Provider Administrative Manual

Missouri/Illinois | 2016
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General Information

Calling Essence: Options to Select

Customer Service
(314) 209-2700 or (866) 597-9560

Press 1
Pharmacy or Provider calling to prior authorize a Part B prescription

Press 2
Someone interested in obtaining information about joining Essence

Press 3
Pharmacy issue

Press 4
Medical issue

Press 5
Member

Press 6
Provider

All other calls

Press 1
Medical Management

Press 2
For non-routine questions or complex issues

Press 3
For routine questions, assistance with member eligibility, claims, inquiry, and benefit validation
# Plan Information Contact List

<table>
<thead>
<tr>
<th>Essence Healthcare</th>
<th>13900 Riverport Drive</th>
</tr>
</thead>
<tbody>
<tr>
<td>(314) 209-2700 or (866) 597-9560</td>
<td>Maryland Heights, MO 63043</td>
</tr>
<tr>
<td>For the hearing impaired, contact the National Relay Service 711</td>
<td><a href="http://www.essencehealthcare.com">www.essencehealthcare.com</a></td>
</tr>
<tr>
<td>Fax (314) 770-6096 or (888) 480-2577</td>
<td></td>
</tr>
</tbody>
</table>

**Provider Correspondence/Claims Address:**

- Essence Correspondence or Claims
- P.O. Box 12488
- St. Louis, MO. 63132-0188

## Compliance/Fraud, Waste and Abuse

**Call Main Number and ask for Compliance Department**

**Call Chief Compliance Officer:** (314) 209-3957

**E-mail:** evenable@essencehealthcare.com

**Compliance Hotline:** (800) 450-0068 or www.integrity-helpline.com/essence.jsp

For questions related to Essence’s Compliance Program and Code of Conduct; Provider responsibilities relative to the Compliance Program, including required training; reporting any suspected or actual violation of regulations, laws, policies or procedures; or fraud, waste and abuse relative to Essence’s Medicare Advantage Program.

## Provider Services

**Call Main Number then Press Option #5, then Option #3**

**Call Main Number then Press Option #5, then Option #2**

For routine inquiries such as claims status checks, member eligibility, benefit verification, or confirmation of referrals/prior authorizations check our website at www.essencehealthcare.com or this option.

Assistance to network providers with detailed/complex questions, provider database updates, credentialing, and general information.

Changes regarding your practice can be done online through our Provider Portal. Look for the Provider Demographic Change Form under Forms after you log in.

## Pharmacy (Part D Prescriptions)

**Call Main Number then Press Option #1**

Assistance for prior authorization for a formulary drug. A form for Part D Coverage Determination is located on the Provider Portal.

## Provider Technical Support for the Provider Portal and ADSP

**Call:** (866) 397-2812

**E-mail:** Maestro-Support@lumeris.com

Assistance with technical questions relating to registration, login or web application access. The Provider Portal provides information on member eligibility, claims, referral look up and if a PCP, the ability to complete your referrals online. ADSP provides information for our Primary Care Physicians.
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Management</strong></td>
<td>Assistance with case management, pre-authorization of procedures, referrals, notification and benefit determination.</td>
</tr>
<tr>
<td>Call Main Number then Press Option #5, then Option #1</td>
<td></td>
</tr>
<tr>
<td>Fax: (314) 770-6048 or (877) 755-7715</td>
<td></td>
</tr>
<tr>
<td><strong>Sales</strong></td>
<td>Assistance with promotional and sales activities.</td>
</tr>
<tr>
<td>Call Main Number then Press Option #2</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Dental</strong></td>
<td>Advantica – Contracted provider for routine dental care.</td>
</tr>
<tr>
<td>(800) 501-3471</td>
<td></td>
</tr>
<tr>
<td>Claims Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Advantica</td>
<td></td>
</tr>
<tr>
<td>PO. Box 8510</td>
<td></td>
</tr>
<tr>
<td>St. Louis, MO 63126</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td>Mercy Behavioral Health – Contracted provider of inpatient and outpatient mental health / substance abuse services to Essence members.</td>
</tr>
<tr>
<td>(877) 405-7612</td>
<td>or for the hearing impaired contact the National Relay Service 711</td>
</tr>
<tr>
<td>Claims mailing address:</td>
<td></td>
</tr>
<tr>
<td>Essence Claims</td>
<td></td>
</tr>
<tr>
<td>PO Box 12488</td>
<td></td>
</tr>
<tr>
<td>St. Louis, MO 63132-0188</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td>Eye Med – Contracted provider for routine vision services, eye glasses, and other eye hardware.</td>
</tr>
<tr>
<td>(866) 723-0514</td>
<td></td>
</tr>
<tr>
<td>Submit claims through Eye Med’s on-line system at : <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></td>
<td></td>
</tr>
<tr>
<td><strong>Transportation Services</strong></td>
<td>Members have limited non-emergent transportation services available to them contingent on their plan type. They can call to make these arrangements on their own.</td>
</tr>
<tr>
<td>Medical Transportation Management (MTM)</td>
<td>(888) 513-0705</td>
</tr>
<tr>
<td><strong>Fitness Program/Classes</strong></td>
<td>Members have a fitness benefit contingent on their plan type. They can arrange for membership on their own.</td>
</tr>
<tr>
<td>SilverSneakers: For locations call 888-423-4632 or go to <a href="http://www.silversneakers.com">www.silversneakers.com</a></td>
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</tr>
</tbody>
</table>

For help remembering the plan contact numbers please refer to the “Provider Quick Reference Guide.”
Our Mission

Our Mission is to lead the positive evolution of healthcare by providing doctors with the tools, information, and financial incentives they need to practice quality medicine, thereby providing our members access to high-quality service and affordable medical care. We strive to do this by beginning with primary care physicians who seek to coordinate the delivery of healthcare within the Medicare Advantage program, making use of risk-adjusted reimbursement to fund the ongoing vitality and organizational development of their medical groups. We strive to provide innovative and efficient electronic tools and data to our providers in order to support all of these efforts.

Our Model

The first Collaborative Payer® Model, that was established by Essence Healthcare in 2004 is what we practice and endorse. This model is built on a foundation of reciprocal accountability, aligned patient and provider incentives, cultural and data transparency, and information and technology tools that support continuous improvement and behavior change. It favors the wellness of patients and fosters stewardship of health care resources in pursuit of the Triple Aim Plus One: better health outcomes, lower costs and improved patient experience plus physician satisfaction. We:

• Partner with progressive medical groups and physician organizations to establish, design and locally manage a Medicare Advantage health plan in their own community.
• Provide the most generous healthcare benefits to members at the lowest out-of-pocket costs in every community we serve.
• Properly align financial incentives, affording our physician partners the time and funds necessary to spend more time with patients, allowing them to focus on the long-lasting health of their patients.
• Empower physicians to make the most appropriate care decisions for their patients.
• Proactively share clinical and financial data, revenue and risk with our physician partners.
• Help our physician partners to economically and successfully leverage technology to control costs, improve income and provide outstanding patient care.

Provider Assistance

If you are a Primary Care Physician, you have direct support for all issues related to the plan through your Provider Partnership Program Representative (P3Rep). Their focus is to assist you with our Accountable Deliver Services Platform (ADSP)*, and deal with any issues you may have with the plan.

If you are not a Primary Care Physician but a contracted provider you too have assistance through our Customer Service Department. Should you need assistance beyond this department ask to speak to your provider relations representative.

*explained on page 16
Our Product

Essence offers Medicare recipients an excellent alternative to the options they currently have available, with a comprehensive benefit package that covers more than traditional Medicare. Members have coverage available for a wide array of services including outpatient prescription drug coverage, hospitalization and home care, preventive care services, and ambulance transport, as long as the service is medically necessary and rendered by a participating provider. Essence members may have a co-payment or co-insurance they are responsible to pay for some services.

Essence members select a primary care physician (PCP) at the time of enrollment. The member’s PCP will then be responsible for providing, coordinating, and making arrangements for all medically necessary services for the member. The PCP must generate a referral for many of the services the member is to obtain outside the PCP’s office.

Essence is currently available to Medicare beneficiaries in the Missouri Counties of St. Louis City, St. Louis County, Jefferson, St. Charles, St. Francois, and Boone (central Missouri) and Greene, Christian, Stone and Taney (southern Missouri). In Illinois, Essence is available in the counties of Madison, Monroe and St. Clair.

Selecting a Primary Care Physician (PCP)

Upon enrollment with Essence Healthcare, a member must choose a physician to be their PCP. In rare cases, if the member has not identified a PCP and we cannot verify their choice, a PCP may be assigned.

A Primary Care Physician serves as their total care coordinator and will be responsible for providing, coordinating, and making arrangements for all medically necessary services for the member. The PCP must generate a referral for many of the services the member is to obtain outside the PCP’s office.

Primary Care Physicians are available to members 24 hours a day, 7 days a week through regular scheduling or on-call coverage. There will always be a doctor on call to help them.

Changing a Primary Care Physician (PCP)

It is important that members have a good relationship with their PCP, as they provide most of their care. A member can change their PCP to another Essence Healthcare contracted PCP at any time for any reason except when they are in an acute episode of care. Members can do so by contacting Essence Customer Service. The phone number is denoted in the front of the manual. The change will be effective the first day of the month following receipt of the member’s request. Please note that the member, not their current or newly identified PCP can facilitate this change for them. Please note that any referrals, prior authorizations, planned surgeries etc. generated by one PCP are active and effective when the member changes PCP’s.

There are rare situations a member could be retro assigned to you i.e. current PCP terminated and gave no notification. We will assist the member in finding a replacement PCP as quickly as possible, but there maybe a gap that causes the assignment to become a retro effective date.

We suggest you put office procedures in place to confirm via our on-line member eligibility look up that you are the PCP of record prior to a member’s appointment. You can find the on-line member eligibility ‘look up’ tool on the Essence Provider Portal.
Compliance Responsibilities for Essence Providers

As a Medicare Advantage Organization (MAO) with an established contract with the Centers for Medicare & Medicaid Services (CMS), Essence Healthcare is required to communicate its compliance program requirements to Providers and to ensure compliance with these requirements. Providers contracted with Essence to provide medical or administrative services to our members are required, to comply with all applicable Medicare laws, regulations, reporting requirements, and CMS instructions, with all other applicable federal, state and local laws, rules and regulations; to cooperate with Essence in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all health care professionals employed by or under contract to render Health Services to Plan MA Members, including covering physicians, comply with these provisions.

Essence requires written attestation of such compliance through its Provider contracting process as well as through its contracted entity compliance training and education program. Essence may send written notification to Providers and other contracted entities with a description of the compliance training and education requirements and a request to attest that Essence’s Code of Conduct, selected policies and procedures, and other compliance-related documents (or their equivalents) are read, followed, and distributed to any individuals employed or contracted by the entity to provide medical or administrative services to Essence members. Additionally, contracted entities must verify that training courses in General Compliance and Fraud, Waste and Abuse have been completed.

Upon request, your attestation of compliance must be completed within 60 days of notification, and can be accomplished either electronically through Essence’s Compliance Communication and Education Website, which can be accessed through Essence’s Provider Portal, or by hard-copy forms.

Responsibility To Check For Exclusions

Medicare payment may not be made for items or services furnished or prescribed by a Provider or entity that has been excluded by the Department of Health and Human Services Office of Inspector General (OIG) or General Services Administration (GSA). Providers have compliance responsibility for routinely verifying that no employees or contracted entities that perform administrative or health care service functions relating to Essence are excluded by the OIG/GSA, and should immediately communicate any such exclusion to Essence Healthcare’s Compliance Department.

Reporting Compliance Concerns

Actual or suspected Medicare program noncompliance, potential fraud, waste and abuse, or any compliance concerns or violations relating to Essence or its members must be reported. Providers must ensure that employees or contracted entities that perform administrative or health care service functions relating to Essence are aware of Essence’s expectation of reporting, and its policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns and participation in the compliance program. Information about how to report compliance concerns is denoted in the front of this manual, and should be publicized or otherwise made available throughout your facilities.
Guidelines for Providers When Discussing Medicare Advantage

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

Health care providers and their staff must not:

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

Health care providers and their staff are permitted to:

- Provide the names of all Medicare Advantage and/or Part D plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS)
- Make available and/or distribute plan marketing materials for a subset of contracted Medicare plans, so long as the provider offers the option of making available and/or distributing marketing materials to all plans with which they participate.
- Provide objective information on Medicare plan sponsors’ specific plan formularies, based on a particular patient’s medications and health care needs should a beneficiary seek advice.
- Provide objective information regarding plan sponsors’ plans, including information such as covered benefits, cost sharing and utilization management tools should a beneficiary seek advice.
- Refer their patients to other sources of information, such as SHIPs, their state Medicaid office, local Social Security office, Medicare website (www.medicare.gov) or the Medicare helpline (1-800-MEDICARE).
- Print out and share information with patients from the Medicare web site.
- If patients ask, you can provide the name of the plan marketing representative.
Essence Member ID Card

Essence Healthcare provides each member with an identification card. This card contains demographic information about the covered member, as well as important coverage information such as PCP name and phone number, copayment or coinsurance responsibilities and important phone numbers.

Essence encourages providers to make a copy of the member’s card for their records. We also encourage you to confirm with the member each time you see them, if their insurance coverage has changed and if you are their Primary Care Physician. The date on the card represents their effective date with the plan, not necessarily the effective date with the Primary Care Physician.

You may confirm member eligibility, current assigned PCP, deductible, maximum out of pocket and COB information via our on-line provider portal. It is the member’s responsibility to present their member ID card at the time medical services are obtained.

Below is an example of the Essence Healthcare Member ID:

Front View Essence Advantage, St. Louis/IL (005):

<table>
<thead>
<tr>
<th>Member Name Here</th>
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<tbody>
<tr>
<td>ID</td>
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<tr>
<td>000000000</td>
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<td>GROUP</td>
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<tr>
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<tr>
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<td>CMS H0610005</td>
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Front View Essence Advantage Plus, St. Louis/IL (006):

<table>
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<tr>
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Front View Essence Advantage, Boone (011):

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<td>00/00/0000</td>
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Front View Essence Platinum, St. Louis (014):

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Front View CoxHealth MedicarePlus, Springfield (015):

<table>
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<tr>
<td>CMS H2610015</td>
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</tbody>
</table>

Back View (all):

<table>
<thead>
<tr>
<th>ESSENCE CUSTOMER SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE¹</td>
</tr>
<tr>
<td>(314) 209-2700</td>
</tr>
<tr>
<td>TTY CLAIM ADDRESS</td>
</tr>
<tr>
<td>711, P.O. Box 12488, St. Louis, MO 63132</td>
</tr>
<tr>
<td>TOLL FREE</td>
</tr>
<tr>
<td>(888) 597-9560</td>
</tr>
<tr>
<td>WEBSITE</td>
</tr>
<tr>
<td><a href="http://www.essencehealthcare.com">www.essencehealthcare.com</a></td>
</tr>
</tbody>
</table>

MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES AUTHORIZATIONS TTY CLAIM INQUIRY CLAIM ADDRESS (877)405-7612 711 See above "See above"

PHARMACY BENEFIT MedImpact ESSENCE MEMBERS CALL PHARMACIES CALL Essence Customer Service MedImpact (844) 513-6003

DENTAL BENEFIT ADVANTICA PHONE³ CLAIM ADDRESS (800) 501-3471 P.O. Box 8510, St. Louis, MO 63126 ID PAYOR ID WEBSITE 0701010000000000 43168 www.advanticabenefits.com

ESSENCE MEMBERS CALL Essence Customer Service (314) 209-2700 711, P.O. Box 12488, St. Louis, MO 63132

ID PAYOR ID WEBSITE 0701010000000000 43168 www.advanticabenefits.com

TTY 711
WEBSITE www.essencehealthcare.com

PAYOR ID WEBSITE 0701010000000000 43168 www.advanticabenefits.com
Essence Member Rights and Responsibilities

Each Essence member has the right:

• To be treated with dignity, respect and fairness at all times.
• To receive advice or assistance in a prompt, courteous and responsible manner.
• To confidentiality. All information concerning enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing. Essence members are entitled to access their medical records according to state and federal law; and with adequate notice, they have the right to review their medical records with their physician. Essence members also have the right to ask plan providers to make additions or corrections to their medical records.
• To choose an Essence contracted Primary Care Physician. Members are asked to establish an ongoing relationship with their physician. Essence members have the right to change physicians at any time and for any reason except when they are in an acute episode of care.
• To get appointments and services within a reasonable amount of time (see page 17 for specifics).
• To participate fully in decisions about their health care and have providers explain things in a way that they can understand. This includes knowing all of the treatment choices recommended for the condition, no matter what they cost or whether they are covered by Essence.
• To ask someone such as a family member or friend to help with decisions about health care. To have a guardian or legally authorized person exercise their rights on their behalf if their medical condition makes them incapable of understanding or exercising their rights.
• To make a complaint if they have concerns or problems related to coverage or care.
• To information about Essence Healthcare, its services, its participating physicians and other health care providers providing care and members’ rights and responsibilities.
• To discuss health care concerns or complaints about Essence with those responsible for their care or with Essence Healthcare, and to receive a response within a reasonable time period.

