Steward Health Care Network

HEALTH | CHOICE

GENERATIONS

2019 PROVIDER MANUAL

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CHAPTER 1:

Introduction to Steward Health Choice Generations Utah HMO SNP

Steward Health Choice Generations Utah Provider Manual

The Steward Health Choice Generations Utah Provider Manual focuses on the requirements for relationships between Medicare Advantage organizations (MA organizations) and the physicians, hospitals, and other health care professionals and providers with whom they contract to provide services to Medicare beneficiaries enrolled in a Medicare Advantage (MA) plan.

This Steward Health Choice Generations Utah Physician/Provider Manual is not a replacement to the Steward Health Choice Utah, Inc. Provider Manual (SHCU Physician/Provider Manual). All Steward Health Choice Utah Providers who participate in the Steward Health Choice Generations Utah HMO SNP (Steward Health Choice Generations) plan are subject to the same responsibilities and rules under the Centers for Medicare and Medicaid Services (CMS). Please refer to the SHCU Physician/Provider Manual for contractual requirements, processes and forms associated with Steward Health Choice Generations.

Introduction to Steward Health Choice Generations HMO SNP

Steward Health Choice Generations, an affiliate of Steward Health Choice Utah, Inc. (SHCU), has contracted with the Centers for Medicare and Medicaid Services (CMS) to be a Dual Eligible Special Needs Plan (HMO D-SNP) under the Medicare Advantage program beginning January 1, 2019. Since May 1, 2012, we have served beneficiaries eligible for Utah Medicaid.

This SHCU Provider Manual contains basic information about the administration of Steward Health Choice Generations. The intent of this Provider Manual is to furnish contracted providers and their staff with information about Steward Health Choice Generations, covered services, processes and claim submission requirements.

Steward Health Choice Generations HMO SNP Overview

Steward Health Choice Generations provides covered services to members in five Utah counties:

- Davis
- Salt Lake
- Tooele
- Utah
- Weber

Our commitment is to provide high quality, cost-effective healthcare to dual eligible Medicare and Medicaid members throughout the state of Utah.

Network Management

Steward Health Choice Generations is responsible for covering services for members through a comprehensive provider network of physicians and facilities that contract with Steward Health Choice Generations including primary care physicians, specialists, dentists, medical facilities, and ancillary service providers. The Steward Health Choice Generations network has been carefully developed to include those contracted healthcare professionals who meet certain criteria such as availability, location, specialty, hospital privileges, quality of care, and acceptance of Steward Health Choice Generations managed care principles and financial considerations.

Contracted healthcare professionals are required to coordinate member care within the Steward Health Choice Generations Provider Network. That means all referrals for Steward Heath Choice Generations Members must be directed to Steward Health Choice Generations contracted providers. Referrals outside of the network *may* be permitted but only with prior authorization from Steward Health Choice Generations.

Questions concerning the Steward Health Choice Generations network should be directed to our Network Services Department, specifically to the attention of your Network Services Representative. Within Steward Health Choice Generations, the Network Services Department is the primary point of contact for providers who require assistance. Its Network Services Representatives are responsible for getting providers information, fulfilling their requests, and serving as their liaison to other departments within Steward Health Choice Generations. Please do not hesitate to contact your Network Services Representative whenever necessary.

CHAPTER 2:

Member Services

Member Services

Phone: 1-844-457-8943 (TTY 711)
Email: Comments@steward.org
Hours of Operations: 8 a.m. – 8 p.m., 7 days a week

Steward Health Choice Generations Utah (Steward Health Choice Generations) Members and their medical care are very important to us. To ensure their needs are met, Steward Health Choice Generations Member Services coordinates all membership activities.

The primary functions of Member Services include:

- • Verification of Member eligibility
- • Primary care physician (PCP) assignment and changes
- • Responding to and resolving Member complaints
- • Arranging translation services including hearing impaired and sign language
- • Conducting Member Satisfaction Surveys

Member Eligibility

There are two (2) ways for providers to check eligibility:

(1) By accessing the Steward Health Choice Generations **Web Site, located at www.stewardhcgenerations.com**. All providers are required to pre-register on the website to gain access for member eligibility through the Provider Portal. If you need assistance registering, please contact your Network Services Representative.
(2) By calling Steward Health Choice Generations Member Services at: **1-844-457-8943**.

The Member's ID card covers both Medical and Prescription benefits. All providers, including pharmacies, should ask to see the Steward Health Choice Generations Member ID Card at each point of contact.

Steward Health Choice Generations has asked members to keep their original "Red, White and Blue" Medicare card in a safe place, but the Steward Health Choice Generations ID card is needed to get Medicare covered services. If the Member's Steward Health Choice Generations card is damaged, lost or stolen, encourage the Member to contact Member Services at 1-844-457-8943 for a replacement.

"Disenrollment" from Steward Health Choice Generations means ending membership in Steward Health Choice Generations. Disenrollment can be voluntary (member choice) or involuntary (not member choice). Generally, there are limits on when and how often members can change the way they get Medicare. Switching from one plan like Steward Health Choice Generations to a plan offered by another organization, or to Original Medicare, counts towards making a change.

Since members have Medicare and Medicaid coverage from Utah Medicaid, members can change to another plan once per quarter and the change is effective the first day of the following month. If the member lives in a long-term care facility like a nursing home, they may qualify for a SEP which will allow a plan change outside of the quarterly enrollment.

Some of the reasons members might want to leave Health Choice Generations and join another plan:

- Voluntary: Members might leave Steward Health Choice Generations because members have decided that they want to leave. Members can do this for any reason.
- Involuntary: There are also a few situations where members would be required to leave. For example, members would have to leave Steward Health Choice Generations if members move permanently out of our geographic service area; if members lose Utah Medicaid coverage or Medicare Parts A and B coverage; or if Steward Health Choice Generations leaves the Medicare program.

We are not allowed to ask members to leave the plan because of their health status.

What happens if Member loses their Utah Medicaid benefits?

Steward Health Choice Generations Members must have Utah Medicaid and have Medicare Parts A and B. If members lose Utah Medicaid eligibility, we are required by CMS to give members a six month grace period after which members will be disenrolled from Steward Health Choice Generations if members do not re-establish their Utah Medicaid eligibility.

During this time, members will receive Medicare benefits through Steward Health Choice Generations because they will be deemed eligible. In other words, if members lose Utah Medicaid eligibility, Steward Health Choice Generations will pay for their Medicare benefits for six months from the date the member loses their Utah Medicaid benefits.

Steward Health Choice Generations generally follows Medicare coverage rules for services, meaning when Original Medicare benefits run out, Steward Health Choice Generations benefits will terminate. However, there may be instances where an addition or an extension of exhausted Medicare benefits is available from Steward Health Choice Utah or another Utah Medicaid plan.

Steward Health Choice Generations encourages members to contact Member Services. Steward Health Choice Generations will assist members in the coordination of medical care between Medicare services and Medicaid services - whether it is Steward Health Choice or another Utah Medicaid health plan - with appropriate staff, to the extent possible.

If Members decide to Leave Steward Health Choice Generations

What members must do to leave Steward Health Choice Generations depends on whether members want to switch to Original Medicare or to another Medicare Advantage plan.

- **Original Medicare** is available throughout the country. Original Medicare is fee-for-service coverage that lets members go to any doctor, hospital, or other healthcare provider who accepts Medicare. The government pays providers directly for the Medicare-approved amount, and members pay their share (coinsurance). For members with Medicare and Utah Medicaid, in most cases, their cost sharing is covered by Utah Medicaid.
- **Medicare Advantage Plans** (including HMOs such as Steward Health Choice Generations, PPOs, and Private Fee-for-service plans) are available in most parts of the country. In HMOs and PPOs, members get all their Medicare-covered Part A and Part B health care through the plan. Most Medicare Advantage Plans ***also include prescription drug coverage*** as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays Medicare Advantage plans a set amount of money every month to cover services for its members.

Primary Care Physician (PCP) Selection

Steward Health Choice Generations contracts with Family Practice, General Practice, Geriatric, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled Steward Health Choice Generations Members. If a member does not choose a PCP, the Steward Health Choice Generations Member Services Department assigns the member to a PCP based on geographic location and language preference.

Each new Steward Health Choice Generations Member enrolled with Steward Health Choice Generations will receive an Explanation of Coverage (EOC) that outlines the Member's Rights and Responsibilities. The EOC is a resource that provides assistance for members on how to obtain health care services through Steward Health Choice Generations.

There are instances when Steward Health Choice Generations may restrict a Member's choice of PCP. Examples include, but are not limited to, when a member frequently changes their PCP or for medically necessary reasons.

Member Rosters

Member Rosters list PCPs' assigned members as of the first day of the month. This information can be accessed on the Steward Health Choice Generations Provider Portal.

If a member seeking care is not listed on your roster, please have the member call Steward Health Choice Generations Member Services to change PCPs. The panel addition form is also available for your use in adding a member to your panel. Please contact your Network Services Representative for assistance.

Steward Health Choice Generations Member Add To a Closed Panel

Should a provider whose panel is closed wish to add a member to their Health Choice Generations panel, it must be submitted in writing and signed by a practice representative with signature authority. You can fax or email the form to us. Contact your Network Services Representative for the form and assistance.

Physician Request to Remove Steward Health Choice Generations Member from Panel

Member removal from your roster should be considered as a last resort.

Rather than remove these members from your roster, we prefer to collaborate with members in managing their health care. Depending on the issue, we will either contact the member directly or coordinate with our Case Management Department to attempt to resolve the issue.

It is important for your office to continue providing care to the member during this process. If no improvement is achieved after our interventions, it may be agreed that the member needs a new primary care physician.

However should you request a Steward Health Choice Generations Member be removed from your panel the following are required:

- It must be submitted in writing and signed by the physician.
- A copy of the notice to the member must also be given.

Member assignment changes are effective approximately 5 days following notification. Both Members and Providers can fax requests to Member Services.

Resources and Contacts for Steward Health Choice Generations Members

Medicare Program

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including Steward Health Choice Generations). Here are ways to get help and information about Medicare from CMS:

- Call **(800) MEDICARE** (800-633-4227) toll free to ask questions or get free information booklets from Medicare. Members can call this national Medicare Help line24 hours a day, 7 days a week. TTY users should call 711.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information.** This website gives members up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets members can print directly from their computer. It has tools to help members compare Medicare Advantage Plans and Prescription Drug Plans in your area. Members can also

search the "Helpful Contacts" section for the Medicare contacts in your state. If members do not have a computer, your local library or senior center may be able to help members visit this website using their computer.

Utah State Health Insurance Assistance Program (SHIP) – an organization in Utah that provides free Medicare help and information

The Utah State Health Insurance Assistance Program is paid by the federal government to give free health insurance information and help to people with Medicare. The Utah State Health Insurance Assistance Program can explain Medicare rights and protections, help members make complaints about care or treatment, and help straighten out problems with Medicare bills. The Utah State Health Insurance Assistance Program has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan (like Steward Health Choice Generations) for the first time.

Members can contact the Utah State Health Insurance Assistance Program at:

Utah Aging and Adult Services
195 North 1950 West
Salt Lake City, Utah 84116
Phone: (801) 538-3910
Toll free: 1-877-424-4640
Website: https://daas.utah.gov/

Members can also find the website for the Utah Health Insurance Assistance Program at www.medicare.gov on the web.

The Utah Department of Health (UDOH) – administers the Utah Medicaid Program which serves Utah residents that meet certain income and other requirements.

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid.

Steward Health Choice Utah is one of the Utah Medicaid health plans in Utah. Most healthcare costs are covered if members qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for Medicare premiums and other costs, if members qualify. To find out more about Medicaid and its programs you can contact:

(Utah Medicaid) Medicaid Information
288 N 1460 W, Salt Lake City, UT 84116
Phone: (801) 538-6155
Toll-free 1-800-662-9651

Alternatively, contact Steward Health Choice Generations Member Services Department at 1-844-457-8943 (TTY users711), 7 days a week, 8 a.m. - 8 p.m.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivor's benefits, and benefits for the aged, blind, and disabled. Members can call the Social Security Administration toll free at (800) 772-1213. TTY users should call 711. Members can also visit www.ssa.gov on the web.

Railroad Retirement Board

If members get benefits from the Railroad Retirement Board, members can call (877) 772-5772 TTY users should call 711. Members can also visit https://www.rrb.gov/ on the web.

CHAPTER 3:

Provider Responsibility

Medicare Participation Standards

All providers must meet the standards for participation and all applicable requirements for providers of health care services under the Medicare Program and follow facility standards established by CMS.

Persons Excluded from Medicare Participation

Providers must not employ, or contract with, any person who has been excluded from participation in the Medicare Program under Sections 1128 or 1128A of the Social Security Act (42 USC Sections 1320a-7 and 1320a-7a) for the provision of any (1) health care services, (2) utilization review, 3) medical social work or (4) administrative services. Please ensure that you check the Exclusion Lists prior to hiring new employees.

Medicare, UPIN, National Provider Identification Numbers

All contracted providers who participate with Steward Health Choice Generations Utah (Steward Health Choice Generations) may not be a “Medicare Participating” provider; however providers are required to follow the appropriate requirements that apply to their specialty type identified by CMS.

