Provider Manual

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I. Introducing American Health Advantage of Tennessee

Welcome to the American Health Advantage of Tennessee HMO Institutional Special Needs Plan (HMO I-SNP) Plan, offered by American Health Plan, Inc., American Health Advantage of Tennessee is a Health Maintenance Organization (HMO) with a Medicare contract. We are pleased to have you as a participating provider. American Health Advantage of Tennessee serves individuals with Medicare Parts A and B that reside in a participating long-term care facility and meets the institutional level of care.

Institutional Special Needs Plan (I-SNP) is a Medicare Advantage (MA) coordinated care plan that enrolls individuals with Medicare Parts A & B, reside or agree to reside in a participating long-term care facility within the approved service area, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility, a LTC nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility for 90 days or longer; and do not have ESRD at the time of enrollment as set forth in §422.4(a)(1) (iv) of the MA regulations and that, beginning January 1, 2006, provides Part D benefits under 42 CFR Part 423. An Institutional SNP is also an MA plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) as meeting the MA I-SNP requirements, as determined based on review of the Model of Care (MOC) using criteria that includes the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and the MOC does not discriminate against sicker individuals of the target population.

Members must reside in the approved American Health Advantage of Tennessee service area. The American Health Advantage of Tennessee service area includes the following counties:

- Anderson, Bedford, Blount, Carroll, Carter, Cheatham, Chester, Crockett, Davidson, Decatur, Dyer, Gibson, Giles, Hamilton, Hancock, Hardin, Hawkins, Haywood, Henderson, Henry, Humphreys, Knox, Lauderdale, Lewis, Loudon, Madison, Marion, Maury, McNairy, Meigs, Monroe, Montgomery, Obion, Rhea, Roane, Rutherford, Shelby, Sullivan, Sumner, Tipton, Washington, Weakley and Wilson.

Model of Care

Our model of care ensures early diagnosis and intervention by the Primary Care Physician (PCP) and/or Advanced Practice Provider, to encourage improved communication between Providers and Members (and family, if desired), and the delivery of the appropriate services. Care coordination is central to our model of care. This approach is centered in the belief that an individualized, closely monitored and highly coordinated level of care can reduce fragmentation, enhance well-being and improve outcomes.

As a result, American Health Advantage of Tennessee's model of care is grounded in the following core principles:

- Advance Practice Providers will orchestrate and provide care for Members residing in a participating long-term care facility, with an emphasis on a Member's psychosocial well-being and maintaining an optimal level of wellness.
- RN Case Managers will orchestrate care for Member through face-to-face visits, the Member's family and care givers, Primary Care Physician and/or Advance Practice Provider, Specialists and other participating Providers when necessary

- Advanced Practice Providers will monitor the complete picture of a Member's physical, social and psychological needs.
- American Health Advantage of Tennessee Providers will have experience or additional education in geriatric medicine, with a specific interest in caring for the frail elderly and disabled.
- The model will minimize Member transfers of care and provide a greater amount of care within the nursing home or other least restrictive setting by bringing Providers to the Member, when possible.
- Advanced Practice Providers will place a strong focus on prevention, working with nursing home staff and other Providers to help ensure regular assessments and early detection.
- Care teams advocate on the Member's behalf and assist with maximizing the benefits available to them
- Families will be encouraged to be more involved in a Member's care, with stronger and more consistent communication among the family, their care team, and nursing home staff.

Each Member has a Primary Care Physician and are also assigned an Advanced Practice Provider who works with the Primary Care Physicians, nursing facilities staff, and families to provide intensive primary and preventive services to Members who have long-term, advanced illness or have disabilities.

The Role of the Primary Care Physician

The following specialties are considered Primary Care Physicians, or PCPs:

- Family practice, General practice, Geriatrics and Internal medicine

All American Health Advantage of Tennessee Members must select a participating PCP. If the Member has not selected a participating PCP, American Health Advantage of Tennessee will assign a participating PCP based on the Member's geographic area.

The scope of services to be provided by the PCP may include, but is not limited to, the following:

- Diagnostic testing and treatment
- Injections and injectable substances
- Office or nursing facility visits for illness, injury and prevention

The PCP has the primary responsibility for coordinating the Member's overall healthcare among the Member's various healthcare providers. The PCP works closely with the American Health Advantage of Tennessee Advanced Practice Provider who is a nurse practitioner or physician assistant, to reduce fragmented, redundant or unnecessary services and provide the most cost-effective care. American Health Advantage of Tennessee monitors referrals to promote the use of participating network providers, analyze referral patterns and assess medical necessity.

PCPs, as well as all other participating Providers, are expected to:

- Maintain high quality
- Provide the appropriate level of care
- Use healthcare resources efficiently

The Role of the Advanced Practice Provider

Our model of care introduces the concept of the Advanced Practice Provider as a trusted partner in the integrated care team. Together with physicians, administrators, Members, and families, the Advanced Practice Provider treat the "whole person," rather than addressing the patient's disease or illness only.

- The Advanced Practice Provider visits the nursing home on a regular basis, working with the nursing home staff, interdisciplinary team and physicians to closely monitor changes in health, focus on early diagnosis and intervention, and coordinate communication between all relevant practitioners and family members.
- The Advanced Practice Provider assess and help develop and manage personalized care plans for American Health Advantage of Tennessee Members. The Advance Practice Provider work closely with the nursing facility interdisciplinary staff and PCPs, the Member and his/ her family to ensure a responsive plan of care for the Member. Based on an initial Health Risk Assessment (HRA), which is done within 90 days of enrollment and at least annually unless triggered by a change in health status or condition, or admission to the hospital, the Advanced Practice Provider develops a plan of care and assures that the care plan is implemented and the Member's needs are met.
- The Advanced Practice Providers perform the Health Risk Assessment, oversee diagnostic services and treatments to ensure medical and mental health parity, ensure access to comprehensive benefits, as needed, and provide education on the health risks and care to the Member and his/her family. They coordinate multiple services; help facilitate better communication between physicians, institutions, patients and their families; and help ensure effective integration of treatments.
- The Advanced Practice Providers are available 24 hours per day, 7 days per week and are on-site for providers and Members during normal working hours, Monday – Friday. After-hours, weekend and holiday coverage is provided 24 hours per day, 7 days per week by one of the designated on-call Advanced Practice Providers.

The Role of the Case Manager

Each Member is assigned a RN Case Manager. Depending on the needs of the Member, the RN Case Manager may visit the Member in facility at least monthly or more frequently.

The RN Case Manager assures timely and appropriate delivery of services, providers' use of clinical practice guidelines developed by professional associations, seamless transitions, and timely follow-up to avoid lapses in services or care when there is transition across settings or providers and conducts chart and/or pharmacy reviews.

The RN Case Manager analyzes and incorporates the results of the initial and annual Health Risk Assessment into the care plan and collaborates to develop and at least annually update an individualized care plan for each Member. The interdisciplinary team also manages the medical, cognitive, psychosocial, and functional needs of Members through the initial and annual health assessments and communicates to coordinate care plan with all key stakeholders, including the PCPs, Providers, Member, family and care givers, as needed.

The Role of the Specialist

Members may see in-network specialists without a prior authorization a referral, from the PCP or Advanced Practice Provider. Female Members may see network gynecologists or their PCP for a well-woman examination without prior authorization or referral.

To maximize the Member benefits and reduce out-of-pocket costs, Members are required to see network specialists. If Members see a non-network provider, the service may not be covered. Please call (844) 321-1763 with questions about network participating Providers or visit our website at: tn.AmHealthPlans.com.

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Provider, Member and Member's Family Satisfaction Surveys

Satisfaction surveys provide American Health Advantage of Tennessee with feedback on performance relating to:

- Access to care and/or services
- Overall satisfaction with American Health Advantage of Tennessee
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Preventive Screenings and Disease Management

The Advanced Practice Provider visits each Member at least monthly. In addition, a PCP visit is recommended at least annually to perform a complete medical evaluation, addressing the Member's specific needs and conducting appropriate preventive screenings.

Preventive guidelines to be addressed include, but are not limited to:
- Screening for colorectal cancer
- Mammography (females)
- Influenza vaccine administration
- Pneumonia vaccine administration

Gaps in Member compliance require appropriate intervention to improve and meet recommended goals. Either the Member's PCP or the Advanced Practice Provider may provide this intervention.

The following charts list suggested guidelines for Providers to follow when ordering preventive tests and treatments for Members with chronic conditions.

Prevention Measurements Table

GENERAL PREVENTIVE CARE:	
Pneumonia Vaccine	Once per lifetime = >65
Influenza Vaccine	Once every 12 months
Breast Cancer Screening	Once every 12 months
Body Mass Index (BMI)	Once every 12 months
Prostate Cancer Screening	Once every 12 months
Colorectal Cancer Screening: Fecal Occult	Once every 12 months

Chronic Conditions Measurements Table

DIABETES/OBESITY:	
Eye Exam	Once every 12 months
HgbA1C	Once every 6 months
Microalbumin	Once every 12 months
CHF:	
Ejection Fraction measurement	Once per lifetime
CAD:	
LDL levels	Once every 12 months

II. Provider Standards and Procedures

Provider Credentialing

Credentialing of providers may be conducted internally by American Health Advantage of Tennessee or delegated to an external entity. If delegated, American Health Advantage of Tennessee will conduct both pre-delegation and annual delegation audits to ensure credentialing standards are maintained throughout the network. The standards below outline the overall approach to credentialing by American Health Advantage of Tennessee. The delegated entity's standards shall be conducted consistent with American Health Advantage of Tennessee credentialing standards. If there are any questions, please contact the Provider Help Desk at (844) 321-1763.

The provider credentialing process involves several steps: application, primary source verification, notification and Credentialing Committee review.

Providers who would like to participate in the American Health Advantage of Tennessee network should request a Participation Agreement by calling the Provider Help Desk at (844) 321-1763.

Once accepted, the provider may either submit the CAQH (Council for Affordable Quality Healthcare) provider identification number or fill out the applicable state-mandated credentialing application form along with all required supporting documents to the Provider Relations Department at the address listed below:

American Health Advantage of Tennessee
201 Jordan Road, Suite 200
Franklin, TN 37067
Attn: Credentialing

American Health Advantage of Tennessee follows NCQA standards involving credentialing and re-credentialing of Providers. Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information to the primary source data. If American Health Advantage of Tennessee notes any discrepancies, it notifies the provider in writing and gives the provider two weeks to forward the correct information.

In addition, a provider has the right to review the information submitted in support of the application. If the provider discovers erroneous information on the application, he or she has an opportunity to correct this information before American Health Advantage of Tennessee Credentialing Committee reviews. The provider must initial and date the corrected information.

Credentialing Committee Review

Completed credentialing files are presented to the American Health Advantage of Tennessee Credentialing Committee for review and final decision.

American Health Advantage of Tennessee will send a welcome letter to providers who are approved as providers in the American Health Advantage of Tennessee Provider Network.

Providers are notified in writing if they are denied credentialing status. If a provider wishes to appeal a denial decision, the provider must submit a request in writing to the chair of the American Health Advantage of Tennessee Credentialing Committee.

Re-credentialing Process

All providers must be re-credentialed within three years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except providers are also evaluated on their professional performance, judgement, clinical competence and compliance with American Health Advantage of Tennessee Quality Program, Utilization Management Program and policies and procedures. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with American Health Advantage of Tennessee policies and procedures
- American Health Advantage of Tennessee sanctioning related to utilization management, administrative issues or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

American Health Advantage of Tennessee or its designee will send an application for re-credentialing to providers six (6) months before their re-credentialing due date to allow the process to be completed within the required period.

Failure to return the completed re-credentialing application and supporting documentation by the deadline may result in suspension and/or termination from the network.

Malpractice Insurance

American Health Advantage of Tennessee requires Providers to carry minimal professional liability insurance. Please refer to the Provider's Participation Agreement to verify those amounts.