Cultural Competency

Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural similarities and differences, and to understand how these differences influence relationships and interactions with members. Members are entitled to dignified, appropriate and quality care, with sensitivity to cultural differences.

Network providers must ensure the following:

• Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.
• Care is provided with consideration of the member’s race/ethnicity and language and its influence on the member’s health or illness.
• Office staff that routinely comes in contact with members has access to and participate in cultural competency training and development.
• Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
• Treatment plans are developed and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
• Office sites have printed and posted materials in English, and all other prevalent non-English languages if required.
**Second Opinions**

Essence members have the right to receive a second opinion should they desire to do so. If the second opinion fails to confirm the primary recommendation for a treatment plan and/or if the member so desires, a third opinion, provided by a third provider can be sought. Second and third opinions do require a referral from the PCP and should be obtained within the Essence contracted provider network provided that there is a qualified physician. If there is no qualified physician, the PCP will need to contact the Medical Management Department for assistance and approval to go outside of the network.

**Advance Directives**

Members have the right of self-determination. An Advance Directive enables an individual to outline, in advance of a serious illness, what kind of treatment they want or do not want, should they become unable to decide or speak for themselves.

Because this is an important matter, members are advised to talk to family, close friends and their physicians before completing an Advance Directive.

The two most common forms of Advance Directives are:

- A Health Care Directive ("Living Will"); or
- A "Durable Power of Attorney for Health Care."

A Health Care Directive is a document that allows an individual to state in advance their wishes regarding the use of life-prolonging procedures. It may be relied upon if the individual becomes unable to communicate their decisions. It is sometimes called a "Living Will". In most states, adults may complete and sign a pre-printed form or draw up their own forms.

A Durable Power of Attorney for Health Care is a signed, dated and notarized legal document that allows an individual to appoint someone to make all kinds of health care decisions for them if they are not able to do so. These decisions may include instructions about any treatment they desire or those they wish to avoid, including decisions to withhold or withdraw life-prolonging procedures.

Essence participating physicians are encouraged to ask their patients if they have an Advance Directive and are advised to place a signed, notarized copy of any Advance Directives in the patient’s medical record.

Individuals may change their minds or cancel either document at any time in accordance with state laws. Any change or cancellation should be written, signed, and dated in accordance with state law and copies given to their health care providers.

If an individual wishes to cancel an Advance Directive while he/she is in the hospital, he/she should notify his/her physician, his/her family and others who may need to know.

For those who live in Missouri, you can find further information, including advance directive forms, in Life Choices on the Attorney General’s website [http://ago.mo.gov/other-resources/publications](http://ago.mo.gov/other-resources/publications).

For those who live in Illinois, you can find further information and advance directive forms at [http://www.idph.state.il.us/public/books/advin.htm](http://www.idph.state.il.us/public/books/advin.htm)
**Member Orientation**

Essence Customer Service Representatives are available to assist members, once they have enrolled in the plan. These representatives are the member’s contact at Essence and provide a variety of information to the member. Members should contact Customer Service if they have questions concerning the plan, such as:

- The role of the PCP
- How to access a specialist and the referral process
- Criteria for emergency room coverage
- Use of their Member ID card
- Medical and Prescription drug benefits

If you believe your patient is confused about their benefits or has general questions about the plan you may call into Customer Service on their behalf and request that a representative call the member to assist them.

**Explanation of Benefits (EOBs)**

Essence issues two types of EOBs to members.

1. A medical EOB is generated monthly and reflects all claims processed the prior month with the exception of services which are rejected back to the provider of service. Rejected claims are claims which require additional or corrected information in order to consider the service for benefits. (i.e. requires a corrected procedure code or requires a primary carrier’s EOB)
2. A Part D Prescription drug EOB is generated monthly and reflects both the prior month’s Part D claims activity as well as their year to date total drug spend and true out of pocket costs which determines which phase of the benefit they are currently in.

Members can also obtain real time information on-line via our website once they establish a secure log in and password. EOB’s are only issued if the member has had claims activity the prior month.

**Making Changes in Health Care Coverage**

Medicare restricts the number of times a beneficiary can voluntarily change their membership in a health plan. When a beneficiary is new to Medicare they are given an Initial Coverage Election Period (ICEP) that allows them to enroll in a Medicare Advantage plan. After the ICEP there is one primary time, the Annual Enrollment Period (AEP), when all Medicare beneficiaries may choose to make a change to the way they receive Medicare Coverage. The AEP is the time when all beneficiaries should review health care and drug coverage options for the upcoming year and are able to make changes that will be effective 1/1 of the following year.

The Medicare Advantage Disenrollment Period (MADP) is the time when all beneficiaries can disenroll from the plan and return to Traditional Medicare.

Individuals may also qualify for what is called a Special Election Period (SEP). A SEP is a special timeframe outside the normal AEP when an individual may make a change to their membership in a health plan such as enroll in a new plan or request to disenroll from their existing plan. Examples of circumstances that warrant an SEP include but are not limited to the following: individuals who qualify for Medicaid benefits, individuals who get extra help (low income subsidy) and individuals who move out of the service area.
For more information on when changes can be made, see the enrollment table below (please note: this is not an all inclusive list of available SEPs).

<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>When?</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Coverage Election Period (ICEP)</strong></td>
<td>Starts three months before the beneficiary’s first entitlement to both Medicare Part A and B</td>
<td>Determined by the entitlement dates and the date the enrollment request is received</td>
</tr>
<tr>
<td>The beneficiary is given one ICEP when they are first eligible for both Medicare Part A and B. During this period a beneficiary may enroll in a Medicare Advantage Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fall Open Enrollment (Annual Election Period)</strong></td>
<td>From October 15 to December 7</td>
<td>January 1</td>
</tr>
<tr>
<td>Time to review health and drug coverage and make changes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Advantage Disenrollment Period (MADP)</strong></td>
<td>From January 1 to February 14</td>
<td>First day of next month after plan receives the disenrollment request</td>
</tr>
<tr>
<td>A beneficiary who is enrolled in a MA or MAPD plan may disenroll</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• These individuals may enroll in a stand alone PDP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• These individuals may not use the ADP to enroll into an MA or MAPD plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Special Enrollment Periods (SEP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for limited special circumstances such as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary has a change in residence</td>
<td>Determined by the SEP</td>
<td>Determined by the SEP</td>
</tr>
<tr>
<td>• The beneficiary has Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary becomes eligible when they have, are getting or are losing their low income subsidy (LIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary goes to live in an institution (such as a nursing home)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary qualifies for a Qualified State Pharmaceutical Assistance Program (SPAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary was a member of a special needs plan, but lost the special needs qualification required to be in that plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary has employer group coverage or is losing employer group coverage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PCP Provider Information

Provider Reports for PCPs

Between the 2nd and the 15th of each month, the administrative group for each PCP office will receive electronic files monthly with reports including eligibility information, Medical and Pharmacy claims data, capitation and premium information, Essence news and updates. The administrative group is then responsible to forward this information on to each individual PCP office.

Daily Inpatient Hospital Census and Prospective Inpatient Admissions are available to all PCPs via their group's administrator.

Accountable Delivery Services Platform (ADSP)

The ADSP is a web-based informatics application containing a set of tools designed to put information in the hands of our primary care physicians. The information is provided in a series of reports and criteria driven rules that allow a unique vantage point into the patient's health status across the entire continuum of care. The platform aggregates and analyzes data—including medical claims, EMR encounter data and lab and pharmacy data—to provide a comprehensive view of patient care. It then sends actionable clinical and financial data to physicians and other stakeholders at the point of medical decision-making to enable timely value-based health care decisions. This information is also intended to help monitor the patient population's chronic diseases and co-morbidities to improve patient outcomes and successfully practice medicine within a risk-adjusted Medicare reimbursement model.

How to Register for ADSP

Access to ADSP is through the Provider Portal. To gain access you must first register for the Provider Portal, follow the instruction outlined on page 18. Once you have that access then you need to register for ADSP by completing the ADSP application.

Go to: http://www.essencehealthcare.com
1. Click on ‘For Providers’ (upper blue band at the top of the page)
2. Click ‘Visit the Provider Portal’
3. Click on the blue ‘Lumeris ADSP’ link on the right hand side of the page to complete the application.

Once you have been given access, you can gain entry to ADSP via the same link to get to the Provider Portal. It is a single sign on for access to both.
Appointment Scheduling and Waiting Time Guidelines

All Essence contracted providers will use their best effort to adhere to the following standards for appointment scheduling and waiting time:

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP-New Patient</td>
<td>Within 30 days of the Patient’s effective date on the PCP’s panel – to be initiated by the PCP’s office</td>
</tr>
<tr>
<td>Routine Care without symptoms</td>
<td>Within thirty (30) days</td>
</tr>
<tr>
<td>Non-Routine Care with symptoms</td>
<td>Within 5 business days or 1 week</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Must be available immediately 24 hours per day, 7 days per week.</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>1st and 2nd Trimester within 1 week</td>
</tr>
<tr>
<td></td>
<td>3rd Trimester within 3 days</td>
</tr>
<tr>
<td></td>
<td>OB emergency care 24/7</td>
</tr>
<tr>
<td>Phone calls into the provider office from the member</td>
<td>Same day no later than next business day.</td>
</tr>
</tbody>
</table>

- Routine care without symptoms include physical exams and well woman exams
- Non-Routine care with symptoms include rashes, coughs and other non-life-threatening conditions
- Urgent Care means medical attention is needed right away for an unforeseen illness or injury, but the member’s health is not in serious danger.
- Emergency means medical attention is needed in connection with a sudden onset of a medical condition (including pain), that a prudent layperson with an average knowledge of health and medicine would reasonably expect with the absence of medical attention could result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Practitioners should make every effort to see the patient within an average of one hour from the patient’s scheduled appointment time. This time includes time spent both in the lobby and the examination room.

Members who are late for their scheduled appointment may not be able to be seen within the hour.

PCP Patient Access

Essence encourages all new members to get established with their PCP and not wait until they are sick or have a health problem. We understand that medical issues can arise prior to the member being established and those problems need to be addressed by the provider’s office until that initial appointment can be completed. It may be warranted to prepare front office personnel to ask appropriate questions of the member when they call, in order to triage and resolve the medical need(s) of the member.
Provider Portal

Web Site: Essence Provider Portal for All Providers

www.essencehealthcare.com: Click “For Providers” located in the navigation bar at the top of the page.

The Essence Provider Portal was developed for all Essence providers to gain access to information that will assist in improving patient care and office efficiency.

**Landing Page:** Provides user access to:
- Provider Administrative Manual
- Provider Quick Reference Guide
- Drug Formulary Search
- Provider Directory Search
- Summary of Member Benefits
- Members’ Evidence of Coverage (EOC)
- Essence Forms
- Claims Guides
- EFT Enrollment Forms (see additional info on page 61)
- HealthHelp Advanced Radiology requirements/codes

**Advanced Access (requires a login with supplemental security steps):** Allows the user additional access to:
- Claims Lookup
- Member Eligibility Lookup - includes current PCP, maximum out of pocket, and COB information.
- Referral Inquiry
- Online Referral Entry
- Provider Demographic Change Form

Any provider may be granted access to Claims, Eligibility and Referral Inquiry. Only Primary Care Providers (not Specialists) may be granted access to generate online Referrals.

**To Obtain Access:**

A. http://www.essencehealthcare.com
   1. Click “For Providers” (in the blue band at the top of the page)
   2. Click “Visit the Provider Portal”
   3. Click “Log In”
   4. Click “Register for access to the Essence Provider Portal”.

B. For Advanced Access follow the screen prompts to complete the Personal Information portion of the registration screen. Then continue to Account Information
   1. Create Login ID:
      • At least 6 characters and CANNOT be an email address.
   2. Create Password:
      • At least 8 characters and contains at least 1 uppercase letter, 1 lower case letter, and 1 number.
      • Select Security Word Hint question and Security Hint answer.

C. Follow the prompts to complete the Provider Access portion of the registration.
   1. Complete all Provider Access fields and select requested Access Levels.
   2. Provide information for each provider in the group. (If user needs access to more than five providers they are instructed to contact technical support.)
   3. Click “Sign Up”

D. When registration is complete, the user will receive a Sign-Up Complete message indicating their access is being validated. For Advanced Access requests, the user will be contacted by Essence Technical Support within 24 to 48 hours to complete the process.
**Note: Registering for access to the Provider Portal creates an account in the Essence SecureMail application. SecureMail is used for sending protected health information (PHI), passwords, and other sensitive correspondence to our provider partners and offices. The user will get an email with a code to activate the secure mail account however; the user is not required to activate SecureMail to continue the registration process.

If you have any questions or concerns about this process, have difficulty logging into the Provider Portal, or need your password reset, please contact Provider Technical Support at the number listed in the front of this manual. You may also download the "Provider Portal Registration and Tools User Guide" for assistance in how to utilize the site. You can find this guide on the log-in page of the portal.
Verifying Member Eligibility for All Providers

Essence encourages all participating providers to utilize the Provider Portal for standard member eligibility and plan benefit confirmation. This allows the Customer Service staff to be available to address more complex issues that can not be handled via an automated process.

Current member eligibility can be found on-line with appropriate security access by all providers.

At the beginning of each month, eligibility reports will be sent to all administrative PCP groups. Throughout the month you may also check member eligibility on line by going to the Essence website www.essencehealthcare.com. A secure log on will be needed to access this information. Directions to secure this access are noted above under Web Site Essence Provider Portal.