Providers must submit claims with the appropriate provider identification number, regardless of reimbursement method, on a valid claim form or via an electronic method. Providers must utilize the most current diagnostic and procedure coding guidelines, including International Classification of Diseases (ICD), American Medical Association Current Procedural Terminology (AMA CPT), Health Care Financing Administration Common Procedural Coding System (HCPCS), National Drug Code (NDC), Diagnostic Statistical Manual (DSM), Current Dental Terminology (CDT), CMS 1500, Uniform Billing Data Elements (UB) Specification Manual, and State identified CPT/HCPCS codes as directed by Steward Health Choice Utah, Inc.

National Provider Identification (NPI) vs. Tax Identification Number (TIN)

Important Information about NPI Numbers: The NPI rule will require health plans to identify providers based first on NPI number, instead of Tax ID. Therefore, all electronic payments and ERA’s (835s) will be based on the NPI. This is especially important for Group Practices. If Group Practices that now bill under one Tax ID do not register for a Group NPI, individual electronic payments will have to be made to each individual NPI holder. To avoid this administrative burden, request a Group NPI for your Group Practice.

In the past, a provider's tax identification number determined the address to which payment is sent. Steward Health Choice Generations requires providers to enter their tax identification number on all claims. If the tax identification number is not included in the appropriate box of the claim form or match what is in our Steward Health Choice Generations payment system, payments may be denied or claims may be rejected and returned to the provider. We highly encourage providers to both enroll to be paid via electronic funds transfers (EFTs) and to receive electronic remittance advices (ERAs).

Notifications-Practice/Company Changes, Updates, Additions

Contracted providers are required to notify your Network Services Representative in writing of ***any changes*** at least 30 days prior to the effective date of change. Examples of changes, updates, additions, terminations:

- Practice/company name
- Physical services addresses
- Payee address
- Tax identification number
- Provider additions/terminations
- Phone and/or fax numbers

By not keeping your information current, you may experience claim rejections, non-payments or returned check payments.

Providers may use the Request for Participation / Update Information and Change Sheet or fax the information on Letterhead or a notice signed by the Practice/Company staff to (801) 358-3120**.**

Changes in your administrative staffing also should be reported to your Network Services Representative. If we can provide staff training, please contact your Network Services Representative. Keeping your staff trained saves you time and money.

Provider Contract/Terminations

Because Steward Health Choice Generations members must be notified at least 30 (thirty) days in advance of a terminating provider, Providers are required to notify your Network Services Representative in writing of your decision to terminate or of all terminated providers in the group practice at least 90 (ninety) days in advance. This notice must be signed by the physician or practice/company staff with signature authority; it may be mailed or faxed to Steward Health Choice Utah, Inc. Attn: Network Services Department.

Providers terminating their contracts without cause are required to continue to treat members until their treatment course is completed. Early notification will assist you and the member in transferring care, should that be required. Authorization may be necessary for these services.

Should a member need to be transferred to another Steward Health Choice Generations provider as a result of termination, the provider can assist in the process by:

- Providing a copy of the member’s medical record to the member or accepting provider, should it be requested.
- Speaking with the accepting provider regarding transfer of care issues.

The transferring provider will communicate all health care treatment to ensure continuity of care for the member. In some areas where there are limited specialty providers, Steward Health Choice Generations may allow a non-participating provider to continue care if a member is under active treatment. Authorization may be necessary for these services. If you identify a member in this circumstance, please contact our Case Management Department for assistance.

Contract Renewal

Provider contracts renew automatically. Providers who move or leave a contracted group will not automatically be offered a contract at their new location. A contract offer or renewal in such cases is contingent upon Network need. Steward Health Choice Generations routinely reviews its Network and may make changes based upon Network management considerations. Should you plan to leave a contracted group and go out on your own please contact your Network Services Representative at least thirty (30) days prior to the departure date.

Credentialing and Re-Credentialing

Providers must be credentialed *before they are permitted to see Steward Health Choice Generations members.* The initial credentialing process takes about 60-90 days of receipt of the completed application. An application is considered to be complete when at least all of the following elements are present:

- A completed, signed, and dated Council for Affordable Quality Healthcare (CAQH) application.
- Current Attestation (not expired)
- Current Certificate of Insurance (COI)
- Current DEA Certification
- 5-Year Work History (If a gap in work history exceeds six (6) months, the provider must explain the gap in writing).

A provider who has **not** been credentialed or contracted should not treat Steward Health Choice Generations members without prior authorization except in certain situations such as: Emergency Medical Services, Urgently Needed Care and Renal Dialysis when the Member is outside the Steward Health Choice Generation service area, but still in the United States.

Steward Health Choice Generations conducts re-credentialing at least once every three (3) years. Contracted providers will be notified by the Steward Health Choice Generations Credentialing Department (See Chapter 5: Quality Management). It is important that providers complete the re-credentialing application as quickly as possible. Failure to maintain a credentialed status with Steward Health Choice Generations can result in contract termination and non-payment of claims.

Credentialing Documentation Updates

Steward Health Choice Generations requires that providers have current copies of DEA certificate and malpractice insurance on file with Steward Health Choice Generations at all times.

Delegation of Provider Functions

A contracted provider may not delegate any provider function without the advance written consent of Steward Health Choice Generations. Upon receiving consent of Steward Health Choice Generations, functions further delegated by provider shall be subject to the terms of the Subcontractor Agreement between Steward Health Choice Generations and the provider in accordance with the most current applicable State, Federal, and NCQA standards.

Steward Health Choice Generations maintains established policies to ensure oversight and monitoring of delegated duties which include, but are not limited to the following:

- Participation in pre-delegated audits to ensure the ability to meet or exceed applicable regulatory standards;
- Participation in Steward Health Choice Generations initiated audits (at least annually), to ensure compliance with applicable policies and procedures in coordination with respective regulatory requirements; and
- Submit rosters (at least monthly) identifying terminated providers (aka, provider no longer with the delegated entity) and newly added providers.
- Documentation that the following sites have been queried at the time of Credentialing, Recredentialing, and in between Credentialing cycles on a monthly basis for Ongoing Monitoring.

Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to Steward Health Choice Generations immediately:

- Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) http://oig.hhs.gov/fraud/exclusions.asp, and
- The System for Award Management (SAM) https://sam.gov/portal/SAM/#1 formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).
- CMS Preclusion List –In order for contracted and non-contracted providers to receive payment from a Medicare plan for health care items and services furnished to beneficiaries enrolled in Medicare plan, such providers must not be included on the Preclusion List. Likewise, in order for Part D drugs to be covered by a Part D plan, the prescriber must not be included on the Preclusion List. Notwithstanding the above and prior to denying claims for covered items, prescriptions, or services, Steward Health Choice Generations will provide sixty (60) days prior written notice to members who received a health care item, prescription, or service in the last 12 months from a provider on the Preclusion List.

Verify Eligibility

Providers should check member eligibility at each point of contact, as eligibility can change at any time; however, eligibility is not a guarantee of payment.

Members who lose eligibility with Utah Medicaid and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. For assistance referring members please contact Member Services.

Primary Care Physician

Steward Health Choice Generations' Primary Care Physicians (PCPs) perform critical plan functions. Steward Health Choice Generations relies on the providers to provide an efficient and effective model of care that assures assigned members receive the medical care and services they require. PCPs are gatekeepers or medical managers and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. Steward Health Choice Generations' Quality Management Committee periodically reviews guidelines for PCP management of Steward Health Choice Generations members. Steward Health Choice Generations monitors the over and underutilization of covered services in both the inpatient and outpatient settings. This data is used to improve overall member's treatment outcome. Steward Health Choice Generations monitors PCP's to see if their members are being seen more or less frequently and for what reason in an effort to assist Steward Health Choice Generations to predict and arrange for the necessary specialists, ancillary and hospital services members may require.

Specialists

For a list of specialists and services that require prior authorization refer to the Steward Health Choice Generations ***Prior Authorization Grid*** effective on the applicable date of service at https://www.stewardhcgenerations.org/ut/providers/provider-information/ under *Prior Authorization and Clinical Guidelines***.** Specialists are required to submit the appropriate authorization number on their claims. Steward Health Choice Generations contracted specialists work in concert with the members Primary Care Physicians to coordinate the overall care for the member. Our goal at Steward Health Choice Generations is to develop partnerships with the Specialists in our network, as Specialty Physicians are critical to providing quality services to Steward Health Choice Generations members.

Referrals

The PCP is responsible for initiating and coordinating referrals to specialists within the Steward Health Choice Generations network. It is critical that a strong communication link be maintained with specialists or behavioral health providers who treat your patients. A record of the referral and any treatment notes from the specialists/behavioral health provider must be maintained in the member's record. Steward Health Choice Generations encourages PCPs to maintain communication with the specialist when referring assigned members for specialty care. Steward Health Choice Generations has simplified its referral process to make it easier for the PCPs.

Specialists are responsible for requesting prior authorization for follow up services and other referrals as necessary. For a list of services that require authorization, refer to Steward Health Choice Generations Prior Authorization Grid

Appointment Availability/Appointment Wait Time

Contracted PCPs and Specialists must maintain availability within the appointment standards according to the Steward Health Choice Generations Subcontractor Agreement. Providers are expected to establish a procedure for waiting time so that a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances. Steward Health Choice Generations monitors providers' appointment availability and members' in office waiting time on an on-going basis.

Please note that the following standards are applicable to both new and established patients.

PCP and Specialist Appointment Standards

- Emergency appointments — Immediately
- Urgent appointments — Within 24 hours
- Routine appointments — Within 30 days
- Preventive Care appointments — Within 30 days

OB/Prenatal Care Appointment Standards

- First trimester — Within 14 days of request
- Second trimester — Within 7 days of request
- Third trimester — Within 3 days of request
- High risk pregnancy — Within 3 days of identification of high risk status or immediately if an emergency exists

Telephone Availability

Members are encouraged and expected to contact their PCP to schedule appointments or seek medical advice. Because it is critical for members to be able to reach their physicians, telephones should generally be answered within 5 rings and hold times should not exceed 5 minutes.

Steward Health Choice Generations monitors telephone accessibility to ensure that members can reach your office to schedule appointments or seek advice.

Appointment Availability Non-Compliance

Steward Health Choice Generations ensures contracted physicians; ancillary services and facilities are accessible to members to provide routine and emergent care on a timely basis. Providers will be asked to implement a corrective action plan when the appointment availability standards are not met.

Steward Health Choice Generations monitors the accessibility of contracted providers through:

- Member complaints
- Quality management audits
- Emergency room utilization
- Appointment availability surveys
- Site visits by Steward Health Choice Generations staff
- Member Surveys

Failure to comply with the appointment availability standards is viewed as an access to care issue by Steward Health Choice Generations and may result in a closure of your membership panel.

After-Hours Coverage/Physician Vacation Coverage

Each provider must have 24 hours per day, 7 days per week coverage. It is not acceptable to refer Steward Health Choice Generations members to the emergency room as a means to provide after-hours or vacation coverage. It is the responsibility of the PCP to arrange for after-hours care and vacation coverage by a contracted Steward Health Choice Generations physician.

Acceptable coverage includes the following:

- An answering service that picks up the physician office's telephone after hours. The operator will then contact the physician or his covering physician
- An answering machine that either directs the caller to the office of the covering physician, or directs the caller to call the physician at another number
- Call forwarding services that automatically send the call to another number that will reach the physician or his covering physician

Unacceptable coverage includes the following:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the doctor to retrieve the message)
- An answering machine that directs the caller to go to the emergency room, and gives no other option
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above
- An answering machine that directs callers to page a beeper number
- No answering machine or service
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e. members should not receive a telephone bill for contacting the physician in an emergency)

The PCP must notify their Network Services Representative of the arrangements made for vacation coverage. Notification of vacation coverage includes: expected departure and return dates; name, address and telephone number of covering physician; and if the covering physician office will be available to triage and/or answer questions for assigned members. If the covering physician is not available, the PCP should contact their Network Services Representative. Network Services will provide names and telephone numbers of physicians who may be able to render same day treatment.

Maintaining the Medical Record

The primary care medical record is designated to contain documentation of all care and services rendered to the member by the PCP, Specialist, Inpatient care and Ancillary services. This also includes documentation of care and services provided for mental health and/or substance abuse, ensuring the member has authorized the mental health/substance abuse provider to disclose that information.

Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers. The PCP must establish a medical record when information is received, even if the PCP has not yet seen the member. This information must be maintained in an appropriately labeled file that is associated with the member's medical record.

When a member changes to a new Steward Health Choice Generations PCP, the medical records must be transferred to the new provider in a timely manner.

Inspection and Audit of Records and Facilities

Providers must provide medical records or copies of medical records for any Steward Health Choice Generations member upon request by Steward Health Choice Generations. Medical records must be available within five (5) working days of a request. Failure to provide Steward Health Choice Generations with medical records that result in a sanction to Steward Health Choice Generations by CMS will result in such sanction being deducted in full from future payments to the offending provider. Steward Health Choice Generations will issue a written notification seven (7) days prior to the sanction being imposed.

Managing Members with Disabilities or Specific Needs

The health care needs of members with disabilities or specific needs often differ from the general population in the type, scope, frequency, coordination and duration of care needed. Should you have a member with special health care needs, please contact Steward Health Choice Generations Member Services by calling 1-844-457-8943 (TTY 711).

