Farm Bureau HEALTH PLANS Tennessee®

Provider Manual

2024

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Chapter 1 - Welcome / Introduction

1.1 Welcome

Welcome to Farm Bureau Health Plans' Medicare Advantage network! We are thrilled that you are joining with us to serve Tennessee seniors.

Our company's mission is focused on providing access to the most affordable and highest quality health care coverage available in Tennessee. We also aim to provide exceptional service to our Members and Providers. We recognize that achieving this mission requires collaboration. Our ability to provide unmatched health services to Tennesseans is inextricably linked to the quality of our provider network. Providers like you that compose this network are fundamental to the success of our service delivery. Working together in close collaboration, we are one step closer to achieving our mission.

We are proud to offer Tennesseans a broad range of health coverage products beyond our newest Medicare Advantage product. We launched our Medicare Supplement product line in 1966 – one year after Medicare was created – and are now the largest writer of Medicare Supplements in the state. In addition, we have been offering a range of individual coverage options (including individual/family, dental, vision, and short-term coverage plans) for over 75 years.

Farm Bureau Health Plans' goal is the absolute satisfaction of not only our Members but also our affiliated providers. We consistently strive to serve you with the same high level of customer care that we deliver to our Members. Do not hesitate to reach us at ProviderNetwork@FBHP.com with any question or concern that arises.

On behalf of Farm Bureau Health Plans, thank you for your decision to collaborate with us. We look forward to working with you to make a genuine difference in the health and well-being of the people and communities we serve.

Sincerely,
Ryan Brown, Chief Executive Officer
Farm Bureau Health Plans

This manual will provide important information and resources to assist you and your staff through the sections about policies, procedures, state, federal and regulatory requirements. Also included in this manual are phone numbers, websites, and links for additional reference tools.

We reserve the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations or internal changes that impact our Providers.

1.2 Product Lines

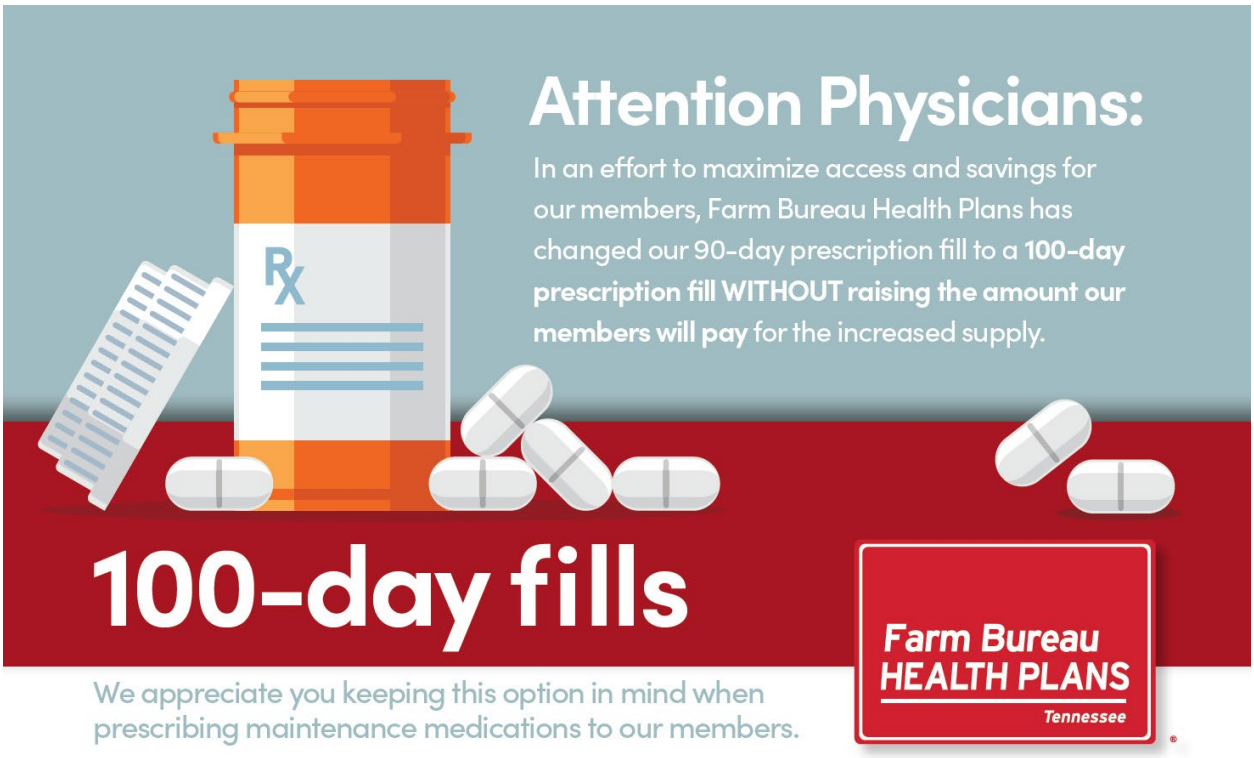
Medicare Advantage Plans, also known as Medicare Part C plans, are a type of health Insurance in the United States that provides Medicare benefits through a private insurer. Medicare Advantage Plans are another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D). In most cases, your patients need to use health care providers who participate in the plan’s network.

Farm Bureau Health Plans is proud to offer a Medicare Advantage Plan that has a Part D, Dental, Hearing and Vision benefit to Tennesseans.

Farm Bureau Advantage offers value added benefits as identified in the graft below.

