

West Virginia 
Senior Advantage



Provider Manual

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WEST VIRGINIA SENIOR ADVANTAGE HMO SNP

Institutional Special Needs Plan

West Virginia Senior Advantage HMO SNP (“health plan” or “Plan”) is a Medicare Advantage Institutional Special Needs Plan (ISNP) designed to improve the care for the residents of long-term care facilities in West Virginia. West Virginia Senior Advantage’s target population is an institutionalized Medicare beneficiary who resides or is expected to reside in a contracted long-term care (LTC) facility for 90 days or longer.

Model of Care

West Virginia Senior Advantage’s Model of Care organizes best practices and industry innovations such as the Primary Care Physician (PCP) and West Virginia Senior Advantage Nurse Practitioner care team providing onsite, facility-based primary health care support; Health Risk Assessment (HRA) that drives an Individualized Care Plan (ICP); a care management platform that helps identify needed preventive health/HEDIS® services, ensures the use of evidence-based guidelines, and facilitates care team communications for care coordination; and frequent face-to-face member and caregiver/family member interactions that identify member care preferences and allow time for important care decision discussions and counseling.

The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs, and the coordination of care to improve members’ overall health. WVSA’s ISNP MOC has the following goals:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Improve member health outcomes

ISNP members receive a health risk assessment initially and annually thereafter. Based on this assessment, an individualized care plan is developed, based on evidenced-based clinical protocols. The WVSA NP is responsible for care management; the interdisciplinary care team participates in the care planning. Members are highly encouraged to participate in this process, as may all of their healthcare providers. The individual care plan is stored centrally so that it can be shared with all members of the interdisciplinary care team, as indicated. All providers are encouraged to participate in the ISNP Model of Care and interdisciplinary care teams. The WVSA NP will coordinate, with the member and the PCP, to ensure ongoing or alternative treatment plans are acceptable and medically appropriate.

West Virginia Senior Advantage uses a data-driven process for identifying the frail/disabled, multiple chronic illnesses and those at the end of life. Risk stratification and protocols for intervention around care coordination, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the

needs of Plan members, a specialized provider network is available to assure appropriate access to care, complementing each member's primary care provider.

The PCP is an important and unique part of West Virginia Senior Advantage's provider network. A PCP is (1) contracted with West Virginia Senior Advantage, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for WVSA members in the Nursing Facility (NF) or Skilled Nursing Facility (SNF) setting, including coordination and management of the delivery of all covered services.

West Virginia Senior Advantage's model ensures that every member has direct access to primary care services onsite in the nursing facility and that the member's PCP has experience understanding the special needs of nursing facility residents. PCPs provide regular patient care services in the nursing home facilities, working to streamline care and minimize the need for transfers out of the facility for ambulatory services. They work directly with the WVSA NP to provide and oversee all aspects of member care including evaluating, recommending, or providing treatments to optimize health status. When possible and clinically appropriate, PCPs may decide to treat some acute exacerbations or conditions in place in the nursing facility rather than transfer the member to an external site of care, such as an acute care hospital or emergency room.

All West Virginia Senior Advantage members are required to choose or designate a PCP at enrollment. WVSA members are able to choose their PCP from the list maintained and published by West Virginia Senior Advantage. Members are able to change their PCP at any time. Physicians contracted as PCPs and available to be chosen as a primary care physician with WVSA are identified in WVSA's Provider Directory as credentialed at time of publication.

WVSA's evidenced-based Model of Care includes the following components:

- The clinical team provides integrated health care management with a strong primary and preventive care focus to treat acute and chronic conditions.
- All members receive a Health Risk Assessment (HRA) and care plan within 90 days of enrollment and visits at least once a month thereafter.
- WVSA NPs utilize a health risk assessment tool to rate each member's medical condition as low (green), moderate (yellow), or high (red).
- Risk levels dictate the WVSA NPs clinical visit/monitoring schedule.
- Risk levels are evaluated at each comprehensive and post-hospital visit/monitoring and tracked over time.
- An Individualized Care Plan (ICP) is developed with goals and measurable outcomes specific to the targeted special needs of each member.
- An interdisciplinary care team is formed for each member.
- There is access to a specialized provider network that has expertise pertinent to the targeted special needs of the member population.
- There is a medication therapy management program.
- Staff and providers demonstrate cultural competency.
- Members and their caregivers/families engage in decision-making at all times.
- Members and their caregivers/families participate in plan policy and operations through surveys and formal feedback.

Execution of the ISNP Model of Care is supported by systems and processes to share information between the health plan, healthcare providers, and the member. The ISNP MOC includes periodic analysis of effectiveness, and all activities are supported by the Quality Improvement Program.

MEMBER INFORMATION

Member Identification and Eligibility

All participating providers are responsible for verifying a member’s eligibility at each and every visit. Please note that membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) retroactively terminates members for various reasons. When this occurs, the West Virginia Senior Advantage claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the member’s actual benefit coverage for the date of service in question.

Each member is provided with an individual membership identification card. Noted on the ID card are the member’s identification number and plan code. If the member does not have an ID card, you must verify eligibility through one of the following ways:

- By going to the WWSA Provider Portal at <https://www.wvsenioradvantage.com/>
- By calling the WWSA Member Services Department at (866) 250-6352, TTY/TDD 711

ID Card Example
(front and back)



Maximum Out-of-Pocket (MOOP)

West Virginia Senior Advantage members have a Maximum Out-of-Pocket (MOOP) benefit—a limit on the amount they will be required to pay out of pocket each year for medical services which are covered under Medicare Part A and Part B. Once this maximum out-of-pocket expense has been reached, the member is no longer responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the member’s Medicare Part B premium and West Virginia Senior Advantage Plan Part D premium).

Member Hold Harmless

Participating providers are prohibited from balance billing West Virginia Senior Advantage members, including, but not limited to, situations involving nonpayment by WVSA, insolvency of WVSA, or WVSA's breach of its agreement. Providers may not charge, collect a deposit from, seek payment from, or have any recourse against members or their representatives, other than WVSA, for covered services provided based on the participating provider's Agreement. The provider may, however, collect co-payments, coinsurance, or deductibles for covered services in accordance with WVSA ISNP terms. If a member has both WVSA and Medicaid as a secondary payer, providers may not balance bill members.

Member Confidentiality and Privacy

West Virginia Senior Advantage is committed to protecting our members' personal information. West Virginia Senior Advantage does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law.

West Virginia Senior Advantage's privacy practices apply to all of West Virginia Senior Advantage past, present, and future members. When a member joins West Virginia Senior Advantage, the member agrees to give West Virginia Senior Advantage access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for the provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium.

Access to the PHI allows West Virginia Senior Advantage to work with providers to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the members' medical records. Medical records and claims are generally used to review treatment and to conduct quality assurance activities. In addition, it allows WVSA to look at how care is delivered and to conduct programs to improve the quality of care WVSA's members receive. This information also helps WVSA manage its members' health conditions to improve each enrolled member's quality of life.

West Virginia Senior Advantage's members have additional rights over their health information. They have the right to:

- Send West Virginia Senior Advantage a written request to see or receive a copy of their health information or amend their personal information that they believe is incomplete or inaccurate. If WVSA did not create the information, we will refer the member to the source of the information.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.

- Receive an accounting of West Virginia Senior Advantage’s disclosures of their medical information, except when those disclosures are for the treatment, payment, health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws to protect member PHI.

Member Rights and Responsibilities

Member Rights

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect, and fairness at all times. West Virginia Senior Advantage must obey laws against discrimination that protect members from unfair treatment. These laws say that West Virginia Senior Advantage cannot discriminate against members because of a person’s race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697, or the Office for Civil Rights in their area.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of member medical records and personal health information. West Virginia Senior Advantage keeps members’ personal health information private as required under these laws. Any personal information that a member gives WVSA is protected. WVSA staff will ensure that unauthorized people do not see or change member records. Generally, WVSA will get written permission from the member (or the member’s designated representative or power of attorney) before WVSA can give member health information to anyone who is not providing the member’s medical care. There are exceptions allowed or required by law, such as the release of health information to government agencies that are checking on the quality of care. The laws that protect member privacy give members rights related to getting information and controlling how their health information is used. WVSA is required to provide members with a notice that tells them about these rights and explains how WVSA protects the privacy of their health information. For example, members have the right to look at their medical records (a fee may be charged for making copies).

Members also have the right to ask plan providers to make additions or corrections to their medical records (if members ask Plan providers to do this, they will review member requests and determine if the changes are appropriate). Members have the right to know how their health information has been given out and used for routine and non-routine purposes.