Members with special needs may be characterized as:

1. Persons who have communication barriers, such as speaking a different language; low literacy, visual or hearing impaired; geographically isolated people; and/or people who are homeless
2. People who require health and related services of a type or amount beyond required by people in general as:
   a. Common and often-mild chronic health issues with unique presentations, for example, allergies, arthritis, and hypertension
   b. Complex and manageable health issues, for example, asthma, diabetes, heart failure
   c. Complex and difficult-to-address health issues such as lupus, cerebral palsy, major functional disabilities
   d. Chronically mentally ill adults, substance abuse
   e. Diagnosis specific groups, such as HIV/AIDS cases

f. Physically disabled adults, children and frail elderly
g. Organ transplant recipient or waiting for transplant
3. Persons whose eligibility status complicates understanding of managed care and enrollment, such as:
a. Dually eligible Medicare/Medicaid members
b. Uninsured families and children less familiar with the health system or managed care, who may be eligible under the states' expansion programs.

History and Physical

It is expected that a complete history and physical is documented in the Steward Health Choice Generations member's medical chart. The member's medical record will be reviewed during medical record audits.

Hospital Admissions

Steward Health Choice Generations uses a fully participatory hospitalists program at most of its network hospitals within Davis, Salt Lake, Utah, and Weber counties. The PCP may contact the appropriate contracted hospitalist group to arrange hospitalization or call Steward Health Choice Generations for assistance. The PCP will continue to manage the patient's care after discharge. The PCP or Specialist should communicate directly with the Prior Authorization Department when a hospital admission is necessary. **All hospital admissions require prior authorization**. Steward Health Choice Generations conducts concurrent review of all inpatient admissions. Steward Health Choice Generations uses accepted nationally recognized criteria when performing concurrent inpatient reviews.

Adult Immunization/Preventive Services

Steward Health Choice Generations members may directly access a contracted provider for routine eye exams, mammography, influenza and pneumonia vaccines, and women's health specialists for routine and all preventative health care.

Physicians are strongly encouraged to provide immunizations for influenza and pneumonia vaccinations when medically indicated and in conjunction with current CDC recommendations. Collection of co-payments is prohibited for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

Patient Education

Steward Health Choice Generations contracted providers are expected to provide appropriate prevention and disease management education. Providers may discuss medically necessary or appropriate treatment options with members even if the options are not covered services. Health maintenance education is required. Members should receive counseling about disease prevention and the importance of regular health maintenance visits and they must be included in the planning and implementation of their care.

It is expected that providers will educate patients about their unique health care needs; share the findings of physical examinations; discuss potential treatment options, side effects and

management of symptoms; and in general recognize that the patient has the right to choose the final course of action among clinically acceptable options.

It is expected that members will also be advised of the difference between urgent conditions, such as earaches or flu and emergent conditions. The member is to be instructed to contact their PCP first before visiting an emergency room or calling an ambulance, unless it is a true emergency.

Prescriptions

Prescriptions should be written to allow generic substitution when available and signature on prescriptions must be legible in order for the prescription to be dispensed. It is the responsibility of the physician to obtain prior authorization prior to prescribing drugs not on the Steward Health Choice Generations formulary. For further detail, refer to Chapter 10: Prescription Benefits and Drug Formulary.

Steward Health Choice Generations Formulary is available on the Steward Health Choice Generations web site at https://www.stewardhcgenerations.org/ut/members/prescription-drug-information/

(Note: if you do not have internet access, contact your Network Services Representative to arrange for a paper copy).

Drug Utilization Concerns

Providers with concerns about a member's drug utilization should refer the member or contact Steward Health Choice Generations Case Management Department. Steward Health Choice Generations may identify members as having a potential substance abuse issue through provider information, utilization review, pharmacy reports, or emergency room visits. Steward Health Choice Generations will contact the PCP when there is a suspected substance abuse problem and assist with coordination of care.

Member Death

Steward Health Choice Generations providers are required to notify the Member Services Department of a member's death. Please provide the member's name, member's ID number, date of birth, date and place of death.

Emergency Room

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

- Serious jeopardy to the health of the individual;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Providers may not refer members to the Emergency Room due solely to non-availability of a same day appointment.

Steward Health Choice Generations contracts with a number of Urgent Care Centers. Ask your Network Services Representative for details and a location near you.

Fraud and Abuse

Steward Health Choice Generations is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse is defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law. (Source: 42 CFR 455.2)

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault. (Source: 42 CFR 455.2)

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicare or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Providers must train staff on the following aspects of the Federal False Claims Act provisions;

- The administrative remedies for false claims and statements;
- Any state laws relating to civil or criminal penalties for false claims and statements;
- The whistleblower protections under such laws.

Reporting Fraud, Waste and Abuse

If a provider is aware of potential Fraud, Waste or Abuse of the Medicare system, a referral should be made to Steward Health Choice Generations. The process for reporting is the same as you report now with the Utah Medicaid program for Steward Health Choice Utah.

Steward Health Choice Generations HMO SNP
Attn: Compliance
410 North 44th Street, Suite 900
Phoenix, AZ 85008

The Medicare Drug Integrity Contractor (MEDIC) for Utah is assigned to take in all Fraud Waste and Abuse referrals. Steward Health Choice Generations will work with the MEDIC on all referrals.

You may also call the Steward AlertLine to report Fraud, Waste and Abuse at (877) 898-6080. The line is available 24 hours a day, 7 days a week.

CHAPTER 4:

Cultural Competency

CMS requires Steward Health Choice Generations Utah (Steward Health Choice Generations) to make certain its providers ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Examples of how a Medicare Advantage organization can meet these accessibility requirements include provision of translator services, interpreter services, teletypewriters or TTY connections.

Non-Discrimination

Members enrolled in Steward Health Choice Generations have the right to be treated with respect and with recognition of the member's dignity and need for privacy; to not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, mental or physical disability, sexual orientation, genetic information or source of payment; to have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations.

Cultural competency in healthcare refers to the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients' social, cultural and linguistic needs. A key component is being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice to ensure better communication with patients, families to improve health outcomes and patient satisfaction.

Steward Health Choice Generations is committed to providing access to high quality services in a culturally competent manner. Cultural competency generally refers to the provision of high quality, medically necessary health care services without regard to religious, racial, ethnic or social group and within the context of diverse human behavior. Diverse human behavior includes thought, communication, actions, customs, beliefs and values.

Linguistic Services

Steward Health Choice Generations offers interpretation and translation services at no cost to you or your patients. Steward Health Choice Generations encourages members to request translation services, instead of relying only on family members, in order for the member to have the best opportunity to understand their health care. To coordinate linguistic services for your

patient, please contact our Member Services Department. Steward Health Choice Generations offers Language Interpretation Line, onsite translators, and Sign Language interpreters.

Ask Me 3

Steward Health Choice Generations supports and highly recommends the Ask Me 3 program. As described on the Ask Me 3 webpage, the program encourages patients to ask and understand 3 basic questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

You can learn more about this patient education program online at https://npsf.site-ym.com/default.asp?page=askme3 .

Materials for downloading can be found on this website: https://c.ymcdn.com/sites/npsf.site-ym.com/resource/resmgr/AskMe3/AskMe3_Implementation_dwnld.pdf

Information is provided by the Partnership for Clear Health Communication at the National Patient Safety Foundation. Member materials are available in English, Spanish, French, Chinese, Russian and Arabic.

Additional Resources

For additional resources, links, and educational material on Cultural Competency, please visit the Steward Health Choice Generations website Provider section at https://www.stewardhcgenerations.org/ut/providers/provider-information/.

CHAPTER 5:

Quality Management

Overview

The Steward Health Choice Generations Utah (Steward Health Choice Generations) Quality Management/Performance Improvement (QM/PI) Program, under the leadership of the Chief Medical Officer and/or Medical Director, with the Quality Management Committee, provides the framework for a systematic and organization-wide approach for quality of care measurement and evaluation. QM/PI provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and services utilizing a multidimensional approach to quality. Activities are planned in accordance with the unique needs of the beneficiaries and all applicable regulatory agencies. The purpose is to continuously improve care and service outcomes to meet the needs/expectations of Steward Health Choice Generations members/beneficiaries and their providers while fulfilling all regulatory and contractual requirements. The QM/PI Program encompasses all Steward Health Choice Generations departments, primary care providers, mid-level practitioners, ancillary services, behavioral health, extended care and acute care facilities.

All referrals of potential quality of care issues are investigated within the Steward Health Choice Generations QM Department under the direction of the Steward Health Choice Generations Quality Management Director in collaboration with the Chief Medical Officer and/or Medical Director, and oversight by the Quality Management Committee. All cases referred to the QM Department are investigated and reviewed for potential quality issues. Cases are assigned a severity level and tracked for trending purposes. Reported potential quality of care concerns or service issues may require additional evaluations/reviews.

The Steward Health Choice Quality Management Department also processes and retains records of complaints from members and providers that may not be directly related to quality of care. These complaints are evaluated and trended as indicated per Steward Health Choice Generations policies and procedures.

The Steward Health Choice Generations Quality Management/Performance Improvement Committee (QMPIC), chaired by the Steward Health Choice Generations Chief Medical Officer/Medical Director, provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Contracted physicians, representing a variety of medical specialties, serve on the Committee and are appointed by the Chief Medical Officer/Medical Director. If a provider issue is investigated by the QMPIC, and that particular specialty is not represented within the Committee, the Chief Medical Officer/Medical Director may consult on an ad hoc basis with a peer from that specialty.

The Credentialing/Recredentialing process is an activity of the Steward Health Choice Generations QM/PI Program. The Credentialing Committee is a sub-committee of the QMPIC. A site evaluation may be a required component of the initial credentialing process for PCP's. The QMPIC is responsible for the oversight of the credentialing process.

All contracted Steward Health Choice Generations providers are re-credentialed every three (3) years. Each provider must complete a recredentialing application. At that time, primary source verification of credentials is updated. The National Practitioner Data Bank is queried to obtain current information. The recredentialing process also may include an on-site evaluation, a medical chart audit and an appointment availability survey.

Steward Health Choice Generations encourages communication between the Health Plan and the Primary Care Provider regarding quality of care issues or concerns. Issues may involve specific patient cases or systems problems, which can impact patient care. Concerns may be communicated directly to the QM Department or Chief Medical Officer/Medical Director. All information is confidential and is peer-protected.

The Quality Management Department at Steward Health Choice Generations consists of the following functions:

- Oversight of Medicare quality performance measures and development of quality improvement projects.
- Review, research, resolution, and monitoring of complaints and quality of care issues.
- Oversight of medical record/site evaluation process in coordination with initial credentialing, re-credentialing and in response to identified quality issue.
- Credentialing and Re-credentialing for providers and organizational providers.
- Oversight of Part C and Part D Star Ratings performance measure project.
- Model of Care development and oversight.

Steward Health Choice Generations strongly encourages a working relationship with providers and welcomes comments, questions, or suggestions.

Peer Review

The formal peer review process at Steward Health Choice Generations is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM Department and other review committees of Health Choice. This process is pursuant to the QM/PI (Performance Improvement) Plan and applicable laws and regulations. If an adverse action is taken against a provider as a result of the peer review process, the provider has certain rights pursuant to Steward Health Choice Generations Policy “Peer Review Process and Appeals”. This policy is available upon request from your Network Services Representative, and will be sent to any provider when an adverse action is taken. The provider has the right to appeal. If you would like to participate on the Peer Review Committee, please contact the Quality Management department.

This policy, in summary, contains the following provisions:

- The Steward Health Choice Generations Chief Medical Officer/Medical Director and/or QM Director will review all issues referred to the QM department, and will ask the provider for comment and clarification, where indicated. The issue may be referred to the QM Committee for peer review if the care involved is questioned and had potential to harm or did harm the member. If a provider in the same medical specialty is not represented on the Committee, the Steward Health Choice Generations Chief Medical Officer/Medical Director and/or the Committee may secure an ad hoc consultation and participation in the investigation from a provider of the same specialty.
- If the Steward Health Choice Generations Quality Management Committee determines, after initial review of all available information regarding a referred Quality of Care concern, that further information is needed, the Committee may invite the provider for a formal interview to obtain the provider's perspective on the case and/or send the provider a letter of inquiry.
- The Committee may take one or more of several possible actions:
    1. It may impose concurrent or retrospective review of care for specified periods of time, or a Provider Focus Review.
    2. It may recommend focused informal education for the provider, communicated by Steward Health Choice Generations staff.
    3. It may recommend formal CME requirements.
    4. It may recommend limitation of privileges, or termination of privileges.

Performance Measures

As a health plan serving Medicare SNP members, Steward Health Choice Generations is held accountable by The Centers for Medicare and Medicaid Services (CMS) to meet performance standards, as identified in Part C and Part D Star Ratings. The Star Ratings are comprised of 9 domains, covering all aspects of beneficiary interactions with their health pan and provider ranging from health plan customer service to beneficiary experience with care received from their physician. The Star Ratings are also based on several sources of data and information, including but not limited to: HEDIS®, CAHPS®, Health Outcome Survey and Patient Safety, all which will be explained below.

HEDIS®: The Healthcare Effectiveness Data and Information Set

The **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et is the most widely used set of performance measures in the managed care industry. HEDIS® is designed to ensure that purchasers, regulators and consumers have the information they need to reliably compare the performance of managed care plans. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA) with funding from CMS for the Medicare related measures.

