opioid Overutilization

According to HHS, at least 130 individuals die from opioid overdoses every day and 2.1 million people had an opioid use disorder in 2017. Opioid overutilization is a national epidemic that affects every part of the country and nearly every demographic. To address this crisis, Ochsner Health Plan and MedImpact have launched an integrated suite of services designed to:

- Identify high-risk members
- Intervene at the point of sale
- Engage prescribers
- Promote naloxone access

Ochsner Health Plan/MedImpact's Opioid Overutilization and Safety Controls Program

The Opioid Overutilization and Safety Controls program helps prevent opioid overutilization by implementing CMS or plan-specific predefined drug utilization controls. The program also promotes naloxone use to prevent death or other serious overdose complications in patients found to have risk factors.

Interventions are conducted in real-time at the point-of-sale or through prescriber mailings for members at risk for overdose due to:

- Receiving excessive dosages
- Combining CNS depressants
- Potential coordination of care issues
- Lack of a naloxone prescription

We also integrate high-touch prescriber outreach through case management by clinicians to further improve coordination of care and prevent overutilization. Case management services for monitoring opioid overutilization include a review of the prescriber fax-back forms from the Opioid Overutilization-Benzodiazepine/Potentiators Retrospective Intervention Program. If opioid utilization is deemed inappropriate, we will collaborate with the prescriber to determine the best course of action to resolve the overutilization, which may include member-level drug/quantity edits or prescriber and/or pharmacy "lock-in" edits. We will prepare and mail notification to prescribers, members, and pharmacies (if applicable) of any member-level restrictions deemed necessary after case management.

Preventing Overutilization for Better Health

Our focus is on clinical quality for overall better member health. Our program helps to:

- Improve coordination of care
- Reduce controlled substances overutilization
- Increase member safety
- Reduce opioid-related overdose and death

[1.]U.S. Department of Health and Human Services. **The Opioid Epidemic in Numbers**. Accessed on April 2019. Available at https://www.hhs.gov/opioids/sites/default/files/2018-09/opioids-infographic.pdf

[2.] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. **Prescription Opioid Data**. Updated August 30, 2017. Available at https://www.cdc.gov/drugoverdose/data/overdose.html

[3.] Dowell D, Haegerich TM, Chou R. **CDC Guideline for Prescribing Opioids for Chronic Pain** — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

[4.]Majestic M. Department of Health & Human Services. Centers for Medicare & Medicaid Services. **Opioid Potentiators.** Published March 16, 2018. Available at: https://mmp.michigancompletehealth.com/content/dam/centene/michigan-complete-health/pdfs/Opioid_Potentiators_Memo.pdf

[5.]Bebinger M. **What Doesn't Kill You Can Maim: Unexpected Injuries From Opioids.** Published April 13, 2017. Available at: https://www.npr.org/sections/health-shots/2017/04/13/523452905/what-doesnt-kill-you-can-maim-unexpected-injuries-from-opioids

[6.]National Institutes of Health. National Institute on Drug Abuse. **Naloxone for Opioid Overdose: Life-Saving Science.** Updated March 2017. Available at: https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science.

[7.] GAO, Prescription Opioids: **Medicare Needs to Expand Oversight Efforts to Reduce Risk of Harm**, GAO-18-15. Published October 6, 2017. Available at: https://www.gao.gov/reports/GAO-18-15/

Additional reference:

HHS OIG Data Brief • May 2020; **Medicare Part D Beneficiaries at Serious Risk of Opioid Misuse or Overdose: A Closer Look** (OEI-02-19-00130; 05/20) (hhs.gov); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7181702/

Medication Therapy Management (MTM)

If Ochsner Health Plan members have complex health needs, they may be able to participate in an MTM program. MTM is a service offered by Ochsner Health Plan at no additional cost to members. The MTM program is **required** by the Centers for Medicare and Medicaid Services (CMS) and is not considered a benefit. This program helps members, and their providers make sure that their medications are working. It also helps identify and reduce possible medication problems.

To take part in this program, members must meet certain criteria set forth in part by CMS. These criteria are used to identify people who have multiple chronic diseases and are at risk for medication-related problems. If members meet these criteria, Ochsner Health Plan will send them a letter inviting them to participate in the program and information about the program, including how to access the

program. Member enrollment in MTM is voluntary and does not affect Medicare coverage for drugs covered under Medicare.