Credentialing Denials and Appeals

American Health Advantage of Tennessee will send to a provider who has been denied credentialing a letter that includes the following:

- The specific reason for the denial
- The provider's right to request a hearing
- A summary of the provider's right in the hearing
- The deadline for requesting a hearing

  - The provider has thirty (30) days following receipt of the notice in which to submit a request for a hearing
  - Failure to request a hearing within thirty (30) days shall constitute a waiver of the rights to a hearing
- A request for consent to disclose the specifics of the provider's application and all credentialing documentation to be discussed
- Appropriate requirements specific to the state in which the practice is located

Upon receipt of the provider's request for a hearing, American Health Advantage of Tennessee will notify the provider of the date, time and place of the hearing.

The provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause for denial. The provider may be represented by legal counsel or another person of the provider's choosing, as long as, American Health Advantage of Tennessee is informed of such representation at least seven (7) days before the hearing.

There is no appeal process if a provider is denied credentialing based on administrative reasons, such as:

- Network need
- Failure to cooperate with the credentialing or re-credentialing process
- Failure to meet the terms of minimum requirements (e.g., licensure)

Provider Termination

The relationship between a provider and American Health Advantage of Tennessee may be severed for several reasons, which may include any of the following:

- Provider is non-compliant with Malpractice and/or Liability insurance coverage requirements
- Provider's license, certification or registration to provide services in the provider's state is suspended or revoked
- Provider makes a misrepresentation with respect to the warranties set forth in the Provider Participation Agreement
- Provider is sanctioned by the Office of Inspector General (OIG), Medicare, Medicaid or any Federal Health Care Program

American Health Advantage of Tennessee may initiate the termination action or the provider may initiate the termination. In all cases, if a provider began treating a Member before the termination, the provider should continue the treatment until the Member can, without medically injurious consequences, be transferred to the care of another participating provider. The terminating provider will be compensated for this treatment according to the rates agreed to in the Provider's Participation Agreement.

Should the terminating provider note special circumstances involving a Member – such as treatment for an acute condition, life-threatening illness, or disability – the provider should ask American Health Advantage of Tennessee for permission to continue treating that Member. In such cases, American Health Advantage of Tennessee will reimburse the provider at the compensation rates specified in the Provider's Participation Agreement.

The provider may not seek payment from the Member of any amount for which the Member would not be responsible if the provider were still in American Health Advantage of Tennessee's network. The provider shall abide by the determination of the applicable grievance and appeals procedures and other relevant terms of the Provider's Participating Agreement.

When the American Health Advantage of Tennessee Credentialing Committee decides to terminate a provider's participation or impose a corrective action that will result in a report to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and/or applicable state licensing agency, American Health Advantage of Tennessee shall promptly notify the affected provider by certified mail, return receipt requested.

Such notice shall:

- State the specific reason for the termination or corrective action
- Inform the provider that he/she has the right to request a hearing
- Contain a summary of the provider's right in the hearing under this policy
- Inform the provider that he/she has thirty (30) days following receipt of the notice within which to submit a request for a hearing
- State that failure to request a hearing within the specified time period shall constitute a waiver of the right to a hearing
- State that upon receipt of the hearing request, the provider will be notified of the date, time and place of the hearing
- Allow the provider to be represented by an attorney or another person of his/her choice and shall notify American Health Advantage of Tennessee seven (7) days in advance of the scheduled hearing date.

A provider shall have thirty (30) days following receipt of notice to file a written request for a hearing. Requests shall be hand delivered or sent by certified mail, return receipt requested, to the chairperson of the American Health Advantage of Tennessee Credentialing Committee. If such a hearing is requested, the American Health Advantage of Tennessee Credentialing Committee shall follow the steps as defined by the American Health Advantage of Tennessee Credentialing and Fair-Hearing policies and procedures. (Copies of such policies and procedures are available upon request.)

A provider who fails to request a hearing within the time and in the manner specified in this policy waives any right to a hearing. Such a waiver shall constitute acceptance of the action, which then becomes the final decision of the American Health Advantage of Tennessee Credentialing Committee and is not subject to appeal.

In accordance with 42 CFR §422.202(d)(4) and as specified in the Provider Participation Agreement held between American Health Advantage of Tennessee and Provider, the Provider must provide at least ninety (90) days advance written notice to American Health Advantage of Tennessee before terminating the Provider Participation Agreement without cause and leaving the American Health Advantage of Tennessee network. Provider must supply copies of medical records and facilitate a Member's transfer of care upon request by American Health Advantage of Tennessee, the Member or the Member's authorized representative.

For terminations initiated by PCPs, American Health Advantage of Tennessee shall notify affected Members in writing providing the effective date of PCP termination, provide the effective date, name of the new assigned PCP, office phone number and address. In addition, the notice shall provide instructions on how to select a new PCP. As specified in the Provider Participation Agreement, PCPs must continue to provide care for up to ninety (90) days following the termination date.

For terminations initiated by specialists, non-PCP providers and/or facilities, American Health Advantage of Tennessee will send a written notification to all Members who are currently receiving care from or has received care within the past three (3) months. This notification will alert the Member of the provider's forthcoming termination date and allow for transition of care to another contracted provider or facility.

Practice Information

At the time of credentialing and re-credentialing, American Health Advantage of Tennessee will verify important demographic details about a Provider's practice to help ensure the accuracy of information, such as, claims payments and provider directory information. Providers should notify American Health Advantage of Tennessee of any changes in practice information at least sixty (60) days before the effective date of the change to avoid improper claims payment and incorrect directory information. All network Providers must have the hours of operation clearly posted in their office.

Office Requirements

Providers should bill American Health Advantage of Tennessee for all services performed in their offices, the Nursing Facilities or other participating provider locations for assigned Members. The services should be within the standard practices of the Provider's license, education, board certification and generally accepted standards of medical practice in the community. However, reimbursement for such services will vary by Provider. Providers should refer to the Provider Participation Agreement for compensation rates and terms.

American Health Advantage of Tennessee wants to make sure that all Members—including those with limited English proficiency, diverse cultural backgrounds, the homeless and individuals with physical and mental disabilities—receive healthcare services and assistance with their health plan in a culturally competent manner. Each Member is entitled to receive healthcare needs in a manner that is respectful and consistent with the Member's cultural perspective. The goal of this policy is to enhance patient care compliance.

Once cultural expectations and health service needs are determined, providers may be required to supply interpreters to overcome barriers of language and/or understanding. To further promote understanding and support, providers also may be required to supply the Member with appropriate educational materials and information about community resources.

For assistance with Members requiring culturally competent services, providers may call the Provider Help Desk at (844) 321-1763.

While on vacation or a leave of less than thirty (30) days, a network Provider must arrange for coverage by another American Health Advantage of Tennessee participating Provider. If a Provider goes on a leave of thirty (30) days or longer, the Provider must notify American Health Advantage of Tennessee by calling the Provider Help Desk at (844) 321-1763.

If a American Health Advantage of Tennessee network Provider arranges with either a participating or non-participating provider to cover for his/her patients during an absence, the network Provider is responsible for making sure the covering provider will:

- Accept compensation from American Health Advantage of Tennessee as full payment for covered services
- Not bill the Member, except for applicable copayments, coinsurance and deductibles
- Obtain Prior Authorization from American Health Advantage of Tennessee, as set forth in this manual and the terms of the Member's American Health Advantage of Tennessee Evidence of Coverage
- Comply with the rules, protocols, policies, procedures and programs set forth in this manual

All network Providers are required to provide 24-hour/7-days per week/365 days per year on-call coverage. If a Provider delegates this responsibility, the covering provider must participate in American Health Advantage of Tennessee's network and be available 24 hours a day, seven days a week, 365 days a year.

Accessibility Standards

American Health Advantage of Tennessee follows accessibility requirements set forth by applicable regulatory and accrediting agencies. The purpose of these standards is to make sure services are available and accessible to Members in a timely fashion. American Health Advantage of Tennessee monitors compliance with these standards. The following table describes sample types of services and the respective standards to be followed:

Accessibility Standards

REASON FOR APPOINTMENT	COMPLIANCE STANDARD
PRIMARY CARE PHYSICIAN	
Chest pain	Same day
Mild respiratory symptoms>3 days	Next day
Routine physical examination	Within 30 days
Obstetricians-Gynecologists	
Urgent referral	Next day
Non-urgent referral	Within 2 weeks
Well-woman examination	Within 10 weeks
SPECIALISTS	
Emergency	Same day
Urgent referral	Next day
Routine referral	Within 30 days

Member Administration

Contacting American Health Advantage of Tennessee

Website:	tn.AmHealthPlans.com
Provider Services:	(844) 321-1763 (TTY: 711) 8:00 a.m. to 8:00 p.m. Central Time networkservices@AmHealthPlans.com American Health Advantage of Tennessee 201 Jordan Road, Suite 200 Franklin, TN 37067 Attn: Provider Services

Medical:

Authorization Department:	(844) 321-1763
Authorization Fax Number:	(844) 869-0884

Medical Claims submissions:

Electronic Claims:	EDI Payer ID 31130
Paper Claims Mailing Address:	American Health Advantage of Tennessee P.O. Box 93780 Lubbock, TX 79493

Credentialing:

To request a hearing:	American Health Advantage of Tennessee 201 Jordan Road, Suite 200 Franklin, TN 37067 Attn: Credentialing

Pharmacy:

Pharmacy Management Department:

Phone:	(844) 321-1763, option 2

EnvisionRx Coverage Determination and Appeals:

Phone:	(833) 478-6370
Web:	envision.promptpa.com/

Compliance, Ethics, Fraud Waste & Abuse Hotline:

American Health Advantage of Tennessee

Compliance Hotline	(866) 205-2866
Email	compliance@AmHealthPlans.com

Medicare

Customer Service	(800) 633-4227
TTY	(877) 486-2048
Website	medicare.gov/forms-healp-resources/help-fight-medicare-fraud/how-report-medicare-fraud

Office of the Inspector General

Hotline	(800) 447-8477
TTY	(800) 377-4950
Website	oig.hhs.gov/report-fraud/index.asp
US Mail	US Department of Health and Human Services Office of Inspector General ATTN: OIG Hotline Operations PO Box 23489 Washington, DC 20026

Member ID Cards

All American Health Advantage of Tennessee members are provided a Member ID Card and should be presented at the time of medical services. Refer to the American Health Advantage of Tennessee website at tn.AmHealthPlans.com for information about specific benefits, Evidence of Coverage, Member cost-sharing and other coverage information.

Selecting a Primary Care Physician

All American Health Advantage of Tennessee Members must select a PCP from the list of participating primary care physicians in the American Health Advantage of Tennessee Provider directory. If a Member does not select a PCP, American Health Advantage of Tennessee will assign a PCP based on geographic access. A PCP is not permitted to refuse services to an eligible Member.

Members may change PCPs by contacting Member Services. The change becomes effective on the first day of the following month.

Verifying Member Eligibility

Possession of an ID card is not a guarantee of eligibility. Providers should photocopy the card and check it for any change of information, such as address and eligibility date. Providers should verify Member eligibility before each visit using the telephone number listed on the back of the Member's ID card.

Member Copayments and Coinsurance

American Health Advantage of Tennessee covers the same benefits as Original Medicare as well as some supplemental benefits. For a list of benefits and their respective cost-sharing amounts, go to tn.AmHealthPlans.com for the most recent Summary of Benefits and Evidence of Coverage.

Members may also be eligible for the cost sharing benefits provided by State Medicaid. Generally, this will provide the member with no cost sharing for covered services provided by in-network providers.

Providers are not allowed to charge co-payments, co-insurance, or deductible charges that are the responsibility of Tennessee Medicaid.