HEDIS Measures included in the Star Ratings:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Care for Older Adults – Medication Review

- Care for Older Adults – Pain Screening
- Care for Older Adults – Functional Status Screening
- BMI Assessment
- Osteoporosis Management in Women Who Have Had a Fracture
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – Monitoring for Nephropathy
- Comprehensive Diabetes Care – HbA1c Control
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Medication Reconciliation After Discharge
- Statin Therapy for Patients with Cardiovascular Disease

Pharmacy Quality Alliance Medication Adherence

The Pharmacy Quality Alliance (PQA) was established in 2006 as a public private-partnership with CMS specifically to develop Part D drug coverage quality measures. Currently there are 5 PQA developed measures in the Star Ratings that address the quality of medication use. These measures figure prominently in the Stars Ratings due to the heavy measure weighting assigned by CMS.

PQA Measures included in Star Ratings:

- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Statin Use in Persons with Diabetes
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CMS is committed to measuring and reporting information from the consumer perspective for Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) contracts. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are a set of surveys that provide information to Medicare beneficiaries on the quality of health services provided through MA and Medicare Part D programs. Consumer evaluations of health care and prescription drug services, such as those collected through the Medicare CAHPS® surveys, measure important aspects of a patient's experience that cannot be assessed by other means.

The Medicare CAHPS® surveys produce data on the patient's experience of care on domains that are important to consumers, including: Your Health Plan, Your Healthcare in the Last 6 Months, Your Personal Doctor, Getting Healthcare from Specialists, Coordination of Care, Your Medicare Rights, Your Prescription Drug Plan, and About You.

Star Ratings include CAHPS® questions related to:

- Obtaining an Annual Flu Vaccine
- Overall Rating of Health Care Quality

- Overall Rating of Health Plan
- Overall Rating of the Drug Plan
- Getting Needed Care
  - *In the last 6 months, how often was it easy to get appointments with specialists?*
  - *In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?*
- Getting Appointments and Care Quickly
  - *In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?*
  - *In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?*
  - *In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?*
- Care Coordination
  - *When you visited your personal doctor for a scheduled appointment, how often did she/he have your medical records or other information about your care?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?*
  - *How often did you and your personal doctor talk about all the prescription medicines you were taking?*
  - *Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?*
  - *How often did your personal doctor seem informed and up-to-date about the care you got from specialists?*
- Getting Needed Prescription drugs
  - *In the last 6 months, how often was it easy to use your prescription drug plan to get medicines your doctor prescribed?*
  - *In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?*
  - *In the past 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?*

Health Outcomes Survey (HOS)

Each spring a random sample of Medicare beneficiaries is surveyed using the Health Outcomes Survey. Two years later, these same respondents are surveyed again to assess if beneficiaries' health was the same, better or worse than expected between the baseline survey and the subsequent re-measurement.

Stars Ratings include the following topics from the Health Outcomes Survey:

- Percent of all plan members whose physical health was the same or better than expected after two years.
- Percent of all plan members whose mental health was the same or better than expected

after two years.

- Percent of senior plan members (≥65 years old) who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
- Percent of plan members (≥65 years old) with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.
- Percent of plan members (≥65 years old) with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.

Patient Safety

Performance and quality measures are used by CMS so that Medicare beneficiaries have the information necessary to make informed enrollment decisions by comparing available health and prescription drug plans. As part of this effort, CMS currently calculates and publicizes eight patient safety measures:

- High Risk Medication (HRM)
- Diabetes Treatment (DT)
- Drug-Drug Interaction (DDI)
- Diabetes Medication Dosage (DMD)
- Adherence (ADH) for:
  - Oral Diabetes Medications**
  - Hypertension (RAS Antagonists)**
  - Cholesterol (Statins)**
  - HIV/AIDS (Antiretrovirals)

** Impact Stars Ratings

Medical Record Requests

Each year, Steward Health Choice Generations participates in an audit of the data collected for HEDIS measures that make up part of our Star Rating. We rely on participation from our partners and providers to have a successful audit.

Steward Health Choice Generations has developed a medical records retrieval team to perform HEDIS® medical record data abstraction. . It is important that you know our record retrieval specialists serve Steward Health Choice Generations in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As defined by HIPAA, our specialist's role is of "Covered Entities," and as such, our specialists are ethically and legally bound to protect, preserve, and maintain the confidentiality of any Protected Health Information (PHI) it gleans from clinical records provided by medical practice locations pursuant to its contractual obligations to Health Choice Generations. In this setting, you may be assured that Steward Health Choice Generations will treat patients' PHI with the appropriate level of protection and confidentiality. The HEDIS® medical record data abstraction process will begin in February or early March. Prior to conducting an onsite review, one of our specialists will contact your office to schedule a visit and subsequently distribute information about the scheduled visit to explain its data abstraction process. Specialists may also request that copies of chart components be sent via mail, fax or provider portal for off-site review.

The professional courtesy you provide in collaborating with Steward Health Choice Generations Utah is very much appreciated. If you have questions or concerns about any component of this process, please contact us at 1-844-457-8943. We thank you for partnering with us to improve the health of individuals, families and communities.

Privacy

Steward Health Choice Generations appreciates the diligence of providers and their office staff in following protocol and protecting PHI. Below are references to the disclosure and permitted use of such information for health care operations, including activities related to quality assessment and improvement.

In 45 CFR 164.502 (a)(1)(ii) Uses and Disclosures of Protected Health Information: general rules includes permitted uses and disclosures for the treatment, payment or health care operations, as permitted by and in compliance with §164.506.

In 45 CFR 164.506 (c)(4), the Privacy Rule states:

> "A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is for a purpose listed in paragraph (1) or (2) of the definition of health care operations."

In 45 CFR 164.501, Definitions, "Health Care Operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions: …conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines…"

Disease Burden Management (HCC Hierarchical Condition Category)

Steward Health Choice Generations Utah works with our providers to improve the documentation and coding for our Medicare members. Medicare requires appropriate condition coding (ICD-10) to the highest level of specificity. Through proper documentation and coding, patients' medical conditions can be better understood and managed by all providers who serve them. Steward Health Choice Generations Utah has multiple initiatives aimed at reducing coding errors, improving documentation practices, and advancing continuity of care, including:

- Monthly "Tips and Tricks" publications
- Coding quick reference guide
- Comprehensive Health Evaluations
- Clinical documentation improvement consultations
- Annual chronic condition management program
- Continuing Medical Education (CME) offerings

CHAPTER 6:

Medical Authorizations & Notifications

Overview

Steward Health Choice Generations Utah (Steward Health Choice Generations) is confident that our Primary Care Physicians are capable of providing the majority of medically necessary services to the patients who present to them. However, should the need arise for medically necessary specialty services, Health Choice Utah, Inc.'s Chief Medical Officer, Medical Director(s), or their designees make determinations of medical necessity based on nationally recognized, evidence-based standards of care. Accurate and prompt determinations of medical necessity depend upon the comprehensive content and the quality of medical documentation received with each request.

Steward Health Choice Generations is committed to making the prior authorization (PA) process as efficient and simple as possible, however a requesting provider should make a best effort to submit requests in a manner which can complete an effective review process. Please keep the following key points in mind when requesting a medically necessary prior authorization:

For a complete listing of services which require Prior Authorization please refer the Steward Health Choice Generations Prior Authorization Grid effective to the applicable date of service at https://www.stewardhcgenerations.org/ut/providers/provider-information/ under *Prior Authorization and Clinical Guidelines*. The guidelines can also serve as reference guide and answer many questions which may arise but are not directly referred to in this chapter.

THE FOLLOWING DIRECTIVES APPLY TO ALL STEWARD HEALTH CHOICE GENERATIONS PRIOR AUTHORIZATIONS:

- Only one Medical service may be requested per PA form
- ALL Out of Network Providers (OON) require prior authorization. OON Providers should not be requested unless there is a compelling medical necessity basis.
- Steward Health Choice Generations does not perform prior Authorization for Emergency Services
- Steward Health Choice Generations does not pay for experimental and/or investigational services

PLEASE FOLLOW THESE STEPS WHEN REQUESTING A MEDICALLY NECESSARY PRIOR AUTHORIZATION:

Provider offices must:

1. Legibly complete all necessary fields of the most current Health Choice Generations

Prior Authorization Request Form. The most current Health Choice PA forms can be found on our website: https://www.stewardhcgenerations.org/ut/providers/provider-information/ under *Prior Authorization and Clinical Guidelines*.

2. Include accurate ICD-10 codes which support the request, and must provide specific CPT codes, HCPCS codes, and J-codes.
3. Only request prior authorization for services listed on the Steward Health Choice Generations Prior Authorization Grid.
4. Include ALL necessary documentation to support medical necessity in order to avoid unnecessary denials or inappropriate delays in the medical review/approval process.
5. Clearly indicate in the check boxes provided on the Steward Health Choice Generations prior authorization form whether the request is *Standard* or *Expedited* (see below for details).
6. Submit the form and appropriate documentation by fax or through an online portal. Offices can fax the Steward Health Choice Generations Prior Authorization Request Form (24 hours a day/7 days per week) to the appropriate Steward Health Choice Generations fax number. Steward Health Choice Generations has designated fax numbers for Steward Health Choice Generations Medical requests and Steward Health Choice Generations Pharmacy requests. The office should confirm the fax receipt and this record should be kept for your documentation.

Steward Health Choice Generations Medical PA Fax Line **1-844-457-8942**

Health Choice Generations Pharmacy PA Fax Line **1-877-424-5690**

Time Frame for Medical Approvals (As Defined by the Medicare Managed Care)

Standard: Within 14 calendar days. Under CFR 438.210, *"Standard"* means a request for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. The requesting provider is responsible for communicating the procedure approval to the member.

Expedited: Within 72 hours. Under 42 CFR 438.210, *"Expedited"* means a request for which a provider indicates or a Contractor determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than 72 hours following the receipt of the authorization request, with possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. The requesting provider is responsible for communicating the procedure approval to the member.

Supporting Documentation – Prior Authorization

Documentation of medical necessity must accompany all PA requests. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/requesting Provider
- All pertinent medical history and physical examination findings
- Diagnostic imaging and laboratory reports (if applicable)
- Indications for the procedure or service
- Alternative treatments, risks and benefits (including the indication of such discussions with patient)
- For Out-Of-Network (OON) providers/facilities/ services, and/or Non-Formulary (NF) medication requests, specific information which explains the medical necessity for an OON or NF service is required. A PA is required in order for any service to be covered at OON providers/facilities.

Organization Determination Process

- The PCP or Specialist must determine if a service requires the organization determination process.
- The PCP should initiate the referral process; Specialists should not generally refer directly to other specialists;
- Members should not be permitted to self-refer to specialists without direct intervention of the PCP except for routine eye exams and women's health services.
- The PCP must complete the **Steward Health Choice Generations Organization Determination (Prior Authorization) Request Form** and fax it along with ALL documents to support medical necessity.
- The PCP must facilitate care and/or alert the member to make the necessary appointments.
- When difficulty in coordinating and/or facilitating care exists, the referring provider must contact the plan for assistance.
- Steward Health Choice Generations will contact the Primary Care Physician (or consulting physician) with the authorization number via fax/phone upon approval.
- The PCP or Specialist should document the authorization number in member's medical record.
- Authorizations are valid for 90 days and are contingent upon continued member eligibility unless indicated otherwise on the prior authorization form that is faxed back to the provider.
- *Provider offices are responsible for confirming current member eligibility prior to service.*
- Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.
- Steward Health Choice Generations encourages providers to advocate on behalf of members within the utilization management process.

- Steward Health Choice Utah Medical Director(s) and clinical staff are available to discuss the review determination with the attending physicians or other ordering providers.

Note: Receipt of authorization **DOES NOT** guarantee payment of services. If the claim is billed incorrectly, or the member was not eligible on the date of service, the claim may be denied.

Referrals to Specialists

Please check the Prior Authorization Grid to verify which specialties and services require medical review and a prior authorization number prior to referring a member to the specialist office or facility. If a Prior Authorization number is required, please ensure this number has been obtained and the specialist/facility has the number prior to the member's appointment. Please verify the provider/facility you are referring to is in-network except where out-of-network (O.O.N.) authorization had been obtained. The Steward Health Choice Generations website has an updated listing of contracted providers at https://www.stewardhcgenerations.org/ut/providers/provider-information/

Hospital Services

Acute Inpatient Admissions

All elective inpatient procedures require a prior authorization. Please use the prior authorization fax line for these requests.

Emergent admissions require notification. For all Steward Health Choice Generations admissions. Inpatient Notification faxes are sent to 801-758-3370.

Steward Health Choice Generations Utilization Review staff will review the medical necessity criteria to make admission and level of care determinations. Continued stay review will be conducted by Steward Health Choice Generations Utilization Review staff and communicated to the hospital case management staff. Steward Health Choice Generations Utilization Review staff will assist in coordinating services identified for discharge planning as well as required follow up post discharge.

Outpatient Services

Select ambulatory and outpatient procedures require authorization. Providers should refer to the Steward Health Choice Generations Prior Authorization Grid to determine which services require prior authorization.