Members are to call Member Services, (866) 250-6352, if they have questions or concerns about the privacy of their personal information and medical records.

West Virginia Senior Advantage will release a member's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The right to see participating providers, get covered services, and get prescriptions filled in a timely manner

Members will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of West Virginia Senior Advantage. Members have the right to choose a participating provider (West Virginia Senior Advantage will work with members to ensure they find physicians who are accepting new patients). Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit at any network pharmacy in a timely manner. Timely access means that members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know about treatment choices and to participate in decisions about their health care

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. West Virginia Senior Advantage's providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by West Virginia Senior Advantage. This includes the right to know about the different Medication Management Treatment Programs West Virginia Senior Advantage offers and those in which members may participate. Members have the right to be told about any risks involved in their care. Members must be told in advance if a proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from West Virginia Senior Advantage if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctors advise them not to leave. This also includes the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to use advance directives

The Federal Patient Self-Determination Act 38 CFR §17.32 ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining or withdrawing life-sustaining treatment. In accordance with guidelines established by the CMS, HEDIS® requirements, and West Virginia Senior Advantage's own policies

and procedures, WVSA requires all participating providers to have a process in place to support member decisions. To ensure providers maintain the required processes to advance directives, WVSA conducts periodic patient medical record reviews to confirm that required documentation exists.

All providers contracted directly or indirectly with WVSA may be informed by the member that the member has executed, changed, or revoked an advance directive. If the PCP or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must advise the member and WVSA. WVSA and the PCP or treating provider will arrange for a transfer of care.

Additionally, in the development of the ICP, the PHP or plan case manager will undertake a discussion with the member and family regarding advance care planning and include any applicable interventions in the ICP. If an advance directive has not already been executed, the PHP or plan case manager will provide education and encourage the member or responsible party to execute an advance directive to ensure that the member's wishes are supported.

Benefits and Services

All West Virginia Senior Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC).

If a West Virginia Senior Advantage member calls or comes to a provider's office for an unscheduled non-emergent appointment, attempt to accommodate the member and explain your office policy regarding appointments. If this problem persists, contact West Virginia Senior Advantage.

Emergent and Urgent Services

West Virginia Senior Advantage follows the Medicare definitions of "emergency medical condition," "emergency services," and "urgently needed services" as defined in the Medicare Managed Care Manual, Chapter 4, Section 20.2:

- **Emergency medical condition:** "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
 - Serious impairment to bodily functions; or,
 - Serious dysfunction of any bodily organ or part."
- **Emergency services:** "covered inpatient and outpatient services that are furnished by a provider qualified to [render] emergency services; and needed to evaluate or treat an emergency medical condition."
- **Urgently needed services:** "covered services that are not emergency services as defined [above] but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition; are provided when (A) the [member] is temporarily absent from the plan's service area; or (B) [under unusual and

extraordinary circumstances,] when the [member] is in the service area and the network is temporarily unavailable or inaccessible; and given the circumstances, it was not reasonable to wait to obtain the needed services from the plan provider.”

The West Virginia Senior Advantage network includes multiple hospitals, emergency rooms, and providers able to treat the emergent and urgent conditions of West Virginia Senior Advantage members 24 hours a day, seven days a week. For urgent and emergent issues that occur onsite in the member’s nursing home or in the service area, the PCP is responsible for providing, directing, or authorizing a member’s urgent or emergent care, including urgent or emergent services provided onsite in the nursing facility (“treatment in place”) and telemedicine. The PCP or his/her designee must be available 24 hours a day, seven days a week to assist members needing emergent or urgent services.

Emergent or urgent issues requiring services or expertise not available onsite in the member’s nursing home will be addressed with transfer of the member to an acute care hospital or emergency room able to provide the needed care. The PCP, working with the WVSA NP, is responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the member. Members have a copayment responsibility for outpatient emergency visits unless an admission results.

West Virginia Senior Advantage members may receive emergency services and urgently needed services from any provider, regardless of whether services are obtained within or outside the West Virginia Senior Advantage authorized service area and/or network and regardless of whether there is prior authorization for the services. For emergency services outside the service area, West Virginia Senior Advantage will pay reasonable charges for emergency services received from nonparticipating providers, if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a copayment for each incident of outpatient emergency services at a hospital’s emergency room or urgent care facility.

West Virginia Senior Advantage network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent and the ambulance provider is not contracted with West Virginia Senior Advantage, the plan follows Medicare rules on coverage for ambulance services as set forth in 42 CFR 410.40.

Prior authorization is required for all non-emergent ambulance services. Claims for non-emergent ambulance transportation will be denied if prior authorization is not obtained. WVSA follows CMS rules for coverage of non-emergent ambulance transportation. Per the Medicare Benefit Policy Manual, Chapter 10, for Ambulance Services, medical necessity must be established for all ambulance services. “Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. ... It is important to note that the presence (or absence) of a physician’s order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary.”

Grievance and Appeal Process

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of West Virginia Senior Advantage or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

An appeal is the procedure that deals with the review of adverse initial determinations made by West Virginia Senior Advantage on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive.

West Virginia Senior Advantage members or their appointed representatives have the right to file a grievance about problems they observe or experience with the health plan or with any aspect of the care received from a provider. Situations for which a grievance may be filed include but are not limited to:

- Complaints about services in an optional Supplementary Benefit package
- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations
- Complaints concerning the quality of services a member receives

West Virginia Senior Advantage members and their appointed representatives have the right to appeal any decision about WVSA's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside the service area or emergency services worldwide
- A denied claim for any other health services furnished by a nonparticipating provider or supplier they believe should have been provided, arranged for, or reimbursed by West Virginia Senior Advantage
- Services they have not received but believe are the responsibility of WVSA to pay for
- A reduction in or termination of service a member feels is medically necessary

In addition, a member may appeal any decision to discharge them from the hospital. In this case, a notice will be given to the member with information about how to appeal and the member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to the West Virginia Senior Advantage Evidence of Coverage for additional information.

PROVIDER INFORMATION

West Virginia Senior Advantage provides a PCP-driven care model that has medical providers physically located at the contracted nursing facilities to enhance and provide bedside care management and coordination. A Primary Care Physician (PCP) is (1) contracted with West Virginia Senior Advantage, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for WVSA-enrolled members in the nursing home or SNF setting, including coordination and management of the delivery of all covered services.

The PCP is supported by the WVSA NP and RNs with appropriate certification and qualifications for the population to be managed.

Each provider has agreed to participate in West Virginia Senior Advantage's peer review activities as they relate to the Quality Management/Utilization Review program.

Providers Designated as Primary Care Physicians (PCPs)

Each West Virginia Senior Advantage member must select a West Virginia Senior Advantage participating primary care physician (PCP) at the time of enrollment. WVSA members will be able to choose their primary care physician from the list of contracted physicians maintained and published by WVSA. Members will be able to change their primary care physician at any time. Physicians contracted as PCPs and are available to be chosen as a primary care physician with WVSA will be clearly identified in WVSA's member materials, including the Provider Directory.

West Virginia Senior Advantage will contract for PCP services with physicians who are engaged in general practice, family practice, or internal medicine. In some cases, WVSA may contract with internal medicine physicians who also hold a subspecialty board certification in a specialty relevant to WVSA's member population, including pulmonology and cardiology.

The West Virginia Senior Advantage model will ensure that every member has direct access to primary care services onsite in the nursing facility and that the member's PCP has experience understanding the special needs of nursing facility residents.

The Role of the Primary Care Physician (PCP)

PCPs will provide regular patient care services in the nursing home facilities, working to streamline care and minimize the need for transfers out of the facility for ambulatory services. They will work directly with the WVSA NPs and RNs to provide and oversee all aspects of member care including evaluating, recommending, or providing treatments to optimize members' health status. When possible and clinically appropriate, the PCP may decide to treat some acute exacerbations or conditions in place in the nursing facility rather than transferring the member to an external site of care, such as an acute care hospital or emergency room.