Per CMS Guidelines you will need four pieces of information to access/confirm member eligibility, including:

- Member’s first name OR initial
- Member’s last name
- Member’s Essence ID OR Medicare Health Insurance Claim Number (HICN), (typically 9 digits and an alpha)
- Member’s date of birth

In addition to eligibility we provide additional information on this screen that includes:

1. Up to date information regarding the member’s maximum out of pocket (MOOP).
2. The member’s current PCP.
3. COB information

Members have access to their “eligibility” through the Essence Member Portal.

Verifying Member Eligibility for PCPs

The information noted above can be followed or the PCP can access, ‘Enrollment Reports’ on ADSP. There are numerous reports under this heading including ‘Future Membership Count’ and ‘Membership Roster’.
On-Line Referral Inquiry for All Providers

Referrals that have been submitted to the plan can be viewed online by going to the Essence website www.essencehealthcare.com. A secure log on will be needed to access this information. Directions to secure this access are noted above under Web Site-Essence Provider Portal.

You may inquire about a referral created within the past 24 months. A Primary Care Physician can view referrals for all their patients. All other in network providers can only view referrals directed to them.

There are two ways to search for a referral: by referral/authorization ID or by Provider and referral date of service (the first date the referral was effective). For each referral entry, you will see the following:

- Referral ID - the ID by which Essence knows the referral
- Alternate Referral ID – the ID by which a delegated entity or other third-party system knows the referral. This field is blank if the referral did not come from a delegated entity or other third party.
- Description – brief description of what the referral or authorization is for.
- Referred By – referring provider
- Referred To – provider to whom the patient was referred
- From – the first date in the range of referral start dates
- To – the last date in the range of referral start dates
- Status – the status of the referral (approved, pending.)

The detail screen includes service level of the referral, associated diagnosis code and any notes from the PCP to the specialist or ancillary provider.

Members have access to the “Online Referral Inquiry” through the Essence Member Portal.
On-Line Claim Inquiry for All Providers

Essence encourages all participating providers to utilize the Provider Portal for standard claims status checks. This allows the Customer Service staff to be available to address more complex issues that can not be handled via an automated process.

Once a claim has been submitted it can be found on line by going to the Essence website www.essencehealthcare.com. A secure log on will be needed to access this information. Directions to secure this access are noted above under Web Site Essence Provider Portal.

There are two ways you can inquire about a claim: by date range or by a specific claim ID.

For each listed claim the screen displays the claim number, dates of service, provider, member name, claim status, date of the claim status and payment amount. A summary detailed screen is also provided. Please note that if the status of the claim is “In Process” you will not be able to review the summary. The summary detail screen provides: a brief summary, a payment detail and a summary of each line item.

Note: If your office adds a new provider, please contact the Essence Provider Technical Support Department to request added access to the new provider’s claims.

Online Prescription Drug Coverage Determination for All Providers

A prescribing provider can submit their prescription drug coverage determination request on-line through the Provider Portal. There are a variety of reasons in which a coverage determination may be needed i.e. request for coverage of a non-formulary drug, tier exceptions, step therapy etc. This request goes directly to the prior authorization department. A provider can also submit a request for a redetermination (appeal) for a Part D prescription drug on-line. See page 42 of this manual for additional information regarding prior authorization for Part D and Part B covered drugs.

Web Referral for PCP’s Only

Only PCP offices have access to the web referral application and can only submit referrals to network providers. Any service that requires prior authorization can not be completed via the web referral application. Instructions to assist you in completing a web referral are outlined on the website.
Operations

Terminating a Relationship with a Patient

It is the physician’s responsibility to do what he/she can to develop and maintain a positive patient-physician relationship. In the event that such a relationship cannot be established the steps outlined below are to be followed:

• **Call the Essence Customer Service Department** and notify them that you are unable to establish and/or maintain a positive physician-patient relationship. Give your name and title, member’s name and ID number, and a contact number where you can be reached. Please do not send correspondence to the member terminating a relationship prior to notifying Essence.

• The Customer Service Department will transfer your contact information to the Quality Improvement Department who will contact you within 1 business day to collect the documentation needed to process the termination. You will be directed by the Quality Improvement Department to submit documentation supporting the failure to establish and/or maintain a positive relationship, including phone logs and medical record documentation. Documentation must demonstrate a diligent effort including a minimum of three attempts by the PCP to establish and/or maintain a relationship.

• Essence may choose to attempt contact with the patient/member prior to additional action by the physician office. You will be informed if this step is taken.

• If Essence chooses not to make contact with the patient/member, you will be directed to send a certified letter (with return receipt) to the patient giving, in detail, the reason for terminating the relationship. The letter will include a date by which the patient is expected to make a PCP change. The physician must allow the patient a MINIMUM of 30 days in which to find a new PCP. The patient will be effective with the new PCP the first day of the next month following the change. Until that time, the original PCP will be responsible for all aspects of the patient’s healthcare needs.

• If the member does not choose a new PCP, Essence will assign the member to another PCP within the current PCP’s region on a rotating basis. Essence will make every effort to successfully transfer the member to a new PCP by the date specified in the letter. Please note that the member will have the ability to pick another PCP within the PCP’s overall group practice but not within the specific practice of the terminating PCP.

• The existing PCP must assist in the “hand off” of the member by providing a copy of the complete medical file and directly discussing relevant care issues with the newly selected PCP. Please remember that when terminating a relationship with a patient, you are then asking a colleague to assume care of a patient with whom he/she may not be able to establish an effective relationship.

Please note that a request to terminate the relationship with a patient must be based on an inability to establish and/or maintain an effective physician-patient relationship. A member may not be terminated from the provider’s care based upon any of the following: (a) health status; (b) the cost of providing services to the patient; (c) the termination of a family member; (d) the member being institutionalized or home-bound; (e) the member’s ability to pay; or (f) non-payment of any outstanding balance for services previously incurred. PCPs cannot terminate members during an ‘acute episode’ of care i.e. hospitalizations or SNF stays.

Please notify Essence’s Customer Service Department, whenever a member is being disruptive or is abusing benefits. Essence will make every effort to assist the PCP and the member in developing and maintaining a positive relationship.

Document specific behaviors that are interfering with the ability to establish and maintain a positive physician-patient relationship and retain any correspondence to and/or from the patient.

Even though this may be an unusual situation, if you were in the process of terminating a patient prior to them becoming an Essence member, please notify the plan immediately so that we can assist the member in securing a new PCP.
Medical Records

Essence has adopted guidelines for the maintenance of medical records within participating physician offices that support consistent and complete documentation of each member’s medical history and treatment. Appropriate documentation is an essential component of quality care. Medical records guidelines and review procedures have been developed to comply with state, CMS, and other nationally recognized standards. At a minimum, medical records must be retained for ten years.

The Essence Quality Management Committee has established the following minimum set of guidelines for a complete patient record. Essence may from time to time review a sampling of the physician’s medical records to determine compliance with these guidelines. In addition, Essence will review a sampling of the physician’s medical records every 3 years as a component of the re-credentialing process. Whenever possible, Essence will give your office at least thirty (30) days advance notice of the need for any medical record review.

In some cases Essence may make a special request for documentation to investigate a member filed grievance or appeal. Based on the terms of your contract Essence expects to receive that documentation within 10 days. This is necessary due to the tight turnaround time we have to reply to the member based on CMS requirements. Your cooperation is greatly appreciated.

Each medical record will be reviewed for the following:

- Medical record should be organized with no loose papers.
- All sheets should contain the patient's name, date of service and another unique patient identifier (DOB, MRN, etc.)
- Written entries should be complete and legible
- Only standard medical abbreviations should be used
- Each entry must be dated and signed or initialed by the person making the entry. The reviewer must be able to identify the name and professional title of the person who made the entry.
- All charts must contain the following
  - Patient's identification information/demographics
  - List of allergies or a statement that the patient has none
  - Problem list with dates of onset and resolution; Should include names of consulted providers
  - Medication List to include diagnosis treated, and dates initially prescribed and discontinue
  - Past medical history
  - Past surgical history or statement of none
  - Prevention check list to include immunizations, bone mass measurements and screenings for colorectal exams, mammograms, pap smears/pelvic exams, prostate cancer exams, and cardiovascular screening blood tests.
  - Durable Power of Attorney for Health Care and Health Care Directive, or a statement that these documents were discussed with the patient.
- Office visits will document the following information:
  - Reason for the visit: Chief Complaint
  - Pertinent biometrics and vital signs
  - History and physical examination pertinent to the reason for the visit;
  - Assessment of the patient's health problem(s). This should include any medical history related to this episode of care not previously documented
  - Plan of treatment, including testing, referrals, therapies and health education to be provided.
- All associated medical records, including specialist and/or ancillary reports, should be signed and dated with any abnormalities addressed
Providers are expected to achieve an 80% score, at a minimum, on the Medical Record Reviews. Providers scoring below this threshold will be re-audited in 180 days to ensure the documentation meets expected standards. Results of medical record reviews will become part of the physician’s profile.

Essence has an internal audit program that includes both random and targeted medical record audits and medical record reviews. Any deficiencies will be addressed through the Quality Management corrective action plan process.

**Coding Support**

All reported diagnoses must be supported by medical record documentation. A diagnosis can only be coded when it is explicitly spelled out in the medical record. Diagnoses must be clear enough to be abstracted by an average coder. A laundry list of diagnoses or problem list without indication of treatment (or assessment of current disease, specific signs, symptoms, or status) is inadequate and cannot be used for coding purposes. The record must contain evidence of evaluation and be linked to each diagnosis listed.

**Coding Audits**

Coding Audits are conducted by certified coders to ensure that all diagnosis codes reported by the provider of service are appropriate based on supporting medical record documentation. Determination of the type of audit to be conducted is based on reported trends or risk areas, or issues identified upon review of claims, reports, or specific diagnoses.

The Coding Department discusses audit results and provides details of specific coding/documentation concerns to the physician and/or their group administration. In the event audit results are unfavorable, additional monitoring and a possible Corrective Action Plan may be implemented, contingent upon the severity of the issue(s) identified.

**Physician Signature Guidelines**

CMS guidelines mandate the presence of signatures specifically for all “medical review” purposes. Records pertaining to any procedures billed to Medicare Part B are potentially subject to review by not only Essence Healthcare, but other CMS contractors. Because of this, we are alerting you to the importance of these signature requirements and if changes are needed, we suggest you take immediate action.

CMS allows the use of handwritten or electronic signatures. Electronic signatures must be date and time stamped. Please note that the individual performing the service must be the provider that signs the documentation.

*See next page for more information on CMS signature guidelines.*
Please adhere to the following guidelines to ensure that signature requirements are met:

<table>
<thead>
<tr>
<th>Description</th>
<th>Signature Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legible full signature</td>
<td>Not Met</td>
</tr>
<tr>
<td>2. Legible first initial and last name</td>
<td>Not Met</td>
</tr>
<tr>
<td>3. Illegible signature over a typed or printed name</td>
<td>Not Met</td>
</tr>
<tr>
<td>Example: [Signature] John Whigg, MD</td>
<td></td>
</tr>
<tr>
<td>4. Illegible signature where letterhead, addressograph, or other information on page indicates identity of signature</td>
<td>Not Met</td>
</tr>
<tr>
<td>Example: An illegible signature appears on a medical record. The letter head lists 3 provider names. One of the names is circled</td>
<td></td>
</tr>
<tr>
<td>5. Illegible signature <strong>NOT</strong> over a typed/printed name and <strong>NOT</strong> on letterhead, but the submitted documentation is accompanied by:</td>
<td>Not Met</td>
</tr>
<tr>
<td>1. A signature log or</td>
<td></td>
</tr>
<tr>
<td>2. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>6. Illegible signature <strong>NOT</strong> over a typed/printed name and <strong>NOT</strong> on letterhead, and the documentation is UNaccompanied by:</td>
<td>Not Met</td>
</tr>
<tr>
<td>1. A signature log or</td>
<td></td>
</tr>
<tr>
<td>2. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>Example: [Signature]</td>
<td></td>
</tr>
<tr>
<td>7. Initials over a typed or printed name</td>
<td>Not Met</td>
</tr>
<tr>
<td>8. Initials <strong>NOT</strong> over a typed/printed name but accompanied by:</td>
<td>Not Met</td>
</tr>
<tr>
<td>1. A signature log or</td>
<td></td>
</tr>
<tr>
<td>2. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>9. Initials <strong>NOT</strong> over a typed/printed name <strong>UN</strong>accompanied by:</td>
<td>Not Met</td>
</tr>
<tr>
<td>1. A signature log or</td>
<td></td>
</tr>
<tr>
<td>2. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>10. Unsigned typed note with provider’s typed name</td>
<td>Not Met</td>
</tr>
<tr>
<td>Example: John Whigg, MD</td>
<td></td>
</tr>
<tr>
<td>11. Unsigned typed note without provider’s typed/printed name</td>
<td>Not Met</td>
</tr>
<tr>
<td>12. “Signature on file”</td>
<td>Not Met</td>
</tr>
</tbody>
</table>
Electronic Signatures

The following are examples of acceptable electronic signatures:

• Chart “Accepted by” with provider’s name
• “Electronically signed by” with provider’s name
• “Verified by” with provider’s name
• “Reviewed by” with provider’s name
• “Released by” with provider’s name
• “Signed by” with provider’s name
• “Signed before import by” with provider’s name
• “Signed: John Smith MD”
• “Digitized signature”: Handwritten and scanned into computer
• “This is an electronically viewed report by John Smith MD”
• “Authenticated by John Smith MD”
• “Authorized by: John Smith MD”
• “Digital Signature: John Smith MD”
• “Confirmed by” with provider’s name
• “Closed by” with provider’s name
• “Finalized by” with provider’s name
• “Electronically Approved by” with provider’s name
• “Signature Derived from Controlled Access Password”

The following are examples of unacceptable electronic signatures:

• Dictated but not read
• Signed but not read
• Auto-authentication
• Generated by
Record corrections and/or addendums

Any correction, addition or change in any member record, made more than 48 hours after the final entry is entered in the record and signed by the physician, shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change.

Confidentiality of Medical Records

Medical records of members are confidential documents and must be treated as such, so as to comply with state and federal laws and regulations. Providers should maintain the confidentiality of all information contained in a member’s medical record and only release such records and/or information: a) in accordance with the provisions in the signed Provider Agreement, b) subject to applicable laws, regulations or orders of any court of law, c) as necessary, to other providers treating a member, or d) with the written consent of the member.

Availability and/or Transfer of Medical Records

When a member changes his/her Primary Care Physician, he/she may request a transfer of medical records or copies of medical records. These records must be forwarded to the member or to the new provider within ten (10) business days from receipt of the request.

Participating physicians and other providers including facilities are required to comply with Essence’s Quality Improvement and Utilization Management activities. In many instances, this is accomplished by making medical records available to the appropriate health plan representative. In addition, authorized representatives from Centers for Medicare and Medicaid Services (CMS) are allowed access to patient records of Essence members for specific purposes. To facilitate the process, all members sign a release of medical information as part of their enrollment process. This release is in effect for the duration of their status as an Essence member. The statement on our Essence enrollment form signed by the member authorizes disclosure. That statement is as follows:

I authorize any health professional or organization to provide to Essence or any of its affiliates, information related to medical history, care, treatment or consultation provided to me for the purpose of administering or coordinating the Medicare program.

This release authorizes Essence access to members’ medical records and to make copies as necessary. Essence will request, access and if applicable copy only the section or sections of the medical record that is minimally necessary to make a coverage determination, pay claims or otherwise administer plan programs such as HEDIS and quality issues investigation.
Transfer of Information Between Providers

During the office orientation, Essence will educate the provider/physician and/or their office staff on the following to ensure continuity of care for our members:

**Primary Care Physicians:**
When a PCP refers a patient to a specialist they will forward all appropriate notes, x-rays, reports or other medical records to the specialist prior to the patient’s scheduled appointment.