Supporting Documentation - Organization Determination

Documentation of medical necessity must accompany all requests for organization determination. For most requests, supporting documentation should include:

- Current diagnosis and treatment by PCP or Specialist
- Pertinent medical history and physical examination findings
- Diagnostic imaging and laboratory reports (if applicable)
- Indications for the procedure or service

- Failure of conservative treatment
- Alternative treatments, risks and benefits (including the indication of such discussions with patient)
- For out-of-network (OON) providers/facilities, OON services, and non-formulary medication requests, specific information which explains the medical necessity for an OON providers/facilities, non-formulary medication or service is required.

Clinical Practice Guidelines

Clinical Practice Guidelines (CPG's) are designed to support practitioners in developing treatment regimens that conform to current standards and national guidelines and ensure consistency in chronic disease management.

Clinical Practice Guidelines (CPGs) are regularly developed and revised based on scientific evidence described in the clinical literature and/or expert consensus. CPGs help to assess the safety and efficacy of specific healthcare practices, decisions and interventions. Appropriate application of CPGs may reduce inappropriate practitioner variability in diagnosis and treatment. CPGs provide a framework for individual treatment decisions. CPGs should not interfere with, delay or otherwise preclude the delivery of health care services which providers, through their education, experience and assessment of a patient's needs, deem medically necessary for individual Steward Health Choice Generations enrollees. Steward Health Choice Generations adopts and promotes appropriate CPGs to facilitate evidence-based management of acute and chronic medical and behavioral health conditions relevant to the member population. This will help improve the quality and efficiency of health care delivery and reduce unnecessary variations in care, thereby reducing patient harm and unnecessary waste of resources.

Steward Health Choice Generations clinical practice guidelines are available by request and on the website at https://www.stewardhcgenerations.org/ut/providers/provider-information/, under Prior Authorization and Clinical Guidelines.

Authorization Denials

CMS rules and regulations mandate that all members must be notified of a denial of medical coverage request within 72 hours for expedited requests and within 14 calendar days for standard request. When a denial is issued, the health plan must inform the member of the denial of medical coverage and the reason for denial. The Notice of Denial of Medical Coverage (NDMC) also contains information regarding the member's appeal rights. Information regarding the denial of service will be returned to the physician (or their designee) who requested the authorization. Details of the denial language sent to the member may be less technical and/or less sophisticated and at a lower reading grade level than language sent to the requesting provider. (Please see Claims Disputes, Member Appeals and Member Grievances Chapter 9 for additional information).

No rewards are ever offered to PA staff, administrators, practitioners or other individuals to incentivize the issuance of denials of coverage of benefits.

Primary Care Obstetrician Responsibility

The Primary Care Obstetrician (PCO) must notify Steward Health Choice Generations of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Risk Assessment form. This Risk Assessment form is a critical component of coordinated care between Steward Health Choice Generations and the Obstetrician or Maternal Fetal Medicine provider and *MUST* be completed and submitted promptly following the member's first visit. A copy of the member's ACOG Antepartum Record and Obstetric Medical History notes may be submitted in lieu of the clinical documentation requested on the Maternal Risk Assessment form as long as all of the requested information is included in the notes. The Maternal Risk Assessment form should be faxed to Steward Health Choice Generations at **(480) 760-4762**. Upon receipt of the Maternal Risk Assessment form, the Maternal Child Health Department will issue a PA number to the PCO. The PCO will use this number for all professional services related to the pregnancy.

Reimbursement for Obstetrical services provided through the term of the pregnancy is dictated by the authorization or the provider's contract.

OB Ultrasound

Ten (10) obstetrical ultrasounds may be provided without prior authorization. CPT codes that can be used as routine OB ultrasounds are 76801/76802, 76805/76810. 76813/76814, 76815, 76816, and 76817. Please note that any additional OB ultrasounds will require authorization. If you have a pregnant member who presents with symptoms indicating an urgent or emergent need for an ultrasound, you may proceed with the ultrasound. Contact Steward Health Choice Generations within three (3) business days for an authorization of subsequent OB ultrasounds. Medical necessity will continue to be determined based on current evidence and guidelines from the American College of Obstetrics and Gynecology. Review for medical necessity will be conducted retrospectively if there is concern about fraud, waste or abuse, as is the case for all advanced diagnostics, based on outlier utilization and coding.

Education for Pregnant Women

During your patient's pregnancy, be sure to document any and all education done by you and your staff. Important topics to discuss with your patients include proper nutrition, breast feeding, smoking cessation, physiology of pregnancy, labor and delivery process, warning signs, drug and alcohol avoidance, postpartum depression and family planning options. It is best practice to conduct a perinatal depression screening at least once during the pregnancy.

Prior Authorization and Referrals

It is the responsibility of the PCO to obtain prior authorization for services not related to the pregnancy, i.e. if you have to refer the member out, and for services related to pregnancy but not included in the obstetrical authorization. In the event a PCO feels the member needs to be referred to a Maternal Fetal medicine Doctor, it is the responsibility of the PCO to contact the Maternal Fetal medicine Doctor's office, discuss the member's condition, and set up the initial appointment.

Ophthalmology/Optometry

The following services are covered through Steward Health Choice Generations (See Steward Health Choice Generations Organization Determination requirements on the website for a list of services requiring authorization):

1. Routine eye exam, limited to one exam every year
2. One pair of eye glasses or contacts per year ($200 limit)
3. Medicare covered eye exam for the diagnosis and treatment for diseases and conditions of the eye
4. For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older; glaucoma screenings once per year are covered
5. One pair of eye glasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames and replacements needed after a cataract removal without lens implant

Durable Medical Equipment and Infusion / Enteral Therapy

Steward Health Choice Generations has several contracted durable medical equipment (DME) providers in the geographical areas we serve. Please refer to the Steward Health Choice Generations Prior Authorization Grid to determine which equipment requires prior authorization and supporting clinical documentation.

Orthotics/Prosthetics

Steward Health Choice Generations has several contracted orthotic and prosthetic providers in the geographical areas we serve. Please refer to the Steward Health Choice Generations Prior Authorization Grid to determine which equipment requires prior authorization and supporting clinical documentation.

Pharmacy Authorizations

Physicians are required to use the Steward Health Choice Generations Drug Formulary when prescribing medications for Health Choice Generations members. Providers should also note references to step therapy (ST) edits, quantity limits (QL), and Non-extended days' supply (NDS) prior to requesting PA. Steward Health Choice Generations Formulary is available on the web site at www.stewardhcgenerations.org/ut Refer to Chapter 10: Prescription Benefits and Drug Formulary.

If the patient requires medication which is listed as "prior approval required" the requestor may submit the request for prior authorization using the current **Steward Health Choice Generations Pharmacy Medication Prior Authorization Form/Exception Request Form or any form convenient for the requestor,** along with appropriate documentation to support the request. Requests may also be submitted online: https://steward.promptpa.com or via phone by calling member services.

Note: If you do not have internet access, contact your Network Services Representative to arrange for a paper copy to be delivered.

Specialty Medication Program

Steward Health Choice Generations has instituted a special program with our pharmacy benefit manager for certain specialty medications. Examples of such medications are those used to treat multiple sclerosis, rheumatoid arthritis and chronic hepatitis. Please refer Chapter 10 for instructions on how to order these special medications, or contact the Steward Health Choice Generations Pharmacy Department for additional assistance.

Behavioral Health Program

Steward Health Choice Generations has formulary medications available to treat identified Behavioral Health Disorders.

If the patient requires a behavioral health medication listed as "Prior Authorization Required", "Step Therapy" and/or "Quantity Limits" the physician may request prior authorization using the **Steward Health Choice Generations Pharmacy Medication Prior Authorization Form/Exception Request Form or any form that is convenient for the requestor** and submit appropriate documentation to support the request. Requests may also be submitted online: https://steward.promptpa.com or via phone by calling member services.

Referrals to Specialists

Please check the Prior Authorization list to verify which specialties require medical review and a prior authorization number prior to referring a member to the specialist office.

It is the responsibility of the referring provider to ensure that any necessary authorizations have been obtained within the allowable authorization turnaround time frames prior to a scheduled Specialist appointment. If a Prior Authorization number is required, please provide a copy of this authorization number directly to the Specialist in advance of the scheduled appointment to ensure services are provided timely on the scheduled date of service. The specialist and the PCP should retain a copy of the referral authorization in the member medical record.

Specialist Protocol

The specialist is responsible to ensure necessary authorizations have been issued (if the service requires authorization) prior to rendering service. Where referrals are required for member's consultations and/or billing, these requirements must be met in order to receive proper reimbursement. The specialist should verify the member's eligibility on the date of service. If the service required prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.

Retrospective Prior Authorization

It is the policy of Steward Health Choice Generations that retrospective authorization requests (a request for authorization after services which require authorization have been rendered) will not

be provided. Steward Health Choice Generations reserves the right to grant retrospective authorizations in rare circumstances, Steward Health Choice Generations offers an appeal and grievance process per CMS guidelines should the provider disagree with a denial of service, however providers must adhere to Steward Health Choice Generations policies and procedures in attaining PA prior to any non-emergent or urgent service.

Case Management

Steward Health Choice Generations will assist in managing the care of members with chronic or disabling conditions that can benefit from care coordination and assistance. Steward Health Choice Generations providers shall assist and cooperate with Steward Health Choice Generations case management programs. Steward Health Choice Generations case management programs will include the following key areas;

- Identifies individuals with complex or serious medical conditions
- Establish and implement a Case Management plan that is appropriate to the members' specific needs and medical condition(s)
- Assessment of the member's physical, psychological, social environment, financial, and functional status as well as the family, community and institutional support systems
- Includes an adequate number of direct access visits to specialists
- Ensures coordination among providers
- Considers the beneficiary's input

The Steward Health Choice Generations Case Management program promotes quality and utilization management by:

- Defining and tracking quality and performance indicators
- Implementing measures that contribute to improving quality of care and cost effective management of targeted conditions
- Encouraging preventive care strategies to keep members healthy
- Promoting member education and behavioral modifications that improve health outcomes
- Educating members on available community resources
- Monitoring outcomes and programs effectiveness

Providers may enroll members into the Steward Health Choice Generations Case Management program by filling out a case management referral form and attaching any pertinent medical documentation and faxing it to (801) 758-3370.

CHAPTER 7:

Inpatient & Outpatient Hospital Care

Acute Inpatient Admissions

All elective and emergent admissions require prior authorization and/or notification for all Steward Health Choice Generations Utah (Steward Health Choice Generations) Member admissions.

Admission notification must be faxed to the Inpatient Admissions line at (801) 758-3370 on the day of admission. Upon receipt of the information, Steward Health Choice Generations will provide an authorization number for the inpatient admission to the hospital.

Steward Health Choice Generations Utilization Review staff will review the medical necessity criteria to make admission and level of care determinations. Continued stay review will be conducted by Steward Health Choice Generations Utilization Review staff and communicated to the hospital case management staff. Steward Health Choice Generations Utilization Review staff will also assist in coordinating services identified for discharge planning, as well as required follow-up post discharge.

The term “hospital” means a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic and/or therapeutic services. The term “hospital” does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “custodial care,” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Members are covered for **90 days each benefit period.**

A benefit period begins the day the Steward Health Choice Generations Member is admitted into a hospital or skilled nursing facility.

The benefit period ends when the Steward Health Choice Generations Member has not received hospital or skilled nursing care for **60 days** in a row. If the Steward Health Choice Generations Member is admitted into the hospital after one benefit period has ended, a new benefit period begins.

There is no limit to the number of benefit periods a Steward Health Choice Generations Member can have over a lifetime.

Inpatient Hospital Covered Services

Covered services include, but are not limited to, the following:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs Operating and recovery room costs
- Physical therapy, occupational therapy, and speech therapy
- Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral (see Section 11 for more information about transplants)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood needed – Utah Medicaid will pay for the first 3 pints of un-replaced blood. All other components of blood are covered beginning with the first pint used
- Physician Services

Inpatient Services – Hospital or SNF Days Are Not or Are No Longer Covered

When the hospital or SNF days are not or are no longer covered (limits are exhausted), physician services and other medical services will still be covered. These services are:

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and service
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations
- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

Hospitalists

Hospitalists primarily take care of patients when they are in the hospital. Hospitalists may be required to take over inpatient care for PCPs for their Steward Health Choice Generations Members who are in the hospital. The hospitalist must keep the primary doctor informed about the member’s progress and will return the member’s care to the primary doctor when the member is discharged from the hospital.

Skilled Nursing Facility Care

If Steward Health Choice Generations Members need skilled nursing facility care, providers must notify Steward Health Choice Generations. The term *"skilled nursing facility"* (SNF) does not include places that mainly provide *custodial care* only, such as convalescent nursing homes or rest homes. *Custodial care* is defined as care limited to assistance with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Skilled nursing facility care is defined as that level of care ordered by a physician that must be given or supervised by licensed health care professionals. This can be skilled nursing care, skilled rehabilitation services or both.

Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. *Skilled rehabilitation services* include physical therapy, speech therapy and occupational therapy. *Physical therapy* includes exercise to improve the movement and strength of an area of the body and training on how to use special equipment, such as how to use a walker or get in and out of a wheel chair. *Speech therapy* includes exercise to regain and strengthen speech and/or swallowing skills. *Occupational therapy* includes assistance in learning how to perform activities of daily living, such as eating and dressing independently. A SNF can be a separate facility, or part of a hospital or other healthcare facility. No prior hospital stay is required for SNF care.