PCPs will be key participants in the member's interdisciplinary care team, collaborate with plan mid-level care, and are accountable for all care decisions for members assigned to them. Additionally, all PCPs will be required to participate in quarterly caregiver/family meetings with members. The PCP is responsible for managing all of the health care needs of a West Virginia Senior Advantage member as follows:

- Manage the health care needs of West Virginia Senior Advantage members who have chosen the physician as their PCP
- Ensure that members receive treatment as frequently as is necessary based on the member's condition
- Develop an individual treatment plan for each member
- Submit accurate and timely claims and encounter information for clinical care coordination

- Comply with WVSA's prior authorization and referral procedures
- Refer members to appropriate WVSA participating providers
- Comply with WVSA's Quality Management and Utilization Management programs
- West Virginia Senior Advantage member Health Risk Assessment and Individualized Care Plan (ICP) is made available to PCP to provide feedback on
- Use appropriate designated ancillary services
- Comply with emergency care procedures
- Comply with West Virginia Senior Advantage access and availability standards as outlined in this manual, including after-hours care
- Submit claims to West Virginia Senior Advantage on the CMS-1500 claim form or electronically in accordance with West Virginia Senior Advantage billing procedures
- Ensure that, when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to WVSA's medical record standards as outlined in this manual

The Role of the Nurse Practitioner (NP)

The WVSA Nurse Practitioner in collaboration and consultation with PCP, physicians, staff RNs, and other health care professionals, provides holistic, compassionate care to members and families and provides care coordination and care management activities on behalf of WVSA.

The WVSA NP practices within the context of collaborative management with a physician(s) in diagnosing, managing, and preventing acute and chronic illness and disease, and promoting wellness.

The NP's role includes:

- On-site primary care support
- Assessment, care planning, and communication
- Medication review and monitoring
- Early identification and treatment of symptoms

NPs offer:

- Coordinated care and more personal attention
- One point of contact for communication with the member, their caregiver/family, the doctors, and nursing staff
- Clinician visits based on need
- Ongoing visits to help avoid unnecessary and unwanted trips to the hospital
- Completion of tests and treatments in the nursing home that are normally done in the hospital

The WVSA NP will function as an in-the-field clinician and provide protocol driven primary care medicine. Upon member enrollment into the plan, the WVSA NP will conduct a face-to-face HRA, develop a plan of care with interventions based on the member's acuity at that point in time, and direct the Interdisciplinary Care Team (ICT). The WVSA NP, supported by the PCP and ICT, will actively monitor the member's condition and proactively treat chronic conditions.

The WVSA NP will work with the member to assure that the member has access to the following services as needed:

- Range of Choices - The WVSA NP will be instrumental in ensuring access to a range of choices for members by helping the member identify formal as well as informal supports and services and ensuring that the services are culturally appropriate as well as accessible. Interpreter services, if needed, will be available for all enrolled members.
- Coordination with the PCP and Specialists - The WVSA NP supported by the RN will work with the member and PCP in accessing appropriate specialty care. The WVSA NP also will facilitate periodic preventive care and alert the PCP to changes in the member's health status or concerns as appropriate. The WVSA NP will facilitate communication and collaboration between primary care, specialists, and mental health/substance abuse in support of a comprehensive and unified individualized care plan.
- Assessment for Understanding of Treatment Plan and Medications - The WVSA NP supported by the RN will assess the member's ability to understand their medications and ability to follow their prescribed plan. If issues are identified, the WVSA NP/RN will assess the barrier and facilitate care and communication.
- Identification of Special Needs and Referrals to Specialists - The WVSA NP supported by the RN will help the member identify medical issues and functional problems such as poly-pharmacy issues, lack of social supports and high-risk health conditions, and assist the member in obtaining necessary services to meet identified needs.
- Coordination of Transitions between Care Settings - The WVSA NP supported by the RN will be an integral connection when the member moves from one care setting to another. This function will be essential to providing a smooth and safe transition.

The Role of the Specialist Physician

Each West Virginia Senior Advantage member is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. Specialists are required to coordinate the referral process (i.e., obtain authorizations) for the further care they recommend. This responsibility does not revert to the Primary Care Physician while the care of the member is under the direction of the Specialist.

The Specialist Physician is responsible for managing all the health care needs of a WVSA member as follows:

- Provide specialty health care services to members as needed
- Collaborate with the member's WVSA PCP to enhance continuity of health care and appropriate treatment
- Provide consultative and follow-up reports to the referring physician in a timely manner
- Comply with access and availability standards as outlined in this manual including after-hours care
- Comply with WVSA's prior authorization and referral process
- Comply with WVSA's Quality Management and Utilization Management programs
- Submit claims to WVSA or delegated vendor on the CMS-1500 claim form or electronically in accordance with WVSA's billing procedures

- Ensure that when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member’s condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Coordinate additional referral needs with the member’s WVSA NP or PCP
- Submit encounter information to WVSA accurately and timely
- Adhere to WVSA’s medical record standards as outlined in this manual

Administrative, Medical, and/or Reimbursement Policy Changes

From time to time, West Virginia Senior Advantage may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services.

West Virginia Senior Advantage will communicate changes to the provider through the use of a variety of methods including, but not limited to:

- Annual Provider Manual Updates
- Letter
- Facsimile
- Email

Providers are responsible for the review and inclusion of policy updates in the Provider Manual and for complying with these changes upon receipt of these notices.

Communication Amongst Providers

- The PCP or WVSA NP must provide the Specialist Physician with relevant clinical information regarding the member’s care.
- The Specialist Physician must provide the PCP or WVSA NP with information about his/her visit with the member in a timely manner.
- The PCP or WVSA NP must document in the member’s medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Provider Marketing Guidelines

The information below is a general guide to assist WVSA providers, who have contracted with multiple Medicare Advantage plans and are accepting Medicare fee-for-service patients, to understand which marketing and patient outreach activities are permissible under the CMS guidelines. Providers may not steer or attempt to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by a WVSA sponsor or by another sponsor, based on the financial interest of the provider or agent. Providers must remain neutral in assisting plans to market to potential members or assisting in enrollment decisions.

Providers may (from Medicare Communications and Marketing Guidelines, MCMG):

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>) including in areas where care is delivered.
- Provide the names of plans/Part D sponsors with which they contract and/or participate.

- 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 <https://www.medicare.gov>, or 1 (800) MEDICARE.
- Refer patients to plan marketing materials available in common areas.
- Provide information and assistance in applying for the Low-Income Subsidy (LIS).
- Make available, distribute, and display communication materials, including in areas where care is being delivered.
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).
- Announce new or continuing affiliations with specific plans once a contractual agreement has been approved.

Providers may not:

- Accept/collect Scope of Appointment (SOA) forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of plans/Part D 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.
- Accept compensation from the plan for any marketing or enrollment activities.

Member Assignment to New PCP

CMS allows for a limited set of circumstances under which a provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits
- Disruptive, unruly, threatening, or uncooperative behavior not caused by a physical or mental health condition, but which seriously impairs WVSA's or the provider's ability to provide services to the member
- Threats of physical harm to a provider and/or his or her office staff
- Nonpayment of required copayment for services rendered after multiple collection attempts
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary, rising to the level of fraud, waste, or abuse
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan

The provider is expected to make reasonable efforts to address the member's unacceptable behavior through education and counseling and, if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied and the provider feels the relationship has been irreparably harmed, the provider should contact West Virginia Senior Advantage. WVSA will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, WVSA will document all actions taken by the provider and WVSA to cure the situation. This may include member education and counseling. A WVSA PCP cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member may request a change in PCP for any reason. The PCP change that is requested by the member will be effective the first of the month following receipt of the request, unless circumstances require an immediate change.

Provider Participation

Providers must be contracted with and credentialed by West Virginia Senior Advantage or the entity under contract to perform credentialing services. WVSA's credentialing program is compliant with all CMS guidelines and state regulations, as applicable. WVSA is ultimately responsible for all services provided by contracted entities, terms of the contract, and fulfillment of all terms and conditions of its contract. WVSA may agree to delegate credentialing to a provider organization so long as a Delegation Agreement is signed by both parties, and a pre-delegation audit is conducted and found to be satisfactory, with ongoing annual audits being conducted for the duration of the Agreement.

Provider Directory

To be included in provider directories or any other member information, providers must be fully credentialed and contracted. Directory specialty designations must be commensurate with the licensure, education, training, board certification and specialty(ies) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by the credentialing and recredentialing process of West Virginia Senior Advantage.

Plan Notification Requirements for Providers

Participating providers must give West Virginia Senior Advantage adequate notice of changes to provider practice following the terms of their participating agreement with the WVSA health plan.

The following is a list of changes that must be reported to West Virginia Senior Advantage by contacting your Provider Services representative:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name

- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations
- Change of ownership

Updating information in a timely fashion ensures that the practice is listed accurately in the Provider Directory and that claims adjudicate correctly and promptly.

Closing Patient Panels

When a Participating Primary Care Physician elects to stop accepting new patients, the provider's patient panel is considered closed. If a PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against WVSA members by closing their patient panels for WVSA members only, nor may they discriminate among WVSA members by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify WVSA in writing.