**Specialists:**
Specialists are required to report preliminary diagnosis and treatment plans to the patient’s PCP within two weeks from the date of the first office visit. Two weeks after treatment or evaluation is complete, the specialist is required to provide the PCP with a detailed patient summary. Each subsequent encounter should also engender written communication within two weeks.

This and other medical record information transferred by Essence participating providers should be done in a confidential, timely and accurate manner consistent with state and federal regulatory agencies.
**Terminating from Essence**

Contracted healthcare providers may voluntarily terminate their participation with Essence Healthcare by **providing at least ninety (90) days written notice to Essence**. Advanced notification allows Essence to contact those members who have chosen that physician as their PCP or have been identified as being under the care of that physician to allow transition to a new contracted provider. Patient panels can not simply be moved to another PCP within the practice. The member must be given the opportunity to pick a new PCP of their choice. The resigning physician is required to care for his/her Essence patients until the ninety day notification period has elapsed.

Upon receiving your termination notice, if you are a PCP your patient panel will be closed to new members. Essence may terminate the participation of an individual provider for cause. Essence makes all reasonable efforts to work with the provider to resolve the issue. Essence gives notice per the physician contract.

**Changes in Your Practice**

You must notify the Essence in writing if you have any changes within your practice. A form entitled ‘Provider Demographic Change Form’ can be completed via our Provider Portal. Information that needs to be communicated to us may include such things as:

- Change of address, phone, fax or billing location.
- Change in practice personnel – physician leaving, retiring or joining a different practice and/or staff that leave and should no longer have Provider Portal and ADSP access. You may be required to provide a current copy of your practice personnel roster.
- Change in group and/or TIN or tax information.
- Change of NPI.
- Any other changes that effect availability to members.
- For PCP’s ‘opening’ or ‘closing’ your patient panel. Please note, if you close your panel to Essence’s members you have to close your panel to all other MA plans you participate with.

Upon receipt of this information we will direct you as to any further information we may need to process your request.

**Physician Satisfaction Survey**

Provider satisfaction is one of the central tenets of Essence Healthcare. Periodically, we will survey the providers to garner feedback to identify key steps to ensure a high satisfaction of all our valued providers.
Covering Physician Policy

**Primary Care Physicians:** As a capitated primary care physician you need to make appropriate financial arrangements to pay a covering physician for services they render on your behalf OR you need to appropriately file a referral so that the covering physician will get paid fee for service.

**Specialists:** Referrals are driven by the PCP and are addressed to the individual specialty physician for which they want their patient to be seen. After the initial visit, if that specific specialist is not in the office and their “partner” (shares same group name, specialty and tax ID number) who is also in-network, is ‘covering’ for the day, a new referral will not be necessary for payment to be made. If the covering physician is outside of the “group”, internal financial arrangements will need to be made between the two parties or a new referral will need to be secured from the primary care physician. If, in either case noted above, you have questions as to what action should be taken, please contact the Medical Management Department for assistance.

**Please note:** If you are a specialist and you are recommending that the member be seen by your partner (that is a different specialty) because of their expertise, this is not considered ‘covering’. Your treatment recommendation needs to be directed back to the PCP. A specialist can not refer on to another specialists.
Medical Management

For help in determining whether a service requires a referral, pre-authorization or notification please refer to the Provider Quick Reference Guide and DME/Orthotics and Prosthetics list on the Provider Portal. These are subject to change periodically throughout the year.

Benefit Determinations

Providers with questions about a specific benefit or "covered services" should direct their queries to the Essence Medical Management Department. The Medical Management Department is responsible for administering authorizations, medical necessity determinations, and monitoring the appropriateness and efficiency of services rendered. Certain services require a referral or authorization to confirm that the member’s PCP and/or Essence has approved the member’s specialty care services. Essence utilizes the following resources for benefit and medical necessity determinations:

- Member’s Evidence of Coverage (EOC) and Summary of Benefits
- Medicare National Coverage Determinations (NCD) , Local Coverage Determinations (LCD) and Medicare Managed Care Manuals
- InterQual®
- Hayes Health Technology Website.
- CMS Designated Medical Compendia
- HealthHelp, a radiology benefits management vendor

Patient-specific information is needed by Essence to determine the medical necessity and member’s benefit for a requested procedure. This information includes:

- Diagnosis and the current ICD Code(s) as applicable (driven by date of service)
- Prior procedures/testing/treatments that have been tried and failed (include supporting documentation, photos, if applicable)
- Plan of treatment
- Requested service description (include CPT codes)
- Expected outcome.

If the request is for out of network services, also include:

- The reason the member needs to go out of network
- Which in–network providers have been consulted
- Medical records from the requesting physician and consulting physicians.

Please send all requests for benefit determinations to Essence Correspondence at the address or fax noted in the front of the manual or call the Medical Management Department to make a request.

If you are interested in knowing a member’s benefit plan, you may find this information on our web site. Benefits are also outlined in the Evidence of Coverage.
Referrals, Pre-Authorizations and Notifications

A referral is the recommendation by a member’s PCP for the member to receive care or services from a different physician, facility or healthcare provider.

The PCP coordinates all the health care needs of their Essence members through the use of referrals. Members have a responsibility to obtain a referral before visiting an ancillary provider or specialist. The PCP is the only one who can generate a referral. A specialist can make recommendations but can not refer a member to another specialist.

Primary Care Physicians should refer Essence patients to participating specialists. All specialists must have a referral from the member’s Primary Care Physician prior to providing treatment to an Essence member. The referral is the PCP’s instruction to the specialist of the services that the PCP is authorizing for a given member. In general, Essence will not reimburse a provider for tests or care provided without a referral from the PCP.

There are three different referral types:
- Level 1 – Evaluation/Consult Only
- Level 2 – Evaluation and Diagnostic Testing
- Level 3 – Evaluation and Treatment (can also include diagnostic testing)

Note: Level 3 referrals will allow a specialist to continue to treat the member without additional visits as long as treatment is done within the time frame of the referral and (a) is not billed with an E & M Code, (b) is not a procedure that requires authorization from HealthHelp or (c) a procedure that requires a prior authorization listed on the Essence Provider Quick Reference Guide. The number of visits approved will be used for your office visits billed with E & M Codes.

Specialists are expected to limit their services to the request that was made and are required to provide the PCP office with the results of evaluation and treatment, including lab and x-ray results, on all referred patients. Referrals to specialists are not needed when consulting on a member during inpatient hospitalization. Upon discharge if follow up is needed, a referral will be needed.

Essence requires that referrals be generated via the Essence online referral application. The Essence online referral form is a communication tool designed to facilitate appropriate medical treatment of Essence members. Access to the online referral application is through the Provider Portal at www.essencehealthcare.com. A secure login ID and password will be needed. Instructions are located online in the online referral application. If you are not able to utilize the on line referral application due to technical difficulties or an out-of-network referral request, call into the Essence Medical Management Department to have your referral processed.

Services that do not require a referral and which the member can secure on their own are:
- Routine women’s health care, which includes breast exams, mammograms, Pap tests and pelvic exams from a plan contracted provider.
- Flu shots and pneumonia vaccinations.
- Emergency services from either a Plan or non-Plan provider.
- Urgently needed care from non-Plan providers when the member is temporarily outside the Plan’s service area. Also urgently needed care that the member gets from non-plan providers when they are in the service area but because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis services when the member is temporarily outside the Plan’s service area. We encourage the member to advise you or the Plan prior to leaving the service area so that arrangements for maintenance dialysis can be made, including entry of an out-of-network referral to enable claims payment.
- Routine eye care only through a contracted “routine eye provider”.
- Preventive dental care only through a contracted provider.
- Behavioral health service including inpatient and outpatient mental health/substance abuse, only through a contracted provider.
Pre-authorization is the process of collecting information in advance of authorizing the non-emergency use of facilities, diagnostic testing, and other services before care is provided.

The pre-authorization process permits advanced eligibility verification, determination of coverage, and communication with the requesting physician and/or member. Pre-authorization also allows Essence to identify members for pre-service discharge planning and case management.

Pre-authorization is performed telephonically or via fax, with a review conducted by a representative of the Medical Management Department, Medical Director and/or Board Certified Specialist. In each case, the review ensures that coverage for the services are included in the individual's benefit plan, that they are provided at the most appropriate level of care and site, and that they are medically necessary. Only the Medical Director (or designee) may determine a denial of services based on medical necessity.

If the health service has not been performed within the specified time frame, a new authorization will be required before services can be rendered.

Essence's decision regarding an authorization is simply a coverage determination. Essence's decision is never intended to limit, restrict, or interfere with the physician's medical judgment. In all cases, decisions regarding treatment continuation or termination, treatment alternatives, or the provision of medical services are between physician and patient.

- Telephone/remote device checks.
- Securing their fitness benefit through a participating SilverSneakers location.
- Audiology Evaluations from a plan contracted provider.
Notification is the act of providing notice or alerting Essence of a particular service provided to an Essence member. The notification process permits eligibility verification, communication with the PCP and/or member, and identifies members for concurrent review, pre-service discharge planning and case management. The Essence Medical Management Department will accept this verbal notification from the scheduling specialist, the facility or the primary care physician.

Notification Requirements
For outpatient surgical procedures requiring prior authorization, notification needs to be received at least 14 days prior to the procedure.

For elective hospital admissions, providers must contact Essence Medical Management at least five (5) days prior to an elective admission. If a previously elective admission is cancelled, Essence Medical Management must be notified of that cancellation and the reschedule date, if applicable.

For emergency hospital admissions, providers must contact Essence Medical Management within one (1) business day. If an admission changes from observation to inpatient, the provider must notify Essence Medical Management within one (1) business day.

For advanced imaging or radiation oncology services, providers must contact HealthHelp at 1-888-285-6772 or via web at http://Healthhelp.com/essence. The specific CPT codes affected can be found on the Provider Portal. This does not apply to emergency or urgent services or services ordered while a member is hospitalized.

Providers can report outpatient surgical procedures or hospital admissions to Essence Medical Management by phone or fax (see numbers in the front of this manual). The phones are forwarded to a voice mail system during non-business hours. The fax is available 24 hours a day, 7 days a week. Notifications submitted via phone or fax will be confirmed by Essence Medical Management staff with a reference number. This reference number does not guarantee payment. The notification process serves to:

- Confirm that the admission is authorized by the Primary Care Physician, if applicable.
- Verify member eligibility.
- Screen for coverage/benefit exclusions.
- Identify if the facility is an Essence contracted facility.
- Notify the appropriate Essence Case Manager of the admission (hospital) to begin review of continued stay appropriateness and early identification of potential discharge needs.

Upon issuing a reference number for a hospital admission, providers are instructed to submit clinical documentation to Essence within one (1) business day of admission to complete the notification process and receive an authorization for payment. The clinical information provided enables Essence Case Management to initiate the concurrent review process (see section Concurrent Review and Discharge Planning).

Inpatient admissions and outpatient surgical procedures that have received authorization are eligible for payment by Essence, as long as all other requirements have been met. Essence is not obligated to pay claims on an authorization number for the following situations:

- Persons who are not Essence members at the time of service.
- Persons who fail to meet other eligibility criteria.
- Persons who receive care determined not to be medically necessary.
- Claims that may deny based on claims editing logic.

Providers who are denied payment because notification/prior authorization is lacking may not bill the member. Provider pay disputes should be submitted in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Essence Correspondence. The address is located in the front of this manual.
Concurrent Review and Discharge Planning

Concurrent review encompasses those aspects of patient care management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. Concurrent review is conducted on-site, telephonically or via fax utilizing InterQual® medical necessity review criteria and Medicare guidelines. The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to members.
- Assessment of the clinical condition and ongoing medical services and treatments to determine benefit coverage and medical necessity.
- Early identification of continuing care needs to facilitate discharge to the appropriate setting.
- Discharge planning and coordination.

To facilitate concurrent review and discharge planning, facilities are required to:

- Provide clinical information to Essence Case Management upon one (1) business day of admission to obtain an initial length of stay authorization.
- Provide updated clinical information as requested by Essence Case Management within one (1) business day of request to obtain authorization for days beyond the initial length of stay authorization.
- Provide discharge dates to Essence Case Management to issue final length of stay authorization for claims payment.

Using InterQual medical necessity review criteria and Medicare guidelines, the Case Managers perform prospective review for requests of extended care facility (rehabilitation hospital, long term care hospital (LTAC) and skilled nursing facility) services, concurrent reviews for continued inpatient care reviews for acute hospital, rehabilitation hospital, LTAC and skilled nursing facility services to determine if the case meets criteria for authorization and when needed, retrospective requests for inpatient services. When a Case Manager’s review demonstrates the criteria are not met, the case is referred to an Essence Medical Director for review.

The Case Manager will authorize the services based on whether the services meet all of the following conditions:

- The services are appropriate given the symptoms and member’s medical history and are consistent with the diagnosis. “Appropriate” means that the type, level and duration of services and setting are necessary to provide safe and adequate care and treatment;
- The services are rendered in accordance with Medicare and/or professionally recognized standards;
- The services are not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies; and,
- The services are permitted by the licensing statutes which apply to the provider who renders the services.

If a member’s condition is not appropriate for admission according to the criteria or the member’s condition has improved or stabilized to the point where acute inpatient care is no longer necessary, the Case Manager helps coordinate arrangements to transition the member to an alternative level of care. The Case Manager will communicate with the physician(s), member, member’s family and support staff regarding the member’s future needs. Once the physician has communicated what is needed to facilitate the discharge of the member, the Case Manager coordinates the elements including transfer to other facilities, ordering DME, Home Health Care and other post-hospitalization services.

Complex and controversial cases which require the advice of the Medical Director will be referred for immediate review.

When medically appropriate, observation care is an option for patients whose problems are reasonably expected to be resolved within 24 to 48 hours. Observation care includes ongoing short-term treatment, assessment, and reassessment, that is provided while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services must also be reasonable and necessary to be covered. Notification is not required for observation services that are 48 hours or less. Hospitals must notify Essence Medical Management of members with observation stays of greater than 48 hours.
Notice of Discharge from an Inpatient Facility

The Important Message from Medicare (IM) is an existing statutorily required notice designed to inform Medicare beneficiaries that their covered hospital care is ending. The physician who is responsible for the member’s inpatient hospital care must make the decision that discharge is appropriate. The IM must be given to the member within two days of discharge.

The Notice of Medicare Non-Coverage (NOMNC) is issued to the Medicare beneficiary notifying them that their skilled services, home health care, or CORF services are ending. Per CMS guidelines, the NOMNC must be given to the member and/or their identified representative a minimum of two days prior to their discharge even if they agree the service should end. A signed NOMNC must be faxed to Essence Medical Management at (314) 770-6048 or (877-755-7715).

Both of these forms are located in the ‘Forms/Sample’ section of this manual.

The member’s appeal rights are included in both the IM and the NOMNC.
Provider Network and Out-of-Network Referrals

Essence strives to provide a comprehensive network of providers to meet our member's healthcare needs. Participating physicians' help ensure the affordability and success of their patients health care by referring them to participating network providers. In rare instances, a patient may have a medical need for a non-emergent service that cannot be met by a network provider. If the primary care physician is unable to refer to a network provider, pre-authorization from the Medical Management Department will be required before the patient can be referred to a non-participating provider.