BENEFIT	CENTRAL TN H4863-001	TRI-CITIES TN H4863-003	KNOXVILLE TN H4863-005	NOTES
Fitness Benefit				
Home Fitness Kit	$10.00	$10.00	$10.00	
Gym membership -- Annual Fee	$25.00	$25.00	$25.00	Member must select at Silver and Fit participating fitness center
Dental Benefit				
NOTE: Maximum Plan Benefit Coverage Amount is $3500.00				
Oral Exams	$0.00	$0.00	$0.00	2 per year
Prophylaxis (Cleaning)	$0.00	$0.00	$0.00	2 per year
Fluoride Treatment	$0.00	$0.00	$0.00	2 per year
Bitewing Dental X-rays	$0.00	$0.00	$0.00	1 per year
Panoramic X-rays	$0.00	$0.00	$0.00	1 every 5 years
Comprehensive Dental				
Restorative Services	20 -50%	20-50%	20-50%	1 per year; filings and crown repair - 20% coinsurance; crowns and onlays - 50% (once per 5 year period)
Diagnostic Services	0%	0%	0%	Unlimited
Endodontics	50%	50%	50%	1 per year
Periodontics	0-50%	0-50%	0-50%	1 per year; perio maintenance -- 0% coinsurance; perio surgical -- 50% coinsurance; Perio non-surgical -- 50% coinsurance
Extractions	20-50%	20-50%	20-50%	1 per year; simple extractions -- 20% coinsurace; other oral surgery -- 50% coinsurance
Prosthodontics/ Oral/Maxillofacial Surger/Other Services	20-50%	20-50%	20-50%	1 per year; Anesthesia -- 20% coinsurance; bridges -- 50% coinsurance; dentures -- 50% coinsurance; implant services -- 50% coinsurance; occlusal guards -- 50% coinsurance. Dentures and bridges are covered once per 5 year period.
Eye Exams/Eyewear				
NOTE: Maximum Plan Benefit Coverage Amount is $200.00				
Routine Eye Exam	$0.00	$0.00	$0.00	1 per year
Eyeglasses/Contact Lenses	$200.00	$200.00	$200.00	$200 maximum benefit per year
Hearing Exams/Hearing Aids				
Routine Hearing Exam	$0.00	$0.00	$0.00	1 per year
Hearing Aids	$599.00-$899.00	$599.00-$899.00	$599.00-$899.00	2 hearing aids per year -- must be TruHearing branded hearing aids. Must obtain hearing aids through a TruHearing provider.
Over the Counter Card (OTC)				
Over the Counter Card	$100 per quarter	$100 per quarter	$100 per quarter	$400 per year -- member must use the $100 per quarter. Amount does not roll over.

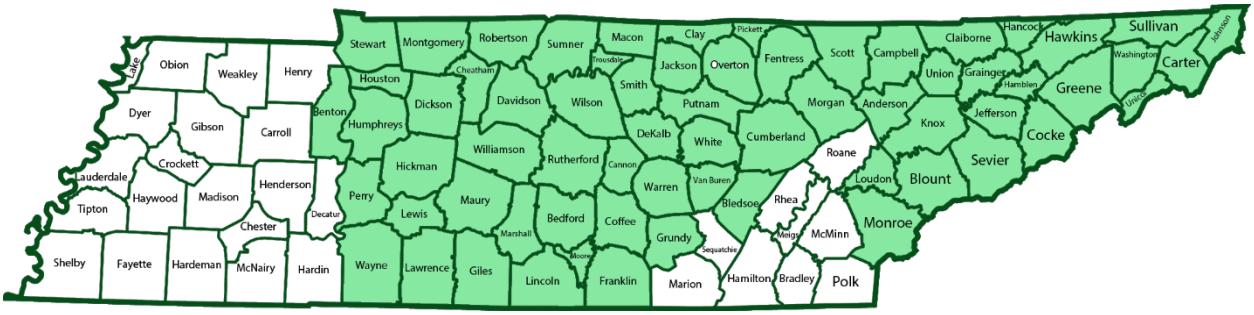
100 Day Medication Refills



SERVICE AREA

The plan will be offered in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines for Plan Year 2024 for Medicare Eligible individuals in:

Anderson	Bedford	Benton	Bledsoe	Blount
Campbell	Cannon	Carter	Cheatham	Claiborne
Clay	Cocke	Coffee	Cumberland	Davidson
DeKalb	Dickson	Fentress	Franklin	Giles
Grainger	Greene	Grundy	Hamblen	Hancock
Hawkins	Hickman	Houston	Humphreys	Jackson
Jefferson	Johnson	Knox	Lawrence	Lewis
Lincoln	Loudon	Macon	Marshall	Maury
Monroe	Montgomery	Moore	Morgan	Overton
Perry	Pickett	Putnam	Robertson	Rutherford
Scott	Sevier	Smith	Stewart	Sullivan
Sumner	Trousdale	Unicoi	Union	Van Buren
Warren	Washington	Wayne	White	Williamson
		Wilson		



1.3 Responsibility of the Provider

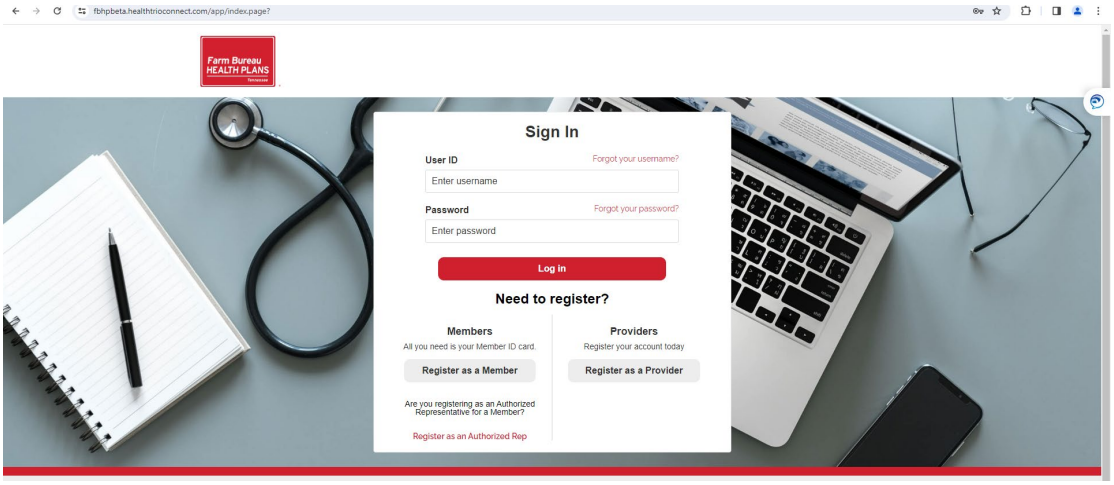
FBHP requires all participating Providers to comply with regulations and follow our policies and procedures for caring for our valued Members. These policies and procedures include but are not limited to care coordination for individuals with targeted improved outcomes Healthcare Effectiveness Data and Information Set (HEDIS), Star Ratings, compliance with data confidentiality procedures, including the Health Insurance Portability and Accountability Act (HIPAA), Cultural Competency, and Electronic Data Interchange (EDI). Details of this list and other information is contained in this manual.