Access and Availability Standards for Providers

West Virginia Senior Advantage has established written standards to ensure timeliness of access to care that meet or exceed the standards established by CMS, to ensure that all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. West Virginia Senior Advantage requires that all providers offer standard hours of operation that do not discriminate against Medicare enrollees and are convenient for West Virginia Senior Advantage members, and facility staff who aid in member care.

Timeliness of Access to Care

West Virginia Senior Advantage members have access to care 24 hours a day, seven days a week, as medically necessary. It is the expectation of WVSA that Providers follow the Model of Care to ensure members have timely access to routine, preventive, and urgent care services.

Primary Care Physicians are required to provide:

- Routine, preventive care, and monitoring visits for their assigned members at the member's nursing facility at least every 30 days for the first 90 days the member resides in the facility, and every 90 days thereafter
- Routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (seven days) on-site at member's nursing facility residence
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner

- 24 hours a day, seven days a week, telephonic access for medically necessary member care, with approved and contracted physician call coverage during time off, with immediate response to emergency care calls, 30-minute response to weekday and after-hours urgent care calls, and end-of-day return or routine care calls. It is not permissible to pre-record directions for members to utilize the Emergency Department for after-hours needs.

Specialists are required to be available for a consult or new patient appointment within 21 days of initial request and to be immediately available to Primary Care Physicians for an urgent or emergent consult regarding a member.

Telephone access (applicable to all contracted providers regarding calls from members, members' caregivers, WVSA Nurse Practitioners, the WVSA physician and Utilization Management staff, and nursing home facility staff):

- Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately.
- Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
- Routine care calls, both weekdays and after-hours calls, will be returned by the end of the day or the following morning.
- All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

Monitoring of Network Access

West Virginia Senior Advantage will use valid methodology and data sources to continually collect and perform analysis of provider data to measure performance against WVSA's written standards and against CMS requirements. In addition to regularly scheduled performance measurement, WVSA will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access to care are collected through the WVSA Member Services line or through submissions to the Quality Improvement Committee. Complaints related to access to care are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Practitioners or sites identified for access improvement opportunities will be contacted in a timely manner regarding survey or measurement results, and follow-up inquiries and measurements may be scheduled.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Provider Rights and Responsibilities

Provider Rights

West Virginia Senior Advantage encourages provider feedback and suggestions on how service may be improved within the organization.

If a contracted provider feels he/she has not been paid according to policy, he/she may dispute the payment.

Provider Responsibilities

- All Primary Care Physicians must provide continuous 24 hours, seven days a week, access to care for WVSA members. During periods of unavailability or absence from the practice, providers must arrange coverage for their WVSA members and notify WVSA of the physician who is providing coverage for their practice.
- All providers are required to code to the highest level of specificity necessary to fully describe a member's acuity level. All coding must be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- Each provider has agreed to treat WVSA members with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Providers are required to provide services that do not discriminate against any patient in any manner including, but not limited to, source of payment, race, ethnicity, national origin, sex, sexual orientation, gender identity, age, religion, place of residence, health status, mental or physical disability, medical history, evidence of insurability, or genetic information.
- West Virginia Senior Advantage expects PCP visits to be provided onsite at the member's nursing facility and urges specialists to provide member visits in the member's nursing facility for members' safety and comfort issues. Approval prior to referring outside of the contracted network of providers may be required.
 - Each provider has agreed to follow WVSA's policies and procedures including, but not limited to, Utilization Management, Case Management, and Quality Management processes.
 - A provider may not balance bill a member for providing services that are covered by WVSA. This excludes the collection of standard copays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.
 - Providers may not charge the Medicare cost share to dually-eligible members (members with both Medicare and Medicaid) for covered Part A, B, or D services.

Provider Contracting

For information on becoming a West Virginia Senior Advantage contracted provider, contact Network Operations at wvsa.provider.network@chs-corp.com.

Terminating Participation from the Provider Network

A 90-day notification is required if a provider wishes to terminate his or her participation in the West Virginia Senior Advantage provider network or WVSA terminates a provider for reasons other than cause. Please refer to your contract for specific termination requirements.

Termination of a Provider Contract with Cause

If West Virginia Senior Advantage suspends or terminates an agreement, WVSA must give the affected provider written notice of the following:

- Reason for the action
- Standards and data used to evaluate the health care professional, when applicable
- Mix of health care professionals the organization needs, when applicable

Affected health care professionals have the right to appeal the action and request a hearing. The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional.

If WVSA suspends or terminates a contract with a health care professional due to deficiencies in the quality of care, WVSA must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should send a written notification to West Virginia Senior Advantage at wvsa.provider.network@chs-corp.com. Upon receipt of the termination request, WVSA will send notification of the termination to all affected members at least 30 calendar days before the effective date of termination and will assist members to select alternative providers, as applicable.

Credentialing and Recredentialing Process

The Credentialing Program ensures that the West Virginia Senior Advantage network consists of quality providers who meet clearly-defined criteria and standards. The credentialing policy and procedure can be requested by contacting your Provider Services representative.

The decision to approve or deny credentialing is based upon primary source verification, secondary source verification, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law. The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised and updated as needed.

While specific to each practitioner type, facility, or ancillary provider, the credentialing process validates licensure, clinical privileges, malpractice insurance, and Medicare participation, and screens for Office of Inspector General (OIG) and other applicable exclusions, licensure restrictions or recent actions, and other regulatory or business requirements.

Once a complete application is received and processed, a recommendation to approve, deny, or pend for additional information will be forwarded to the Credentialing Committee, along with the applicable information from the file to support the recommendation. The Credentialing Committee will review the information and recommendations from the Credentialing Department and render a determination. A decision letter will be mailed to the provider within 30 days of the determination decision. The credentialing process generally takes up to 90 days to complete but in some instances may take longer.

To maintain participating status, all practitioners are required to recredential at least every three years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information four months in advance of their three-year anniversary date. Three good faith attempts will be made to obtain the required information via mail, email, or telephonic request.

If no response is received, the Credentialing Department will submit a notice to the provider that failure to apply for recredentialing is interpreted as voluntarily relinquishing credentialed status, and the provider will be terminated in accordance with contractual requirements.

Application Process

Individual practitioners:

- If participating in Council for Affordable Quality Healthcare (CAQH), complete and return the Provider Profile Sheet
- If not participating in CAQH, complete and return the Provider Profile Sheet and the full Provider Credentialing Application

Facility or ancillary providers:

- Complete and return the Provider Profile Sheet and the full Ancillary/Facility Credentialing Application

Practitioner Rights in Credentialing

Right to be Informed of Your Credentialing Application Status Upon Request: Upon receipt of a written request, West Virginia Senior Advantage will provide written information to the applicant of the status of the credentialing application within 15 business days. West Virginia Senior Advantage will advise the provider of any items still needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared to information provided by the applicant.

Right to Review Information Submitted to Support Your Credentialing Application: The applicant may review any documentation he or she submitted in support of the application, together with any discrepant information received from a professional liability insurance carrier, state licensing agencies, and certification boards.

Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame: If discrepancies are found between information submitted by the applicant and information

obtained by WVSA during the primary source verification process, WVSA will notify the applicant. The applicant may submit corrections for the discrepant information or provide a written explanation within 30 calendar days of the request.

Credentialing Committee/Peer Review Process

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or reapproval as a participating provider. Providers who meet all of the acceptance criteria may be approved by the plan physician. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and recredentialed process must be obtained and verified within 160 days prior to presentation to the plan physician or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discriminatory Credentialing

West Virginia Senior Advantage's Credentialing Program is compliant with all CMS and State regulations, as applicable. Through the universal application of specific assessment criteria, WVSA ensures fair and impartial decision-making in the credentialing process. No provider shall be denied participation based solely on race, gender, age, religion, creed, ethnic origin, sexual orientation, type of population served, or for specializing in certain types of procedures.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers may not render services to West Virginia Senior Advantage members until the notification of successful credentialing is received except in the case of urgently needed care or emergency care and treatment, or unless prior authorization has been obtained. Applicants who are denied by the Credentialing Committee will be notified via letter within 30 days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Credentialing and Participation Appeals Process and Notification of Authorities

Practitioners who receive an adverse participation decision receive written notification of the reasons for the decision, and appeal rights will be included with the determination letter.