Authorization for SNF Services

Steward Health Choice Generations Members may not be admitted to any SNF without prior authorization by Steward Health Choice Generations. The Steward Health Choice Generations utilization review nurse managing member care at the acute facility will provide authorization to the SNF.

Members are covered for **90 days** each benefit period. As a member of Steward Health Choice Generations, the member qualifies for Utah Medicaid benefits. If this remains true, then Medicaid will cover the Steward Health Choice Generations Member copay and deductible. These will be billed through our Steward Health Choice Utah (Utah Medicaid) plan if a member or another Utah Medicaid plan.

A benefit period begins the day a member is admitted into a hospital or SNF.
The benefit period ends when the Steward Health Choice Generations Member has not received hospital or skilled nursing care for **60 days** in a row. If the member goes into the SNF after one benefit period has ended, a new benefit period begins.

There is no limit to the number of benefit periods Steward Health Choice Generations Members can have in a lifetime.

SNF Covered Services

Covered services include, but are not limited to, the following:

- Semi-Private room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs (this includes substances that are naturally present in the body, such as blood clotting factors)
- Blood - Including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood needed. Utah Medicaid will pay for the first 3 pints of un-replaced blood
- All other components of blood are covered beginning with the first pint used. Coverage begins with the third pint of blood needed including storage and administration Medical and surgical supplies
- Laboratory tests
- X-rays and other radiology services Use of appliances such as wheelchairs
- Physician services

Criteria for Steward Health Choice Generations Members to Be Covered in a SNF

To be covered, Steward Health Choice Generations Members must need *daily* skilled nursing or skilled rehabilitation care, or both. If the member does not need daily skilled care, other arrangements for care would need to be made.

The Steward Health Choice Generations UR nurse will assist with transition to the right level of care.

Stays for Custodial Care Only Are Not Covered

Custodial care is that care limited to assistance with activities of daily living that can be provided by people who do not have certified professional clinical skills and training. This assistance with activities of daily living includes help with walking, dressing, bathing, eating, meal preparation and taking medication. Custodial care is not covered by Steward Health Choice Generations unless it is being provided *in addition to* medically necessary daily skilled nursing care and/or skilled rehabilitation services.

Observation Services

Observation is a medically necessary outpatient service provided in the hospital for patient evaluation and management when the clinical criteria for inpatient hospital admission, discharge or transfer have been met. Covered observation services include:

- The use of a bed
- Periodic monitoring by a hospital's nursing (or other appropriate) staff that is necessary to evaluate, stabilize and treat unstable medical conditions and/or disability on an outpatient basis

Observation admissions must be provided in a designated *observation area* of the hospital, unless such an area does not exist.

A scheduled *outpatient procedure* or *treatment* that is expected to keep the patient in the hospital for fewer than 24 hours for a known diagnosis does *not* qualify as an observation admission. This kind of *outpatient procedure* is not an observation admission, regardless of the hour at which the patient presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation admission status *must* be ordered in writing by a physician or another individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The following factors must be taken into consideration by the physician or authorized individual in ordering observations status:

- The severity of the signs and symptoms of the patient
- The degree of medical uncertainty that the patient may experience an adverse occurrence.
- The need for diagnostic studies that can be appropriately managed on an outpatient basis to assist in assessing whether the patient should be admitted as an inpatient (i.e., tests that do not typically require the patient to remain in the hospital for 24 hours or more)
- The availability of diagnostic procedures at the time and location where the patient presents for medical treatment

The following services are *not* Steward Health Choice Generations-covered observation services:

- Substitution of outpatient services provided in lieu of observation status for physician ordered inpatient services
- Services that are neither reasonable, cost-effective nor necessary for diagnosis or treatment.
- Services provided for the convenience of the patient or physician
- Excessive time and/or amount of services than are medically required by the condition of the recipient
- Services customarily provided in a hospital-based outpatient surgery center and for which the need for observation status is not supported by medical documentation.

In general, observation status does not exceed 24 hours. Prior authorization is required for medically necessary extensions beyond 24 hours. A physician or another individual authorized to admit patients to the hospital or to order outpatient tests or treatments must sign an order for continuing observation each day.

Observation services, without labor, billed on the UB claim form must be billed with a 762 revenue code (Treatment/Observation Room - Observation Room*)* and the appropriate observation HCPCS procedure code 99218, 99219 or 99220 (note that 99217 is *not* appropriate *for* hospital billing). Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

Observation services, with labor, billed on the UB claim form must be billed with a 721 revenue code (Labor Room Delivery - Labor) and the appropriate HCPCS procedure codes. Each hour or portion *of* an hour that a recipient is in observation status must be billed as one unit of service.

Steward Health Choice Generations will review the immediate and continuing observation status by assessing the medical criteria for that level of care. Medical review for continued observation status will consider each case on an individual basis. At a minimum, the following documentation is required, as appropriate:

- Emergency room record
- Progress notes
- Operative reports
- Diagnostic test results
- Nursing notes.
- Labor and delivery records
- Physician orders:
  - Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation." Rubber-stamped orders are not acceptable.
  - Follow-up orders must be written at least every 24 hours
  - Changes in status such as "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual
  - Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient.
  - Inpatient/outpatient status change must be supported by medical documentation

Outpatient Hospital Services

Steward Health Choice Generations covers preventive, diagnostic, rehabilitative and palliative items or services ordinarily provided in hospitals on an outpatient basis for all Steward Health Choice Generations Members.

If Steward Health Choice Generations Members are treated in the emergency room, observation area or other outpatient department and are directly admitted to the same hospital, the emergency room, observation or other outpatient charges must be billed on the inpatient claim.

Inpatient Behavioral Health Care

Inpatient behavioral health services that require a hospital stay are covered, but Medicare beneficiaries may only receive 190 days in a free-standing psychiatric hospital in a lifetime. Providers must notify Steward Health Choice Generations of the admission.

Outpatient Behavioral Health Care and Partial Hospitalization Services

Outpatient behavioral health services may be provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other behavioral health care professional as allowed under applicable state and federal coverage guidelines.

CHAPTER 8:

Coordination of Benefits or Other Insurance Liability

Providers must cooperate with and support coordination of benefits activities by Steward Health Choice Generations Utah (Steward Health Choice Generations). In the event that there is a third party liability or third party coverage for a Steward Health Choice Generations Member, Providers agree to identify and seek such payment before submitting claims to Steward Health Choice Generations.

When Steward Health Choice Generations Is Primary

If a Steward Health Choice Generations Member possesses health benefits coverage through another policy which is secondary to Steward Health Choice Generations under applicable coordination of benefits rules, providers must accept payment from Steward Health Choice Generations for Covered Services as full payment for such services, except for applicable co-payments, coinsurance or deductibles. Other than for co-payments, coinsurance or deductibles under the applicable Steward Health Choice Generations Benefit Plan, Health Choice Generations Members – for as long as they are also Utah Medicaid eligible - must have no obligation for any fees, regardless of whether secondary insurance is available.

Nothing in this section is meant to prevent providers from receiving payment from any secondary payer.

When Steward Health Choice Generations Is Secondary

If a Steward Health Choice Generations Member possesses health benefits coverage through another policy which is primary to Steward Health Choice Generations under applicable coordination of benefits rules, including the Medicare secondary payer program, or if a Steward Health Choice Generations Member is entitled to payment under a worker's compensation policy or automobile insurance policy, providers must pursue payment from the primary payer consistent with the applicable State and Federal Law.

Providers must include a complete copy of the other first or third-party carrier's explanation of benefits (EOB) or remittance advice (RA) when submitting a claim for the balance due under coordination of benefits. Such claims(s) for any balance due must be received by Steward Health Choice Generations within thirty (30) days from the date of remit from the primary carrier or six (6) months from the date of service, whichever is less.

For Steward Health Choice Generations Members, payment will be based upon the Steward Health Choice Generations fee schedule, less the beneficiary co-insurance, co-payment, and applicable deductible. This will constitute payment in full to Providers.

In situations where providers have not received notification from the primary payer, providers may submit the claim without the EOB/EOMB and it must be received by Steward Health Choice Generations within the prescribed initial submission deadline of six (6) months. Steward Health Choice Generations will deny the claim for failure to submit the EOB/EOMB thereby allowing providers to resubmit the claim with the EOB/EOMB within eighteen (18) months from the date of service.

Motor Vehicle Accidents (MVA) or Work Related Injuries

If a member requires services for an injury or condition resulting from circumstances involving a third party, (e.g., automobile accident or work related injuries) the provider must notify Steward Health Choice Generations at (480) 968-6866 or (800) 322-8670.

Providers are required to furnish the following information:

- Name of provider
- Address of provider
- Name of patient
- Patient's Health Choice Generations identification number
- Address of patient
- Date(s) of hospitalization and/or outpatient services
- Amount due for care of patient
- Date of accident
- County in which injuries were sustained
- Names, if known, of liable persons, firms, corporations, employer and insurance carriers claimed by the patient or patient's legal representative to be liable for damages

Steward Health Choice Generations third party liability administrators will coordinate and pursue collection from underinsured motorist insurance, third party liability insurance, and tortfeasors in cases of probable third party liability.

Note: *Medicaid is never the primary payer for services that are covered by Medicare. Medicaid only pays after Medicare, employer group health plans and/or Medicare Supplemental Insurance policies have paid.*

CHAPTER 9:

Claims Disputes, Member Appeals, and Member Grievances

Steward Health Choice Generations Claims Resubmissions

Providers may resubmit claims that have been previously adjudicated by Steward Health Choice Generations Utah (Steward Health Choice Generations) and must be received by Steward Health Choice Generations within twelve (12) months from the date of service.

If your claim has denied due to needing additional information or corrections, it is considered a *Resubmission (i.e. missing medical records, an itemized bill (IZ form), not a clean claim, etc.)*. Claim resubmissions should be sent back to the plan for reconsideration with a stamp or legible notice that the claim is a "Resubmission". If the services were performed by a facility, the appropriate bill type must be used to indicate a replacement claim. Appropriate documentation is required to re-evaluate the claim's original disposition in addition to the correct claim form with the services listed in detail.

All claim resubmissions can be mailed to:

> **Steward Health Choice Generations Utah**
> **Attn: Claims Department – Resubmissions**
> **410 North 44th Street, Suite 510**
> **Phoenix, AZ 85008**

Steward Health Choice Generations will re-adjudicate claims resubmitted by providers only if the initial claim had been filed within the prescribed submission timeframe.

Claims resubmissions must be designated as such and must consist of the following:

1. Copy of claim
2. Copy of Steward Health Choice Generations remittance advice
3. Supporting documentation
4. Written explanation as to reasons for resubmission

Steward Health Choice Generations Claims Reconsideration

If your claim has denied due to reasons other than the above it is designated as a **Reconsideration.** Provider requests for claims reconsideration must be received by Steward Health Choice Generations within eighteen (18) months from the date of service or from the date of discharge for an inpatient hospital stay. Providers need to submit in writing a cover letter for

each member's claim being disputed directly to the Steward Health Choice Generations Claims Resubmission Department. Included with this cover letter should be a written explanation of the reason for the reconsideration, including a copy of the explanation of payment, documentation if appealing coding, or modifier use and medical records if needed.

Steward Health Choice Generations will make a determination within sixty (60) calendar days following receipt of the completed claims reconsideration cover letter. All decisions rendered by Steward Health Choice Generations are final.

All Steward Health Choice Generations claim reconsiderations should be mailed to:

Steward Health Choice Generations Utah
ATTN: Claims Resubmission
410 North 44th Street, Suite 510
Phoenix, AZ 85008

Provider Appeals

Whenever possible, Steward Health Choice Generations attempts to informally resolve issues raised by contracted providers at the time of initial contact. If the issue cannot be resolved informally, Steward Health Choice Generations offers a two-level internal contracted provider payment review process for resolving disputes with contracted providers. Below are the two-level provider payment review processes.

First Level Contracted Provider Payment Review

The first level of the contracted provider review process must be initiated by the practitioner/provider within 180 calendar days from the date of the plan determination (authorization or payment denial) by Steward Health Choice Generations.

The payment review request will be handled by a reviewer who was not involved in the initial decision. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.

Contracted Providers who are not satisfied with the first level review decision may request a second level provider payment review.

Second Level Contracted Provider Payment Review

The second-level of the contracted provider review process must be initiated by the practitioner/provider within 60 calendar days from the date of the first-level decision. Any request received after the 60 calendar day will automatically be upheld without further review.

The payment review request will be handled by a reviewer who was not involved in the initial decision or the first-level review. Decisions will be consistent with Medicare rules and regulations, the Provider's contract terms and/or the member's benefit plan.

Submit your appeal request to:

Steward Health Choice Generations Utah
ATTN: Provider Appeals/Disputes
410 North 44th Street, Suite 500
Phoenix, AZ 85008

Member Appeals and Grievances (Complaints)

Steward Health Choice Generations adopts Medicare requirements as they relate to member appeals and grievances (complaints). Steward Health Choice Generations will advise Providers of any member appeal or grievance relating to Providers' services under their Contract. Providers agree to cooperate with the Steward Health Choice Generations in the resolution of member requests for service, appeals and grievances, including, but not limited to, providing any information or records needed to render a decision on a request for service, appeal, or grievance. Providers will submit information and records with sufficient promptness to allow the Steward Health Choice Generations to meet CMS requirements for the timely processing of requests for service, appeals, and grievances. It is understood that certain requests for service and appeals must be processed by Steward Health Choice Generations, on an expedited basis, no later than seventy-two (72) hours of receipt. Providers will, to the extent permitted by law, advise Steward Health Choice Generations of any Member appeal or grievance as it relates to services provided under the provider agreement.