These policies and procedures include but are not limited to the following:

- Care coordination
- Disease management

- Chronic condition improvement
- Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Star Rating Program.
- Compliance with data confidentiality procedures, including the Health Insurance Portability and Accountability Act (HIPAA)
- Cultural competency
- Electronic Data Interchange (EDI)
- Prior authorizations and utilization management
- Referrals to non-contracted providers
- Farm Bureau Advantage Payer ID – 62045
- Farm Bureau Advantage EDI – RP061 (R, P, zero, 6,1)

Details of this list and other information are contained in this manual. The Farm Bureau Health Plans website has a portal for Provider Resources at https://fbhealthplans.com/mapd-provider/. Providers can have access to this portal by registering at https://fbhpbeta.healthtrioconnect.com/app/index.page? .



Change Healthcare

Change Healthcare is the clearinghouse for Farm Bureau Advantage. Providers can register with Change Healthcare at http://www.changehealthcare.com. Providers should use the **Payer ID 62045** and Electronic Interchange ID **(EID) RP061** (R, P, zero, 61) to connect to the CHC portal for Farm Bureau Advantage. Providers can submit claims, check on claim status, register for Electronic Funds Transfer (EFT) and other options through this portal.

Provider Agreement: FBHP Provider agreements outline additional participating Provider requirements.

Provider Attestation: Health plans are expected to update directory information any time they become aware of changes. All updates to the online Provider directories are expected to be completed within 30 days of receiving information. Updates to hardcopy Provider directories must be completed within 30 days, however, hardcopy directories that include separate updates

via addenda are considered up to date. Plans should contact their network/contracted Providers on a quarterly basis to update the following information in Provider directories:

- Ability to accept new patients.
- Street address.
- Phone number.
- Any other changes that affect availability to patients.

Non-discrimination: Provider shall not, and shall ensure that all Group Providers and Downstream Entities with which Provider contracts shall not, deny, limit or condition coverage or the furnishing of health care services or benefits to all Members based on health factors, such as medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, race, color, ethnicity, national origin, religion, sex, age, sexual orientation, gender identity or presentation, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Communication: Providers are required to

- Educate Members, and/or their representative(s) about their health needs
- Share history and physical exams
- Review Member options for treatment
- Explain side effects of medications to Members
- Recognize cultural differences in choices
- Collaborate with other health care professionals
- Have after hour access 24/7
- Access to records (including the Health Plan availability to access records)
- Communicate with plan case managers when assistance is needed with case management, disease management, and/or the chronic condition improvement program.

Provider Notification: Provider will give notice no later than three days following the removal or addition of any Provider from the group and will update any Group Provider's information. See Exhibit A and Section 2.2 of the Provider Agreement. Provider shall notify Plan of any other changes of a change occurring; (i.e., termination, bankruptcy, any criminal charge related to your practice, sanction from a state or federally funded program, loss or suspension of your license to practice).

Quality: Providers will participate in any quality assessment and/or improvement activities, clinical guidelines, Member risk reduction, and data confidentiality policies and procedures.

1.4 Glossary Terms and Acronyms

Term	Definition
Appointed Representative	Someone a member would choose to act on their behalf, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.

Balance Billing	When a care Provider bills a Member for the difference between billed charges and the health plans allowable charge after the health plan pays a claim.
Carve Out Services	Carve Out Services refers to the elimination of coverage of a specific category of benefit services, most commonly medical services which are not included in a standard health insurance contract.
Case Management	Coordination of care and services for members who have an acute need related to a chronic condition or who experience a critical event or diagnosis that requires extensive use of resources.
Chronic Condition Improvement Program	The statutory and regulatory intent of the CCIPs includes the promotion of effective chronic disease management and the improvement of care and health outcomes for enrollees with chronic conditions. Effective management of chronic disease can achieve positive outcomes, including: slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency room (ER) encounters and inpatient stays, improving quality of life, and cost savings for the MAO and the enrollee.
Clearing House	Clearinghouses are electronic stations or hubs that allow electronic transmission between Providers and health plans in a secure environment.
Copayment	A specified dollar amount that a Member must pay out-of-pocket for a specified service at the time the service is rendered.
Disease Management	A prospective, disease-specific approach to delivering healthcare for chronic illnesses managed medically. The goal of disease management is to reduce the frequency and severity of exacerbations of chronic illness so that readmissions are reduced.
Health-Related Social Needs	An individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).
Monitoring Activities	Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Network Adequacy	A network of appropriate Providers that is sufficient to provide adequate access to covered services to meet the needs of the population served as dictated by CMS rules and regulations for Medicare Advantage programs. The contracted network of Providers must be consistent with the pattern of care in the network service area.
Network Disruption	Risk to a change that impacts a significant percentage of Members and/or Providers or may result in the network no longer meeting network adequacy standards within the geographic area served by the network.
Preclusion List	A list generated by CMS that contains the names of prescribers, individuals, and or entities that are unable to receive payment for Medicare Advantage items and service provided to Medicare Advantage beneficiaries.
Termination	The termination of the Provider Agreement is the process of voiding the agreed upon relationship between a Provider and FBHP. This may be done by written notice with or without cause for the dissolution of the Agreement.
Termination for Cause	This may be due to breach of contract, performance, sanctions, threats or harm to Member, fraud, disenrollment from Federal programs, loss of license.
Termination without Cause	Either party may terminate the Agreement without cause.
Transition of Care	The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another

Acronym	**Description**
ACA	Affordable Care Act
APC	Ambulatory Payment Classification
ASL	American Sign Language
ASC	Ambulatory Surgical Center