Credentialed providers who receive a corrective action plan or admonition receive written notification of the reasons for the decision, including appeal rights. For decisions to recommend limitation or loss of privileges, the notification will include the reasons for the action, outline the appeals process or options available to the provider, and provide the time limits for submitting an appeal. Such recommendations are placed in the provider's credentialing file and may be reported to the applicable state oversight agency and National Practitioner Data Bank (NPDB) if they involve continuing medical education, proctoring, a written admonition, relicensing or accreditation efforts, or other applicable activity. If the Peer Review or Credentialing Committee learns that a

provider has experienced termination or suspension of privileges, West Virginia Senior Advantage will notify the appropriate state and federal authorities, including the NPDB.

Confidentiality of Credentialing Information

Information and documentation obtained in the credentialing process is confidential. Only employees of West Virginia Senior Advantage or persons with authority to act in the committee peer review/approval process, or agents of WWSA performing in a legal capacity of reviewers of the plan, or agents of accreditation, federal or state regulatory agencies, acting in the capacity of reviewers of WWSA, or others as provided by law may have access to credentialing files.

Ongoing Monitoring

West Virginia Senior Advantage Credentialing Department performs ongoing review of licensure and OIG-sanctioned websites on a regular monthly or quarterly basis, as applicable.

Participating providers who are identified as having been sanctioned are subject to review by the WWSA physician or the Credentialing Committee who may elect to limit, restrict, or terminate participation. Any provider whose license has been revoked or has been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health-related program or who has opted out of Medicare will be automatically terminated from the WWSA provider network.

Provider Directory

To be included in the Provider Directory or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the education, training, board certification, and specialty(ies) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by the Credentialing and Recredentialing Process of the plan.

CLAIMS

Claims Submission

West Virginia Senior Advantage encourages providers to submit claims electronically via a clearinghouse and to check the status of claims electronically. Paper claims are also accepted; however, electronic claims are highly encouraged to promote more accurate, efficient, and secure processing and payment of claims.

EDI PAYER ID NUMBER: 70023

CLEARINGHOUSE: SSI Claimsnet

Paper claims may be sent to:

West Virginia Senior Advantage Claims Department
PO Box 3398
Little Rock, AR 72202

Timely Filing

Clean claims for reimbursement must be filed no later than:

- 1) 90 days from the date of service, or,
- 2) the time specified in your participation agreement, or,
- 3) the time frame specified in the state guidelines, whichever is greater.

If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) that are denied for untimely filing cannot be billed to a member.

Claim Format Standards

Standard CMS-required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals at this link:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912>

West Virginia Senior Advantage can only pay claims which are submitted accurately and completely. The provider is, at all times, responsible for accurate claims submission. While WVSA will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties, may bill and be paid without regard to their membership in the same group.

Corrected Claims

A corrected claim is used to update a previously processed claim with new or additional information. A corrected claim is member and claim specific and should only be submitted if the original claim information was incomplete or inaccurate. A corrected claim does not constitute an appeal. Corrected claims may be sent electronically or on paper and must be received within 365 days from the date of the original determination.

To submit a corrected claim, the appropriate resubmission code or type of bill must be used per CMS guidelines. Frequency codes for CMS-1500 Form, box 22 (Resubmission Code), or UB-04 Form, box 4, (Type of Bill), should contain a 7 to replace the frequency billing code (corrected or replacement claim), or an 8 (Void Billing Code). All corrected claim submissions should contain the original claim number. Electronic replacement claims submitted with claim frequency code 7

or 8 with the original claim number must be submitted in Loop 2300 REF02-Payer Claim Control Number with qualifier F8 in REF01. See the table below for frequency code details.

FREQUENCY CODE	DESCRIPTION
5 - Late Charge(s) (Institutional Providers Only)	Use to submit additional charges for the same date(s) of service on a previous claim.
7 - Replacement of Prior Claim	Use when replacing the entire claim (all but identity information).
8 - Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."

Claim Payment

West Virginia Senior Advantage pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety may include lack of data fields required by WVSA or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for nonparticipating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of WVSA, the claim is not considered clean.

Pricing

Original Medicare typically has market adjusted prices by code (i.e., CPT or HCPCS) for services that traditional Medicare covers. However, there are occasions where West Virginia Senior Advantage offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, WVSA will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. WVSA requests that providers make every effort to submit claims with standard coding. As described in this Manual and/or the Provider Agreement, providers retain their rights to submit a Request for Reconsideration if they feel the reimbursement is incorrect.

West Virginia Senior Advantage will apply correct coding edits, Multiple Procedure Payment Reductions (MPPRs) as outlined by CMS in the Relative Value Units (RVU) table. WVSA will also follow guidelines put forth by the AMA CPT, and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing

applied by WVSA is subject to grievance, appeals, and clinical review policies and procedures outlined in this manual.

New or Non-Listed Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when new codes are developed/added for new and newly-approved services or procedures or if existing codes are changed.

West Virginia Senior Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, WVSA shall make every effort to load the new code with approved pricing set at 100% of the current published Medicare rates, subject to all applicable copayments, deductibles, and cost-sharing amounts, as quickly as possible.

In the event a provider submits a code and the West Virginia Senior Advantage claims system does not recognize it as a payable code, or does not have a contracted allowance, the following process will occur:

1. West Virginia Senior Advantage will maintain the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. This would include, but is not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS;
2. Provider may then appeal the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and,
3. West Virginia Senior Advantage shall pay for any such services that include proof of payment by Original Medicare within the past six months at the applicable Medicare rates or according to their participating provider contract less all applicable copayments, deductibles, and cost-sharing.

Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re-adjudication process.

All codes/services submitted for payment and not recognized by the claims system shall be subject to verification of medical necessity. Providers must contact WVSA to verify if any procedure or service code requires prior authorization and detailed coverage information.

Claims Encounter Data

Providers who are being paid under capitation must submit claims within the same timely filing limit required for fee-for-service or non-capitated claims to capture encounter data as required per your West Virginia Senior Advantage Provider Agreement. In addition to submitting a claim to the Medicare Advantage plan (WVSA), Medicare requires an encounter submission to the “fee for service” A/B MAC (A) to subtract benefit days from the Common Working File (CWF) records.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by West Virginia Senior Advantage. The statement provides a detailed description of how the claim was processed.

Nonpayment/Claim Denial

Any denials of coverage or nonpayment for services by West Virginia Senior Advantage will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line, if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the member may or may not be billed for services denied by WVSA. The member may not be billed for a covered service when the provider has not followed WVSA's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the member, or the services are not covered, the EOP/RA will alert the provider and the provider may bill the member.

Verifying procedure or service code coverage information and/or prior authorization requirements with WVSA will reduce denials and the need for post service clinical review with possible denials.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice AND the premium West Virginia Senior Advantage receives from CMS is adjusted to hospice status, the financial responsibility for that member shifts from West Virginia Senior Advantage to Original Medicare. While these two conditions exist, Original Medicare covers all Medicare-covered services rendered. The only services WVSA is financially responsible for during this time include any benefits WVSA offers above Original Medicare benefits that are non-hospice-related, non-Medicare covered services such as vision (eyewear allowable), prescription drug claims, medical visit transportation, etc.

Until both conditions listed above have been met, West Virginia Senior Advantage remains financially responsible for the member. Example: If a member is certified hospice on the 8th of the month, WVSA continues to be financially responsible for that member until the end of that month. The financial responsibility shifts to Original Medicare on the 1st day of the following month; the date the CMS premium to WVSA has been adjusted to hospice status for that member. These rules apply for both professional and facility charges.

For additional details on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 —Special Rules for Hospice Care, Section C, which outlines the Medicare payment rules for members who have elected hospice coverage. The following references outline payment responsibility and billing requirements for services rendered during a hospice election period: Medicare Benefit Policy Manual, Publication 100-02—Chapter 9, Coverage of Hospice Service, Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication Chapter 4, Benefits and Beneficiary Protections, Section 10.2.2 Exceptions to Requirement for MA plan to Cover FFS Benefits and Section 10.4 Hospice Coverage; and the CMS Change Request 8727 dated May 1, 2014. This documentation is available on the CMS website: <https://www.cms.gov>

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding 100% of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

Order of Benefit Determination Rule: Rules which, when applied to a particular member covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that member. A plan will be determined to have primary or secondary responsibility for a person's coverage with respect to other Plans by applying the NAIC rules.

Primary: The carrier responsible for costs of services provided up to the benefit limit for the coverage or as if no other coverage exists.

Secondary: The carrier responsible for the total allowable charges, up to the benefit limit for the coverage, less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary for health care services provided as well as covered by the member's health care plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and which plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Basic NAIC Rules for Coordination of Benefits (COB)

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both members have the same date of birth, the plan which covered the member the longest is considered primary.