Member Appeals for the Reduction, Suspension, or Termination of an Authorization

A member may file an appeal with Steward Health Choice Generations in response to an adverse action such as the:

- Payment for temporary out-of-the-area renal dialysis services, emergency services, post-stabilization care or urgently needed services,
- Payment for any other health services furnished by a provider other than Steward Health Choice Generations that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Steward Health Choice Generations,
- Steward Health Choice Generation's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by Steward Health Choice Generations,
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment or
- Failure of Steward Health Choice Generations to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

The member must forward the appeal within sixty (60) days of the action. In addition to a member or a member's authorized representative, the member's primary care physician or other in-network physician can request an appeal of a denied prior authorization or *Notice of Adverse*

Benefit Determination (NOA). A written appeal request must be received by Steward Health Choice Generations within 60 calendar days from the date of the original denial. Appeal requests should be sent to the Appeals/Disputes Department:

Steward Health Choice Generations Utah
ATTN: Member Appeals
410 North 44th Street, Suite 900
Phoenix, AZ 85008

Appeal requests should be clearly marked as *"appeal"* and should be accompanied by justification and additional medical documentation supporting the request.

Once the Appeal process has been initiated, Steward Health Choice Generations will send the member an acknowledgment letter. Steward Health Choice Generations will respond to all appeals within thirty (30) calendar days from the date that the health plan received the request. Steward Health Choice Generations will mail a final written decision to the Member. If an extension is necessary, Steward Health Choice Generations will notify the Member. Before we make our decision, your office can provide additional documentation to assist Steward Health Choice Generations in its determination of the Appeal.

If your office is filing an appeal on behalf of the member and a delay in processing could seriously jeopardize the member's the life, health or the ability to attain, maintain or regain maximum function your office can request an Expedited Appeal. In these instances the appeal will be decided within 72 hours from the date the appeal is received.

Extensions of up to 14 additional days can be requested by the member's provider or Steward Health Choice Generations. If your office, the member, or Steward Health Choice Generations establishes the need for the additional days and delay is in the best interest of the member, an extension will be granted. If Steward Health Choice Generations requests the extension, then Steward Health Choice Generations will call your office and the member, to notify you of the time and information needed to make a decision. Steward Health Choice Generations will also document the request in writing. If your office requires an extension to providing Steward Health Choice Generations with additional supporting documentation for the Member's appeal, please contact Steward Health Choice Generations by calling the phone number on the acknowledgement letter.

Pharmacy Appeals (Redeterminations)

Pharmacy appeals requests (redetermination requests) must be submitted to Steward Health Choice Generations within 60 calendar days from the notice of the initial coverage determination. A request may be made orally or in writing. A requestor may request a redetermination in any format.

To request a redetermination by phone, please call 1-844-457-8943. TTY/TTD users call 711.

Mail or fax a written request for a coverage redetermination to:

Steward Health Choice Generations Utah
ATTN: Pharmacy Department
410 North 44th Street, Suite 943
Phoenix, AZ 85008
Fax: 1-877-424-5690

Member Grievances (Complaints)

A member may file a Grievance (formerly a member Complaint) with Steward Health Choice Generations regarding the dissatisfaction with any aspect of their care, other than the appeal of any NOA. If a member wants to file a grievance, please direct him/her to Steward Health Choice Generations Member Services at 1-844-457-8943, or inform him/her that he/she can submit his/her grievance in writing to:

Steward Health Choice Generations Utah
ATTN: Quality Management Department Member Grievance
410 North 44th Street, Suite 920
Phoenix, AZ 85008

If the grievance is against your office, Steward Health Choice Generations will contact you to get your input on the grievance.

CHAPTER 10:

Prescription Benefits and Drug Formulary

Steward Health Choice Generations Utah (Steward Health Choice Generations) is a Medicare Advantage Special Needs Plan (SNP) with Medicare Part D Prescription Drug Coverage. Medicare Part D drugs covered by Steward Health Choice Generations are found on our Comprehensive Formulary. The Formulary Drug List as well as criteria for drug coverage can be found on the Health Choice Generations website at https://www.stewardhcgenerations.org/ut.

Prescription Drug Benefit

Medications are covered by Medicare in numerous categories. Some medications are covered under Medicare Part A and/or B, and some medications are covered under Medicare Part D. Medicare Part D coverage is commonly referred to as the outpatient prescription benefit. The list of drugs covered by Steward Health Choice Generations Medicare Part D Benefit is known as our Formulary Drug List.

If drugs are covered under Medicare Part A or Part B, they are in most instances not covered under Medicare Part D. Therefore, drugs covered under Medicare Part B will not be found on the Formulary Drug List. Examples of Medicare Part B drugs include, but are not limited to:

- Drugs usually not self-administered by patients and injected with physician services
- Drugs used with durable medical equipment (e.g. nebulizers, blood glucose meters)
- Clotting factors self-administered by patients with hemophilia
- Immunosuppressive drugs in patients whose organ transplant was covered by Medicare
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs used during dialysis
- Intravenous immune globulin for the treatment of primary immune deficiency diseases.

Steward Health Choice Generations outpatient prescription drug benefit covers drugs not otherwise excluded from Medicare Part D coverage. Drugs not covered by Medicare Part D, and therefore not considered Part D drugs include: non-prescription Over-the-Counter (OTC) drugs*; drugs used for anorexia, weight loss, or weight gain; drugs used to promote fertility; drugs used for cosmetic purposes, hair growth or erectile dysfunction; drugs used for the symptomatic relief of cough or colds; and, prescription vitamins and mineral products, except prenatal vitamins and fluoride.

* In 2019, under the supplemental benefit package, Steward Health Choice Generations offers a catalog of OTC medications which enrollees may order. Up to $100 of OTC products are covered

per quarter. Interested Members should call the Member Services phone number on their card for additional information.

Formulary (List of Medications)

The Steward Health Choice Generations formulary lists all Part D drugs covered by Steward Health Choice Generations. We will generally cover the drug as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on coverage.

The drugs on the formulary are selected by a CMS compliant Pharmacy and Therapeutics (P&T) Committee which consists of medical and pharmacy providers. The P&T Committee selects Part D eligible prescription drugs necessary to meet the clinical needs of our members and comply with Medicare's formulary requirements. Not all Part D eligible drugs are covered by Steward Health Choice Generations based on P&T Committee decisions.

Per Medicare regulation, Steward Health Choice Generations covers Part D drugs for "medically-accepted" indications, approved by the FDA. Coverage of off-label uses of a prescription drug can only occur in very specific situations. We may cover the off-label use only in cases where the use is supported by Part D approved compendia. If the use is not supported by one of these compendia then the drug would not be covered by our plan.

Brand and generic drugs are included on the formulary. A generic drug has the same amount of active-ingredient(s) as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

The Steward Health Choice Generations Formulary has a single drug tier (1 tier) for all covered drugs.

Steward Health Choice Generations formulary medications may be subject to utilization management tools such as Prior Authorization, Step Therapy and/or Quantity Limits. The utilization management tools serve as additional requirements for coverage or limits on coverage. These requirements and limits ensure that our Health Choice Generations m embers use these drugs in the most effective way. A team of doctors and pharmacists developed and the P&T Committee approved the requirements and limits to help provide quality coverage to our enrollees.

Prior Authorization

Steward Health Choice Generations requires Prior Authorization for certain drugs. This means Steward Health Choice Generations needs to review and approve a Coverage Determination request before the enrollee can fill the prescription. Coverage Determinations may be requested by the provider, member, or the member's appointed representative. We will not cover prescriptions for certain drugs unless they have been authorized.

Steward Health Choice Generations' Prior Authorization criteria speak to Part D eligible "medically accepted" indications, approved by the FDA and/or supported by certain peer review reference and Part D approved compendia such as American Hospital Formulary Service Drug Information, DRUGDEX Information System, and the United States Pharmacopeia-Drug Information citations. If the use is not supported by one of these compendia then the drug would not be covered.

Step Therapy

Steward Health Choice Generations may require providers to try one drug to treat a member's medical condition before covering another drug for that condition. For example, if Drug A and Drug B both treat a specific medical condition, we may require the provider to prescribe Drug A first. If Drug A does not work for the enrollee, then we will cover Drug B.

Quantity Limits

For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period. Requestors must request an exception to the limit via the coverage determination process for Steward Health Choice Generations to cover quantities above the listed amounts on the formulary.

Formulary Exception Requests

Providers can use the Health Choice Generations Pharmacy Medication Prior Authorization/Exception Request Form located on the website or any form that is convenient for the requestor to request formulary exceptions for enrollees. Requests may also be submitted online: https://steward.promptpa.com or via phone by calling member services. The exception request must include documentation of medical necessity. Formulary exception requests can be requests for non-formulary medications, or a request for exceptions to Prior Authorization or Step Therapy criteria, or quantity limits that need to be exceeded based on enrollee medical necessity. If Steward Health Choice Generations approves the exception request, the approval is valid through the end of the current benefit year so long as the plan provider continues to prescribe the drug and the member continues to be eligible under Steward Health Choice Generations.

Steward Health Choice Generations enrollees may request an exception to the formulary or utilization management criteria. When an enrollee requests an exception, a provider's supporting medical documentation is needed to appropriately process the request or coverage determination.

Pharmacy Appeals (Redeterminations)

Make your appeal (redetermination) request to Steward Health Choice Generations within 60 calendar days from the notice of the initial coverage determination. A request may be made orally or in writing. A requestor may request a re-determination in any format.

To request a redetermination by phone, please call 1-844-457-8943. TTY/TTD users call 711.

Mail or fax a written request for a coverage redetermination to:

Steward Health Choice Generations
Attn: Pharmacy Department
410 North 44th Street, Suite 943
Phoenix, AZ 85008
Fax: 1-877-424-5690

Requests may also be submitted online: https://steward.promptpa.com

Formulary Changes

The Medicare Part D program allows Health Choice Generations to make changes in our prescription drug formulary list at any time during the calendar year. Changes to our formulary within a plan year can be found on the Health Choice Generations website under Members > Prescription Drug Information > Formulary Change Notice. The Formulary Change Notice is posted at least 60 days prior to a negative change. Additionally, the most up to date copy of the formulary and utilization management tools (e.g. Prior Authorization Criteria, Step Therapy Criteria, and Quantity Limits) are found on the website.

If Steward Health Choice Generations removes a drug from the formulary, adds prior authorizations, quantity limits, and/or step therapy restrictions on a drug, and an enrollee is taking the drug affected by the change, we will notify the enrollee of the change at least 60 days before the date that the change becomes effective. If we do not notify the enrollee of the change in advance, we will give a 60-day supply of the drug when the member requests a refill of the drug. However, if a drug is removed because the drug has been recalled from the market, we will not give 60 day notice before removing the drug or give a 60-day supply of the drug when a refill is requested. Instead, we will remove the drug from our formulary immediately and Steward Health Choice Generations enrollees and providers will be notified about the change as soon as possible.

Immediately after receiving the 60-day notice or supply, providers and enrollees should work with Steward Health Choice Generations to either switch to a formulary alternative drug or request a formulary exception (which is a type of coverage determination). The provider should request a formulary exception if the provider determines that the drug being removed is needed and none of the drugs on formulary are medically appropriate for the member.

Transition Policy

New enrollees in our plan may be taking drugs that are not on our formulary or that are subjected to certain restrictions, such as prior authorization or step therapy. Therefore new enrollees have access to a 30 day transition supply of the specific drug within the first 90 days of their enrollment; if the new enrollee is in a long-term care facility, up to a 98 day transition supply will be provided. Additionally, enrollees that experience a change in level of care or a formulary change from one year to another have access to a transition fill of their drug. When a transition fill occurs the enrollee and prescriber will get letters explaining next steps needed to continue coverage of the drug. Steward Health Choice Generations enrollees should talk to their doctors

to decide if they can switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug.

Please note that the transition policy applies only to those drugs that are "Part D eligible" and that are purchased at a network pharmacy. The transition policy cannot be used to obtain non-Part D drugs or drugs out-of-network.

Drug Management Programs

Generic Substitution

When there is a generic version of a brand-name drug available our network pharmacies will automatically dispense the generic version, unless the provider has provided documentation to Steward Health Choice Generations and the dispensing pharmacy that the member must be dispensed the brand-name drug as written.

Drug Utilization Review

Steward Health Choice Generations conducts drug utilization review on our Steward Health Choice Generations enrollees to make sure they are receiving safe and appropriate care. We conduct drug utilization review each time prescriptions are filled by an enrollee and on a retrospective basis. During the review, we look for medication problems such as:

- Possible medication errors
- Unnecessary duplicate drugs being taken to treat the same medical condition
- Drug overutilization or underutilization
- Drugs inappropriate because of age or gender
- Harmful Drug-Drug or Drug-Disease interactions
- Drug allergies
- Drug dosage errors

If Steward Health Choice Generations identifies a medication problem during our drug utilization review, we will work with the provider to correct the problem.