If a PCP wishes to refer to an out-of-network (OON) specialist, they must call in a request to the Essence Medical Management department at the number in the front of this manual. Medical Management will then:

- Confirm the provider is OON.
- If OON, they search the provider directory to determine if there is an in-network specialist, of the same type as being requested, within a 20 mile radius of the member's residence. If there is not, the OON request is approved.
- If there is an in-network specialist, Medical Management requests the PCP's office to withdraw the request for the OON specialist and redirect the referral to an in-network specialist.
- If the PCP does not want to redirect, the PCP is asked to send in clinical information to Medical Management to support the need for the OON specialist.
- If clinical information is sent, it is reviewed against Transition of Service criteria, below. If it does not meet criteria, a denial letter is sent to the member and PCP that includes appeal rights.
  - Transition of Service criteria: With the exception of transplant services, the services requested are not available from contracted providers within a 20 mile radius;
  - Dialysis, until the member can be transitioned to a participating provider or up to a period of 60 days from the effective date for new members or from the time that the member’s provider terminated from the network;
  - Newly diagnosed or relapsed cancer in the midst of a course of treatment (radiation or chemotherapy);
  - Members who are a recipient of an organ or bone marrow transplant, and are within a year post transplant;
  - Current hospital confinement;
  - A terminal illness, for the length of the terminal illness;
  - Performance of a scheduled surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment and is scheduled to occur within 30 days of the provider’s contract termination date or the effective date of coverage for a new member;
  - Post operative period following global payment schedule by procedure need to find global payment schedule;
  - A pregnancy in the second or third trimester of pregnancy on the member’s effective date and the immediate post-partum period.

Non-emergent services accessed outside of the network, which are not pre-authorized by Essence’s Medical Management Department, will not qualify for coverage.
Initial Organizational Determination (IOD)

Whenever a member contacts Essence to request a service, the request itself indicates that the member believes that Essence should provide or pay for the service. Thus, the request constitutes a request for a determination and Essence's response to the request constitutes an organization determination. However, if a provider declines to give a service that a member has requested or offers alternative services, this is not an organization determination (the provider is making a treatment decision). In this situation, the member must contact Essence to request an organization determination for the service in question or the provider may request the organization determination on the member's behalf. When there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an organization determination form Essence regarding the services or treatment being requested. Essence is required to make an independent decision in these matters and will request medical records in order to make that decision. All parties will be notified in writing of the plan's decision.

Adverse Initial Organizational Determination Process

An adverse determination is a decision by the plan or its designee, that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Plan's requirements for coverage. These requirements include medical appropriateness and necessity, appropriate health care setting/level of care and/or quality and effectiveness of care. As a result of not meeting these requirements the coverage for the requested service is subsequently denied or reduced. Essence provides an appeal process for members in the event of an adverse determination.

Adverse determinations of requested services, made in the course of the review process are communicated verbally or via fax to the requestor within one business day from when the determination was made. This communication is confirmed in writing via the Integrated Denial Notice (IDN) within three days of the oral communication. A copy of the Integrated Denial Notice is included in this manual in the “Forms” section. This notification is sent to the patient or responsible party, the physician, and facility (if applicable). The reason(s) for the adverse determination of requested services, available alternatives and the appeal rights and procedures are included in the notices of denial. An Essence member must receive this determination, within 14 days of service request, unless an expedited determination is necessary. Other levels of the members’ appeal process are addressed in the Essence Evidence of Coverage.

Expedited Member Appeals

Expedited appeals for requested services pertain to those services in which the standard appeal time period (30 days) could seriously jeopardize the member's life, physical or mental health or the member's ability to regain the maximum function. Essence must resolve an expedited review within seventy-two (72) hours or as expeditiously as the member's physical or mental health requires. An expedited appeal can be made by the member or provider on behalf of the member.

Health Risk Assessments

Essence sends a Health Risk Appraisal (HRA) to each member upon confirmation of the member's effective date from CMS. These HRAs are analyzed in order to identify those members who have complex or serious medical conditions. The information gathered through the HRA is forwarded to the PCP for inclusion in the patient's record. The PCP is expected to conduct an assessment, establish and implement treatment plans appropriate to the condition and monitor each case on an ongoing basis.
Clinical Trials

There are certain requirements for Medicare coverage of clinical trials. Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage (MA) plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. Essence pays the enrollee the difference between original Medicare cost-sharing incurred for qualified clinical trial items and services and Essence’s in-network cost-sharing for the same category of items and services. When a member is in a clinical trial, the member may stay enrolled in Essence and continue to get the rest of their care that is unrelated to the clinical trial through Essence. In addition, if plan guidelines are followed a member maybe made whole for the difference between original Medicare’s member cost share and their Essence cost share for identical benefits. Please supply documentation such as the Medicare provider remittance notice or the member’s Medicare Summary Notice along with the claim as this shows the amount of member cost share incurred.

If you have a patient that you intend to refer for a clinical trial, please notify Essence’s Medical Management Department prior to enrolling the member in the clinical trial or providing service related to the clinical trial.

Modifiers Q0 and Q1 should be billed if applicable.

Mental Health and Substance Abuse Services

Essence Healthcare has contracted with Mercy Behavioral Health for the provision of mental health services. To arrange for care, the physician or member may call Mercy Behavioral Health at the number denoted in the front of the manual. No referral is needed however the member must be directed and seen by a provider within the Mercy Behavioral Health network to receive covered services.

Participating providers include:
• Professional Counselors and Psychologists
• Psychiatrists
• Psychiatric nurses and Social Workers
• Facilities for inpatient and outpatient care including rehabilitation.

Mercy Behavioral Health's team of mental health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.
Pharmacy Management

Pharmacy Network

Essence provides coverage for prescription medications and members may have their prescriptions filled through a wide network of pharmacies, including mail order. Please refer your Essence patients to their provider directory for a comprehensive list of participating pharmacies including preferred and non-preferred pharmacies.

Medicare Part D Formulary

Essence utilizes a formulary (list of covered drugs) for Medicare Part D coverage. For a specific list of covered drugs, please refer to the Essence formulary, which is available in print and also on our website. The Medicare Modernization Act of 1996 specifically prohibits certain medications from being covered under Medicare Part D; therefore, the following types of drugs are specifically excluded from coverage for Essence members:

• Drugs used for anorexia, weight loss, or weight gain;
• Drugs used to promote fertility;
• Drugs used for cosmetic purposes or hair growth;
• Drugs used for the symptomatic relief of cough and colds;
• Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
• Non-prescription (over-the-counter) drugs;
• Inpatient drugs;

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Essence published formulary. Prior authorization requests and requests for coverage of drugs subject to quantity limits or step therapy requirements may be made by calling the Pharmacy contact as outlined in the front of this manual or by faxing or mailing in a request. Faxed or mailed requests can be made using the Part D Prescription Drug Coverage Determination Request Form. The form is available for download from the Provider Portal under the ‘Forms’ link, or you can call the plan and request that we fax the form to your office. Completed forms should be faxed or mailed to the fax number/address located at the top of the form. From the Provider Portal you can also access an electronic version of the form which can be securely submitted online.

Medicare Part D Benefit

The Essence Part D formulary is organized into five (5) drug tiers.

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<thead>
<tr>
<th>Drug Category (Tier)</th>
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<tbody>
<tr>
<td>Tier 1 - Preferred Generic</td>
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<tr>
<td>Tier 2 - Generic</td>
</tr>
<tr>
<td>Tier 3 - Preferred Brand</td>
</tr>
<tr>
<td>Tier 4 - Non-Preferred Brand</td>
</tr>
<tr>
<td>Tier 5 - Specialty</td>
</tr>
</tbody>
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Members pay a copayment for drugs in Tiers 1 through 4, and a co-insurance for drugs in Tier 5. In general, the lower the drug tier the lower the member’s cost share. Copays for drugs in Tiers 1 through 4 are lower at preferred pharmacies compared to a non-preferred, in-network pharmacies. There is no cost differential between preferred and non-preferred pharmacies for drugs in Tier 5. Members are not required to use preferred pharmacies and may choose any in-network pharmacy to obtain their medications. Some members may have an annual front-end deductible on Part D drugs, depending on their benefit plan.

There are three coverage phases under the Medicare Part D benefit. During the Initial Coverage Phase, a member pays part of the cost (co-payment or co-insurance) of a covered Part D drug and Essence pays the remainder. The member remains in the Initial Coverage Phase until their total drug costs (amount member pays plus the amount Essence pays) reaches a pre-determined dollar amount. This is also known as the Initial Coverage Limit, or the “ICL”. CMS establishes an ICL dollar amount, annually, but allows Medicare Advantage plans to offer an enhanced benefit that expands the Initial Coverage Phase.
Once a member has reached the ICL, they move into what is called the Coverage Gap Phase, also known as the “donut hole”. Once a member is in the Coverage Gap Phase, they must pay 100% of their prescription drug costs before catastrophic coverage begins. Members receive a discount off the cost of brand and generic drugs while in the coverage gap; the amount of the discount is predetermined by CMS each year. Some members may have coverage of generic drugs while in the Coverage Gap Phase, depending upon their Part D benefit design. Members remain in the Coverage Gap Phase until they have paid a True Out Of Pocket Amount (TrOOP amount) equal to a pre-determined dollar amount as established annually by CMS. Once a member has reached this TrOOP amount, they move into the Catastrophic Coverage Phase. In the Catastrophic Coverage Phase, members are responsible for paying a small co-payment or co-insurance, as established annually by CMS, for covered Part D drugs and Essence pays the remainder of the drug cost.

**Medicare Covered Drugs (also called Medicare Part “B” Drugs)**

Drugs that are covered under Original Medicare are also covered for Essence members. “Drugs” include substances that are naturally present in the body, such as blood clotting factors. There is no benefit limit on these drugs and their cost does not count against the member’s outpatient prescription drug benefit. Certain Part B drugs require pre-authorization from Essence.

The following drugs are Medicare covered drugs:
- Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Essence also covers some drugs that are “usually not self-administered” even if the member injects them at home.
- Drugs used with durable medical equipment (such as nebulizers) that was authorized by Essence.
- Clotting factors self-administered by a member that has hemophilia.
- Immunosuppressive drugs, if the member had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and the member cannot self-administer the drug.
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Insulin when administered via insulin pump
- Erythropoietin by self-injection if the member has end-stage renal disease, receives home/outpatient dialysis, and needs this drug to treat anemia.

**Part D and Part B Drugs Requiring Prior Authorization**

Requests for coverage of drugs are routed differently within the health plan depending on who is furnishing and billing for the drug (i.e. pharmacy vs. medical). Please review the information below and educate office staff as needed to ensure that coverage requests are submitted through the proper channels. This helps prevent situations where a drug was authorized through one channel but billed through another channel and subsequently denied for no authorization in place.

**Part D Drugs Billed Through Pharmacy - Part D Prescription Drug Coverage Form**

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Essence published formulary. Prior authorization requests and requests for coverage of drugs subject to quantity limits or step therapy requirements may be made by calling the Pharmacy contact as outlined in the front of this manual or by faxing or mailing in a request. Faxed or mailed requests can be made using the Part D Prescription Drug Coverage Determination Request Form. The form is available for download from the Provider Portal under the ‘Forms’ link or you can call the plan and request that we fax the form to your office. From the Provider Portal you can also access an electronic version of the form which can be securely submitted online. Completed forms should be faxed or mailed to the fax number/address located at the top of the form.
Some drugs require a coverage determination for the purpose of determining whether they should be covered under Part D or Part B for the specific situation, based on Medicare rules. You might be asked to provide information regarding diagnosis or other pertinent information in order to facilitate the determination.

**Part B Drugs Billed Through Medical - Part B Drug Prior Authorization Request Form**

Certain Part B drugs billed through the medical benefit are subject to prior authorization, as noted in the Essence Provider Quick Reference Guide. Prior authorization requests may be made by calling Essence Medical Management as outlined in the front of this manual. Requests may also be made by completing the Part B Drug Prior Auth Request Form or one of the drug-specific forms found under the Forms section of the Essence Provider Portal. Completed forms should be faxed or mailed to Essence Medical Management at the fax number/address located at the top of the form.

**Opioid Overutilization Monitoring Program**

The Centers for Medicare and Medicaid Services (CMS) mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications; specifically to address opioid overutilization among its Part D enrollees. CMS recognizes “overutilization” as: filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically-accepted norms of dosing. For more information about the Essence opioid overutilization monitoring program, please refer to the Provider Portal and click on the link called 2016 Pharmacy Benefit Resources, under the heading 2016 Guides and Resources.

**Part D Payment for Drugs for Beneficiaries Enrolled in Hospice**

The Centers for Medicare and Medicaid Services (CMS) requires that Part D sponsors place beneficiary-level prior authorization requirements on four categories of drugs for patients enrolled in hospice, to prevent hospice-related drugs from paying under Part D. These categories include analgesics, antiemetics, laxatives, and anxiolytics. For members enrolled in hospice, these drugs will not pay under Part D, unless the hospice provider attests that the drug is unrelated to the terminal illness and related conditions. If the drug is deemed to be unrelated to the terminal illness and related conditions, an authorization will be placed into the pharmacy claims system to allow the drug to pay under Part D. Otherwise, members will be directed to obtain the medicine from the hospice provider.

**Payment for Drugs for Beneficiaries with ESRD**

The Centers for Medicare and Medicaid Services (CMS) requires that Part D sponsors utilize point-of-sale edits to prevent ESRD-related drugs from paying under Part D. If a member has an ESRD flag, drugs that are considered by CMS to be always related to ESRD will not pay under Part D. Members will be directed to obtain the medicine from their dialysis facility.

**Medication Therapy Management Program (MTMP)**

The Essence MTMP is a patient-centric program aimed at improving medication use and adherence, reducing the risk of adverse events, and helping patients who have difficulty paying for medicines find lower-cost therapeutically appropriate medications or resources to help pay for medications. Certain members who have chronic diseases, take multiple medications, and have high cost for medicines are enrolled in the program. We provide telephonic comprehensive medication reviews (CMR) as well as targeted medication reviews (TMR) to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians, and does not interfere with the doctor-patient relationship. We have found that our members are very appreciative of the program.
Case Management

As a partner in managing the health needs of our members, Essence Healthcare offers a variety of case management services which are available upon referral by their PCP, providers, Plan staff, or upon self-referral. Members identified as high risk are also outreached to. These services are available at no charge to all members not enrolled in a hospice program, or residing in a long term care facility and who agree to case management. Our programs focus on improving our members’ health status and quality of life, access to community resources, and reduction of unnecessary costs for CMS, our members and the plan. Our physician-led interdisciplinary team includes a health outreach specialist, nurse case managers, social work, behavioral health specialists, and clinical pharmacists.

Quality Improvement Initiatives

In addition to case management services, Essence Healthcare also participates in several CMS-mandated quality improvement initiatives.

• **Chronic Care Improvement Program – CCIP**
  The CCIP is a five year program focused on reducing cardiovascular disease as part of the Million Hearts® initiative. Moderate to high-risk members with diabetes and cardiovascular disease are identified for outreach. Targeted members who opt-in to the program receive telephonic case management services aimed at optimizing management of diabetes, hypertension, and cardiovascular disease. Population based outcome measures are tracked and reported to CMS and include blood pressure, LDL and A1c. Participating members receive a customized care plan from the Essence case manager with a copy to their PCP. Please note that this program will change in 2017 as CMS-mandated initiatives change.