Benefit Exclusions

American Health Advantage of Tennessee follows Medicare coverage guidelines and may offer supplemental benefits as approved by CMS. A list of exclusions is contained within the Member's Evidence of Coverage which may be accessed on the American Health Advantage of Tennessee's website at tn.AmHealthPlans.com.

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Quality Improvement

American Health Advantage of Tennessee's approach to quality improvement is built on a model that involves the entire organization and related operational processes. The Quality Improvement program incorporates information from all of American Health Advantage of Tennessee departments and encourages providers to participate in quality improvement initiatives.

The Quality Improvement model employs a cycle of continuous improvement and a "Plan-Do-Study-Act" (PDSA) methodology. Opportunities for improvement are identified through qualitative and quantitative reviews of member care and services.

Quality improvement is a shared responsibility between American Health Advantage of Tennessee and its participating providers and other delegated entities. The Quality Improvement department oversees and assists with many of the activities that support continuous quality improvement, including:

- Reviewing processes to identify quality improvement needs
- Organizing work groups and committees, such as the Clinical Quality Improvement Committee
- Identifying best practices
- Developing and implementing improvement initiatives
- Collecting data to evaluate the results of the activities and initiatives

Member satisfaction and quality of care/quality of service issues evaluated and reviewed on a regular basis using the PDSA Methodology. The CMS Star program results and the Quality Reporting Metrics serve as ongoing indicators for the Quality Improvement Work Plan. Participation in the collection, review, and submission of CMS Star quality rating system performance data is one means by which American Health Advantage of Tennessee evaluates the quality of Member Services, care and satisfaction.

In addition, American Health Advantage of Tennessee is a full participant in CMS-required activities, including but not limited to the Chronic Care Improvement Program (CCIP) that targets the improvement of care for Members with cardiovascular disease. Program development is also underway to further develop and expand our tobacco use cessation strategies, medication adherence initiatives, blood pressure reduction and cholesterol management activities.

The American Health Advantage of Tennessee Quality Improvement Program includes initiatives related to the reducing the incidence of All-Cause Readmissions to an Acute Care Setting within 30 days.

HEDIS and CAHPS are sets of measurements developed and defined by the National Committee for Quality Assurance (NCQA) as a basis for comparing quality, resource utilization and Member satisfaction across health plans. The submission of HEDIS and CAHPS data is required by American Health Advantage of Tennessee. American Health Advantage of Tennessee is rated against Stars indicators which are set by CMS and derived from HEDIS, CAHPS, the health outcomes survey, and additional administrative measures.

Advance Directives

All American Health Advantage of Tennessee Providers must offer Members written information about their right to make their own healthcare decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

An Advance Directive generally is a written statement that an individual has established – in advance of serious illness – regarding a medical decision. The Advance Directive must be in accordance with the Member's state regulatory guidelines in order for it to be considered valid. All adults have the right to create and initiate an Advance Directive.

The two most common forms of advance directives are a living will and a healthcare durable power of attorney.

Living Will – A living will take effect while the individual is still living. It is a written document concerning the kind of medical care a person wants or does not want if he or she is physically or mentally unable to make a decision.

Healthcare Durable Power of Attorney – A healthcare durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is physically or mentally unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Neither document becomes effective unless the individual is unable to make decisions (generally as certified by a treating physician). The individual can change or revoke either document at any time. Otherwise, it should remain effective throughout the person's life.

A Member who decides to execute a living will or a healthcare durable power of attorney is encouraged to notify their PCP, or treating provider, of its existence, provide a copy of the document to be included in personal medical records and discuss this decision with the PCP or treating provider. If a Member is under the care of a provider who is unable to honor the Member's Advance Directive, the Member may transfer to the care of a provider willing to do so.

Member Appeals

The Evidence of Coverage is distributed to each Member and provides instruction on a member's rights to file an appeal (refer to Chapter 9). Additionally, the Evidence of Coverage is available on American Health Advantage of Tennessee's website at tn.AmHealthPlans.com.

A Member or their authorized representative must file an appeal within 60 calendar days of receiving notification of American Health Advantage of Tennessee's denial decision (adverse organization determination) or provide "good cause" for the delay in filing.

Examples of good-cause reasons include the following:

- The Member did not personally receive the adverse organization determination notice or received it late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the appeal (reconsideration) process
- The Member lacked the capacity to understand the time frame for filing a request for reconsideration

A Member may appoint an authorized representative or request that a physician, represent him/her in the appeal process. To be appointed, both the Member and the proposed representative (including attorneys) must sign, date, and complete the Appointment of Representative (AOR) form (CMS 1696 form) or an equivalent written notice. A Member's legal power of attorney (POA) does not need to submit the AOR form, rather the POA would provide a copy of the document. The AOR form is available on the American Health Advantage of Tennessee website or on the CMS website at: https://www.cms.gov/cmsforms/downloads/cms1696.pdf. A Member's treating physician may file an appeal on the Member's behalf without completing an AOR form. However, the provider must notify the Member that the appeal is being filed on their behalf.

A standard appeal must be submitted in writing, whereas an expedited appeal may be submitted either orally or in writing.

A standard appeal must be resolved within 30 days, which may be extended by up to 14 days, if in the best interest of the member.

American Health Advantage of Tennessee provides an expedited determination if a Member or their physician indicates that applying the standard time frame could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. American Health Advantage of Tennessee has up to 72 hours to make a decision, which may be extended by up to 14 days, if in the best interest of the Member.

Appeals may require that American Health Advantage of Tennessee obtain additional medical records from the treating provider to adequately perform a complete review. American Health Advantage of Tennessee medical director may request a peer-to-peer conversation to assure understanding of the Member's unique care needs and the Provider's rationale for the service.

If American Health Advantage of Tennessee upholds its original decision (denial), the Member has additional appeal rights as outlined in their Evidence of Coverage.

Appeals regarding payment (service is already provided) cannot be expedited and American Health Advantage of Tennessee has up to 60 days to make a decision.

Note: Contracted Providers should refer to the “Provider Disputes” section for their reconsideration rights and process.
Appeals may be faxed to (844) 280-5360. Standard appeals may be faxed to the same number or mailed to:

American Health Advantage of Tennessee
201 Jordan Road, Suite 200
Franklin, TN 37067
Attn: Member Appeals

Provider Timeliness to Submit Additional Information for Member Appeals

In order for American Health Advantage of Tennessee to meet CMS timeliness standards, Providers must respond to requests for additional information within five (5) calendar days for a standard appeal and within twenty-four (24) hours for an expedited appeal.

Member Grievances

A grievance is a type of complaint, or expression of dissatisfaction, including those that concern quality of care. A grievance does not involve coverage or payment disputes. The Evidence of Coverage, Chapter 9 provides details on grievances and how Members can file. Members may file a written or oral grievance at any time.

For more information about the appeals and grievances policies and procedures, please contact the Provider Help Desk at (844) 321-1763

III. Utilization Management (UM)

Utilization Management

Utilization Management is the process of influencing the continuum of care by evaluating the medical necessity and efficacy of health care services and affecting care decisions through assessing the appropriateness of care. Medical necessity means covered services which are medically necessary.

All American Health Advantage of Tennessee contracted Providers are required to obtain authorization from the UM Department as outlined on the “Authorization List”, located on American Health Advantage of Tennessee’s website tn.AmHealthPlans.com. Authorization requirements may change annually. Authorization is also known as an Organization Determination. Failure to submit an authorization request, or failure to submit an authorization in a timely manner, may result in a provider administrative denial of services. An authorization is not a guarantee of benefits or payment. Member eligibility should be verified prior to requesting or providing services.

American Health Advantage of Tennessee operates a toll-free call center to respond to physicians and other providers requesting authorization. The UM department is available Monday through Friday, except holidays during normal business hours. Providers may also leave messages via voice mail, so that information may be submitted for action 24 hours a day, 7 days a week. After business hours or on holidays, a provider can leave a message and a representative will return the call the next business day.

Requests for authorization of services may be faxed to: (844) 869-0884. The UM department reviews requests against clinical criteria and internal policies. For those requests meeting the established medical necessity criteria, an authorization will be provided. For inquiries regarding the status of an authorization, call (844) 321-1763.

Requests not meeting established medical necessity criteria will be referred to the American Health Advantage of Tennessee medical director for further review and evaluation.

When requesting an authorization, at a minimum, documentation must include:

- The Member's name and American Health Advantage of Tennessee ID number;
- The diagnosis for which the treatment or testing procedure is being sought with CPT codes;
- Other treatment or testing that have been tried, duration and outcomes, and any additional clinical information as applicable for the requested service;
- Applicable sections of the Member's medical record; and
- Provider contact information

Requests must be received prior to the service unless the Member's condition prevents. Requests that provide the above information, including the necessary clinical documentation can be addressed quickly. Otherwise, a call will be placed to the provider office requesting additional information. American Health Advantage of Tennessee decisions for standard authorization requests shall be made within 14 calendar days. However, American Health Advantage of Tennessee makes determinations as quickly as possible based on the needs of the Member.

For services that do not meet criteria once clinical information is received, the UM Department will offer a peer-to-peer call with the Provider and the American Health Advantage of Tennessee medical director.

Utilization Management Decision Making

UM decision making is the result of:

- Applying InterQual Criteria
- Application of Medicare National and Local Coverage Determinations
- American Health Advantage of Tennessee Policy
- A Member's individual medical condition and social considerations
- Overall needs of the Member's condition

The UM RN initially applies InterQual criteria related to the clinical information provided by the requesting Provider (except for DME, where Medicare Coverage Determinations apply). Following application of InterQual criteria, the UM RN reviews all relevant Medicare National and/or Local Coverage Guidelines. The UM RN then considers any relevant American Health Advantage of Tennessee policy and the unique medical condition and social situation of the individual member.
Following review of the above criteria, the UM RN either applies the InterQual recommendation, including the authorization of additional days or length of services.

Services that cannot be authorized after considering the above, will be referred to the American Health Advantage of Tennessee medical director for a decision on whether to:

- approve based or existing information,
- determine that additional information may be helpful, and offers a peer-to-peer discussion with the requesting Provider, or
- make a decision to deny the request.

At the request of a Member or a Provider, the UM Department will provide a copy of the InterQual or other guidelines. A Member or a Provider has the option to request the guideline, have the guideline read over the telephone or review the guideline at: American Health Advantage of Tennessee, located at 201 Jordan Road, Suite 200, Franklin, TN 37067.

Continuity of Care

American Health Advantage of Tennessee promotes continuity of care for Members that are newly enrolled, or if a Provider's contract is discontinued (other than for cause), while the Member is in an active course of treatment. Continuation of treatment may be authorized through the current period of active treatment, or for up to 90 calendar days, whichever is less, for Members undergoing active treatment for a chronic or acute medical condition. Continuation of care includes a Member in their second or third trimester of pregnancy, through approximately six weeks following childbirth.

An active course of treatment, as defined by NCQA, is when a Member has regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition. All out of network provider requests must be prior authorized by American Health Advantage of Tennessee (exceptions include: emergent services, urgently-needed services and out-of-area dialysis services at a Medicare certified dialysis facility). Non-contracted providers must agree to comply with American Health Advantage of Tennessee's terms during the transition and provide a transition plan.

Authorization Requirements

Authorization requirements may change annually and can be viewed on American Health Advantage of Tennessee website at tn.AmHealthPlans.com. American Health Advantage of Tennessee recommends that standard authorization requests be submitted at least seven (7) days prior to service.

Durable Medical Equipment (DME)

CMS defines DME as certain reusable medical equipment that is ordered by a physician or practitioner for use in the home. The term DME is defined as equipment which:

- Can withstand repeated use (i.e. could normally be rented and used by successive patients;
- Is primarily and customarily used to serve a medical purpose (not for convenience);
- Generally, is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a member's home

A hospital and/or skilled nursing facility that is providing Medicare-covered care does not qualify as the Member's home. The facility is responsible to provide equipment in these circumstances. A long-term care facility may qualify as the Member's home.