To qualify for Ochsner Health Plan's MTM program, members must meet one of the two following criteria:

1. Be an At-Risk Beneficiary or
2. Meet ALL of the following criteria:
    a. Have at least 3 of the following conditions or diseases: Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, Asthma, COPD, and
    b. Take at least 8 covered Part D medications, and
    c. Are likely to have medication costs of covered Part D medications greater than $5,330 per year.

To help reduce the risk of possible medication problems, the Ochsner Health Plan MTM program offers two types of clinical review of your medications:

- **Targeted medication review:** at least quarterly, we will review all of an MTM-enrolled members prescription medications and contact the member, caregiver, pharmacist, and/or your provider if we detect a potential problem.
- **Comprehensive medication review:** at least once per year, we offer a free discussion and review of all of an MTM-enrolled member's medications by a pharmacist or other health professional to help the member use medications safely. This review, or CMR, is provided to members confidentially via telephone by pharmacies operated by Tabula Rasa HealthCare.

  The CMR may also be provided in person or via telehealth at members' providers office, pharmacy, or long-term care facility. If members or their caregiver are not able to participate in the CMR, this review may be completed directly with member's provider. These services are provided on behalf of Ochsner Health Plan. This review requires about 30 minutes of time.

  Following the review, members will get a written summary of this call, which they can take with them when they talk with their doctors. This summary includes:
    - Medication Action Plan (MAP): The action plan has steps that members should take to help get the best results from their medications.
    - Personal Medication List (PML): The medication list will help members keep track of their medications and how to use them the right way.

Section 10: Definitions and Abbreviations

Definitions

The following terms as used in this manual shall be construed and/or interpreted as follows,unless otherwise defined in the Agreement.

Agreement means the contract under which provider participates in Ochsner Health Plan's network for Medicare Advantage Benefit Plans.

Appeal means a request for review of some action taken by or on behalf of Ochsner Health Plan.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by Ochsner Health Plan or (b) administered by Ochsner Health Plan, pursuant to a government contract. Benefit Plans and their designs are subject to change periodically. This manual applies only to Benefit Plans issued under the Medicare Advantage program.

Centers for Medicare & Medicaid Services (CMS) means the United States federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Clean Claim means a claim for Covered Services provided to a member that (a) is received timely by Ochsner Health Plan, (b) has no defect, impropriety, or lack of substantiating documentation from the members medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows current HIPAA Administrative Simplification ASC X12 837 standards and additional Ochsner Health Plan-specific requirements in the *Ochsner Health Plan Companion Guide*, including all current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Ochsner Health Plan to (1) meet requirements of laws and program requirements for reporting of Covered Services provided to members, and (2) determine payer liability, and ensure timely processing and payment by Ochsner Health Plan. A Clean Claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim that is under review for Medical Necessity.

Co-Surgeon means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

Covered Services means Medically Necessary healthcare items and services covered under a Benefit Plan.

Emergency Medical Condition means 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

Encounter Data means encounter information, data and reports for Covered Services provided to a member that meets the requirements for Clean Claims.

Grievance means any complaint or dispute, other than one that involves a Ochsner Health Plan determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Ochsner Health Plan, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to,and/or setting of a provided item and may only be brought on behalf of a member.

Ineligible Person means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may beidentified in the list of excluded individuals/entities maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG), or (ii) federal procurement or non-procurement programs, as may be identified in the excluded parties list system maintained by the U.S. General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or state procurement or non-procurement programs as determined by a state governmental authority.

Medically Necessary or **Medical Necessity** means those healthcare items or services that are

(i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain,
(ii) individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the members needs,
(iii) consistent with generally accepted professional medical standards and not experimental or investigational,
(iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide,
(v) provided in a manner not primarily intended for the convenience of the member, the members caretaker, or the healthcare provider, and
(vi) not custodial care as defined by CMS. For healthcare items and services provided in a hospital on an inpatient basis, "Medically Necessary" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a healthcare provider has prescribed, recommended, or approved healthcare items or services does not, in itself, make such items or services medically necessary.

Member means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

Member Expenses means co-payments, coinsurance, deductibles, or other cost-share amounts, if any, that a member is required to pay for covered services under a benefit plan.

Organization Determination means any determination made by a Medicare health plan with respect to the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services*;*

- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan*;*
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan*;*
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for healthcare services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Primary Care Provider (PCP) means a licensed medical doctor (MD) or doctor of osteopathy(DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to members. A PCP shall include general/family practitioners, pediatricians, internists, physician assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

Provider means an individual or entity that has contracted, directly or indirectly, with Ochsner Health Plan to provide or arrange for the provision of covered services to members under a benefit plan as a participant in Ochsner Health Plan's network.