• **Quality Improvement Program – QIP**
  The QIP is a three year program focused on reducing readmissions as part of the Partnership for PatientsSM initiative. We implemented our QIP in 2013 and will be completing our third project year and will submit our final results to CMS in the fall of 2015. We will be required to begin a new QIP cycle in January 2016. The 2016 QIP will focus on the promotion of effective management of chronic diseases. Effective management of chronic conditions is expected to result in slowing of the disease progression, prevention of complications and development of comorbidities, preventable emergency room visits and inpatient stays, improved quality of life for the member and cost savings to the plan, provider and member. QIPs should improve enrollee health outcomes, improve satisfaction and have measurable outcomes.
Emergent/Urgent Care

Emergency Care

Essence advises their members to go to the nearest hospital emergency room if they believe that their health is in serious danger. A medical emergency may include severe pain, a serious injury or illness or a medical condition that is rapidly getting worse.

The Essence Medical Management Department MUST be notified of a hospital admission within 24 hours or by the end of the next business day. If an admission through the emergency room is made by a doctor other than the PCP, the PCP should be notified within 24 hours or the next business day following the admission.

Ambulance service for transportation to the hospital is a covered benefit for members in emergencies only. In such an emergency, 911 or another local emergency number should be called.

Out-of-Area Care/Urgently Needed Care

Urgently needed care refers to care delivered when members need medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for members to get medical care from their PCP or other plan providers. Members or their authorized representatives are instructed to contact their PCP as soon as possible. When urgent care is needed in the service area, members should contact their PCP to direct their care. Notification is required for all urgent out-of-area hospital admissions. You may satisfy this obligation by contacting a member of the Medical Management Department.

Non-Participating Hospitalization

Whenever we are advised that an Essence member has been hospitalized on an emergency basis in a non-participating facility, we will notify the member’s Primary Care Physician. If the member calls the Primary Care Physician, the PCP is required to notify Essence within one business day. The patient may be transferred to an Essence participating facility when the patient's condition has stabilized. These services require authorization by the Medical Management Department.
**Dialysis Patients**

For those patients who initiate hemodialysis for ESRD, CMS requires dialysis providers to enter the CMS-2728 form into the CMS established and governed system, CROWNWeb. Once the information is entered into the system, the provider should print out the form, sign it, have the member sign it, and mail it to the Social Security Administration. The website for CROWNWeb is http://projectcrownweb.org/

**Institutionalized Patients**

When a member is in need of long term custodial care, they and their family can choose any facility within our service area to reside. Please note that they are going to that facility in a private pay capacity, as Essence nor Traditional Medicare cover the cost of custodial care. The plan needs to be informed of this action either by the member, their family or the PCP. The individual can remain a member of the plan however, they must continue to abide by plan rules for any care that they require while living in the facility, i.e. their care must be driven by an in network primary care physician, etc.

The PCP has various options to manage a custodial patient, which are:

1. If practical, the patient can continue to be seen in the PCP’s office.
2. See the patient in the facility themselves.
3. The PCP can extend a referral to the Medical Director of the facility and request that they oversee their patient’s care on their behalf. Good communication needs to be established between the PCP and the Medical Director for the continuation of good coordinated care.

**New Technologies**

Essence Healthcare advocates the physician’s freedom to communicate with patients regarding available treatment options, including medication alternatives, regardless of benefit coverage.

Essence Healthcare also has a process for accepting requests from physicians to consider new and emerging technologies and criteria. Such requests should be submitted with a letter outlining the medical necessity of the procedure or criteria and any medical documentation on the subject. Essence Healthcare will determine if the new treatment or procedure is a covered benefit.

Please note that new and emerging technology must be a covered benefit under traditional Medicare before it is approved for Essence members.

Requests for coverage of a new or emerging technology should be submitted in writing, prior to providing or securing the service, to Essence Correspondence. The address and fax number are located in the front of this manual.
Outpatient Laboratory Tests

Primary Care Physician Offices

The Primary Care Physician has the following options for lab work:
• Perform lab work at his/her office (refer to contract for payment terms).
• Draw labs in the office and send specimens to one of our participating lab facilities identified in our Provider Directory.
• Send member to one of our participating lab facilities.

Transportation Benefit

Essence provides non-emergency transport services, through Medical Transportation Management (MTM), as an additional benefit to our members (Please note this benefit is not being offered in the counties of Greene, Christian, Stone and Taney). A specific, limited amount of one way trips are covered contingent on the region/plan the member picks. The transportation benefit may be used for any approved benefit destination such as physician visits, trips to the pharmacy, etc. The benefit can not be used for non Essence benefit related trips such as visiting a friend at a nursing home or hospital. The trip must be scheduled at least 2 business days in advance. MTM is not expected to arrange for transportation for trips with less than 2 business days notice. The transportation benefit is not meant to be used in place of emergency transportation such as an ambulance.

The member makes their own arrangements by calling 888-513-0705, 24 hours a day, 7 days a week. They need to provide:
• Their name and Essence member ID number which is located on their Essence ID card.
• The address and zip code of the location from which they need to be picked up, and
• The name, address, zip code and phone number of their destination.

When scheduling transportation, they will be asked a series of questions that will help MTM determine the most appropriate mode of transportation for their needs. If the driver does not show to pick the member up, one should call the number on the card given to the member by the driver. If there is no response, contact MTM at 888-513-0705 explain the situation and that the member needs immediate assistance.
Financial Assistance for Patients

Essence is contracted with ‘My Advocate,’ a service of Altegra Health, a private company that provides education and assistance free of charge to our members for enrolling into Medicare Savings Program (MSP) which pay the member’s Medicare Part B Premium. ‘My Advocate’ also provides assistance with Part D Extra Help and other social programs.

What are Medicare Savings Programs?
An MSP will pay for an individual’s Medicare Part B premium and are available in every state in the nation. They are federally funded but are administered at the state level by the various Medicaid agencies.

What is Part D Extra Help?
Part D Extra Help will off set the cost of prescription drugs. It lowers the monthly Part D Premium or eliminates it all together and it protects members from higher costs in the future.

‘My Advocate’ will conduct periodic mailings and telephone calls throughout the year to educate our members about the benefits of enrolling into a MSP and Part D Extra Help. They also screen our members for eligibility. If one of our members appears to qualify for one of these programs they will assist in the completion of their application and in obtaining the necessary supporting documentation that needs to accompany their application. They will function as their advocate in this process and in their annual recertification process.

You may contact ‘My Advocate’ direct at (877) 887-9269, TTY (877) 644-3244 or through their website at www.myadvocatehelps.com. You may also contact Essence’s Medical Management Department and ask to speak to our social worker who can also assist you with members who may need financial assistance.
 Billing Guidelines  

Claims and Encounter Data Submission

Claims and encounter data (for capitated providers) must be submitted using standard Medicare guidelines. Essence accepts CMS 1500 or UB-04’s and electronically submitted claims from several clearing houses.

Contracted providers should seek electronic claims solutions as indicated in their Plan contract. If the provider must bill on paper they should follow standard CMS claims submission requirements including submission of the Essence Member ID with leading zeros and NPI in the appropriate claim form field.

The provider is responsible for ensuring accurate and complete data for submission. The provider is also responsible for any request made on their behalf by the staff personnel. Claims are not accepted via fax. When filing claims for secondary coverage please be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied.

Essence processes all clean claims within the 30 day CMS required standards. Status checks can be performed via our Provider Portal. Since Essence permits submission of the claims for up to 12 months from the date of service, it is not necessary to establish short auto claims submission refiling cycle.

Not all claims for Essence members are filed directly to the Essence Administration office. The following should be filed directly to the vendor:

• Routine dental services are filed to Advantica Dental
• Routine eye exams and eyewear to Eye Med

Contact information for the above vendors is located in the front of this manual.
**Electronic Claims**

Electronic claims require the same information as paper, however, electronic submission of claims dramatically improves the exchange of information and the acceptance rate of claims while reducing opportunities for error as well as decreasing the turnaround time for claims payment. These factors combine to reduce a provider’s overall administrative costs. Essence Healthcare accepts initial claims submissions electronically through Gateway EDI (Essence payor # 57082), Emdeon (Essence payor # 20818) and The SSI Group (Essence payor # 999990648).

Claims filed electronically are NOT considered ‘received’ unless they have passed our system edits and have been accepted into our system. For every claim filed electronically the provider should receive 2 reports back:

1. A report that the clearing house accepted the claim;
2. A file stating the action taken by Essence Healthcare (Second Level Acceptance Report);

If you are not receiving both reports please check with your clearing house. It is important to review rejection reports. Working your electronic rejection reports prior to looking up the information via the Essence Provider Portal for claim status increases the timeliness of the process.

To confirm we are receiving your claims and processing them electronically the sixth position of the claim number that appears on your remittance notice will be an ‘E’. If the sixth position is a zero or ‘I’, we are receiving paper claims. If your EDI submissions are being rejected and you are not receiving clear direction as to the cause, contact Essence Customer Service. Explain you are experiencing an ongoing EDI submission issue and you will be directed to the appropriate staff to help work on a resolution.
**Electronic Claims Submission**

All electronic claims must be received via one of our 3 clearinghouses: Gateway EDI (professional 1500’s only) ~ Emdeon (professional and facilities/UB’s) ~ SSI (facilities/UB’s only) Essence is unable to receive claims filed directly from any other source.

A provider must notify either our clearinghouse that they want to file or their clearinghouse must notify one of ours, before their claims will be accepted. They must first, also be established within our system which can be done by an initial single paper claim submission.

Essence does offer Electronic Remittance Advice availability. Please contact Essence Customer Service for more information.
Proper Submission of Provider ID’s

Since Essence is a Medicare Advantage Plan we follow Medicare billing guidelines. To ensure payment is issued to the correct provider of service we suggest the following claims submission tips:

All physician services require identification of the rendering provider’s NPI. If you have indicated payment should be issued to a group, this will be done via set up processes within our system.

All extenders, i.e. Nurse Practitioners, Physician Assistants, must be identified since under Medicare guidelines a slightly reduced fee schedule applies.

Provider ID’s via paper claims:

CMS 1500
The tax ID must be indicated in Box 25
The rendering provider’s name in Box 31 and NPI in Box 24J
Box 32 the location in which the services were provided & NPI Box 32a
Box 33 Billing provider name i.e. the group practice, company name etc., and NPI in Box 33a. The Essence legacy ID in Box 33b (see below)

UB-04
Box 1 Provider name, address and telephone number
Box 2 Pay to name, address and telephone number
Box 5 The tax ID
Box 56 NPI
Box 57 Essence legacy ID (see below)

Essence does not require your Essence legacy ID on paper or EDI claims UNLESS you have requested additional legacy ID’s to track claims payment separately for different practice locations that carry the same Tax ID and NPI’s.

As outlined in our EDI reference material, Essence directly contracts with three EDI Clearinghouses, SSI, Gateway EDI and Emdeon. Essence submits to these clearinghouses a file of all registered providers known as a “Provider Look up File”. Until you are properly set up with Essence as a provider of service you will not appear on this file and be able to submit your claims electronically. To ensure you “register” with us, submit your first claim on paper and once that is processed you will be registered and appear on the Provider Look up File. However, do not forget to notify any clearinghouse your claims may go to, either directly or via the clearinghouse you use, to ensure they have you set up in their system as well.

In addition, Essence provides a “Member look up file” to the clearinghouse as well. The Essence member ID and last name of the individual must match in order for the claim to bypass that edit. If you receive individual member rejects, confirm the spelling and spacing in the last name submitted on your file.
Claim Dispute Process

Essence Healthcare permits claims submission up to 12 months from the date of service. In exchange, Essence Plan policy requires providers resubmit as a new claim any standard billing denials, (i.e., wrong or incomplete member ID, invalid procedure code modifier combination, etc.) as a new claim either on paper or electronically, whichever applies to your regular billing method. This is the most expeditious way to receive payment. The resubmitted claim will not be denied as a duplicate claim as long as no payment was issued on the service line in question. If the claim was denied for no referral or prior authorization, please make sure the referral was submitted to the Plan by the Primary Care Physician or the prior authorization was obtained from Essence prior to resubmitting the claim.

Timely Filing Requirements

- Both par and nonpar providers have 12 months from the date of service to file an initial claim.
- Both par and nonpar providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim.
  - Resubmit if the whole claim was previously denied or the claim line in question was previously denied.
  - Following the corrected claims process, they must submit a corrected claim if all lines of the claim were previously paid and they are wanting to add or remove a claim line or change something on a claim line i.e. date of service, procedure code etc.
- Nonpar provider has 60 days from the date the claim was processed (remit date) to appeal a claim determination.
- Participating providers have 12 months from the date the claim was processed (remit date) to dispute a claim determination.

Defining Plan terms:

Claim re-submission: A claim is processed by Essence and provider resubmits the claim generally due to a denial that occurs on either a claim line or the entire claim (i.e., no referral on file). If an amount was paid on the claim line in question, the provider should not use the Claim re-submission process. See additional options below. However, if no payment was issued on the claim line in question the claim can be resubmitted on paper or electronically, not faxed, unless an approved exception is made due to special circumstances. No provider explanation is necessary on the resubmitted claim. The claim will be treated as an initial claim for processing purposes.

Corrected claims: A corrected claim, per the standard contract language, is a claim in which the provider needs to add, remove or change a previously paid claim line. This must be done within the time frames outlined in the individual provider contract, but is often a very short span of time - 30-90 days from the original claim submission. An example of adding or removing a previously paid claim line are charges billed for a service that ended up not being rendered or forgot to bill for a service that was rendered. Examples of changing a previously paid claim line are incorrect dates of service or incorrect procedure code billed. All requests must be submitted as corrected claims. All Corrected claims must be clearly indicated as a correction as follows:

- **CMS 1500 Claim Forms**: EDI/1500/Professional claim forms submitted as “Corrected Claims” can be submitted electronically. In Loop 2300 ~ CLM05-03 must contain a “7”, REF01 must contain an “F8” and REF02 must contain the Original Reference Claim Number. 1500 paper claim forms submitted as “corrected claims” can also be submitted on paper. The paper 1500 claim submitted must indicate a Frequency of 7 in Box 22 (Resubmission Code Box) and the Original Reference Claim Number in Box 22 (Original Ref. No. Box). The claim form should reflect a clear indication as to what has been changed. All previous unchanged line items must be submitted on the corrected claim along with the line items that are being corrected.
- **UB Claims Forms**: EDI/UB/Facility claim forms submitted as “Corrected Claims” can be submitted electronically. The TOB must indicate a freq 7 and the claim submitted must indicate in Loop 2300 REF01 an “F8” and REF02 must contain the Original Reference Claim Number. UB04 paper claim forms submitted as “corrected claims” can also be submitted on paper. The paper UB04 claim submitted must indicate a Frequency of 7 in field 4, the Original Reference Claim Number in field 64 and a reason for the correction in field 80.

Any questionable requests will be returned with a cover letter that can be used to notate the change and return the claim, this includes if you are adding additional billed charges.
**Provider Pay Disputes:** Per contract definition the Plan has made payment on a claim or line but the provider disagrees with the amount that has been paid. Again, the time frame is indicated in the provider’s individual contract, but in general, is permitted if brought to our attention within 12 months from when the initial claim was paid. In no case may participating providers seek additional compensation from members other than co-payments, co-insurance and payment for non-covered services.

Provider pay disputes should be submitted in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Essence Correspondence. The address is located in the front of this manual.