American Health Advantage of Tennessee covers all medically necessary DME covered by Original Medicare. American Health Advantage of Tennessee complies with all Medicare National and Local Coverage Determinations and covers the same items and services as Original Medicare, including relevant limitations and quantity limits. Services, supplies and equipment must be reasonable and medically necessary for the individual Member.

All DME requires the Member's doctor or treating Provider to prescribe the equipment. The Provider must prescribe the type of equipment needed by completing a detailed written order, with medical necessity documented within the Member's medical record. The prescribing Provider must have evaluated or treated the Member for a condition that supports the DME order within 6 months prior to the written order.

Pre- service authorization is required prior to the Member receiving the DME item, unless the item is less than the dollar limits set by American Health Advantage of Tennessee, which may change annually. DME authorization limits are delineated on American Health Advantage of Tennessee website, as well as within the Evidence of Coverage (EOC). The dollar limits are for monthly billed charges in the case of rented DME or per DME item. American Health Advantage of Tennessee limit is set monthly or per item and not cumulative for the life of the item. All services must meet Medicare Coverage Determinations and are subject to retrospective audit.

American Health Advantage of Tennessee complies with Original Medicare claims payment rules and guidelines. DME items, such as oxygen may be authorized through the current benefit year. New authorizations, including updated medical necessity, must be submitted for DME services that will continue after an authorization expiration date.

Durable Medical Equipment (DME) authorization requests require diagnosis code(s), HCPCS code(s) and quantity and date(s) of service.

Inpatient Admissions

All inpatient admissions require authorization. Elective admissions must be authorized prior to the date of the requested service. The facility should notify American Health Advantage of Tennessee within one business day for an emergent admission. For weekend admissions or for services delivered after normal business hours, authorization must be obtained within one (1) business day of the admission or service being provided.

If a Member's condition meets inpatient criteria after the observation period, the stay will be converted to inpatient beginning with the observation stay admission date. All claims for this type of stay should be submitted with the entire length of stay as an inpatient.
If a Member is discharged from an inpatient level of care and subsequently readmitted to the same hospital within 24 hours, the UM Department continues the Member's inpatient care under the same authorization number.

Skilled Nursing Facility (SNF) Care

American Health Advantage of Tennessee covers up to 100 medically necessary days per benefit period consistent with Original Medicare. A benefit period begins the day a Member goes into a hospital or SNF. The benefit period ends when the Member has not received any inpatient hospital, LTAC or skilled care in a SNF for 60 consecutive days. The benefit period resets after 60 consecutive days without care in an acute inpatient, LTAC or SNF.

Services must be reasonable and medically necessary for the individual Member.

A denial notice will be provided to Members that exceed the 100-day benefit limit.

Concurrent Review

The UM Department conducts concurrent review for Members that are receiving inpatient hospital services, Part A skilled nursing facility (SNF), home health agency (HHA) (including Part B therapies in a nursing facility), or comprehensive outpatient rehabilitation facility (CORF) services. Following the initial authorization decision, the UM staff enters a follow-up date in the UM system based on the medical necessity guideline recommendation. The UM RN applies medical necessity criteria and establishes a new length of stay/service, or the potential discharge date.

If the Provider requests additional authorization, and the request does not meet medical necessity criteria, the case is referred to American Health Advantage of Tennessee's medical director for review and decision. American Health Advantage of Tennessee's medical director or designee makes all medical necessity denial decisions.

Once continued inpatient services no longer meets medical necessity guidelines as determined by American Health Advantage of Tennessee's medical director, the Provider will again deliver the Member the "Important Message from Medicare", if relevant. Once continued SNF/HHA/CORF services no longer meets medical necessity guidelines as determined by American Health Advantage of Tennessee's medical director, the Provider will deliver the Member the CMS model "Notice of Medicare Non-Coverage (NOMNC) no later than 2 days in advance of the service end date. Both the "Important Message From Medicare" and the "Notice of Medicare Non Coverage (NOMNC)" outlines the Member's

appeal rights. The Provider must fax a copy of the NOMNC or Important Message to American Health Advantage of Tennessee within one business day of issuance.

Non-Contracted Providers

All out-of-network provider requests require prior authorization from American Health Advantage of Tennessee except in emergent situations, urgently needed care when access to American Health Advantage of Tennessee network provider is not available and/or out-of-area dialysis services at a Medicare-certified dialysis facility, American Health Advantage of Tennessee should be notified within one business day following an emergent or urgent service.

Retrospective Authorization

Retrospective authorization may be requested when the service is performed without prior authorization in extenuating circumstances, which includes:

- Services and situations which may be urgent or emergent, and the Member has already received services
- The ability of the Member to communicate their insurance information either verbally or by providing their member identification card

Providers should initiate a request for authorization via American Health Advantage of Tennessee's dispute resolution process within 60 days of the denied claim. Please refer to the applicable section of this manual for additional information.

Medical Necessity Denials

An authorization request may be denied for failure to meet guidelines, protocols, medical policies, or to follow administrative procedures as outlined in this provider manual.

Members may not be billed by contracted Providers, except as allowed by CMS. If prior authorization requirements are not met resulting in a denied claim, Members must be held harmless for denied services.

American Health Advantage of Tennessee medical director or designee renders all medical necessity denial decisions. Whenever a denial is pending, the UM Department provides the name, telephone number, title and office hours of American Health Advantage of Tennessee's medical director, for an opportunity of a peer-to-peer conversation. A peer-to-peer conversation allows the requesting Provider to discuss the nuances of the request with American Health Advantage of Tennessee's medical director.

Administrative Denials

An administrative denial is issued for those services for which the contracted Provider has not followed requirements set forth in the Provider Participation Agreement or this provider manual. An administrative denial may be issued for failure to follow prior authorization of an elective service, procedure or admission. It may also be issued for failure to notify the UM Department within one business day of an emergency service, procedure or admission.

Situations that may result in an administrative denial include:

- Failure to obtain authorization pre-service for an elective service
- Failure to request authorization within one business day of determining the Member has coverage, and extenuating circumstances do not exist
- Failure to follow American Health Advantage of Tennessee's requests for clinical updates related to continuing care (e.g. acute hospitalization, Part A skilled nursing facility services, Part B physical therapy, etc)

American Health Advantage of Tennessee offers contracted Providers an administrative dispute process as specified in the Provider Participation Agreement and an overview is included in this manual.

Members may not be billed by contracted Providers, except as specified in the Provider Participation Agreement as allowed by CMS. If prior authorization requirements are not met resulting in a denied claim, Members must be held harmless for contractually denied services.

Notice of Medicare Non-Coverage (NOMNC)

Skilled Nursing Providers, Home Health Agencies or Comprehensive Outpatient Rehabilitation Facility Providers must deliver an advance, completed Notice of Medicare Non-Coverage (NOMNC) to members receiving skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services no later than two days before the termination of services. The NOMNC is an OMB-approved standardized notice designed to inform Medicare enrollees, in writing, that the enrollee's Medicare health plan and/or provider have decided to terminate their covered SNF, HHA, or CORF care. The NOMNC language provides instructions on how to request a fast-track appeal, when the Member and/or their representative disagrees covered services should end.

The Provider must deliver the NOMNC face-to-face, except in rare circumstances. In circumstances that prevent physical delivery of the NOMNC to a member or their representative, an alternate delivery method may be used. In these cases, the Provider must document the reason for employing the alternative delivery method.

If the Member's services are expected to be fewer than two days in duration, the Provider must provide the NOMNC to the Member at the time of admission. If a Member is in a non-residential setting, and the span of time between services exceeds two days, the Provider may deliver the notice at the next to last time that services are furnished.

All Home Health Agencies (HHA), Skilled Nursing Facilities (SNF) and Comprehensive Outpatient Rehabilitation Facilities (CORF) Providers must deliver the Notice of Medicare Non-Coverage (NOMNC) to American Health Advantage of Tennessee Members (or their authorized representative) when the Member's Medicare covered service(s) are ending in compliance with CMS requirements. Providers should place the NOMNC in the Member's medical file and fax a copy of the signed NOMNC to American Health Advantage of Tennessee within one business day to (844) 869-0884.

New Technology Requests

American Health Advantage of Tennessee follows Original Medicare coverage policies. American Health Advantage of Tennessee utilizes the following process for requests for new technology, or a new use for existing technology:

- Review of information from appropriate government regulatory bodies, such as CMS coverage guidance, FDA, etc.
- Review of information from published scientific evidence, such as peer-reviewed articles, recommendations from professional societies or summaries from organizations that rely on the judgment of experts when determining the effectiveness of new technology.
- Review and input from relevant specialists who have expertise in the technology. Behavioral health professionals are included in the review of any BH service.

Following medical director review, the information is considered by the QI Committee for final recommendation on whether to include the new technology as a covered Plan benefit.

American Health Advantage of Tennessee's Pharmacy Benefits Manager (PBM), Envision Rx, is delegated to conduct all pharmaceutical reviews on behalf of American Health Advantage of Tennessee. American Health Advantage of Tennessee oversees and monitors the PBM is conducting the reviews in accordance with American Health Advantage of Tennessee's contractual requirements.

IV. Claims and Reimbursements - Billing Guidelines

Providers should bill American Health Advantage of Tennessee rather than Medicare or a Medicare Supplement carrier. Providers should bill all Medicare-covered services in accordance with Medicare and CMS rules, standards and guidelines applicable to Parts A and B. In addition, providers should use applicable CMS billing forms (i.e., UB-04/CMS1450, CMS1500, or such successor forms) and follow the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers.

Diagnosis codes should be billed to the highest level of specificity. The following information should be included on claims:

- National Provider Identifier
- The Member's identification number
- Date(s) of service
- Required CMS modifiers
- Diagnosis
- All other required CMS fields (e.g., number of service units, service location, etc.)

Providers who are paid based on interim rates should include with the claim a copy of the current interim rate letter

Billing questions and/or problems should be directed to the Provider Help Desk at (844) 321-1763.

Filing a Claim for Payment
Electronic Submissions

Filing claims electronically reduces administrative costs, speeds claims payment and improves payment accuracy. To begin submitting claims electronically, contact American Health Advantage of Tennessee, as follows:

American Health Advantage of Tennessee
P.O. Box 93780
Lubbock, TX 79493

For questions regarding electronic claims (EDI) billing, contact the Provider Help Desk at (844) 321-1763.

Paper Submissions

Providers who prefer to submit claims by mail should send them to the following address:

American Health Advantage of Tennessee
P.O. Box 93780
Lubbock, TX 79493

Filing Deadlines

For services furnished after January 1, 2010, Section 6404 of the Patient Protection and Affordable Care Act of 2010 amended the timely filing requirements to reduce the maximum time period for submission of all Medicare claims to one calendar year following the date of service.

Many providers have agreed to a shorter filing deadline in their applicable Provider Participation Agreement. In the event this manual differs from the deadline specified in the Provider Participation Agreement, the Provider Participation Agreement shall prevail.

For institutions or providers billing with span dates exceeding a month in duration, the date of service is considered the discharge date, or when the service is completed, not the date treatment begins or the patient is admitted for care.

Key Points

Here are some key points to consider when filing claims:

- Do not bill the Medicare carrier or fiscal intermediary. Doing so will delay payment and Medicare will not process the claim.
- Providers must include their NPI number on all claims.
- Durable medical equipment suppliers must use a 10-digit DME Medicare supplier number.
- Laboratories must use their 10-digit CLIA number.
- Providers should submit claims to American Health Advantage of Tennessee as soon as possible after the service is rendered.
- Submit claims using the same coding rules as original Medicare and use only Medicare-approved CPT codes and defined modifiers.
- Bill diagnosis codes to the highest specificity.
- Dates of service on or before September 30, 2015 should be billed to applicable ICD-9 codes.
- Dates of service on or after October 1, 2015 should be billed with applicable ICD-10 codes.