Medication Therapy Management Programs

Steward Health Choice Generations offers a medication therapy management (MTM) program at no additional cost for enrollees who have multiple medical conditions, or who are taking many prescription drugs, or who have high drug costs. These programs were developed by a team of pharmacists and doctors. Steward Health Choice Generations uses the medication therapy management program to help enrollees use medications more appropriately. The program provides the enrollee the opportunity to talk with a pharmacist and create a medication action plan. Providers are made aware of the pharmacy medication action plan when created. The MTM program helps our enrollees use drugs appropriately by encouraging adherence with chronic medications, identifying gaps in care, and preventing adverse drug outcomes.

When enrollees meet specific MTM program criteria, Steward Health Choice Generations will contact enrollees to encourage participation in the program. MTM program criteria include presence of three (3) or more medical conditions (e.g. diabetes, hypertension, hyperlipidemia, arthritis, Alzheimer's Disease, osteoporosis) , who are taking eight (8) or more Part D chronic medications, and who have drug costs greater than $1,011 per quarter (three month period of time).

If you serve Steward Health Choice Generations enrollees who meet the criteria, contact Medical Services to enroll your patients into a medication therapy management program. Steward Health Choice Generations will send information about the specific program including information about how to access the program.

Pharmacy Network

The Steward Health Choice Generations pharmacy network directory can be viewed on our website at http://www.stewardhcgenerations.com/ut.

A network pharmacy is a pharmacy at which enrollees can get Part D prescription drug benefits. We call them *network pharmacies* because they contract with Steward Health Choice Generations. In most cases, prescriptions are covered only if they are filled at one of our network pharmacies.

Steward Health Choice Generations enrollees may switch to a different network pharmacy at any time. Providers must either provide a new prescription written or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

Steward Health Choice Generations will pay for prescriptions at non-network pharmacies under certain circumstances as described in the Steward Health Choice Generations Evidence of Coverage.

Retail Pharmacy Network

Steward Health Choice Generations retail pharmacy network consists of chain and independent pharmacies in Utah and throughout the United States. Enrollees can fill prescriptions for most medications (up to a 93 day supply) at our retail pharmacies. When writing a prescription for an extended day supply of a medication the prescription should most commonly be written for a 90-day supply. Formulary drugs which are *not* available in extended days' supply are noted on the Formulary with "NDS" in the limits column.

Mail Order Pharmacies

Steward Health Choice Generations enrollees can use our network mail order pharmacy to get up to a 93 day supply of medication. When ordering prescription drugs through our network mail order pharmacy service at least a 90-day supply must be ordered.

OptumRx home delivery: 1 (844) 368-7174.

If the provider is going to send a prescription to the mail order pharmacy please verify the enrollee has registered with the mail order pharmacy.

Specialty Pharmacies

Specialty drugs are include certain high-cost medications, including biologically-engineered medications that are supplied by Steward Health Choice Generations via a preferred specialty pharmacy, BriovaRx. Additionally, enrollees may acquire their specialty medication from any network pharmacy that carries specialty medications.

Many of the specialty drugs on our formulary require prior authorization. Steward Health Choice Generations staff will coordinate the provision of these approved medications to your patients.

Home Infusion Pharmacies

Steward Health Choice Generations covers home infusion therapy under the Part D benefit if

- The prescription drug is on Steward Health Choice Generations formulary or a formulary exception has been granted for the prescription drug,
- Steward Health Choice Generations has approved the prescription for home infusion therapy and
- The prescription is written by an authorized prescriber.

Please refer to the Pharmacy Directory to find a home infusion pharmacy provider or contact your Network Services Representative or contact Member Services.

Long Term Care Pharmacies

In some cases residents of a long-term care facility may access their prescription drugs through the facility's long-term care pharmacy or another network long-term care pharmacy.

Please refer to the Pharmacy Directory to find out what long-term care pharmacies are part of the network. Contact your Network Services Representative for assistance.

Indian Health Services/Tribal/Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies through the Steward Health Choice Generations pharmacy network. Members other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies).

Please refer to the Pharmacy Directory to find an I/T/U pharmacy. Contact your Network Services Representative for assistance.

Extra Help with Medicare Part D Benefit Available for Enrollees

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include savings and stocks, but not a home or a vehicle. If an enrollee qualifies he/she will get help paying for a Part D plan's monthly premium, yearly deductible and prescription drug co-payments. **All Steward Health Choice Generations enrollees qualify for extra help since they are eligible for Utah Medicaid or get Supplemental Security Income benefits**. Our enrollees do not have a Part D premium or deductible and pay a

specific generic drug or brand drug co pay based on their subsidy level. The specific prescription drug co pay is the same for a 30 or 90 day supply of medication. Writing prescriptions for chronic medications for a 90 day supply instead of a 30 day supply will decrease an enrollee's drug costs and may potentially increase patient adherence to their prescribed therapy.

The amount of extra help Steward Health Choice Generations enrollees get depends on their income and resources. If the provider believes an enrollee may qualify, have the enrollee contact Social Security at **(800) 772-1213**, www.socialsecurity.gov, or apply through the State Medical Assistance (Medicaid) office. TTY users call (800) 325-0778.

CHAPTER 11:

Transplant Services

Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Chapter 7: Inpatient and Outpatient Hospital Care for more information about Inpatient Services.

Organ Transplants

Steward Health Choice Generations will arrange to have the member's case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether the member is a candidate for a transplant.

The following transplant and transplant-related services are not covered when the transplant procedure itself is not covered by Steward Health Choice Generations:

- Artificial or mechanical hearts or xenografts
- Workups to evaluate the patient as a possible transplant candidate
- Hospitalization for the above procedures
- Organ procurement
- All other medically necessary, non-experimental services are covered

CMS Approved Transplants Centers

At the following link you will find a list of facilities certified for Medicare payment of transplants for non-renal organs, along with the effective date of such certification: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html

This information is used by Medicare beneficiaries in need of transplants and their families, to locate facilities that are eligible for Medicare payment for transplants and associated care. The information is also used by other individuals and organizations critical to the effective operation of the Medicare transplant programs. Such individuals and organizations include, but are not limited to, prospective donors, CMS Regional Offices, the Health Resources and Service Administration (HRSA), the United Network for Organ Sharing (UNOS), organ procurement organizations (OPOs), medical schools and other academic institutions, and researchers.

Authorization Requirements

The most important requirements are to submit appropriate medical documentation with the Transplant Request Form. (i.e., Labs, Diagnostic test results, History and Physical, Consultation notes, and last office visits).

Billing Requirements

Billing for the acute care hospitalization in which the transplant occurred: The provider must enter the proper ICD-10 procedure code identifying the transplant procedure in the primary procedure field (Field 67) on the claim form.

Steward Health Choice Generations contracts with providers to provide covered transplant services to eligible recipients.

- The contract specifies the inpatient, outpatient, and ancillary services that are included and the payment amount to be received for the services provided.
- The contract may include all services rendered by the following providers:
    - Hospitals
    - Inpatient and outpatient services before, during, and after the transplant
    - Physicians, surgeons, anesthesiologists, etc.
    - Laboratory
    - Pharmacy
    - Temporary housing
    - Clinics
    - Pre- and postoperative office visits
- Providers must notify Steward Health Choice Generations when a recipient requires a transplant procedure.
- Steward Health Choice Generations will ensure contract terms with the provider prior to services being provided. The services included in the terms of the contract shall be submitted to Steward Health Choice Generations as separate case stages or as a package.
    - A transplant stage type is assigned to each transplant case
    - Each stage has a set dollar value that determines the payment amount for specific dates of service
- Services will be reimbursed based on the terms of the contract
- Steward Health Choice Generations will provide the Reimbursement Services Department with the payment requirements, including the provider name and number under which claims are to be submitted
- Steward Health Choice Generations will review the case stage or the package submitted, and the services will be paid according to the terms of the contract
- All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis codes, CPT and HCPCS procedure codes, and revenue codes to meet clean claim status
- The claim will automatically pend for medical review for compliance with federal regulations, Steward Health Choice Generations rules and policies
- Physician and other medical services billed on the CMS 1500 claim form are part of the contracted components and will be pended for medical review

CHAPTER 12:

Benefits and Covered Services

Steward Health Choice Generations covers the same benefits covered under Original Medicare. Sometimes Medicare adds coverage for a new service during the year. Steward Health Choice Generations will cover those added services. Some services may require prior authorization. For a complete listing of the Medicare services that require prior authorization, please refer to the Steward Health Choice Generations prior authorization grid effective to the applicable date of service at https://www.stewardhcgenerations.org/ut/providers/provider-information/ under Prior Authorization & Guidelines.

General list of services that are covered under Steward Health Choice Generations (Medicare coverage criteria applies):

- Ambulance services
- Cardiac rehabilitation
- Chiropractic services
- Durable medical equipment and related supplies
- Emergency care
- Hearing services (diagnostic evaluations)
- Home health agency care
- Hospice consultation
- Inpatient hospital care
- Inpatient mental health care
- Inpatient services covered during a non-Medicare covered inpatient stay
- Medicare Part B prescription drugs
- Outpatient diagnostic tests and therapeutic services and supplies
- Outpatient hospital services
- Outpatient mental health care
- Outpatient rehabilitation services
- Outpatient substance abuse services
- Outpatient surgery
- Partial hospitalization services
- Physician/Practitioner services
- Podiatry services
- Prosthetic devices and related supplies
- Pulmonary rehabilitation services
- Spinal subluxation treatment

- Services to treat kidney disease and conditions
- Skilled nursing facility care
- Urgent care

Preventive Services

Steward Health Choice Generations also covers many preventive services including (Medicare coverage criteria apply):

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular disease risk reduction visit
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Diabetes self-management training, diabetic services and supplies
- HIV screening
- Immunizations (pneumonia, flu, hepatitis B)
- Medical nutrition therapy (diabetes and renal disease)
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy
- Prostate cancer screening
- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and prevention counseling
- Smoking and tobacco use cessation counseling
- Vision screening for glaucoma
- Welcome to Medicare preventive visit

Additional educational resources for the Medicare covered preventive services may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html .

Supplemental Benefits

Steward Health Choice Generations also covers supplemental benefits that are not covered under the Original Medicare program. These additional services include dental, vision, hearing, over the counter products, podiatry and chiropractic care (also refer to: Chapter 6 Medical Authorizations and Notifications).

Vision – 2019
$200 per year for one pair of glasses (lenses plus frames), and/or contacts ($0 copay).
One routine Eye Exam per year ($0 copay)

Dental – 2019
$1,350/Year Comprehensive + Preventive
Two Oral Exams and Two Cleanings per year (exams and cleanings must be performed in the same preventive office visit). $0 copay
One Dental X-Ray per year ($0 copay), which can consist of: • One of either bitewing x-rays or single x-rays • OR One complete aka full mouth (fox) aka panoramic set once every 36 months.
Deep Cleanings, Non-Routine Diagnostic Services, Non-routine Restorative Services, Non-routine Endodontics/Periodontics (0% coinsurance)
Non-routine Extractions (0% coinsurance)
Not Covered: Prosthodontics (including dental and facial restoration including cosmetics, dental implants, bridges, dentures, and temporomandibular restorative procedures

Over the Counter (OTC) – 2019
$100 every 3 months for items found in the OTC catalog provided to members (no roll-over).

Hearing – 2019
$1,500 per every 3 years for one hearing aid and one fitting
One routine hearing exam per year $0 copay

Meal Benefit – 2019
10 meals per admit, once per calendar year, immediately following an inpatient hospital stay

Excluded Services

Certain services are excluded under the Original Medicare program. Steward Health Choice Generations does not cover these types of services. Members will be required to pay 100% of the cost for these services. The list below describes some of the excluded services and items that are not covered by the plan:

- Services considered not reasonable and medically necessary, according to the standards of Original Medicare.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Home-delivered meals
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in home.
- Custodial care provided in a nursing home, hospice, or other facility setting.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged for care by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, except in the case of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.

PCP Prescribing of Medications for Behavioral Health Diagnoses

PCP's can prescribe and monitor behavioral health medications; however, please check the Steward Health Choice Generations Formulary for prescribing requirements. PCP's must obtain prior authorization for non-formulary medications. Documentation of medical necessity is required for review by the Medical Director.

Non Behavioral Health Medications Covered by Utah Medicaid

Members can receive Part D non-covered medications from contracted providers through the member's Utah Medicaid health plan. All non-formulary medications in these categories will require Prior Authorization.

Member Rights to Participate in Their Treatment Decisions

All providers participating in the member's care must give information on the available treatment options (including the option of non-treatment) or alternative courses of care and other information regarding treatment options in a language that the member understands. This information should include:

- Member's condition
- Any proposed treatments or procedures and alternatives
- Benefits, drawbacks and likelihood of success of each option
- Possible consequences of refusal or non-compliance with a recommended course of care.

Members who are unable to fully participate in their treatment decisions may be represented by parents, guardians, other family members or other conservators, as appropriate and by the members wishes. This determination can be based on the law and circumstances of the: Minors being represented by their parents/legal guardians, Advance Directives, and Family members with Power of Attorney.

Member Rights to Request Any Covered Service

Members have the right to request any covered services, whether or not the PCP or Specialist has recommended the service. Services should be recommended by the PCP or Specialist and may be subject to approval through the Steward Health Choice Generations utilization management system.

Toll-Free: 1-844-457-8943 (TTY 711)
7 Days a week, 8 a.m. – 8 p.m.

www.StewardHCGenerations.org/UT

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