Essence will communicate the decision either verbally or in writing if we feel the correct amount was previously paid. If we correct the payment it will appear on a remittance advice to the requesting provider. The review by Essence and its determination is final.

If a provider is disputing a timely filing denial of a claim, and the claim is filed:

- **Electronically:** The only proof Essence will accept as timely filing is the second level acceptance report from the clearing house that the claim was accepted by Essence Healthcare.

- **Paper:** The provider must submit supporting documentation from their practice management system including the applicable field descriptions since the documentation is specific to your system OR a UB04, CMS 1500 with the original date billed AND documentation must support the claim being submitted within 12 months from the date of service, AND follow-up done at a minimum of every 60 days. If there is no documentation supporting the follow-up activity, i.e., filed second submission MM/DD/YYYY or contacted plan and spoke with _________, on MM/DD/YYYY, the timely filing denial will stand. We must have the documentation for CMS audits.

Disputes other than claims or authorizations should be submitted in writing to Essence Correspondence.

**Appeals:** A claim appeal can be filed by either a member or a non-participating provider. Appeals must be filed within 60 days from the date of the initial organizational determination (i.e., EOB is issued or provider remit, whichever is applicable). Appeals must be submitted in writing and do not apply to participating providers unless it involves a pre-service request. Any non-participating provider appeals must include a CMS waiver of liability statement, which states the provider will not bill the member regardless of the outcome of the appeal. The form is sent to the provider upon receipt of any non-participating appeal requests and is also available on our website.

**Re-openings:** Is generally used by the Plan if they discover an issue and proactively reprocess claims based on that finding. For example, we find we have incorrectly denied a certain type of claim for a particular provider and run an extract to identify past denied claims and adjust them in an effort to send out correct payment.

A re-opening may be initiated by a par provider if the situation does not fall under one of the before mentioned categories, i.e., Mod 22 is billed and provider is expecting additional payment. This is not a contract dispute issue and plan did not pay additional monies. Provider must submit their request for a re-opening in writing.

If a denial occurred as the result of a **Plan error**, the provider is permitted to contact Customer Service and if possible, the necessary action to correct the situation will occur without additional action from the provider.
Member Co-Payments and/or Co-Insurance

Co-payments
It is the provider’s responsibility to collect applicable co-payments from members at the time of service.

Co-insurance
Essence members have the responsibility of co-insurance rather than a co-payment for some services. If you provide a service to a member that has a member co-insurance, it is your responsibility to bill the member for the co-insurance amount after Essence makes payment on the claim. The remittance advice will indicate the member’s liability to be billed by your office.

Maximum Out of Pocket (MOOP)
Maximum out of pocket, is the maximum a member pays, out of pocket for medical (not Part D drugs) covered services within a calendar year.

Balance Billing
The term “balance bill” refers to billing a member above an approved amount for a payable service or billing a member for a service Essence denied. Please note that Essence members can not be “balance billed” in most cases, whether you are a contracted Essence provider or not. Essence members are protected under Medicare balance bill guidelines. They are held harmless for payment beyond their plan cost share (i.e., deductible, copayment, or coinsurance). Both the member’s EOB, “Your Share” and the providers remit notice, “Member Responsibility” indicates whether an amount is owed by the member and that is what the provider should follow when billing the member.

If Essence denies a claim for administrative reasons (e.g., invalid procedure code billed, services are not separately payable, timely filing denials, etc.), the claim should be corrected, if applicable, and rebilled for payment consideration. The member should not be billed. Please refer to our claims timely filing policy found elsewhere in this manual.

Advance Beneficiary Notice of Non-coverage (ABN)
ABNs are not applicable to members in Essence (or any MA plans). Contracted providers must do the following to hold members financially liable for non-covered services not clearly excluded in the member’s EOC (Explanation of Coverage).

• Request a pre-service organization determination from Essence if they know or have reason to know that a service may not be covered by Medicare.
• If Essence denies the coverage request, it will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.
• After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN, should the member desire to receive them.
General Billing/Reimbursement Guidelines

Multiple Surgeries

Following are the payment guidelines for a facility for multiple surgical procedures when done at the same operative session as denoted in your provider contract:

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable;
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable;
- Third through fifth procedure – lesser of charges or 25% of fee schedule minus copayments, deductibles, as applicable.

Following are the payment guidelines for physician/practitioner for multiple surgical procedures when done at the same operative session as denoted in your provider contract:

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable;
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable;
- Third through fifth procedure – lesser of charges or 50% of fee schedule minus copayments, deductibles, as applicable.

Essence follows Medicare pricing for endoscopy procedures by reducing a multiple, same family, endoscopy claim by the base scope allowable and applying the applicable multiple surgery reductions to different family endoscopy claims.

Assistant Surgeons

Following are the payment guidelines for assistant surgeons (assuming that an assistant surgeon is warranted based upon the surgery performed):

- For MD’s, 16% of total amount paid to the surgeon minus copayments and deductibles, as applicable;
- For PA, nurse practitioner, and clinical nurse specialist, reimbursement is limited to 85% of the surgeon’s allowable minus any copayments, deductibles, as applicable;
- Multiple surgery restrictions apply.

TC vs. 26 Pricing

Based on standard contract language please be aware of how the allowable is determined for procedures that contain both a technical and professional component, since most contracts limit the additional payment amount i.e. 115% of Medicare’s allowable, to the professional component only. That means if you charge a 71020 (no modifier) so you are billing for a global procedure (both components) and your contracted rate is 115% of the Medicare fee schedule the Essence allowable is determined by 100% of the Medicare fee schedule assigned to 71020TC + 115% of the Medicare allowable assigned to 7102026.

Subset Procedure

Procedural unbundling occurs when two or more procedures are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. This practice leads to overpayments. When this occurs the component procedures will be “denied” and rebundled to pay the comprehensive procedure. If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and rebundled to the comprehensive code. If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied and the comprehensive code will be added to the claim for payment.
**Fraud and Abuse**

It is essential for all providers to understand the coding and billing process. Essence Healthcare defines fraud, abuse, and billing error as follows:

- **Fraud** is the knowing and willful deception, misrepresentation, or reckless disregard of the facts with the intent to receive an unauthorized payment.
- **Abuse** is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss to the plan. Abuse usually does not involve a willful intent to deceive.
- **Billing error** is the incorrect submission of services rendered due to factors such as uneducated office staff, coding illiteracy, staff turnover, etc.

If you receive an overpayment, please notify Essence Healthcare.

**Workers’ Compensation Claims**

If you believe that an Essence Healthcare patient requires treatment for a work-related illness or injury, ask the patient to contact his or her employer to report that condition in accordance with the State Workers’ Compensation Law. Claims for your treatment of this patient’s work-related illness or injury should be billed to the employer or the employer’s Workers’ Compensation insurer. Essence Healthcare’s Certificate of Coverage specifically excludes work-related illnesses and injuries.

If the patient’s employer or the employer’s Workers’ Compensation insurer denies reimbursement for your services, you should advise the patient of that fact. The patient may elect to be treated by a provider who the employer or its insurer designates to treat such work-related conditions or to pay for your services on a fee-for-service basis and then seek reimbursement from the employer or insurer. In any case, it is important to follow Essence Healthcare’s authorization procedures so that if the employer successfully contests the issue, you will be reimbursed.

**Coordination of Benefits**

When Essence Healthcare is the primary carrier we will compensate participating providers in accordance with the terms of their agreements. If the payment does not cover all incurred charges, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from members other than copayments and coinsurance.

When we are the secondary carrier, the provider should first seek payment from the member’s primary carrier. For Essence Healthcare to pick up the member’s copayment or coinsurance, up to the amount we would have paid had we been the primary carrier, the provider must send us a copy of the explanation of benefits from the primary carrier.

Essence receives COB information based on CMS records. Claims are adjudicated based on this information. Members are asked to validate the information and notify us immediately if incorrect. Essence will work with the proper CMS party to have the file updated, but until that is completed, we may continue paying claims as secondary. If you are aware of an issue with the member’s records, please do not balance bill them until the issue is resolved.

**Priority Right of Recovery (Subrogation)**

In situations involving settlements to beneficiaries paid by liability insurance, no-fault insurance, and uninsured or underinsured motorist insurance that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance Section 1862 (b) of the Social Security Act grants Medicare a priority right of recovery. Section 1862 (b) also gives the Medicare program the right of subrogation for any amounts payable to the program under the Act.
Therefore, Essence operating a Medicare Advantage contract has the same right of recovery. Essence Healthcare's right to recover its benefits takes precedence over the claims of any other party, including Medicaid. Claims that contain potential third party liability (TPL) will be paid by Essence on a conditional basis which permits us to recoup any payments if/when a settlement is reached.

**Adjusted Claims, Additional Payments, Overpayments & Voluntary Refunds**

Upon discovery of an incorrectly processed claim Essence will perform an adjustment. Adjusted claims can be identified on the Provider Remittance Notice as ending in 01, 02, 03, etc. For example, claim ID 160060E000000 would be 160060E000001. Facility claims often reflect several “adjustments” due to interim bills.

Essence claims processing system will compare the adjusted claim payment amount to the prior payment to determine whether the adjustment will result in an additional payment or overpayment. If the claim is adjusted several times it will not consider the action of all prior adjustments only a single prior one. So a 02 adjustment will not consider what was paid on the 00 only what occurred under the 01 claim. As a result if an 01 adjustment is created in error, causing an overpayment you may be required to issue the refund in order for us to perform an 02 adjustment and issue an additional payment, so for 1099 (tax purposes) our records reflect the correct payment amount on that particular account.

If the adjustment results in additional payment this will appear on the weekly provider remit. Essence issues additional payments within 30 days of discovery. If the adjustment results in an overpayment, Essence will issue an overpayment letter, providing all of the previous payment details. Only one notification is sent. Per par provider’s contractual agreement and for non-par CMS regulations, Essence expects to receive a refund within 30 days of receipt of Essence notification. To ensure the refund is applied to the proper overpayment, a copy of the overpayment letter should be included with your refund. If no refund is made within 45 days of the date of the overpayment letter the overpaid amount will be withheld from your next Essence Provider Remittance Notice. Since this often creates confusion for some providers, since the funds are taken from other claim payments, we suggest timely processing of Essence overpayment requests. If there is insufficient claim activity to recoup the overpayment, via this method, the file will be sent to a collection agency for further collection activity. Once the file is referred for collection, an additional fee is imposed by the collection agency. Essence can not waive this fee. If you disagree with the overpayment in whole or in part, contact Essence Customer Service immediately to “dispute” the overpayment. During the investigation of the dispute the overpayment will be placed on hold to ensure we do not perform a withhold until the dispute is resolved.

If you discover an overpayment via posting your Essence payments you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund. Essence has created a Voluntary Refund form (see copy in the Forms section of this manual) to ensure all information necessary to process the refund is provided. Your cooperation of timely refunds is greatly appreciated.

**Preadmission Diagnostic Services**

Diagnostic services including, but not limited to, clinical diagnostic laboratory tests, provided by the admitting hospital within 3 days prior to and including the date of an inpatient admission are not separately payable, but are included in the inpatient payment. The technical component of those diagnostic services performed by a hospital’s wholly owned or wholly operated entities (e.g. physician practices and clinics) are also not separately payable when the Essence member is admitted as an inpatient within 3 days.

**Rembursement When Hospice Has Been Elected**

The regulations state the provider of service will bill “Original Medicare” for both hospice and non-hospice related services. Once original Medicare has processed the claim and if (a) plan guidelines were followed (i.e. in network providers were used and required referrals or prior authorizations were obtained) and (b) the member’s cost share under Essence is less than original
Medicare the services must be submitted to Essence along with a copy of the remittance notice from original Medicare. Since this will require a paper claims submission, please indicate on the claim “hospice coordination payment request”. This will allow Essence to reimburse the difference in the member cost share amount lowering their out of pocket expense. This is especially true once the member has met their Essence maximum out of pocket (MOOP) for a given calendar year. Provider’s may confirm both the member’s cost share by benefit category, as well as their current MOOP balance, on the Essence Provider Portal via the Member Eligibility feature.

**Example:**

Member is hospitalized 3 days for a total Medicare allowed amount of $25,000. Medicare pays 80% of the allowed charge or $20,000 leaving a member cost share balance of $5,000. The hospital is in network with Essence and prior authorization was obtained. Based on the Essence plan this member is enrolled in, the member cost share is $325.00 per day for days 1-6 therefore a total of $975.00 would be the member’s cost share that would apply. This assumes their annual MOOP has not been met.

In the above example, since their Essence benefit cost share ($975.00) is less than the cost share applied by original Medicare ($5,000) and plan guidelines were followed Essence will reimburse the facility the difference of $4,025.

If you are a capitated primary care physician, you will still continue to receive your applicable monthly capitation payment, since you will remain responsible for coordination of care when the member follows plan guidelines. In order to be paid for any ‘carve outs’ within your contract; you will have to follow the direction noted above (file with Medicare).
Capitation

Reporting Patient Encounters for PCPs

Your agreement with Essence Healthcare stipulates that all patient encounters must be reported, regardless of your reimbursement methodology. In addition, state regulatory agencies and CMS require reporting patient encounters. For Essence members, reporting all patient encounters is a requirement.

Submitting encounter information also benefits the Essence physician in two ways:
1. Essence develops its capitation tables based on actual member usage. Having accurate encounter information will assist in establishing tables that are fair and reflect true utilization.
2. Reporting patient encounters relieves the provider of the burden of sorting.

All patient encounters should be submitted to Essence Healthcare monthly by ASCII file on disk or on a claim form using the appropriate format outlined in the claims submission portion of this manual. Send this information to Essence Claims.

Failure to submit encounter information may result in our withholding your capitation payment.

Electronic Payment and Remittance

Essence is capable of sending an Electronic Fund Transfer (EFT) for payment of services and an Electronic Remittance Advice (ERA).

To register for EFT, please go out to the Provider Portal and complete the EFT Enrollment Form and follow the directions as outlined.

For enrollment in our ERA, please contact our ERA vendor, Emdeon:

Emdeon
Customer Service
Phone: 1-877-EMDEON-6
www.emdeon.com

Please note: If you already are receiving ERA and elect to receive EFT, the paper remit that you have been getting will no longer be sent. See the Emdeon website for additional features such as the ability to pull down a hard copy remittance notice, which maybe available for a fee.
Quality Improvement Services

Purpose of the Quality Management Program

The Quality Management (QM) Program is a coordinated, multi-disciplinary approach designed to objectively and systematically monitor and evaluate the quality and appropriateness of care delivery and to identify opportunities to improve care within the organization.

The primary purpose of the QM Program is to promote excellence in care through continuous objective assessment of important aspects of care/service, the resolution of identified problems and the implementation of process improvements. This program will encompass quality management activities that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have beneficial effect on health outcome and patient satisfaction.

Essence’s QM Committee is an interdisciplinary committee that derives its authority from the governing body and is delegated the responsibility to oversee the QM Program. The mission of the QM Committee is to ensure that members receive quality health care and services. The QM Committee meets every other month and may meet more frequently, if deemed necessary.

Quality Committee Structure
Credentialing for Network Participation

General Information
Ensuring our provider network provides high quality and patient-centered care to all members is at the core of Essence Healthcare's mission. This portion of the manual is designed to serve as a guide in the coordination of collecting and reviewing all information that is material to a decision to approve or deny participation status to a practitioner. Credentialing is the process by which peers evaluate an individual applicant’s background, education, training, experience, demonstrated ability, and licensure. This evaluation is performed through primary and secondary source verifications obtained in accordance with regulatory and Essence Healthcare's policies and procedures. Information and documentation for individual practitioners or facilities is collected, verified, reviewed and evaluated, in order to approve or deny provider network participation.