Clean vs. Unclean Claims

American Health Advantage of Tennessee processes and pays all error-free claims, known as clean claims, for covered services provided to a Member within 30 calendar days of receipt by the plan, or as required by applicable federal law. If a clean claim is not paid within the 30-day time frame, American Health Advantage of Tennessee will pay interest on the claim according to Medicare guidelines.

Under CMS guidelines, a “clean” claim (“Clean Claim”) is a claim with no defects or improprieties. An “unclean” claim may include:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing or incomplete
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of- service codes)
- A missing Explanation of Benefits (EOB) for a Member with other coverage

American Health Advantage of Tennessee will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

National Provider Identifier

All healthcare Providers should have a NPI. The NPI replaces Legacy identifiers such as the Unique Physician Identification Number or UPIN.

The purpose of the NPI is to uniquely identify a healthcare Provider in standard transactions, such as healthcare claims. The NPI may also be used to identify healthcare Providers on prescriptions, in internal files to link proprietary Provider identification numbers, in coordination of benefits between health plans, inpatient medical record systems and in program integrity files. The NPI is the only healthcare Provider identifier that can be used for identification purposes in such transactions.

Reimbursements

American Health Advantage of Tennessee complies with Medicare’s prompt payment of claims requirements for all Clean Claims. Claims must be submitted within the time frame specified in the Provider Participation Agreement. American Health Advantage of Tennessee processes all error-free claims (known as Clean Claims) for covered services provided to a Member within 30 calendar days of American Health Advantage of Tennessee’s receipt by the plan.

Special Circumstances

For certain Medicare-approved providers, American Health Advantage of Tennessee pays as follows:

- Eligible hospitals are reimbursed according to CMS IPPS DRG reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under original Medicare based on rates published on the CMS website (CMS.gov). The payment is added to the Inpatient Prospective Payment System (IPPS). However, because Fiscal Intermediaries are responsible for operating IME and DGME, American Health Advantage of Tennessee does not reimburse those components of the DRG.

- American Health Advantage of Tennessee reimburses qualifying Disproportionate Share Hospitals the same capital exception payments and add-on payments for operating DSH that they would have received under original Medicare. The payment is added to the Prospective Payment System (PPS) rate. American Health Advantage of Tennessee reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.
- American Health Advantage of Tennessee does not reimburse facilities for bad debt incurred as a result of Members not paying their cost-sharing amounts (if any), unless specified in a provider's contract.
- American Health Advantage of Tennessee does not enter into the annual cost settlement process with providers, contracted or non-contracted. Providers who have treated American Health Advantage of Tennessee Members should contact Medicare or their Fiscal Intermediary regarding their cost settlements.

Billing for Non-Covered Services

Providers may not bill a Member if American Health Advantage of Tennessee denies payment because the service was not covered, unless:

- The provider has informed the Member in advance that the services may not be covered, and
- The Member has agreed, in writing, to pay for the services.

Balance Billing Provisions

A Provider may collect only applicable Member cost-sharing amounts from American Health Advantage of Tennessee Members that are not dual-eligible Members and may not otherwise charge or bill Members. Balance billing is prohibited by Providers who furnish covered services to American Health Advantage of Tennessee Members.

Provider Remittance Advice Form

American Health Advantage of Tennessee sends Providers a Provider Remittance Advice Form (PRAF) once it has received and paid a claim.

Questions regarding the PRAF may be addressed to American Health Advantage of Tennessee at (844) 321-1763 from 8 AM to 5 PM (local time zone), Monday-Friday (except holidays).

When calling, Providers should have the following information available for the representative:

- National Provider Identifier (NPI)
- Claim number in question
- Member's name
- Date of service
- Member's date of birth
- Issue requiring review
- Member's ID number
- Copy of claim (if available)

Coordination of Benefits

If a Member has primary coverage with another plan, Providers should submit a claim for payment to the primary plan first. The amount payable by American Health Advantage of Tennessee will be governed by the amount paid by the primary plan and the coordination of benefits policies.

In order to bill the correct payer, the Provider must obtain all the information that determines whether the Member is covered. The Provider must include all this information on the claim form to facilitate the correct adjudication.

For a Provider who accepts Medicaid and who treats an American Health Advantage of Tennessee Member who is a Medicaid patient, American Health Advantage of Tennessee will pay the Medicare portion of the claim. The Provider must then submit the claim to the appropriate state Medicaid entity for the Medicaid portion of the claim.

The following types of situations, not an exhaustive list, will prevent payment by American Health Advantage of Tennessee as the primary payer:

- Elderly Workers Employed Group Health Plan (EGHP): These Members, who are 65 years or older, are covered by an EGHP with 20 or more employees or the spouse of a person covered by an EGHP. The spouse's age is not material to the determination of primary coverage, only the qualification of the EGHP.
- Disabled Beneficiaries Employer Group Health Plans: These Members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member's employment. LGHP is defined by at least one of the employers having at least 100 employees.
- Federal Black Lung Program: The Black Lung Program was established under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The program is billed for all services that relate to either respiratory or pulmonary diseases. American Health Advantage of Tennessee is the primary payer for all other care and service needs.
- Workers' Compensation: The Workers' Compensation carrier is responsible for all injuries and illnesses that result from employment. American Health Advantage of Tennessee pays only when the Workers' Compensation benefits are exhausted or the services/care were not covered by the Workers' Compensation carrier but are Medicare benefits.
- Veterans Administration Coverage: Care and services authorized by the VA are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. American Health Advantage of Tennessee may supplement VA payment when the Member files a claim for Part B services that were not fully reimbursable by the VA.

Provider Payment Dispute Resolution Process

If a Provider believes a Clean Claim should have been paid differently, the Provider has the right to dispute the payment.

Providers must address disputes regarding claims payments (such as denied claims, inappropriate payments, the timing of payments or the amount of the claim) in writing. Providers may direct any questions to the Provider Help Desk at (844) 321-1763.

To file an official payment dispute, the Provider should submit a Provider Dispute Resolution Request form along with any supporting documentation. The form can be found in the Appendix of this Provider Manual and on the American Health Advantage of Tennessee website. Providers may include a cover sheet outlining the reason for the requested review along with the claim and Provider Remittance Advice Form, or PRAF. American Health Advantage of Tennessee will respond to all written disputes regarding claims within 30 business days.

If American Health Advantage of Tennessee agrees with the reason for the payment dispute, American Health Advantage of Tennessee will issue a new PRAF and Explanation of Payment (EOP) and pay the additional amount due, including any interest due.

American Health Advantage of Tennessee will inform the Provider in writing if the decision is unfavorable and no additional amount is owed, as well as supply information regarding the provider's appeal rights.

Claims must be disputed within one-hundred twenty (120) days from the initial American Health Advantage of Tennessee payment date/denial date. American Health Advantage of Tennessee.

NOTE: A copy of the Provider Dispute Resolution Request form is located on page 62 and is also available on the Providers & Partners page of American Health Advantage of Tennessee's website at: tn.AmHealthPlans.com.

V. Medicare Risk Adjustment
Hierarchical Condition Category (HCC) Model

CMS previously reimbursed Medicare Advantage plans based on a Member's demographics. Now, however, CMS also considers a Member's chronic health conditions. This reimbursement method is called Medicare Risk Adjustment.

Under risk adjustment, health plans receive higher compensation for chronically ill enrollees in anticipation of the cost of paying for their care. Payments are calculated by the diagnoses on each Member's claims for the previous year.

American Health Advantage of Tennessee reviews all claims to identify conditions that yield varying reimbursement rates. To determine the reimbursement rate associated with the diagnosis codes that Providers submit, the risk adjustment process relies on a model called "Hierarchical Condition Category" or HCC.

The HCC model is a list of standard diagnostic codes (ICD-9-CM until September 30, 2015; ICD-10-CM starting October 1, 2015) codes that have been separated into clinically related groups. The model identifies chronic diseases and conditions that may have a corresponding disease management program. The reimbursement also is based on the severity of each qualifying condition.

A qualifying diagnosis must appear on a Member's medical record at least once a calendar year to be counted for risk adjustment. In addition, the physician who dictated or documented the Member's condition must sign the record and note their credentials, regardless of the type of medical record.

Provider's Role in Risk Adjustment

The Provider's role is critical in the risk adjustment process because payments from CMS rely exclusively on complete medical record documentation and the submission of accurate diagnostic coding. The accuracy and quality of the medical record depend on thorough documentation and coding by Providers and their staff.

Providers must sign, add their credentials after their signature and date all medical record information, including but not limited to notes, diagnostic results and reports received from specialists. A signature indicates that the Provider has acknowledged and reviewed this information.

To ensure accurate payment, Providers should consider the following steps to assist in capturing all chronic conditions that qualify under the HCC model:

- All PCPs should have at least one annual face-to-face visit with each Member assigned to their panel.
- At each visit, Providers must document appropriately and provide their credentials. This includes recording all conditions and diseases, indicating the Member's name on

each page of the medical record and signing and dating each entry, making sure to identify the provider's credentials.
- Providers should code a visit based on the documentation in the medical record.
- Providers should code to the highest known specificity for all conditions at the time of the visit.
- Providers should report all of a Member's chronic conditions, using the most updated standard diagnostic code set guidelines.

Providers should submit the ICD-9-CM diagnostic data (for dates of service up to September 30, 2015) or ICD-10-CM diagnostic data (for dates of service starting October 1, 2015) to American Health Advantage of Tennessee via electronic claim form or a CMS-1500 paper claim form.

If a Member has more chronic conditions than provided for on the form, call the Provider Help Desk at (844) 321-1763 to obtain instructions for submission of the additional codes to be captured and reported to CMS.

American Health Advantage of Tennessee's Role in Risk Adjustment

The payments received by American Health Advantage of Tennessee are adjusted according to the severity of each Member's condition. To guarantee that compensation correctly reflects the Member's current health status, American Health Advantage of Tennessee must:

Educate all contracted Providers – To do so, American Health Advantage of Tennessee will provide the following:
- Individual meetings with Providers and their staffs, as requested
- Educational materials upon request.
- Provide updated and accurate reports – American Health Advantage of Tennessee has created several reports for use by Providers and their staffs to make sure Providers capture correct diagnoses.
- Conduct chart reviews – American Health Advantage of Tennessee will conduct periodic reviews and educate Providers and their staffs regarding the importance of capturing correct and full diagnoses. These reviews will be coordinated with the Provider's office staff.
- Submit the encounter data/claims detail to CMS – American Health Advantage of Tennessee must submit all encounter data and/or claims detail to CMS in a timely manner. Providers who need assistance submitting encounter data to American Health Advantage of Tennessee should contact the Provider Help Desk at (844) 321-1763 as soon as possible.

Frequently Asked Questions

These are a few of the most frequently asked questions regarding Medicare Risk Adjustment:

Q: *How often does the diagnosis have to appear to be counted for risk adjustment?*
A: The diagnosis has to appear at least once a calendar year.

Q: *Is a "typed" signature on a report acceptable for office consultation notes, a discharge summary and hospital consultations?*
A: No. The provider who dictated the report must sign it, regardless of the record type, and add his/her credentials. Electronic signatures are acceptable but must be accompanied by such words as "electronically signed by," "authenticated by" or "signed by."

Q: *Are medical records containing dictated progress notes that are dated but not signed acceptable for medical review?*
A: No. Medical record documentation should be signed and dated by the physician.

Q: *If providers submit an unsigned medical record, will American Health Advantage of Tennessee return the record to the provider for a signature?*
A: Yes, as long as it is within 30 days. Otherwise, providers must submit a new medical record with the provider's signature to substantiate the HCC.

Q: *Can a pathology report alone substantiate a risk adjustment assignment?*
A: No. Pathology and other laboratory reports simply present the actual results and generally do not have a documented diagnosis and the physician's signature. However, if such a report is signed by an M.D., has a final diagnosis and can be tied back to the actual visit, then it can be used as a coding source.