Abbreviations

ACS – American College of Surgeons

AEP – Annual Enrollment Period

AHP – Allied Health Professional

AIDS – Acquired Immune Deficiency Syndrome

ALJ – Administrative Law Judge

AMA – American Medical Association

ARNP – Advanced Registered Nurse Practitioner

CAD – Coronary Artery Disease

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CDS – Controlled Dangerous Substance

CHF – Congestive Heart Failure

CIA – Corporate Integrity Agreement

CLAS – Culturally and linguistically appropriate services

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwife

COB – Coordination of benefits

COPD – Chronic obstructive pulmonary disease

CORF – Comprehensive outpatient rehabilitation facility

CPT-4 – *Physician's Current Procedural Terminology, 4th Edition*

CSR – Controlled Substance Registration

DDE – Direct data entry

DEA – Drug Enforcement Agency

DM – Disease Management

DME – Durable medical equipment

DOC – Documentation

DSM-IV – *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*

EDI – Electronic data interchange

EOB – Explanation of Benefits

EOP – Explanation of Payment

ESRD – End-stage renal disease

FBDE – Full Benefit Dual-Eligible Members

FDA – Food and Drug Administration

FFS – Fee-for-service

FWA – Fraud, Waste and Abuse

HEDIS – Healthcare Effectiveness Data and Information Set

HHA – Home health agency

HHS – U.S. Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIV – Human Immunodeficiency Virus

HMO – Health maintenance organization

HMO-POS – Health maintenance organization with point-of-service option

HOS – Medicare Health Outcomes Survey

HRA – Health Risk Assessment

HTN – Hypertension

ICD-10-CM – *International Classification of Diseases, 10th Revision, Clinical Modification*

ICP – Individualized Care Plan

ICT – Interdisciplinary Care Team

INR – Inpatient nursing rehabilitation facility

IPA – Independent physician association

IRE – Independent Review Entity

IVR – Interactive voice response

JNC – Joint National Committee

LCSW – Licensed Clinical Social Worker

LTAC – Long-term acute care facility

MA – Medicare Advantage

MAC – Medicare Appeals Council

MIPPA – Medicare Improvements for Patients and Providers Act of 2008

MOC – Model of Care

MOOP – Maximum out-of-pocket

MSP – Medicare Savings Program

NCCI – National Correct Coding Initiative

NCQA – National Committee for Quality Assurance

NDC – National Drug Codes

NIH – National Institutes of Health

NPI – National Provider Identifier

NPP – Notice of Privacy Practices

OA – Osteopathic Assistant

OB – Obstetric/obstetrical/obstetrician

OIG – Office of Inspector General

OT – Occupational therapy

OTC – Over-the-counter

P&T – Pharmacy and Therapeutics Committee

PA – Physician Assistant

PCP – Primary Care Provider

PHI – Protected health information

POS – Point-of-service

PPC – Provider-preventable condition

Provider ID – Provider identification number

PT– Physical therapy

QDWI – Qualified Disabled Working Individual

QI – Qualifying Individual

QI Program – Quality Improvement Program (*also referred to as* QIP)

QIO – Quality Improvement Organization

RN – Registered Nurse

SFTP – Secure file transfer protocol

SIE – Site inspection evaluation

SNF – Skilled nursing facility

SNIP – Strategic National Implementation Process

SSN – Social Security Number

ST – Speech therapy

Tax ID/TIN – tax identification number

TNA – Transition Needs Assessment

TOC – Transition of care

UM – Utilization management

WEDI™ – Workgroup for Electronic Data Interchange

NOTES

Ochsner Health Plans are availble in the following parishes for 2024:

Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafayette, Lafourche, Livingston, Orleans, St. Charles, St. John the Baptist, St. Martin, St. Tammany, West Baton Rouge

Ochsner Health Plan

Ochsner Health Plan
1450 Poydras St., Suite 110
New Orleans, LA 70112
www.ochsnerhealthplan.com
Call toll-free: 1-833-674-2112
8:00 a.m. to 8:00 p.m.
seven days a week from
October 1st to March 31st
and 8:00 a.m. to 8:00 p.m.
Monday through Friday
April 1st to September 30th.

Ochsner Health Plan *is an HMO with a Medicare contract. Enrollment in Ochsner Health Plan depends on contract renewal.*

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updated January 1, 2024