ADA	Americans with Disabilities Act
CCIP	Chronic Care Improvement Program
CM	Case Management
CMS	Centers for Medicare & Medicaid Services
COE	Centers of Excellence
CNM	Certified Nurse Midwives
CFR	Code of Federal Regulations
CMP	Competitive Medical Plan
COC	Continuity of Care
CQI	Continuous Quality Improvement
CAP	Corrective Action Plan
CVO	Credentialing Verification Organization
CPT	Current Procedural Terminology
DOB	Date of Birth
DEA	Drug Enforcement Administration
DM	Disease Management
DME	Durable Medical Equipment
ECFMG	Educational Commission for Foreign Medical Graduates
EDI	Electronic Data Interchange
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EOC	Evidence of Coverage
FBHP	Farm Bureau Health Plans
TIN	Federal Tax Identification Number
FQHC	Federally Qualified Health Clinics
GSA	General Services Administration

HCPCS	Healthcare Common Procedure Coding System
HCPPs	Health Care Pre-Payment Plans
HITECH	Health Information Technology for Economic and Clinical Health Act
HMO	Health Maintenance Organization
HRA	Health Risk Assessments
HRSN	Health-Related Social Needs
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	The Health Insurance Portability and Accountability Act of 1996
IPA	Independent Practitioner Association
IRF	Inpatient Rehab Facility
LCPC	Licensed Clinical Professional Counselors
LCSW	Licensed Clinical Social Workers
LTACH	Long Term Acute Care Hospital
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MS-DRG	Medicare Severity Diagnosis Related Group
MTM	Medication Therapy Management
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OIG	Office of Inspector General
PHI	Patient Health Information
PA	Physician Assistant
PDP	Prescription Drug Plan
PBP	Plan Benefit Packages
PCP	Primary Care Physician

QI	Quality Improvement
RHC	Rural Health Clinics
SNF	Skilled Nursing Facility
SDOH	Social Determinants of Health
TCM	Transitional Case Management
TRH	Tennessee Rural Health
URAC	Utilization Review Accreditation Commission
UM	Utilization Management
VRI	Video Remote Interpreting

1.5 How to Contact Us

Department	**Contact Information**
Appeals and Grievances	(800) 608-2667
Behavioral Health	(800) 608-2667
Capitation	Email: ProviderNetwork@fbhp.com
Care Management	(800) 608-2667
Claims	Email: ProviderNetwork@fbhp.com
Cultural and Linguistic Services	(833) 999-0135
Customer Service	(833) 999-0103
Dental (Delta Dental)	(866) 327-0274
Disease Management	(800) 608-2667
Eligibility Verification	(833) 999-0135
Health Education Services	(800) 608-2667
Hearing (TruHearing)	(888) 939-9557

Medical Management	(800) 608-2667
Pharmacy	PharmacyProviderCommunications@optum.com
Prior Authorization	(800) 608-2667
Provider Credentialing	Email: ProviderNetwork@fbhp.com
Provider Manual	Email: ProviderNetwork@fbhp.com
Provider Network Management	Email: ProviderNetwork@fbhp.com
Provider Portal	https://fbhealthplans.com/mapd-provider
Provider Engagement	Email: ProviderNetwork@fbhp.com
Provider Training	Email: ProviderNetwork@fbhp.com
Quality Improvement	(800) 608-2667
Regulatory Affairs and Compliance	(844) 223-3451
Utilization Management	(800) 608-2667
Vision (VSP)	(844) 290-8924

1.6 Notice to Providers

FBHP will amend Provider agreements, policies and procedures, Provider directory and Provider manual from time to time to update information and current laws. Providers will ensure all contact information is up to date to be notified via emails, letters, posts, portal, or website.

If there is a question about amendments, policies and procedures, or material changes to any document, Providers can contact Provider relations by emailing ProviderNetwork@fbhp.com.

Chapter 2 - Member and Member Services

2.1 Introduction

In this chapter the sections will cover eligibility, enrollment, disenrollment, Primary Care Physician (PCP) assignment (non-gatekeeper Health Maintenance Organization (HMO) model with PCP assignment at time of enrollment, and Member rights and responsibilities.

2.2 Farm Bureau Health Plans (FBHP) Eligibility and Enrollment

FBHP follows Centers for Medicare and Medicaid Services (CMS) standards and guidelines for application consideration and enrollment verification and validation. FBHP will notify Members upon successful enrollment completion and include the new Member in the daily Provider eligibility file. Members will be issued their plan ID card and Welcome Kit.

2.3 Member ID Card

Below is an example of a Farm Bureau Advantage member ID card.

2.4 Eligibility Verification

A Member's ID card is not a guarantee of current membership or coverage. To ensure payment of health care services, verification of membership and eligibility status is required by the Provider. All Providers will get a daily eligibility feed. To verify eligibility, Providers can consult with these resources:

- Farm Bureau portal - https://fbhpbeta.healthtrioconnect.com/app/index
- Call – (833) 999-0135

2.4.1 Medicare Election Periods

The Initial Enrollment Period is the 7-month window that encompasses the 3 months before the month a senior turns 65 through the 3 months after the month they turn 65.

The Annual Enrollment Period is the annual period starts on October 15 and runs through December 7 each year. If a beneficiary has original Medicare, they can select a Medicare Advantage plan.

The Medicare Advantage General Enrollment Period starts on January 1st and runs through March 31st each year. It allows individuals to make a one-time change to switch Medicare Advantage plans. Medicare Advantage plans are offered through private insurance companies like Farm Bureau Health Plans.

The Special Enrollment Period is an enrollment window that allows individuals to join, switch or drop a Medicare Advantage plan or prescription drug plan outside the basic enrollment periods. To be eligible for a Special Election Period there are certain events that must happen requiring a beneficiary to change coverage under the following conditions:

- Beneficiary moves outside their plan's coverage area.
- Beneficiary returns to the U.S. after living abroad.
- Beneficiary moves into or out of:
- Skilled nursing facility,
- Psychiatric facility,
- Rehab hospital, or
- Long-term care facility.

2.5 Selection and Assignment

PCP assignment follows a non-gatekeeper HMO model with PCP assignment at time of enrollment. Members will have the ability to change their PCP assignment following FBHP policies and procedures.

2.6 Voluntary or Involuntary Disenrollment

A Member may be disenrolled either voluntarily or involuntarily as follows:

Voluntary Disenrollment: A Member may request disenrollment from an MA plan only during one of the election periods.