Q: *Can a radiology report alone substantiate a risk adjustment assignment?*
A: Radiology is not an acceptable source to report diagnoses for risk adjustment because it generally does not have a documented diagnosis but instead provides an impression of the findings.

Q: *Many providers use (ICD-10-CM code 125.2) if the only documentation of an old myocardial infarction (MI) is an EKG report?*
A: No. The EKG report cannot be used as a source until the procedure has been interpreted and documented in the medical record.

Q: *How often should providers document chronic conditions, such as an old myocardial infarction (MI)?*
A: Yearly, or as often as the diagnosis factors into the medical decision making.

VI. Pharmacy– Part D Services

Overview

The American Health Advantage of Tennessee Pharmacy Department manages the administration of pharmacy benefits.

American Health Advantage of Tennessee clinical pharmacist and team members are available to answer formulary and/or medication-related questions. You can contact the American Health Advantage of Tennessee pharmacy team via email at: pharmacysupport@AmHealthPlans.com.

American Health Advantage of Tennessee partners with EnvisionRx, a Prescription Benefits Manager (PBM), to administer the prescription programs for American Health Advantage of Tennessee Members.

The American Health Advantage of Tennessee formulary may be viewed by going online to tn.AmHealthPlans.com.

Pharmacy Policies

Generics

All formularies include the concept of generic medications as the preferred use medication.

Formulary

Physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee develop and maintain the formulary for American Health Advantage of Tennessee.
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits include prior authorizations, quantity limits, and/or step therapy.

-**To request coverage for a drug that has additional requirements call:**
the Pharmacy Technical Help Desk: (833) 478-6370

Excluded Medications

Medicare has excluded certain medication classes from coverage by Part D Medicare programs.

- Medications used for erectile dysfunction
- Medications used for anorexia, weight loss or weight gain
- Medications used for cosmetic purposes or hair growth
- Medications used to promote fertility
- Medications used for the symptomatic relief of cough or colds
- Nonprescription medications – Medications that, by federal law, do not require a prescription
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Alert—No Appeal for Excluded Medications
Medications falling into the categories listed above cannot be covered even for medical necessity. The decision of non-coverage cannot be appealed, nor can exceptions be made to allow for coverage.

Discontinuing, Changing or Reducing Coverage

Generally, if a American Health Advantage of Tennessee Member is taking a formulary drug that was covered at the beginning of the year, American Health Advantage of Tennessee will continue coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or when adverse information about the safety or effectiveness of a drug is released.

Other types of formulary changes, such as removing a drug from the formulary, will not affect Members currently taking the drug and will remain available at the same cost sharing for the remainder of the coverage year.

Notification of Formulary Changes

If American Health Advantage of Tennessee removes drugs from the formulary; adds coverage determinations, such as prior authorizations, quantity limits, and/or step therapy restrictions on a drug; or moves a drug to a higher cost-sharing tier, American Health Advantage of Tennessee must notify affected Members and Providers of the change at least sixty (60) days before it becomes effective.

If the Food and Drug Administration deems a formulary drug to be unsafe or if the drug's manufacturer removes it from the market, American Health Advantage of Tennessee will immediately remove the drug from the formulary and notify Members who take the drug.

Transition Policy

American Health Advantage of Tennessee may provide temporary coverage of medications for new Members who are taking non-formulary drugs or drugs that require coverage determination. American Health Advantage of Tennessee may grant a temporary 30-day supply within the Member's first 90 days of coverage effective date.

Transition coverage also is available for residents of long- term care facilities or Members whose medications are affected by a level-of-care change (e.g., discharge from acute setting or admission to/discharge from long-term care facility).

Pharmacy Network

Members must fill all medications at network pharmacies for coverage at the lowest out-of-pocket cost. Members who use non-participating pharmacies may pay higher out-of-pocket costs and must submit receipts for reimbursement.

Participating pharmacies include retail pharmacies, pharmacies that serve long-term care facilities, specialty pharmacies (home infusion pharmacies) and pharmacies owned by Indian tribal councils.

Mail-order Services

American Health Advantage of Tennessee does not offer mail-order services to our Members.

VII. Physician Rights, Responsibilities and Roles

American Health Advantage of Tennessee is committed to offering its Members access to physicians and healthcare services and facilities that provide quality care in a manner that preserves a Member's dignity, privacy and autonomy.

As such, American Health Advantage of Tennessee employees and contracted providers shall:

- Treat all Members with respect and courtesy.
- Not discriminate against Members in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, and source of payment or other protected class.
- Respond promptly to Members' questions and document communications with Members as appropriate.
- Protect Members' rights by publicizing such rights to Members, employees and network providers.
- Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to health maintenance organizations, their employees and their network providers.
- Provide Members with information concerning the benefits available to them so they may avail themselves of such benefits as appropriate.
- Make sure Members have reasonable access to the services to which they are entitled under their plans.
- Give Members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Healthcare providers shall obtain informed consent as required by law.
- Inform Members of their rights to an appeal if a provider chooses not to supply a service or treatment requested by the Member.
- Preserve the integrity and independence of clinical decision making by network providers. In making such decisions concerning a Member's medical care, network providers shall not allow themselves to be influenced by financial compensation to the provider or provider network that results from such decisions or by coverage of a particular treatment or course of care by the Member's plan.
- Follow the guidance of provider marketing training as required by the Medicare Improvements for Patients and Providers Act (MIPPA).

Provider Role in HIPAA Privacy Regulations

American Health Advantage of Tennessee policies and procedures include regulatory information to make sure American Health Advantage of Tennessee complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach- Bliley Act.

Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations – as is the staff at American Health Advantage of Tennessee.

Throughout its business areas, American Health Advantage of Tennessee has incorporated measures to make sure potential, current and former Members' Protected Health Information (PHI), individually identifiable health information and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. American Health Advantage of Tennessee employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment and healthcare operations), by the Member's written request, or if required to be disclosed by law, regulation or court order.

American Health Advantage of Tennessee developed its referral/authorization request form in accordance with the core elements and required statements contained in the HIPAA privacy rules. To determine pre- service medical necessity, providers should complete, sign and return the referral/authorization form to American Health Advantage of Tennessee.

All Members receive American Health Advantage of Tennessee's Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Members also receive a copy of the privacy information with their Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). These documents clearly explain the Members' rights concerning the privacy of their individual information, including the processes established to provide them with access to their PHI and procedures to request to amend, restrict use and have accounting of disclosures. The documents further inform Members of American Health Advantage of Tennessee's precautions to conceal individual health information from employers.

American Health Advantage of Tennessee's Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. To view the Privacy Statement and Notice of Privacy Practices, contact American Health Advantage of Tennessee Provider Help Desk at (844) 321-1763 or view the Notice of Privacy Practices on the American Health Advantage of Tennessee website.

Complying with the Americans with Disabilities Act

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines and any of its amendments, Section 504 of the Rehabilitation Act of 1973 (Section 504), and other applicable state or federal laws.

American Health Advantage of Tennessee requires that network providers' offices or facilities comply with these aforementioned statutes/laws.

The ADA and Section 504 require that providers' offices have the following modifications: (i) the office or facility must be wheelchair accessible or have provisions to accommodate people in wheelchairs; (ii) patient rest rooms should be equipped with grab bars; and (ii) handicapped parking must be available near the provider's office and be clearly marked. These aforementioned requirements are not an exhaustive list of the standards or access requirements mandated by the ADA, Section 504, or any other applicable state or federal law.

Anti-Kickback Statute

American Health Advantage of Tennessee is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, American Health Advantage of Tennessee must ensure that all Providers adhere to the Federal Anti-Kickback Statute and state equivalents (the “Anti-Kickback Policy”), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties, such as being barred from participation in federal programs.

Discounts, rebates or other reductions in price may violate the anti-kickback statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

In order to be permissible, an activity that implicates the anti-kickback statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

VIII. Medicare Advantage and Part D Fraud, Waste and Abuse

The Scope of Fraud, Waste and Abuse on the Healthcare System

During Fiscal Year (FY) 2012, the Federal government won or negotiated over $3 billion in healthcare fraud judgments and settlements. The National Health Care Anti-Fraud Association (NHCAA) website reports that healthcare loss due to fraud, waste and abuse has an impact on patients, taxpayers and the government because it leads to higher healthcare costs, insurance premiums and taxes. Healthcare fraud often hurts patients who may receive unnecessary or unsafe healthcare procedures or who may be the victims of identity theft.

Healthcare fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any healthcare benefit program.

Healthcare waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Healthcare abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Medical Identity Theft

Medical identity thieves may use a person’s name and personal information, such as their health insurance number, to make doctor’s appointments, obtain prescription drugs, and file claims with Medicare Advantage Plans. This may affect the person’s health and medical information and can potentially lead to misdiagnosis, unnecessary treatments, or incorrect prescription medication.

To limit the number of alleged incidents of medical identity theft involving Members, provider claim personnel should verify Member account numbers when filing medical claims for processing.

Reporting Fraud, Waste and Abuse

Suspected incidents of fraud, waste and abuse may be reported anonymously to the

Compliance Hotline at: (866) 205-2866

You may also report suspected fraud, waste and abuse by regular mail or email by writing to:

American Health Advantage of Tennessee
ATTN: Compliance/FWA Report
201 Jordan Road, Suite 200
Franklin, TN 37067
compliance@AmHealthPlans.com

Additional resources:

Medicare	
Customer Service	(800) 633-4227
TTY	(877) 486-2048
Website	medicare.gov/forms-healp-resources/help-fight-medicare-fraud/how-report-medicare-fraud
Office of the Inspector General	
Hotline	(800) 447-8477
TTY	(800) 377-4950
Website	oig.hhs.gov/report-fraud/index.asp
US Mail	US Department of Health and Human Services Office of Inspector General ATTN: OIG Hotline Operations PO Box 23489 Washington, DC 20026

IX. Medicare Improvements for Patients and Providers Act (MIPPA)

Rules Related to Marketing Medicare Advantage Plans

Effective January 1, 2009, the Medicare Improvements for Patients and Providers Act (MIPPA) imposed prohibitions on certain sales and marketing activities under Medicare Advantage (MA) and Medicare Advantage-Prescription Drug (MA-PD) plans. Such activities include door-to-door sales, cold calling, free meals and cross-selling of non-health-related products. These prohibited activities also include specific marketing activities in a healthcare setting by a plan sponsor or by providers with which the plan sponsor has a relationship, contracted or otherwise.

In general:

- Doctors and office staff may not encourage patients to enroll in the plan in any way; doing so is considered “steering.”
- CMS draws no distinction between exclusive and non-exclusive groups when it comes to regulations on steering.
- Providers may make available to their patients information for all plans with which they are affiliated, including common area availability for health plan events and CMS-approved marketing materials.

Providers may:

- Provide the names of plan sponsors with which they contract and/or participate (See Medicare Communications and Marketing Guidelines for additional information on provider affiliation).
- Provide information and assistance in applying for the Low-Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials.
- Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their State Medicaid Office, local Social Security Office, and CMS’ website at http://www.medicare.gov or **1-800-MEDICARE**.
- Share information with patients from CMS’ website, including the “Medicare & You” Handbook or “Medicare Options Compare” (from https://www.medicare.gov), or other documents that were written by or previously approved by CMS.
- Providers must remain neutral when assisting with enrollment decisions and may not:
  - Offer scope of appointment forms.
  - Accept Medicare enrollment applications.
  - Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
  - Mail marketing materials on behalf of plan sponsors.
  - Offer anything of value to induce plan Members to select them as their provider.
  - Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
  - Conduct health screening as a marketing activity.
  - Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
  - Distribute materials/applications within an exam room setting.