Essence Healthcare uses the CAQH Universal Provider Datasource® (CAQH), to access provider applications. If you are registered with CAQH, please ensure that all information and supporting documents are current and that you have authorized Essence Healthcare to access your application. If you are not registered with CAQH, please contact Essence’s Credentialing department for more information about how to register and complete an application.

Providers are given the opportunity to correct any erroneous information submitted, should the information collected during the credentialing process differ substantially from that on the application. Approved providers are assigned a specialty that is consistent with their boards of certification, accredited training or licensure, as applicable. Specialty designations and delineation of scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by Essence Healthcare that may include certification, licensure, and/or accreditation, as applicable to provider type.

Essence Healthcare credentials medical professionals permitted by law to practice independently and other non-physician practitioners who have an independent relationship with the Plan and are authorized by law to provide care to members, promoting excellence in medical services delivery. These professionals include, but are not limited to:

- Medical doctors (MDs)
- Doctors of osteopathy (DOs)
- Dentists (DDS or DMD)
- Chiropractors (DC)
- Doctors of podiatric medicine (DPM)
- Psychiatrists (MDs)
- Psychologists (PhDs)
- Nurse practitioners (NP’s)
- Physician Assistants (PAs)
- Physical therapists (PT’s)

Those practitioners who practice exclusively within the inpatient setting will not be subject to the credentialing requirements. Practitioners included in this group are, but not limited to: Anesthesiologist, Emergency Room Physicians, Pathologists, Radiologists and Hospitalists.

Criteria

All contracted physicians, professional practitioners, and health delivery organizations must meet minimum credentialing requirements and performance standards. In order to be approved for participation, all practitioners are to be in good standing with Medicare and Medicaid.

Essence Healthcare requires that network participating providers meet the following established criteria:

1. The provider must possess a current, valid, and unrestricted license to practice in the state(s) where he or she provides or seeks to provide services to Health Plan members. The provider’s license must not have been sanctioned, restricted, suspended and/or rescinded within the five years prior to the initial application date.
2. The physician provider must possess in the proposed contracted specialty: (i) American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Board Certification; or (ii) completion of an approved Accreditation Council for Graduate Medical Education (ACGME) residency-training program that is within the board eligible period for specialty and have a board plan on file; or (iii) equivalent training and/or experience acceptable to the Health Plan Credentialing Committee. Allied Health Providers must hold a degree appropriate to their professional designation.

3. The provider must confirm eligibility for payment under Medicare. A provider who opts out of Medicare is excluded from participation in the Health Plan’s network.

4. The provider must have clinical privileges and be in good standing at a hospital participating in the Health Plan’s network or have a documented inpatient coverage plan.

5. The provider must possess a valid, current and unrestricted state and federal Drug Enforcement Agency license and the certificate(s) must be active in the state in which the provider is practicing, as applicable.

6. The provider must supply ten (10) years of malpractice history.

7. The provider must supply evidence of and maintain professional liability insurance coverage.

8. The provider must permit Health Plan representatives to conduct on-site office reviews.

Ongoing compliance with Essence Healthcare policies and procedures is assessed through a variety of methods. Providers failing to meet established standards, such as the presence of sanctions or limitations on licensure, sentinel events, and consistent and objective evidence of poor quality, may be reviewed by the Credentialing Committee. These reviews may result in corrective actions plans, a probationary period or provider termination. In addition, Essence Healthcare will follow State and Federal regulations in reporting select events and actions to the appropriate regulatory bodies and the DataBank.

Recredentialing Process

Re-credentialing process will include a re-credentialing application, and, as necessary, additional primary source verification. Relevant findings from any of the Quality assurance and improvement activities listed below may also be considered key components of the re-credentialing process of the practitioner or other healthcare provider:

a. Medical record review
b. Utilization review screens
c. Review of any sentinel events
d. Peer review assessments
e. Risk management issues review
f. Member complaints and grievances review
g. Member satisfaction survey analysis

Re-credentialing of a provider shall be undertaken at least every 36 months. Providers failing to complete the re-credentialing process will face termination of their Essence contract.

Delegation of Credentialing Authority

Essence may delegate credentialing authority to participating networks after their credentialing program has been audited in accordance with applicable State and Federal regulations, applicable accrediting body standards, and Essence’s credentialing guidelines. At least annually, Essence conducts an audit of the delegated organization’s policies and procedures and the organization’s performance under these standards through review of provider files. Essence Healthcare’s Credentialing Committee includes representation from a range of participating providers. The committee reviews provider credentials and makes recommendations about a provider’s ability to deliver care as a participant in the Essence Healthcare provider network. The committee is also responsible for reviewing and making a determination as to the delegation of credentialing authority to participating networks.

Quality Monitoring and Actions
The Essence Healthcare Credentialing Committee functions as Essence Healthcare's peer review committee for quality of care or quality of service issues and reports peer review activity to the Essence Quality Management Committee. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, member complaints, and over/under utilization comparisons. The scope of the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality. Peer review activity includes the following:

- Monitor and evaluate the quality of medical services rendered by participating providers to Essence members;
- Evaluation of the appropriateness, adherence to standards and outcome of care generally accepted by professional group peers
- Determine whether a quality of care or service issue exists;
- Impose corrective actions based upon Severity Levels;
- Provide educational feedback to providers.

Suspected quality of care and service issues are referred to the Credentialing Committee from various sources including but not limited to: member complaints, case management, concurrent review nurses, and quality improvement monitoring. The Credentialing Committee will identify trends as well as make recommendations regarding the credentialing status of providers. In the event that a participating provider does not conform to Essence's performance and quality of care standards, the Credentialing Committee notifies the provider in writing of the adverse decision within ten business days of the Committee's decision.
Preventive Health Guidelines

These guidelines were developed through a review of the medical literature and are reviewed annually or as new information become available. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. Practitioners must use their own judgment in the care of individual patients.

<table>
<thead>
<tr>
<th>Service</th>
<th>Criteria for Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td>• Sexually active female with an intact cervix</td>
<td>• Screening should begin within three years from onset of first sexual activity and no later than age 21</td>
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<td></td>
<td></td>
<td>• Screening should occur every two years</td>
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<tr>
<td></td>
<td></td>
<td>• Physician may recommend more frequent intervals if risk factors exist - including abnormal pap test in last three years or immunodeficiency virus infection</td>
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<td></td>
<td>• Women over age 65, with previous normal pap smears may be able to discontinue testing.</td>
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<tr>
<td>Mammography</td>
<td>• All women over age 40</td>
<td>• Yearly screening over age 40</td>
</tr>
<tr>
<td></td>
<td>• Patients with high risk family history of breast cancer</td>
<td>• Physician may recommend earlier screening if risk factors exist</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>• All patients over age 50</td>
<td>• Annual occult blood testing annually or flexible sigmoidoscopy every four years or once every 10 years after a screening colonoscopy.</td>
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<tr>
<td></td>
<td></td>
<td>• Colonoscopy every two years if patient is at high risk for colon cancer; and once every 10 years (but not within four years of a screening sigmoidoscopy) if the patient is not at high risk for colon cancer.</td>
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<tr>
<td></td>
<td></td>
<td>• Double contrast barium enema every two years if at high risk or every four years can be used instead of a sigmoidoscopy or colonoscopy</td>
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<tr>
<td>Adult Immunizations</td>
<td>• Patients are recommended to receive certain vaccinations based on age. Other patients with high risk or infection of diseases may be immunized for those.</td>
<td>• Annual influenza vaccine for all patients.</td>
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<tr>
<td></td>
<td></td>
<td>• Pneumococcal vaccine for all immunocompetent or high risk patients over age 65</td>
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<tr>
<td></td>
<td></td>
<td>• Combined tetanus- diptheria toxiods boosters every 10 years (Substitute TDAP for one Td booster if less than age 65)</td>
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<tr>
<td></td>
<td></td>
<td>• Measles and mumps vaccinations to all patients who have not been previously immunized</td>
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<tr>
<td></td>
<td></td>
<td>• Hepatitis B – for all young adults not previously immunized and all other patients with high risk for infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hepatitis A- for all patients at high risk for infection</td>
</tr>
<tr>
<td>Prostate Cancer Screening Exams</td>
<td>• All men over age 50 should discuss with their physician</td>
<td>• Annual Digital rectal exam and Prostate Specific Antigen (PSA) tests are examples of screening</td>
</tr>
<tr>
<td>Service</td>
<td>Criteria for Screening</td>
<td>Recommendations</td>
</tr>
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<td>---------------------------------</td>
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</table>
| Cardiovascular Disease Screening| • All asymptomatic Medicare beneficiaries                                              | • In all asymptomatic Medicare beneficiaries cholesterol and other lipid or triglyceride level blood tests should be drawn once every 5 years (i.e. 59 months after the last covered screening tests)  
• In patients with diabetes or heart disease, cholesterol, and other lipid or triglyceride level blood tests should be drawn at least annually. |
| Bone Mass Measurements          | • All females over the age of 60                                                        | • Patients at risk of losing bone mass or at risk of osteoporosis or all women over 60 should be screened at least every two years. |
| “Welcome to Medicare” Preventive Visit | • Initial Screening is a one time benefit within the first 12 months a member has Medicare Part B.  
• Patients are limited to 1 routine physical exam every year after the initial screening has been completed | • Annual routine physical exam to include: measurement of height, weight, body mass index and blood pressure; visual acuity screen and education, counseling and referral with respect to covered screening and preventive services  
• The initial “Welcome to Medicare” physical exam can also include an EKG |
| Annual Wellness Visits          | • Medicare beneficiaries with certain risk factors for AAA                              | • Once in a lifetime  
• Ultrasound screening                                                                 |
| Abdominal Aortic Aneurysm (AAA) | • Beneficiaries who are at increased risk for HIV infection or pregnant                  | • Annually for beneficiaries at increased risk  
Three times per pregnancy for beneficiaries who are pregnant:  
1. When a woman is diagnosed with pregnancy  
2. During the third trimester and  
3. At labor, if ordered by the woman’s clinician |
| Human Immunodeficiency Virus (HIV) Screening | • Medicare beneficiaries with certain risk factors for AAA                              | • Avoid harm  
• Respect patient preferences  
• Ensure that this policy is not used to discourage screening for this condition |
Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage
Notice of Denial of Payment

Date:         Member number:
Name:

Your request was denied
We’ve denied, stopped, reduced the payment of medical services/items listed below requested by you or your doctor:

Why did we deny your request?
We denied/stopped/reduced the payment of medical services/items listed above because:

You have the right to appeal our decision
You have the right to ask Essence Healthcare to review our decision by asking us for an appeal:

Appeal: Ask Essence Healthcare for an appeal within 60 days of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you
You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 314-209-2700 or 866-597-9560 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us.

Essence is an HMO plan with a Medicare contract. Enrollment in Essence depends on contract renewal.

Y0027_13-155_MM CMS Accepted 00/00/0000
Form CMS 10003-NDMCP (Iss. 06/2013)
Important Information About Your Appeal Rights

There are 2 kinds of appeals

**Standard Appeal** – We’ll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 days.

**Fast Appeal** – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 days.

How to ask for an appeal with Essence Healthcare

**Step 1:** You, your representative, or your doctor must ask us for an appeal. Your written request must include:
- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

**Step 2:** Mail, fax, or deliver your appeal.

**For a Standard Appeal:**
- Mailing Address: PO Box 12488
- St. Louis, MO 63132
- Fax: 314-770-6024

**For a Fast Appeal:**
- Phone: 866-597-9560
- Fax: 314-770-6024

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a service, we’ll send you a written decision and automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

Get help & more information

- Essence Healthcare Toll Free: 866-597-9560 TTY users call: 711
- 8:00 AM - 8:00 PM 7 days a week. You may receive a messaging service on weekends and holidays from February 15 through September 30. Please leave a message and your call will be returned the next business day.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116

Essence is an HMO plan with a Medicare contract. Enrollment in Essence depends on contract renewal.
An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

• Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

• Be involved in any decisions about your hospital stay, and know who will pay for it.

• Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

  Name of QIO: KEPRO
  Telephone Number of QIO: 855-408-8557

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

• You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

• You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

  - If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

• If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

• Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date/Time
Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  
  - Here is the contact information for the QIO:

<table>
<thead>
<tr>
<th>Name of QIO</th>
<th>KEPRO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number</td>
<td>855-408-8557</td>
</tr>
</tbody>
</table>

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.

- Ask the hospital if you need help contacting the QIO.

- The name of this hospital is:

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Provider ID Number</th>
</tr>
</thead>
</table>

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.

  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  
  - If you have Original Medicare: Call the QIO listed above.

  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Notice Instructions: The Important Message From Medicare

Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

**Patient Name:** Fill in the patient’s full name.

**Patient ID number:** Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

**Physician:** Fill in the name of the patient’s physician.

B. Body of the Notice

**Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here**

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

**To speak with someone at the hospital about this notice call:** Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

**Patient or Representative Signature:** Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

**Date/Time:** Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

**First sub-bullet – Insert name and telephone number of QIO in bold:** Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

**Second sub-bullet – The name of this hospital is:** Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

**Additional Information:** Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.
Notice of Medicare Non-Coverage

Patient name: ___________________________  Patient number: ___________________________

The Effective Date Coverage of Your Current Home Health Care Services Will End: ___________________________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Home Health Care services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision
- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above:
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal
- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO (855) 408-8557 to appeal, or if you have questions.
See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you have Original Medicare: Call the QIO listed on page 1.
• If you belong to a Medicare health plan: Call your plan at the number given below.
  Plan contact information: (866) 597-9560. TTY users should call 711.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____________________________  ______________________________
Signature of Patient or Representative       Date
Notice of Medicare Non-Coverage

Patient name: ____________________  Patient number: ____________________

The Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: ____________________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision
- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal
- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO (855) 408-8557 to appeal, or if you have questions.

Essence is an HMO plan with a Medicare contract. Enrollment in Essence depends on contract renewal.

Form CMS 10123-NOMNC (Approved 12/31/2011)  OMB approval 0938-0953
See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below. Plan contact information: (866) 597-9560. TTY users should call 711.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative                                      Date

OMB approval 0938-0953
Voluntary Refund Explanation Form

The purpose of this form is to provide Essence Healthcare with sufficient identifying information to ensure your voluntary refund is processed accurately. Please complete all applicable areas below:

Facility/Provider/Physician/Supplier name: ________________________________

Address: ________________________________

Essence Provider ID number/NPI: ______________
This is located on your Essence remittance notice.

Contact person: ________________________________ Phone #: ______________

Check amount: ________________________________ Check date: __________

Refund Information

Please provide this information for each patient if multiple patients are involved.

Patient’s Name: ________________________________ Essence Mbr ID #: __________

Essence claim number: ________________________________
This is located on your Essence remittance notice.

Refund amount: $ ________________

Reason for refund:
☐ Corrected Bill--  Date of Service  Procedure Code  Modifier
☐ Duplicate
☐ Not our patient
☐ Other insurance
☐ Billed in error
☐ Service paid in error
☐ Patient not effective
☐ Misc.

Completed by Essence

Date processed: ________________________________  Processors initials: ________
Logged in receipts: ________________________________
Claims correction performed: __________________________

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