Involuntary Disenrollment:

- Change in residence (includes incarceration) makes the individual ineligible to remain enrolled in the plan
- Member loses entitlement to either Medicare Part A or Part B
- The Member dies
- The MA organization contract is terminated, or the MA organization reduces its service area to exclude the Member.

- The Member fails to pay his or her Part D-Income Related Monthly Adjustment Amount (IRMAA) to the government and CMS notifies the plan to effectuate the disenrollment.
- The Member fails to pay his or her premiums.
- The Member is not lawfully present in the United States
- The MA organization may request to disenroll a Member if their behavior is disruptive to the extent that their continued enrollment in the MA plan substantially impairs the MA organization's ability to arrange for or provide services to either that particular Member or other Members of the plan. However, the MA organization may disenroll a Member for disruptive behavior only after it has met the requirements of this section and with CMS' approval.
- An MA organization may request to cancel the enrollment of a Member who knowingly provides, on the enrollment request form or by another enrollment request mechanism, fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan.

2.7 Change of PCP

Members will have the ability to change their PCP assignment following FBHP policies and procedures. Members can contact Farm Bureau Advantage to have a Primary Care Provider assigned by calling (800) 608-2667 or by writing to:

Farm Bureau Advantage
P. O. Box 303
Columbia, TN 37402

Members will have the ability to contact customer service to request a change of PCP as well as request assistance in finding a new PCP. Requests to change a PCP received through United States Postal Service (USPS) will go to the FBHP membership team.

2.8 Member's Rights and Responsibilities

Member's Rights:

- Members have the right to know their rights.
- Members have a right to an interpreter.
- Members have a right to assistance for deaf, hard of hearing and speech impaired (TTY).
- Members have the right to respect and dignity.
- Members have the right to be protected from discrimination.
- Members have the right to privacy.
- Members have the right to choose Providers.
- Members have the right to access doctors, specialists, and hospitals.
- Members have the right to participate in their plan of care.
- Members have the right to get understandable information about Medicare to make health care decisions.

- Members have the right to get health care services in a language you understand and in a culturally sensitive way.
- Members have the right to get Medicare covered services in an emergency.
- Members have the right to get a decision about health care payment, coverage of services, or prescription drug coverage.
- Members have the right to request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
- Members have the right to file grievances, including complaints about the quality of your care.

Member's Responsibility:

- Give accurate information.
- Follow treatment plan.
- Report fraud, waste, and abuse if Member is aware of suspicious activities without fear of retaliation.

2.9 Persons with Disabilities

Federal and state laws require Providers honor The Americans with Disabilities Act (ADA) that provides protection from discrimination for people with all types of disabilities. Providers must make reasonable modifications in their practices and procedures to avoid discrimination.

Some of these modifications may include:

- Service dog permission
- Additional time when discussing medical results or care plans to ensure understanding.
- Access and accessibility to facility including parking, entrance, bathrooms, signage, equipment.
- Communication aids and services (sign language, language interpreters, alternative written materials).
- Assistance for deaf, hard of hearing and speech impaired (TTY - 711).

*Individuals may also have an authorized or appointed representative.

2.10 Evidence of Coverage (EOC)

FBHP follows CMS regulations and guidance and provides annual EOC information to all Members. This information is available to the Member in paper or electronic form and Members can request additional copies on demand.

2.11 Continuity of Care (COC)

Provider agrees to provide, or arrange for the provision of, all Covered Services to Members during the normal business hours maintained by Provider. At all other times (including, but not limited to, weekends and holidays), Provider shall, at a minimum, maintain an answering service or direct Members to an answering service. The answering service must provide for direct communication with a person able to assist the Member in obtaining necessary medical care, and Provider shall not provide the contact information for a hospital or other healthcare provider in lieu of a "live" answering service. In the event that a Provider is unable, for any reason, to

provide Covered Services to a Member, Provider shall arrange for a Participating Provider to render such Covered Services to the Member on Provider's behalf.

Chapter 3 - Scope of Benefits

3.1 Member Handbook

Member Handbooks are available from Farm Bureau Advantage each year. Member handbooks are mailed out annually. If a member may not have received a Member Handbook, they may contact Farm Bureau Advantage by calling (800) 608-2667 and request one be sent to them.

3.2 Principal Benefits and Coverage

- Primary Care and Specialist
- Emergency Care
- Hospital Services
- Laboratory, Radiology (x-ray)
- Durable Medical Equipment (DME)
- Prescription Drug
- Dental
- Vision
- Hearing
- Fitness
- Over the Counter Card

Chapter 4 – Cultural and Linguistic Services

4.1 Introduction

Cultural and Linguistic Services are fundamental aspects of equity and quality in health care. Farm Bureau Health Plans (FBHP) will ensure the availability and accessibility of cultural and linguistic services including quality interpreting services and written materials in 6th grade language and in a manner and format that is easily understood. In providing these services, FBHP works to improve health outcomes and decrease disparities. This is an on-going process to evaluate and improve cultural and linguistic services.

4.2 Interpreting Services

FBHP will be choosing a vendor, TransPerfect, assist with translation support through language and technology.

- Over the phone interpretation
- Professional translation services
    - Urgent text-based communication
    - Formal documentation, communications, records

FBHP will provide Members with information around interpreting services by collecting or providing:

- Language proficiency assessment of bilingual Providers and staff.
- Language assistance services that include the following:
    - Interpreting services
    - Translation services
- Cultural and linguistic trainings for Providers and staff American Sign Language (ASL)
- Multiple Languages.
- Require Providers to document the Member's preferred language in their records.
- These services are provided at no cost to the Member in pursuit of effective communication through qualified interpreters to improve quality of care, increase Member satisfaction, and minimize the risk of liability.

All interpreters must be qualified by:

- Documentation of the number of years of employment the individual has as an interpreter (e.g., resume)
- Certification (ex: National Board of Certification for Medical Interpreters, Certification Commission for Healthcare Interpreters)

The federal guidance, published as Section 1557 of the Affordable Care Act, limits the use of bilingual staff as interpreters. However, if a Provider does have staff that can translate, they must document:

- Certification for medical interpreters
- Number of years of service employed as an interpreter
- Certificate of completion of interpreter training program

- Bilingual skills assessment (self or professional assessment)

4.3 Translation Services and Alternative Formats

To be compliant with regulatory guidelines, FBHP Members should receive written “Member Informing Materials” in a Member’s preferred language and in a preferred alternative format (e.g., large print, audio) upon request.