Plan Affiliations

Providers may:

- Release the names of plans with which they are affiliated.
- Announce plan affiliations through general advertising. Providers must make new affiliation announcements within the first thirty (30) days of the new contract agreement. However, new affiliation announcements that name only one plan may occur only once when using direct mail and/or e-mail. Additional communications must include all plans with which the provider contracts.
- Display affiliation banners, brochures and/or posters for all plans that have provided such materials and with which the provider is affiliated.

Plan Benefits

Providers should not compare plan benefits against other health plans, unless the materials were written or approved by CMS (for example, information generated through Medicare Plan Finder via a computer terminal for access by beneficiaries). Plan Benefits offered by American Health Advantage of Tennessee are specified in the Member's applicable Evidence of Coverage. The Evidence of Coverage is available on the Member Resources page of our website at tn.AmHealthPlans.com.

Contact Information

When requested, Providers may provide American Health Advantage of Tennessee's contact information to a prospective enrollee so that the enrollee may contact American Health Advantage of Tennessee directly regarding an expressed interest in enrolling in a plan in which the Provider participates.

However, for marketing purposes, Providers shall not release a prospective enrollee's contact information to American Health Advantage of Tennessee or an agent unless the prospective enrollee approves and/or requests to be contacted by an American Health Advantage of Tennessee representative.

Sales Presentations

Providers may allow American Health Advantage of Tennessee or its representative or agents to conduct sales presentations and to distribute and accept enrollment applications in their offices as long as the activity takes place in the "common areas" and patients are not misled or pressured into participating in such activities. ("Common areas" where marketing activities are allowed would include areas such as a hospital, nursing home or other health provider cafeteria, community or recreational rooms and conference rooms.)

Providers must not allow American Health Advantage of Tennessee to conduct sales presentations and distribute and/or accept enrollment applications in areas where patients primarily receive healthcare services. (These areas generally include but are not limited to: waiting rooms, exam rooms, hospital patient rooms and pharmacy counter areas.)

Marketing Materials

Providers may make available marketing materials about American Health Advantage of Tennessee and inform prospective enrollees where they can obtain information on all available options within the service area (e.g., **1-800- MEDICARE** or www.medicare.gov). If Providers choose to allow information for one plan, they must allow other plans affiliated with that Provider to do the same.

Providers are prohibited from mailing marketing materials (e.g., enrollment kits) on behalf of American Health Advantage of Tennessee or any other Medicare Advantage/Prescription Drug plan with which they participate.

Distributing Information

Providers may distribute Medicare Plan Finder information. They may print out and share such information from the Medicare.gov website with their patients.

Providers must not perform health screening when distributing American Health Advantage of Tennessee information to patients. This is prohibited under MIPPA.

Providers are encouraged to participate in educational events, including health fairs. However, they must not engage in marketing activities at such events.

Providers prohibited from accepting enrollment applications from prospective enrollees or offer scope of appointment forms to prospective enrollees.

Providers must not expect or accept compensation, directly or indirectly, in consideration for the enrollment of a prospective enrollee or for enrollment or marketing activities.

Questions should be directed to the Provider Help Desk at (844) 321-1763.

X. Legal and Compliance

Overview

American Health Advantage of Tennessee Corporate Governance and Compliance program requires adherence with legislation, regulation and general good practice. Compliance itself is the demonstrable evidence of an entity to meet prescribed standards and be able to maintain a history of meeting those standards, which form the requirements of an established compliance structure.

American Health Advantage of Tennessee's Compliance Program provides a framework from which the organization can assess its compliance with applicable State and Federal regulations and established organizational policies and procedures.

In this section, Legal and Compliance refers to State and Federal regulations as well as Federal laws governing the Health Information Portability & Accountability Act (HIPAA), the protection and security of a Member's Protected Health Information (PHI) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The Compliance Program

American Health Advantage of Tennessee has established a comprehensive Compliance Program and is committed to ensuring that all organizational areas are, and remain, compliant with applicable State and Federal regulatory requirements. The Compliance Program is an organizational value-based system that will identify, detect, prevent, correct and report suspected non-compliance with State and Federal regulatory requirements. American Health Advantage of Tennessee works collaboratively with State and Federal regulatory agencies to achieve the mutual goals of providing quality healthcare and the effective elimination of fraud, waste and abuse.

American Health Advantage of Tennessee designed the Compliance Program and all efforts surrounding this program to establish a culture that promotes prevention, detection and resolution of conduct that may not conform to State and Federal laws, including Federal healthcare program requirements as well as American Health Advantage of Tennessee's ethical and legal policies and standards of conduct.

In practice, the Compliance Program and the Code of Conduct and Business Ethics effectively articulate and demonstrate American Health Advantage of Tennessee's commitment to legal and ethical conduct.

Responsibilities

The Compliance Program has responsibilities in three functional areas:

- Medicare Advantage Operational Compliance;
- Monitoring & Delegated Entity Oversight (MDO) and
- Compliance – Sales Oversight (CSO)

The following three sections detail of each areas responsibilities:

Medicare Advantage Compliance Operational Oversight

This functional area includes:

- Managing regulatory affairs
- Distributing and providing guidance regarding interpretation of CMS Health Plan Management System (HPMS) released policy and other regulatory updates
- Ensuring operational and technical compliance across all operations and clinical areas via internal monitoring and audits and open lines of communications
- Enforcing disciplinary and corrective actions for compliance violations and deficiencies
- Ensuring the development and maintenance of operational and corporate policies and procedures
- Building and maintaining relationships with CMS
- Managing the review and approval of all collateral materials including sales and marketing as well as all Member, Agent and Provider materials

Compliance Monitoring & Delegation Oversight

This functional area includes:

- Annual and routine monitoring of the activities of delegated entities and the various Business and Operational Areas
- Assignment and oversight of the Corrective Action Plan process
- Validation of the timely implementation of regulatory mandates which may impact current processes and protocols
- Annual Risk Assessment
- Ensuring the appropriate and timely management of activities to prevent, detect and correct fraud, waste and abuse
- Providing oversight for the Health Information Portability and Accountability Act (HIPAA)

Compliance Sales & Marketing Oversight

This functional area includes:

- Investigating allegations of agent misconduct
- Ensuring appropriate Agent training and certification
- Market Event Surveillance activities (i.e. event secret shopping)
- The Compliant registration of agent marketing/sales events upon CMS' request
- Ongoing review and processing of the HPMS Complaints Tracking Module
- Agent Quality, including, but not limited to, Agent verification call monitoring, telephonic scope of appointment monitoring, monitoring applications for timeliness, etc.
- Ongoing auditing and monitoring of all Agent activities within the service area as well as oversight of sales support, which includes sales training, Agent contracting, Agent commissions and sales quality

Seven Elements of an Effective Compliance Program

The American Health Advantage of Tennessee Compliance Program fulfills all of the requirements as provided by the Office of Inspector General (OIG), Health and Human Services (HHS) and CMS for a comprehensive Compliance Program.

The seven elements of an effective Compliance Program are as follows:

1. Written policies and procedures
2. Designated Compliance Officer and Compliance Committee
3. Effective training and education
4. Effective lines of communication
5. Internal monitoring and auditing
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Prompt response to detected problems through corrective actions

The Compliance Program, as part of each of these elements, addresses the prevention, detection and correction of potential compliance issues as well as the on-going oversight of Fraud, Waste and Abuse (FWA) by American Health Advantage of Tennessee. Throughout, the Compliance Program there are provisions for interpretive rules and guidance to help establish and maintain an effective Compliance Program to prevent, detect and correct FWA and potential Medicare program non-compliance.

American Health Advantage of Tennessee providers and contractors are defined by CMS as “first tier, downstream and related entities,” (FDRs) which are individuals or entities that furnish services to Medicare Advantage members under written agreement with American Health Advantage of Tennessee or contracted entities. American Health Advantage of Tennessee is obligated under its CMS contract to ensure that all these entities receive the Compliance Program and Code of Conduct and Business Ethics.

XI. Federal & State Regulations

Overview

There are a number of Federal Regulations that affect American Health Advantage of Tennessee’s day-to-day operations. These regulations set the benchmarks by which American Health Advantage of Tennessee reviews all internal business and operational processes as well as external business initiatives and relationships.

These regulations include, but are not limited to:

- The Health Information Portability & Accountability Act (HIPAA)
- The Medicare Improvements for Patients and Providers Act (MIPPA)
- The False Claims Act and Fraud Enforcement Recovery Act
- Physician Self-Referral Law (Stark Law)
- Anti-Kickback Statute
- Fraud, Waste and Abuse
- The HITECH Act

Health Information Portability & Accountability Act (HIPAA)

Congress introduced this act in 1996 to protect health insurance coverage for workers and their families when they change or lose their jobs. It also requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans and employers; and helps people keep their information private.

Medicare Improvements for Patients and Providers Act (MIPPA)

Congress introduced this act in 2008 to enhance the quality of healthcare, expand access to care and provide coverage for certain preventative services. MIPPA is addressed in more detail in a prior section of this Manual

False Claims Act and Fraud Enforcement Recovery Act

The False Claims Act (31 U.S.C. Sections 3729-33) allows a private individual or "whistleblower," with knowledge of past or present fraud on the Federal government, to sue on behalf of the government to recover stiff civil penalties and triple damages. The person bringing the suit was formally known as the "Relator." The False Claims Act is also called the "Qui Tam statute." The Department of Justice saw a record 647 qui tam suits filed in fiscal year 2012 and recovered a record $3.3 billion in suits filed by whistleblowers during that period.5

Generally, only the Relator who is the first to file a lawsuit can receive a reward for reporting the fraud. Even if one person uncovers the fraud, someone else can file the lawsuit first and bar the first person from sharing in any recovery.

Congress strengthened and broadened the scope of the False Claims Act by passing the Fraud Enforcement and Recovery Act (FERA) of 2009. FERA extends the liability for False Claims Act violations to claims not directly submitted to the government (e.g., the False Claims Act attaches for false claims presented to Medicare Advantage plans). FERA strengthened whistleblower protection, relaxed the standard for False Claims Act violations, and made retention of overpayments made to a provider a violation of the False Claims Act.

Physician Self-Referral Law (Stark Law)

Congressional concern with the implications of self-referral arrangements led to the inclusion in the Omnibus Budget Reconciliation Act of 1989 ("OBRA 1989") of a provision barring self-referral arrangements for clinical laboratory services under the Medicare program.

The Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"), known as "Stark II," extended the ban, effective January 1, 1995, to an additional list of services and applied it to Medicaid at the same time. CMS has issued a series of implementing regulations. CMS issued "Phase III" of the final regulations September 5, 2007.

"Self-referrals" occur when physicians refer patients to for services in which they (directly or indirectly) have a financial interest. This interest can be in the form of ownership or investment interest in the entity; it may also be a compensation arrangement between the physician and the entity.

In September 2010, CMS published the Medicare Self-Referral Disclosure Protocol ("SDRP") which sets forth a process to enable providers to self-disclose actual or potential violations of the Stark Law. For further information on SDRP, please use the email 1877CallCenter@cms.hhs.gov or call **410-786-4568**.

Anti-Kickback Statute

American Health Advantage of Tennessee is committed to conducting its business activities in full compliance with applicable Federal and State laws. In support of this commitment, American Health Advantage of Tennessee must ensure that all Providers adhere to the Federal Anti-Kickback Statute and state equivalents (the “Anti-Kickback Policy”), which applies to all covered persons.

The Anti-Kickback Statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of Federal healthcare program business may face charges, including felony charges, and/or civil penalties such as being debarred from participation in federal programs.

Discounts, rebates or other reductions in price may violate the Anti-Kickback Statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program.

In order to be permissible, an activity that implicates the Anti-Kickback Statute must qualify for protection under a specific Safe Harbor. For a complete list of Safe Harbor activities, please refer to the Medicare and Medicaid Fraud and Abuse Statute. (42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952) or consult your legal counsel.