General Rules: The following are general rules to follow to determine a primary carrier:

If the Member/ Beneficiary....	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family member's current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	GHP pays primary	West Virginia Senior Advantage/Medicare pays secondary
Is age 65 or older, and is covered by a GHP through current employment or a family member's current employment	The employer has less than 20 employees	West Virginia Senior Advantage/Medicare pays primary	GHP pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family member's current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	LGHP pays primary	West Virginia Senior Advantage/Medicare pays secondary
Is entitled based on disability and is Covered by a LGHP through his/her current employment or through a family member's current employment	The employer employs less than 100 employees	West Virginia Senior Advantage/Medicare pays primary	LGHP pays secondary
Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	West Virginia Senior Advantage/Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	West Virginia Senior Advantage/Medicare pays primary	COBRA pays secondary

Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block one above	GHP pays primary for the first 30 months	West Virginia Senior Advantage/Medicare pays secondary (after 30 months)
If the Member/ Beneficiary....	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
			West Virginia Senior Advantage pays primary
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement insurance pays primary for the first 30 months	West Virginia Senior Advantage/Medicare pays secondary (after 30 months) West Virginia Senior Advantage pays primary
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the member drops the COBRA coverage)	West Virginia Senior Advantage Medicare pays secondary (after 30 months) West Virginia Senior Advantage pays primary
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	LGHP pays primary	West Virginia Senior Advantage/Medicare pays secondary (after 30 months) West Virginia Senior Advantage pays primary
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the member drops the COBRA coverage)	West Virginia Senior Advantage/Medicare pays secondary (after 30 months) West Virginia Senior Advantage pays primary

Best Processing Guidelines for Coordination of Benefits (COB)

For West Virginia Senior Advantage to be responsible as either the primary or secondary carrier, the member must follow all HMO rules (i.e., pay co-pays and follow appropriate referral process).

When West Virginia Senior Advantage is the secondary insurance carrier:

- All West Virginia Senior Advantage guidelines must be met in order to reimburse the provider (i.e., precertification, referral forms, etc.).
- The provider collects only the copayments required.
- Be sure to have the member sign the “assignment of benefits” sections of the claim form.
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of West Virginia Senior Advantage for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form.

When West Virginia Senior Advantage is the primary insurance carrier:

- The provider collects the copayment required under the member’s West Virginia Senior Advantage Plan.
- Submit the claim to West Virginia Senior Advantage first.
- Be sure to have the member sign the “assignment of benefits” sections of the claim form.
- Once payment and/or remittance advice (RA) has been received from West Virginia Senior Advantage, submit a copy of the claim with the RA to the secondary carrier for adjudication.

Please note that West Virginia Senior Advantage is a total replacement for Medicare. Medicare cannot be secondary when members have West Virginia Senior Advantage.

Worker’s Compensation

West Virginia Senior Advantage does not cover worker’s compensation claims. When a provider identifies medical treatment as related to an on-the-job illness or injury, WVSA must be notified. The provider will bill the worker’s compensation carrier for all services rendered, not WVSA.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e., property and casualty insurer, automobile insurer, or worker’s compensation carrier), not two health insurers.

Claims involving subrogation or third-party recovery (TPR) will be processed internally by the West Virginia Senior Advantage Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to West Virginia Senior Advantage with any information regarding the third-party carrier. All claims will be processed per the usual claim procedures.

For claims related questions, please call (866) 225-8501.

Appeals

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also “partial” ones). Your appeal will receive an independent review (made by someone not involved in the initial decision).

Requesting an appeal does not guarantee that your request will be approved, or your claim paid. The appeal decision may still be to uphold the original decision.

An appeal must be submitted to the fax or address listed below within 60 days, unless otherwise specified, from the original decision or the time frame specified in your contract of the receipt of the decision. You must include with your appeal request a copy of your denial, any medical records that would support why the service is needed, and if for a hospital stay, a copy of the insurance verification done at time of admission.

West Virginia Senior Advantage Appeals and Grievances Dept.
c/o CommuniCare Advantage
10123 Alliance Road, Suite 240
Blue Ash, OH 45242

Phone: (866) 250-6352, TTY/TDD 711

BEHAVIORAL HEALTH

West Virginia Senior Advantage provides comprehensive mental health and substance abuse services to its members. Its goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality.

West Virginia Senior Advantage's priority is ensuring that members' behavioral health needs are met. WVSA NPs utilize a holistic clinical approach to identify and address behavioral health needs. Members who warrant behavioral health intervention are provided appropriate education, care coordination, and support to increase member knowledge and encourage compliance with treatment and medications.

WVSA collaborates with providers to deliver quality behavioral health services and encourages ongoing exchange of information among physical and behavioral health providers to achieve desired behavioral health outcomes.

Referrals for behavioral health services are not required, and members can self-refer for evaluation. Treatment plan recommendations should be communicated to the primary care physician and WVSA NP and will be evaluated for medical necessity. Ongoing behavioral health services require a review of the updated member status and treatment recommendations by the PCP or WVSA NP.

Behavioral Health Services

Behavioral health services are available and provided for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care. Services include but are not limited to:

- Access to West Virginia Senior Advantage’s Member Services Department for orientation and guidance
- Routine outpatient services to include psychiatrist, addictionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice.
- Initial evaluation and assessment
- Individual and group therapy
- Psychological testing according to established guidelines and needs
- Inpatient hospitalization
- Inpatient and outpatient detoxification treatment
- Medication management
- Partial hospitalization programs

Responsibilities of Behavioral Health Providers

West Virginia Senior Advantage encourages behavioral health providers to become part of its network. Their responsibilities include but are not limited to:

- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the member

Responsibilities of the Primary Care Physician

The PCP can participate in the identification and treatment of their member’s behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be members with comorbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but requiring treatment
- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other physical and behavioral health providers on a regular basis

Access to Care

Members may access behavioral health services as needed:

- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP scope of practice. They may request a referral to a behavioral health practitioner. Referrals, however, are not required to receive most in-network mental health or substance abuse services.

- Members and providers may call Customer Service at (866) 250-6352, TTY/TDD 711, to receive orientation on how to access behavioral health services, provider information, and prior authorizations.

Medical Record Documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-5-TR™ multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with day of treatment, the development of a treatment plan, and discharge plan as applicable for each member in treatment.

Additionally, case managers will document mental health in the health risk assessment and update the ICT on behavioral health providers' input or recommendations to ensure integrated care planning and management.

UTILIZATION MANAGEMENT

West Virginia Senior Advantage's Utilization Management Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the members.

WVSA's UM staff base their utilization-related decisions on the clinical needs of members, the member's benefit plan, InterQual Guidelines, the appropriateness of care, Medicare national coverage guidelines, CMS guidance, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other such relevant information.

WVSA in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care
- To monitor utilization practice patterns of West Virginia Senior Advantage's contracting physicians, contracting hospitals, contracting ancillary services, and contracting specialty providers
- To provide a system to identify high-risk members and ensure that appropriate care is accessed
- To provide utilization management data for use in the process of recredentialing providers
- To educate members, physicians, contracted hospitals, ancillary services, and specialty providers about West Virginia Senior Advantage's goals for providing quality, value-enhanced managed health care

- To improve utilization of West Virginia Senior Advantage’s resources by identifying patterns of over- and under-utilization that have opportunities for improvement

Departmental Functions

- Prior Authorization
- Decisions and Time Frames
- Notification
- Referral Process
- Referral Guidelines
- Retrospective Review
- Concurrent Review

Prior Authorization

The PCP, WVSA NP, or specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a member for an elective admission, and outpatient service. West Virginia Senior Advantage recommends requesting prior authorization at least seven days in advance of the admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity.

Services requiring prior authorization are listed on the Request for Prior Authorization Form that is on WVSA’s website at <https://www.wvsenioradvantage.com/providers-partners/>. Providers may fax the requests to the number on the form, (866) 439-0065, or submit them via the provider portal by going to <https://www.wvsenioradvantage.com/>.

The Utilization Management Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization utilizing CMS guidelines as well as nationally-accepted criteria. They process the authorization determination and notify the provider of the determination.

Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- Primary Care Physician name
- Servicing/Attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service to be rendered

For members who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP or NP, unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a member appears at an emergency room for care which is non-emergent, the PCP or NP should be contacted for directions. The member may be financially responsible for payment if the care rendered is non-emergent. West Virginia Senior Advantage also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment.

Decisions and Time Frames

Emergency: Authorization is not required but notification is required.

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

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

Expedited: An expedited authorization request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within 72 hours or as soon as the member's health requires.

Routine: If all information is submitted at the time of the request, CMS mandates a health plan determination within seven calendar days.