Translations will be completed by a translation services vendor or qualified internal bilingual staff to ensure compliance and minimize the risk of liability and include:

- Complete and accurate meaning-for-meaning rendition of the source text (English) in the target language(s)
- At the 6th grade reading level
- Culturally appropriate and relevant to the Member population

4.4 Auxiliary Aids and Services

FBHP will ensure Provider’s act in accordance with federal and state regulations by providing Members:

- Equal access for Members with disabilities
- Ensure communications with disabled Members are as effective
- Provide auxiliary aids and services, including, but not limited to:
    - Telephonic
    - Qualified sign language interpreters (face-to-face or remote interpreting)
    - **T**ele**TY**pe (**TTY - 711**)
    - Video Remote Interpreting (VRI) services (Placeholder - confirm if this will be an option)
    - Alternative format (large print, audio)

4.5 Cultural and Linguistic Service Trainings

FBHP will offer cultural and linguistic training on multiple topics to meet compliance on education to network Providers and their staff. All network Providers and staff serving Members at both medical and non-medical locations will complete onboarding and ongoing training requirements. Trainings are conducted on an as needed basis and cover topics such as:

- Knowledge of policies and procedures for language assistance
- Working effectively with limited English proficiency Members
- Working effectively with interpreters
- Understanding cultural diversity and sensitivity to cultural differences relevant to the delivery of health care
- Working with special needs populations, including seniors and people with disabilities
- Understanding health disparities and cultural awareness

Chapter 5 - Access to Care

5.1 Participating Provider Requirement

All Providers are required to ensure Members have access to care 24 hours a day 365 days of the year. Providers can't refuse an enrollment/assignment or disenroll a Member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness, or condition. You may only direct the Member to another care Provider type if that illness or condition may be better treated by someone else. Communication between other participating care Providers helps ensure Members receive both quality and cost-effective health services.

Appointment Type	Standard Time
Emergency	Immediately (24 hours / 7 days a week) – behavioral health emergency within 6 hours
Urgent Care	Within 48 Hours – including behavioral health urgent services
Routine Care	Within 10 business days – including behavioral health routine services
Follow-up Routine Care	Non-Prescriber - Within 10 business days Prescriber - 30 Business Days

5.1.1 Primary Care Appointment

5.1.1 a Plan Responsibilities

- After-hours care phone number: 24 hours a day, 7 days a week
- New Member appointment: within 30 calendar days
- When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified by the provider or practice.
- Establish, maintain, monitor, and validate credentials for a panel of primary care Providers from which the enrollee may select a personal primary care Provider. All MA plan enrollees may select and/or change their primary care Provider within the plan without interference.
- The MA plan must ensure continuity of services through arrangements that include, but are not limited to, the following:

- Implementing policies that specify under what circumstances services are coordinated and the methods for coordination. The policies should specify whether the services are coordinated by the enrollee's primary care Provider or in conjunction or through some other means, e.g. a care management system, a nurse case manager, clinical prompts, etc.
- Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer

5.1.1 b Provider Responsibilities

- Emergency care: Immediately or referred to an emergency facility.
- These standards must ensure that the hours of operation of the plan's Providers are convenient to, and do not discriminate against, enrollees. The plan must also ensure that, when medically necessary, services are available 24 hours a day, 7 days a week. This includes requiring primary care physicians to have appropriate backup for absences.
- Reasonable standards for primary care services are: (1) urgently needed services or emergency - immediately; (2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and (3) routine and preventive care - within 30 days.
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time.
- Routine appointments (non-urgent) shall be made within ten (10) business days of request.
- First prenatal visit within 14 calendar days of request
- Preventative Health Exams within 10 business days of request and should not exceed 30 calendar days after request.

5.1.2 Urgent Care Appointment: within 24 hours

- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments: within 6 weeks

5.1.3 Specialty Care Appointment

- Routine care appointment: within 30 calendar days

5.1.4 Urgent and Emergency Care

- For urgent care: non-life threatening but needs prompt attention.
- Emergency Care Services: potentially life-threatening condition requiring immediate medical intervention.

5.1.5 Behavioral Health Appointment

The Plan follows CMS guidelines for emergent and urgent appointments.

The Plan measures your use of hospital services (including services you get in a psychiatric hospital) in benefit periods. A benefit period begins the day you're admitted as an inpatient in a general or psychiatric hospital. The benefit period ends after you haven't had any inpatient hospital care for 60 days in a row. If you're admitted to a hospital again after 60 days, a new benefit period begins, and you must pay a new deductible for any inpatient hospital services you get.

There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but there's a lifetime limit of 190 days. Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

The benefit periods are:

- Days 1–60,
- Days 61–90,
- Days 91 and beyond,
  day 90 for each benefit period up to 60 days over your lifetime,
- Beyond lifetime reserve days.

5.1.5.1 Outpatient Mental Health Care

The Plan follows CMS guidelines for outpatient care, medical supplies, and preventive services.

The Plan covers these outpatient mental health services:

- One depression screening per year. You must get the screening in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals.
- Individual and group psychotherapy with doctors (or with certain other licensed professionals, as the state where you get the services allows).
- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "self administered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.
- Partial hospitalization.
- Intensive outpatient program services (starting January 1, 2024).

- A one-time “Welcome to Medicare” preventive visit. This visit includes a review of your possible risk factors for depression.
- A yearly “Wellness” visit. Talk to your doctor or other health care provider about changes in your mental health since your last visit.

5.2 Nurse Line and Hearing or Speech Impaired Contact Line

The Plan utilizes the services of TransPerfect for hearing impaired, vision impaired, speech impaired and language translation services.

5.3 Cultural and Linguistic Services

- Hearing Impaired (TTY, 711)
- Impaired Vision
- Language Services
    - Sign Language

See also Section 4.2 and 4.3

5.4 Access to Provider Records

Providers shall agree to make available any medical, financial, or administrative records related to services provided/maintained by the Provider for the FBHP Members. According to CMS, these records must be maintained for 10 years.