Fraud, Waste and Abuse

Congress enacted Fraud, Waste, and Abuse in 2007 as part of the Deficit Reduction Act (DRA) of 2005. This act requires entities to establish written policies providing detailed information about fraud, waste and abuse in Federal healthcare programs and to distribute these policies to employees, agents and contractors.

The HITECH Act

The American Recovery and Reinvestment Act (ARRA) was signed into law on February 17, 2009. Among many other things, the ARRA dedicates substantial resources to health information technology that supports the secure electronic exchange and use of health information.

Title XIII of Division A and Title IV of Division B of the Act are referred to as the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The HITECH Act includes a number of measures designed to broaden the scope and increase the rigor of HIPAA compliance. The HITECH Act expands the reach of HIPAA data privacy and security requirements to include the Business Associates of those entities (healthcare providers, pharmacies, and the like) that are subject to HIPAA. Business Associates are companies such as accounting firms, billing agencies, law firms or others that provide services to entities covered under HIPAA.

Under the HITECH Act, companies are now directly subject to HIPAA security and privacy requirements as well as to the same civil and criminal penalties that hospitals, pharmacies and other HIPAA-covered entities face for violations. Before HITECH came into force, Business

Associates that failed to properly protect patient information were liable to the covered entities via their service contracts, but they did not face governmental penalties.

The HITECH Act specifies that Business Associates will be subject to the same civil and criminal penalties previously imposed only on covered entities. As amended by the HITECH Act, civil penalties range from $100 to $50,000 per violation with caps of $25,000 to $1.5 million for all violations of a single requirement in a calendar year. Criminal penalties include fines up to $50,000 and imprisonment for up to one year. In some instances, fines are mandatory.

State Regulations

Many state regulations also have an impact on American Health Advantage of Tennessee’s day-to-day operations. Many of these regulations relate to Medicaid and/or relationships existing between governmental entities and American Health Advantage of Tennessee.

In addition, many states now have enforceable regulations related to HIPAA, the False Claims Act and Patient Anti-Brokering or Anti-Referral Acts, which mirror the Federal regulations and, rather than being pre-emptive, are in addition to the Federal mandates under which American Health Advantage of Tennessee operates.

To address these regulations on a state-by-state basis would be too voluminous to include in this provider manual. However, American Health Advantage of Tennessee is always available to Providers to discuss any concerns or questions regarding the applicability of state regulations to our relationship with Providers.

XII. Glossary and Abbreviations

Glossary of Healthcare Terms

Abuse
Incidents inconsistent with accepted medical or business practices, improper or excessive.

Advance Directive
A written document that states how and by whom a Member wants medical decisions to be made if that Member loses the ability to make such decisions for himself or herself. The two most common forms of Advance Directives are living wills and durable powers of attorney.

Ancillary Services
Healthcare services that are not directly available to Members but are provided as a consequence of another covered healthcare service, such as radiology, pathology, laboratory and anesthesiology.

Benefit plan
The schedule of benefits establishing the terms and conditions pursuant to which Members enrolled in American Health Advantage of Tennessee receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment, coinsurance, deductible and/or out-of-pocket maximum amounts; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Board-Certified
Term describing a practitioner who has completed residency training in a medical specialty and has passed a written and oral examination established in that specialty by a national board of review.

Claim
A request by a healthcare Provider for payment for services rendered to a Member.

Clean Claim
A claim that has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term shall not include a claim from a healthcare Provider who is under investigation for fraud and abuse regarding that claim.

Coinsurance
A cost-sharing requirement that provides that a Member will assume responsibility for payment of a fixed amount or percentage of the cost of a covered service, where the cost is generally the allowed amount under the fee schedule.

Complaint
A dispute or objection regarding a Provider or the coverage, operations, or management policies that has not been resolved and has been filed with American Health Advantage of Tennessee or with the appropriate state Department of Insurance. A complaint is not the same as a grievance.

Coordination of Benefits (COB)
The process to prevent duplicate payment of medical expenses when two or more insurance plans or government benefits plans provide coverage to the same person. The rules that determine which insurer provides primary or secondary coverage are governed by healthcare industry standards and, in some instances, by applicable regulatory agencies.

Copayment
Cost-sharing arrangement in which the Member pays a specified flat or fixed amount for a specific service (such as an office visit or prescription drugs).

Covered Services
Healthcare services for which a health plan is responsible for payment according to the benefit package purchased by the Member.

Credentialing
American Health Advantage of Tennessee's review procedure in which potential or existing network Providers must meet certain standards to begin or continue participation in the network of American Health Advantage of Tennessee. The credentialing process may include examination of a Provider's certifications, licensures, training, privileges and/or professional competence.

Deductible
Amount the Member may be required to pay for covered services before American Health Advantage of Tennessee begins to pay for such services.

Disenrollment
Process of termination of a Member's coverage.

Durable Medical Equipment (DME)
Medical equipment, owned or rented, that is placed in the home of a Member to facilitate treatment and/or rehabilitation.

Emergency Services
Any healthcare service provided to a Member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the Member (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily function, or
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service, if the condition of the Member is as described above.

Encounter Data
Data relating to treatment or service rendered by a Provider to a Member regardless of whether the Provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

Enrollment
Process by which a health plan signs up groups and individuals for Membership.

Explanation of Benefits (EOB)
Statement that explains the benefits provided; the allowable reimbursement amounts; any deductibles, coinsurance or other adjustments taken; and the net amount paid.

Fraud
The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit.

Grievance
A type of complaint you make about us or one of our network Providers or pharmacies, including a complaint concerning the quality of your care. This type or complaint does not involve coverage or payment disputes.

Health Maintenance Organizations (HMO)
Sometimes called “managed care organizations,” HMOs contract with doctors and hospitals who agree to accept their payments. In an HMO, a member agrees to receive care from the doctors, hospitals, and other Providers who contract with the HMO.

Health Plan Employer Data Information Set (HEDIS)
A core set of performance measures developed and managed by the National Committee for Quality Assurance (NCQA) to assist employers and other purchasers in evaluating health plan performance. Also used by government agencies to monitor quality of care provided or arranged by health plans.

Health Insurance Portability and Accountability Act (HIPAA)
Regulations regarding the use and disclosure of certain information held by "covered entities" (generally, healthcare clearinghouses, employer sponsored health plans, health insurers, and medical service Providers that engage in certain transactions.). Establishes regulations for the use and disclosure of Protected Health Information (PHI), which is any information held by a covered entity concerning health status, provision of healthcare or payment for healthcare that can be linked to an individual.

Medicare Advantage Plan
Medicare Advantage Plans are health plan options offered by private insurance companies that are approved by The Centers for Medicare and Medicaid Services. If a beneficiary joins one of these plans, the beneficiary generally gets all Medicare-covered healthcare through that plan. Medicare Advantage Plans (called MA Plans) combine Part A (hospital insurance) and Part B (medical insurance) together in one plan, and they can also be combined with Part D prescription drug coverage (called MA-PD Plans).

National Provider Identifier
The number used to identify healthcare Providers in standard transactions, such as healthcare claims. The NPI is the only healthcare Provider identifier that can be used for identification purposes in standard transactions by covered entities. It eliminates UPIN numbers – multiple Provider numbers assigned by Medicare, Medicaid and private payers.

Network
Group of physicians, hospitals, laboratories and other healthcare Providers who participate in American Health Advantage of Tennessee's healthcare delivery system. The Providers agree to undergo American Health Advantage of Tennessee's credentialing process, follow American Health Advantage of Tennessee's policies and procedures, submit to monitoring of their practices and provide services to Members at contracted rates.

Out-of-Area Care
Care for illness or injury that is delivered to Members traveling outside the American Health Advantage of Tennessee designated service area.

Out-of-Network Care
Care performed by non-contracted providers who do not participate in American Health Advantage of Tennessee's network.

Out-of-Pocket Expenses
Payments toward eligible expenses that a Member funds for himself/herself and/or dependents, including copayments, coinsurance and deductibles.

Participating or Network Provider
Facility, hospital, doctor or other healthcare provider that has been credentialed by and mutally executed a American Health Advantage of Tennessee Provider Participation Agreement to provide services.

Primary Care Physician (PCP)
A healthcare practitioner who, within the scope of his/her practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide healthcare services to a Member, initiates Member referral for specialist care and maintains continuity of care for enrolled Members of American Health Advantage of Tennessee.

Specialist
Provider or practitioner who specializes in a particular medical specialty (e.g.cardiology, dermatology, orthopedics, general surgery, etc).

Waste
Acting with gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit.

Abbreviations

ADA—Americans with Disabilities Act
ASA—American Society of Anesthesiologists

CAD—Coronary Artery Disease
CAHPS—Consumer Assessment of Health plan Survey
CCI—Correct Coding Initiative
CDC— Centers for Disease Control
CHF— Congestive Heart Failure
CLIA—Clinical Laboratory Improvement Amendments
CME—Continuing Medical Education (credits)
CMS— Centers for Medicare & Medicaid Services
COPD—
Chronic Obstructive Pulmonary Disease
CPT—Current Procedural Terminology
CRNA—Certified Registered Nurse Anesthetist
CRNP—Certified Registered Nurse Practitioner
DO—Doctor of Osteopathy
DME—Durable Medical Equipment

DPM—Doctor of Podiatric Medicine
EAP—Employee Assistance Program
EDI—Electronic Data Interchange
E&M—Evaluation and Management
EPO—Exclusive Provider Organization
EOB—Explanation of Benefits
ESRD—End-Stage Renal Disease
FDA—Food and Drug Administration
HCC—Hierarchical Condition Category
HCFA— Health Care Financing Administration
HEDIS— Health Plan Employer Data Information Set
HIPAA—Health Insurance Portability and Accountability Act
HMO—Health Maintenance Organization
ID—Identification
IPA—Independent Practice Association
LPO—Local Physician Organization
MD—Medical Doctor
MI— Myocardial Infarction
MRA—Medicare Risk Adjustment
NCQA—National Committee for Quality Assurance
NDC#—National Drug Classification Code number
NPI—National Provider Identifier
NSAIDs—Non-Steroidal Anti-Inflammatory Drugs
OB-GYN—Obstetrician-Gynecologist
OTC—Over-the-Counter
PA—Certified Physician Assistant
PCP—Primary Care Physician
PRO— Peer Review Organization
PSA— Prostate Specific Antigen
QIC—Quality Improvement Compliance Committee
TrOOP—True Out-Of-Pocket
UB—Uniform Billing code
UPIN—Universal Provider Identification Number

Appendix

AMERICAN HEALTH ADVANTAGE OF TENNESSEE

PROVIDER DISPUTE RESOLUTION REQUEST

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Mail the completed form, along with any required supporting documentation to:

American Health Advantage of Tennessee
201 Jordan Road, Suite 200
Franklin, TN 37067
Toll-Free: 1-844-321-1763
Or Fax to 1-844-280-5360

*Provider NPI:	*Provider Tax ID:
*Provider Name:	Contracted: ☐ Yes ☐ No
*Provider Address:	
Provider Type: ☐ SNF ☐ Hospital ☐ Ambulance ☐ DME ☐ Rehab ☐ Other(Please specify): _____	
CLAIM INFORMATION: ☐ Single ☐ Multiple (please provide listing) Number of Claims: _____	
*Patient Name:	
*Health Plan ID Number:	Claim Number:
*Date of Service:	Original Claim Amount Billed:
DISPUTE TYPE: ☐ Claim Denial ☐ Disputing Request for Reimbursement of Overpayment ☐ Disputing Underpayment of Claim Paid ☐ Other: _____	
*DESCRIPTION OF DISPUTE:	
EXPECTED OUTCOME:	
Contact Name:	Title:
Signature:	Date:
Phone#:	Fax #:

☐ Mark here if additional information is attached (please do not staple)

Note: **Non-Par Providers have 60 days from denial date to file appeal for post service claims.**
Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.

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