Once the Utilization Management Department receives the request for authorization, they will review the request using nationally-recognized industry standards or local coverage determination criteria. They will assign an authorization number and enter the information in the plan's medical management system. This authorization number can be used to reference the admission, service, or procedure.

The requesting provider is responsible for notifying the member of the decision of approval or denial and of documenting the communication in the medical record.

Notification

Facilities are responsible for Admission Notification for the following inpatient admissions. WVSA needs admission notification, even if advance/prior notification was provided by the physician or facility, and pre-service coverage approval is on file:

- Planned/elective admissions for acute care
- Acute inpatient rehabilitation
- Long-term acute care
- Unplanned admissions for acute care
- Admissions following outpatient surgery
- Admissions following observation

For weekday admissions, providers must notify West Virginia Senior Advantage within 24 hours, unless otherwise indicated. Weekend and holiday admissions, providers must notify WVSA by 5 p.m. EST on the next business day.

For emergency admissions (when a member is unstable and not capable of providing coverage information):

- Providers must notify WVSA by phone or fax within 24 hours, or the next business day if on a weekend/holiday, from the time coverage information is known.
- Notify WVSA about the extenuating circumstances.
- Payment is not reduced due to notification delay in an emergency.
- Receipt of an admission notification does not ensure payment. Payment for covered services depends on the member's benefits, facility's contract, claim processing requirements, and eligibility for payment.
- Providers must include these details in the admission notification:
 - Member name, health care ID number, and date of birth
 - Facility name and TIN or NPI
 - Admitting/attending physician name and TIN or NPI
 - Description for admitting diagnosis or ICD-10-CM diagnosis code
 - Actual admission date
 - Extenuating circumstances, if an emergency admission

All skilled nursing facility admissions for members must be authorized by the NP. Claims may be denied if authorizations are not coordinated through WVSA.

Referral Process

The Primary Care Physician (PCP) or NP is the member's primary point of entry into the health care delivery system for all outpatient specialist care.

The PCP is expected to work collaboratively with specialists to provide the best possible care for West Virginia Senior Advantage members. The specialist is expected to partner/consult with the member's PCP prior to scheduling a visit (except urgent/emergent visits). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment, and the need for any ongoing care.

PCPs have a very important role in directing WVSA members to the appropriate specialists based on their knowledge of the patients' condition and health history. It is essential that members are directed to participating providers only. To ensure this, refer to our online directory or contact the Provider Services Department for assistance.

Referral Guidelines

- PCPs must refer only to West Virginia Senior Advantage participating specialists for outpatient visits.
- Nonparticipating specialist's visits require prior authorization.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines/criteria to support the claim adjudication process after the opportunity for prior authorization or concurrent review time frame has passed. After confirming the member's eligibility and the availability of benefits at the time the service was rendered, providers should submit all supporting clinical documentation with the request for review and subsequent reimbursement to fax (866) 439-0065.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission or SNF or other inpatient admission to ensure:

- Covered services are being provided at the appropriate level of care
- Services are being administered according to the individual facility contract

Emergent or urgent admission notification must be received within 24 hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the member's condition is unstable and the facility is unable to determine coverage information, West Virginia Senior Advantage requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

West Virginia Senior Advantage's Utilization Management Department complies with individual facility contract requirements for concurrent review decisions and time frames. WVSA's nurses will conduct medical necessity review. WVSA is responsible for final authorization.

WVSA's preferred method for concurrent review is to have the facility fax over clinicals within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information WVSA has available. Facilities may fax the member's clinical information within 24 hours of notification to (866) 439-0065.

Review is not required for readmission to the referring SNF (the member's primary nursing facility); however, if the patient is transitioning to an alternate or out-of-network SNF, reviews should be faxed to (866) 439-0065. For these SNF admission requests, a recent Physical Medicine and Rehabilitation (PM&R) or physical, occupational and/or speech therapy consult is requested along with the most recent notes for therapy(ies) or recent medical status and expected skilled treatment and service requirements. Following an initial determination, the UM nurse will request additional updates from the facility on a case-by-case basis. WVSA will render a determination within 24 hours of receipt of complete clinical information. The UM nurse will collaborate with the facility's utilization or case management staff and request additional clinical information to provide a favorable determination.

The West Virginia Senior Advantage physician will review all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and will issue a determination. If the WVSA physician deems that the inpatient or SNF confinement does not meet medical necessity criteria, the physician will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), e.g., facility, attending/ordering provider verbally and in writing.

In those instances, where the attending provider does not agree with the determination, the provider is encouraged to contact the West Virginia Senior Advantage physician at um@communicare-advantage.com. Following the peer-to-peer discussion, the WVSA physician will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For members receiving hospital care and for those who transfer to a non-referring SNF or acute inpatient rehabilitation care, West Virginia Senior Advantage will approve the request or issue a denial if the request is not medically necessary. WVSA will also issue a denial if a member who is already receiving care in an acute inpatient rehabilitation facility has been determined to no longer require further treatment at that level of care. This document will include information on the member's or their authorized representative's right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

West Virginia Senior Advantage also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative, or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is requested and expected to fax a copy of the signed NOMNC back to the Utilization Management Department at (813) 472-7429. The NOMNC includes information on members' rights to file a fast-track appeal.

Adverse Determinations (Denials)

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based on contractual terms, benefits, or eligibility, and using all available and applicable information. Only the West Virginia Senior Advantage physician may render a denial based on medical necessity, but the WVSA physician may also make a decision based on administrative guidelines. The WVSA physician may suggest an alternative covered service. WVSA will notify the provider—and the member, when applicable—of a determination to deny or limit an admission, procedure, service, or extension of stay. Documentation will include the original request that was denied and the alternative approved service, along with the process for appeal.

West Virginia Senior Advantage employees are not compensated for denial of services. The PCP or attending physician may contact the WVSA physician to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification, and sent to the provider and/or member, as applicable. Written

notifications are sent in accordance with CMS and NCQA requirements to the provider and/or member as follows:

- For non-urgent pre-service decisions: within seven calendar days of the request
- For urgent pre-service decisions: within 72 hours or three calendar days of the request
- For urgent concurrent decisions: within 24 hours of the request
- For post-service decisions: within 30 calendar days of the request

Discharge Planning/Acute Care Management

Discharge planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. West Virginia Senior Advantage utilizes assigned NPs to coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. All contracted hospitals, nursing homes, rehab hospitals, LTACHs, and other inpatient facilities are obligated to allow NPs access to WVSA members for purposes of case management and utilization management activities.

Continuity of Care

Continuity of care is essential to maintain member stability. As part of the care transition process, the WVSA NP will work with the primary care team to advocate for the member's well-being through transitions across care settings. The NP will collaborate with the interdisciplinary team to ensure that the member receives the highest quality of health care.

West Virginia Senior Advantage recognizes that new members may have already begun treatment with a provider who is not in WVSA's network. Under these circumstances, WVSA will coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

When a practitioner leaves WVSA's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

If the Plan terminates a participating provider, West Virginia Senior Advantage will work to transition a member into care with a participating physician or other provider within WVSA's network. WVSA is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Program Evaluation

West Virginia Senior Advantage continually monitors its Quality Program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the Program are made under two conditions: (1) changes must benefit members, and (2) changes must be in compliance with applicable regulations and guidance. Changes to the Program are accompanied by policy and procedure revisions and staff training as required. The Program operates under the umbrella of

the plan's Quality Improvement Committee, which reports to the Board of Directors. It is reviewed and updated annually in collaboration with the Quality Improvement Department.

Confidentiality

West Virginia Senior Advantage preserves the confidentiality of its members and practitioners. Written policies and procedures are in place to ensure the confidentiality of member information. Patient data gathered during the care management process are available for the purposes of review only and are maintained in a confidential manner. Employees receive confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of their initial company orientation.

Clinical Practice Guidelines and Reference Material

West Virginia Senior Advantage has adopted evidence-based clinical practice guidelines (CPGs), which are nationally recognized guidelines based on available peer-reviewed clinical publications and medical professional societies that support adherence to evidence-based best practices for effective and efficient care. West Virginia Senior Advantage reviews, revises, and approves these guidelines, using nationally recognized, evidence-based literature.