5.5 Medical Necessity

As defined by and in the Provider Agreement, medically necessary health care services or supplies are medically appropriate and necessary when the following criteria are met:

(a) they are consistent with generally accepted principles of professional medical practice,

(b) they are the most appropriate available supply or level of service for the applicable Member, when considering potential benefits and harm to the Members,

(c) they are known, based on objective scientific evidence, professional standards, and expert opinion, to be necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap, and

(d) they are not solely cosmetics or for the convenience of the Member.

Chapter 6 – Case Management

6.1 Case Management Overview

Case management is a free, voluntary service that offers care coordination and guidance to our Members when they are faced with a serious illness or condition. This service also supports physicians and other healthcare practitioners with a collaborative process that facilitates recommended treatment plans to ensure optimal medical care is provided to our Members. This service provides and additional layer of support to Members and their Providers. We encourage our providers to utilize our case management services to decrease the burden of complex patient care on your practice. Information for reaching the Case Management team is listed in the contract us section of this manual. (Additionally, case management requests can be made through our website (add link)).

The case management process includes:

- Determining the strengths/needs of a Member through identification and assessment.
- Locate and establish community resources.
- Create and develop an individual care plan and monitor progress.
- Reassessments to measure progress.
- Coordinates needs of Member with other medical entities and care team Members.
- Evaluates case management plans designed to optimize Members' health care benefits.
- Give the Members/family the power to exercise options.
- Communicate frequently to ensure value to Member.
- Promote quality and effective outcomes.
- Advocate for the Member.

6.1.1 Identification

Farm Bureau Health Plans (FBHP) Case Management Program utilizes predictive modeling tools and Health Risk Assessments (HRAs) to identify Members with a variety of conditions who may potentially benefit from case management. A Member can be identified for case management in various ways:

- Provider submitting Member to the health plan for case management.
- Member, family, and/or caregiver request.
- Predictive modeling tools and HRAs.
- Review of medical records.
- Monthly or quarterly reports from various sources.

When a Member is identified, we conduct outreach to better understand their needs.

A case manager will be assigned as a single point of contact for Members/families to ensure effective and collaborative planning of needs and services.

6.1.2 Assessment and Planning

Assessments are done with the Member, families, and care team disciplines to identify the member needs and best potential outcomes for the Member. The information obtained during the assessment becomes the individualized care plan. The plan will have both short and long-term goals as prioritized for the Member and in collaboration with the care team.

6.1.3 Locate and Establish Community Resources

Collaboration is at the center of the outreach for the case manager. This helps to ensure continuity of care with the integration of benefits and needs across a variety of services. Coordination is achieved through communication with the Member, family, and Providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual Member to help promote continuity of care.

6.1.4 Monitoring, Measure and Evaluate

Case management plan design will be monitored as an on-going process as the individualized care plan is carried out. All services, interventions, results, and collaborative partners will be viewed to ensure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met, then the case manager should work with the Member/family and involved services to modify the plan for the Member.

6.1.5 Member Advocate

The case manager is an advocate for the Member/family and should incorporate the Member's needs and goals in the plan. As the case manager collections and analyzes all data, they will gather input from all collaborative partners to assist in the optimal Member plan of care.

6.1.6 Communication

Case managers assist with the coordination of communication between care Providers when multiple disciplines are caring for the same individual. This coordination is essential to effectively help ensure the Member's care is comprehensive, safe, and effective. It also provides all care Providers with a holistic picture of the Member's care model. The lack of this coordination may negatively affect the quality of care or overlapping services. Our case management team will work with your practice to support the needs of your patients who have complex conditions, chronic care needs, and health related social needs.

6.2 Transitional Case Management (TCM)

Those Members that are discharging from the hospital may have a case management plan to support the collaboration of evaluating and coordinating post-hospitalization needs. This is for Members who are at risk of re-hospitalization or frequent users of high-cost services. The case manager will engage in the steps and process of case management to identify and develop the appropriate post-hospitalization services or coordinate benefits.

6.3 Disease Management

Disease Management is a prospective, disease-specific approach to delivering healthcare for chronic illnesses managed medically. The goal of disease management is to reduce the frequency and severity of exacerbations of chronic illness so that readmissions are reduced. Currently the scope of our disease management includes hypertension, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, asthma, transplants, and behavioral health conditions. Interventions include member identification, initial assessment of the member's health status to include condition specific issues, medications, activities of daily living, clinical history including medications, assessment of life-planning activities, community resources, cultural and linguistic needs, and health-related social needs. It also includes development of an individualized care management plan, identification of barriers for meeting goals, facilitation of referrals to resources, and development of a schedule for follow up and communication with members. FBHP uses evidence-based clinical and preventive health guidelines to support disease management programs.

6.4 Population Health

FBHP wants to improve the care of their Members and encourage them to participate in their own care planning. The health outcomes of a given group of individuals have goals aimed at improving the health of the entire population. Our process looks at health outcomes, patterns of health determinants and policies and interventions. Part of this model is to reduce health inequities or disparities among different population groups and review factors like Social Determinants of Health (SDOH). These include a Members' social, environmental, cultural, and physical health.

Chapter 7 – Utilization Management

7.1 Introduction

This section summarizes Farm Bureau Health Plans (FBHP) Utilization Management (UM) processes. These processes assist us in reviewing medical decisions based on coverage, medical necessity and on:

- State and federal rules and regulations.
- The Member's benefits and coverage determination guidelines.
- Medicare guidelines.
- Medical utilization review guidelines.
- To assist our determinations of utilization management in administering health benefits, FBHP uses industry tools and resources to make determinations.
- InterQual Evidence Based Guidelines

To contact Utilization Management call **(800) 608-2667**

FBHP UM Department is staffed with Medical Directors, professional registered nurses, licensed vocational nurses, and paraprofessionals who are available to assist Providers with UM activities. These activities include, but are not limited to:

- Benefit Interpretation
- Referral Management
- Coordination of Care and services related to continuity of care previously received or care provided by a terminated Provider
- Care Coordination/Case Management
- Complex Case Management
- Coordination of End Stage Renal Disease benefit

Services and supplies requiring prior authorization and medical necessity and Utilization Review Criteria are available on the FBHP website.