Examples of sources of clinical practice guidelines:

- US Preventive Services Task Force
- STEADI: Stopping Elderly Accidents, Deaths & Injuries
- Center for Disease Control & Prevention Pneumonia Clinical Practice Guidelines
- VA/DoD Clinical Practice Guideline for the Management of Chronic Kidney Disease in Primary Care
- 2022 AHA/ACC/HFSA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines
- Global Strategy for Prevention, Diagnosis, and Management of COPD
- ADA – Standards of Care in Diabetes–2024, Older Adults section
- AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults
- American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- Evidence-Based Guidelines for the Management of High Blood Pressure in Adults

Providers can see West Virginia Senior Advantage's Evidence-Based Medical Guideline at <https://www.wvsenioradvantage.com/providers-partners/>. West Virginia Senior Advantage will review, revise, and approve these guidelines as needed.

This information is provided for general reference and is not intended to address every clinical situation associated with the conditions and diseases addressed by these guidelines. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it when it is appropriate for your eligible patients.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS^(R) (a standardized data set) is developed and maintained by NCQA, an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include measures such as comprehensive diabetes care, adult access to ambulatory and preventive care, controlling high blood pressure, breast cancer screening, and colorectal cancer screening.

Plan-wide HEDIS measures are reported annually and represent a mandated activity for health plans contracting with CMS. Each spring, West Virginia Senior Advantage representatives will be required to collect copies of medical records from practitioner offices to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with West Virginia Senior Advantage's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506]. West Virginia Senior Advantage's HEDIS results are available upon request. Contact the health plan's Quality Improvement Department to request information regarding those results. HEDIS is a registered trademark of NCQA.

Quality Improvement Program Overview

The purpose of the Quality Improvement Program (QIP) at West Virginia Senior Advantage is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that the Plan may fully realize its vision, mission, and commitment to member care. In the implementation of the QIP, WVSA will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver health care services to meet the health needs of its target population. The QIP is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to WVSA's members. In addition, to provide mechanisms that continuously pursue opportunities for improvement and problem resolution.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities

- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes
- Chronic Care Improvement Program (CCIP)
- QI Projects
- Collection and reporting of Healthcare Effectiveness Data and Information Sets (HEDIS^(R))
- Collection and reporting of Structure and Process measures
- Participation and analysis of the Health Outcomes Survey (HOS)
- Participation and analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- Credentialing and recredentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of under- and over-utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and reporting of Part D Medication Management data (Pharmacy Department)

Continuous Quality Improvement Process

The Continuous Quality Improvement (CQI) process will be utilized when an opportunity for improvement is identified through monitoring of either quality of care or quality of service indicators. The steps in the CQI process will be documented, and results and action plans for improvement will be presented to the Quality Improvement Committee (QIC) for review and approval. These steps will include:

- Determination of the relevance of the issue to the population
- Evaluation of baseline measure(s)
- Analysis to identify an opportunity for improvement
- Analysis to identify possible root causes or barriers
- Planning and implementation of actions to eliminate possible root causes or barriers
- Evaluation of performance and effectiveness of the interventions by re-measurement after implementing actions
- Analysis to determine how actions impacted performance
- Continued re-measurement to determine whether improvements are sustained

Proposed action plans will be approved by the QIC allowing the impacted departments to move forward with implementation. After committee review, an improvement action plan such as a quality or process improvement project will be developed and implemented. This improvement action plan will contain a description of necessary corrective actions as well as time frames for implementing the actions and evaluating the outcomes. Specific corrective actions and established time frames for correction will depend on the type of data or process being addressed.

Quality Improvement Projects

West Virginia Senior Advantage will conduct and/or participate in at least one quality improvement project each year. In addition to plan-specific quality improvement projects, West

Virginia Senior Advantage will also consider collaborative quality improvement projects with CMS, through the QIP, and other health plans in a statewide collaborative.

All quality improvement projects will:

- Focus on significant aspects of clinical care and non-clinical services including:
 - Measurement of performance
 - System interventions, including revising practice guidelines
 - Improving performance
 - Systematic and periodic follow-up on the impact of the interventions
- Assess performance under the Plan using quality indicators:
 - Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research
 - Capable of measuring outcomes such as changes in health status, functional status and member satisfaction, or valid proxies of those outcomes
- Include performance assessment on selected indicators based on systematic ongoing collection and analysis of valid and reliable data
- Include interventions which achieve demonstrable improvement
- Allow status and result reports to be reportable to CMS

Quality of Care Issues

Quality of care issues include clinical quality indicators and quality of care complaints. Quality indicators are those issues that are usually identified by the Utilization Management staff and referred to the appropriate department for investigation and then reported to the Quality Improvement Committee. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting that could be indicative of potential inappropriate or incomplete medical care. Quality of care complaints are those concerns reported by members, families, or providers that could indicate a potential problem in the provision of quality care and services.

The purpose of identifying these issues is for tracking concerns related to the provision of clinical care and service, evaluating member satisfaction, and trending specific provider involvement with potential quality of care issues.

Clinical quality indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery (within 48 hours)
- Post-op complications (including unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome)
- Primary care medical record documentation
- Ambulatory follow-up after hospitalization for selected behavioral health diagnosis (HEDIS^(R) results)

Quality complaints are categorized as:

- Access to care

- Availability of services
- Clinical quality concerns
- Provider/staff concerns

All quality of care issues are reviewed and investigated. Quality often requests records from providers and facilities as part of the investigation. Quality of care issues are reviewed by the QIC. Any action taken is documented in the provider's record and reviewed by the Credentialing Committee at the time of recredentialing. Quality of care issues are highly confidential, and outcomes cannot be shared with the member or provider. All quality of care/service issues may be emailed to healthplan-compliance@chs-corp.com.

Utilization Reporting and Monitoring

Risk-based compensation methods may create incentive for West Virginia Senior Advantage providers and practitioners to limit approval of needed care. Over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, and the system as a whole, WVSA monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. WVSA then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions. WVSA also carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. WVSA unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

CORPORATE COMPLIANCE PROGRAM

Overview

The purpose of the West Virginia Senior Advantage Corporate Compliance Program is to articulate a commitment of compliance with pertinent regulatory requirements. It also serves to encourage employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern the operations of WVSA. Furthermore, the West Virginia Senior Advantage Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

West Virginia Senior Advantage and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines the business reputation and credibility of WVSA with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. WVSA and its employees are also committed to meeting all contractual obligations set forth in the WVSA contracts with the CMS. These contracts allow WVSA to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing WVSA's lines of business, including but not limited to, health care fraud, waste, and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote

early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

West Virginia Senior Advantage has policies and procedures for coordinating and cooperating with MEDIC (Medicare Drug Integrity Contractor), CMS, state regulatory agencies, congressional offices, and law enforcement. WVSA also has policies that delineate that WVSA will cooperate with any audits conducted by CMS, MEDIC, law enforcement, or their designees.

Call the Compliance Hotline toll free at (800) 238-1770.

Fraud, Waste, and Abuse

West Virginia Senior Advantage is committed to detecting and preventing fraud and financial waste and abuse.

Therefore, policies and procedures have been developed to ensure compliance with the laws that govern our operations as a healthcare provider. The policies are comprehensive and include requirements for background checks to promote quality of hiring; clinical policies to ensure quality of care; financial policies to ensure accurate billing; billing policies to discourage fraud, waste, and abuse; and conflicts of interest policies to ensure the WVSA patients, residents, and customers receive uncompromised service.

The Federal False Claims Action (FCA), 31 U.S.C. Sections 3729-3733 and similar state laws assist the federal and state government programs, purchases and/or contracts. These laws prohibit the knowing and/or intentional use of false or fraudulent claims, records, or statements for the purpose of obtaining payment from the government. These laws prohibit, among other things, billing for services not rendered; billing for undocumented services; falsifying cost reports, billing for medically necessary services, assigning improper codes to secure reimbursement or higher reimbursement; participating in kickbacks and retaining an overpayment for services or items. A violation of these laws may result in civil, criminal and/or administrative penalties, including monetary penalties, imprisonments, exclusion from participation in Medicare and Medicaid and loss of licensure status.

The evaluation and detection of fraudulent and abusive practices by West Virginia Senior Advantage encompasses all aspects of WVSA business and its business relationship with third parties, including health care providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at (800) 238-1770, TTY/TDD 711. The Compliance Hotline is a completely confidential resource that can be used by employees, contractors, agents, members, or other parties to voice concerns about any issue that may affect WVSA's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By mail at WVSA Compliance Officer, 10123 Alliance Rd., Suite 240, Blue Ash, OH 45242.

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

In addition, West Virginia Senior Advantage conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10, and HCPCS codes billed by our providers. The analysis allows WVSA to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply WVSA's providers with useful information to meet their own compliance needs in this area. WVSA will review your coding and may review medical records of providers who continue to show significant variance from their peers.

To meet your fraud, waste, and abuse obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.