- FBHP requires that all providers (contracted and non-contracted) request prior authorization for services and supplies on the prior authorization list.
- Contracted providers are expected to ensure that a prior authorization has been submitted and approved prior to referring a Member being to a non-contracted provider. This applies to all services and supplies and is not limited to services and supplies on the prior authorization list. Exceptions to this rule include services provided by a non-contracted provider at a contracted inpatient facility or services where a non-contracted provider is filling an FBHP coverage gap.

Medical Policy and proprietary criteria have been developed to support the medical necessity and clinical appropriateness of requests for medical, behavioral healthcare and pharmaceutical health care services requiring review; while considering the individual patient needs and characteristics of the local delivery system.

Evidence-based science forms the basis for determination(s) of coverage. A hierarchy of review takes precedence over clinical practice guidelines/medical policies.

Clinical Review Hierarchy:

- Health Plan eligibility and coverage-benefit plan packages:
  - o The enrollee must be eligible for benefit coverage at the time the service is provided. Without benefit coverage on the date of service, the service is NOT covered, even if supported by scientific evidence.
  - o Certificate of Coverage (COC), Evidence of Coverage (EOC), Coverage of Benefits (COB) or Summary Plan Description (SPD)
  - o Where no applicable federal, state, or contractual requirements exist the coverage/benefit document determines coverage.
  - o Services that are explicitly included or excluded from coverage in the benefit document take precedence over medical policy.
  - o In the event of a conflict between the benefit document and medical policy, the enrollee's specific benefit document takes precedence over medical policy.

- Federal, State or Contractual Requirements for Coverage:
  - o CMS (National Coverage Determinations (NCDs) or appropriate Local Coverage Determinations (LCDs)).
  - o Medicare Benefit Policy Manual
  - o Medical Policies
  - o Drug Policies – Medication determinations
  - o Transplant Review Guidelines - Transplant determinations
  - o Utilization Review Guidelines – InterQual, a clinical decision, support criteria tool used for determining Level of Care, length of stay (LOS) and Predetermination.

- Medical Director clinical determination supported by evidence-based resources
  - o In the absence of applicable InterQual or medical policies mentioned above, other established evidence-based guidelines (e.g., NCCN Clinical Practice Guidelines in Oncology) that have been approved by the appropriate line of service and standing committees may be used.

To contact Utilization Management:

- (Phone: (800) 608-2667,
- Fax: (844) 263-1928,
- Portal: https://fbhealthplans.com/mapd-provider/

FBHP UM Department is staffed with licensed nurses and physicians as well as paraprofessionals who are available to assist Providers with UM activities. These activities include, but are not limited to:

- Benefit Interpretation.
- Referral Management.
- Coordination of Care and services related to continuity of care previously received or care provided by a terminated Provider.
- Care Coordination/Case Management.
- Complex Case Management.
- Coordination of End Stage Renal Disease benefit.

7.2 Goals and Objectives

The goal of FBHP UM Program is to facilitate the provision of appropriate medical and behavioral health care and services to Members.

The UM Program objectives are designed to provide mechanisms that assure the delivery of quality health care services and to optimize opportunities for process improvement through:

- Managing, evaluating, and monitoring the provision of healthcare services rendered to Members to enhance access to, and provision of, appropriate services.
- Facilitating and ensuring continuity of care (COC) for Members within and outside of the network.
- Ensuring a process for UM that is effective and coordinated through committees, work groups, and task forces with the involvement and cooperation of experts in all fields of medicine, management, patient advocacy and other relevant fields.
- Integration with Quality Improvement (QI).
- Providing leadership to Providers by developing and recommending changes and improvements in programs and processes resulting from collection and analysis of utilization data.
- Ensuring that UM decisions are made independent of financial incentives or obligations.

7.3 Scope of Service

The scope of FBHP UM Program includes all aspects of health care services delivered at all levels of care to Members.

At a minimum, the UM Program provides the following:

- Ensures that services which are medically necessary are delivered at the appropriate level of care (meaning the right care, at the right time, in the right place).
- Ensures that authorized services are consistent with the benefits provided by the Plan.
- Provides a comprehensive analysis of care by identifying under-and over-utilization patterns by physicians and within the Plan.
- Reviews care and identifies trends that positively and negatively impact the quality of care provided to the Members.
- Defines, monitors, and trends medical practice patterns impacting Members' care.
- Identifies, develops, revises, and implements appropriate policies, procedures, processes, and mechanisms for UM that can be used to evaluate medical necessity for requested services on a timely and regular basis.
- Ensures that appropriate medical review guidelines are available and used by UM personnel.
- Instructs all institutions, physicians, and other health care clinicians regarding the criteria used, the information sources employed, and the methods utilized in the approval and review processes.
- Ensures that network institutions, physicians, and other health care clinicians provide services unless otherwise mandated by regulatory standards.

- Ensures that guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate.
- Ensures coordination and continuity of care for Members receiving linked and carved out services.

7.4 Required Reporting from UM

FBHP UM Departments shall monitor, report, and address the following services to the appropriate committee structures. The services include, but are not limited to:

- Potentially fraudulent or abusive practices are referred to Regulatory Affairs and FBHP Compliance Hotline at (844) 208-2110.
- Potential under and over utilization are referred to the UM and the Chief Medical Officer.
- Coordination of care for results or facilitation are referred to the UM and the Chief Medical Officer and Utilization Management at (800) 608-2667.
- Opportunities for improvement are referred to the Utilization Management (UM) and the Chief Medical Officer and to Utilization Management Department at (800) 608-2667.
- Breaches of adherence to confidentiality and HIPAA policies are referred to the HIPAA Compliance
  Tom Tutaj
  Medicare Compliance Officer
  ttutaj@fbhp.com
  (844) 223-3451
- Potential quality issues identified through UM activities are referred to the QI department.
- Barriers to accessibility and availability of services are referred to Provider Network Operations and QI Departments, as appropriate.

7.5 Continuous Monitoring Activities

Continuous monitoring activities are used to evaluate oversight of Utilization Management. These activities may include:

- Referral Management – Timeliness, Clinical Decisions, Member/Provider notification, benefits, and medical necessity determinations
- Case Coordination Review for in and out of network referrals and hospitals
- Care Coordination for HRAs and Care Management services for low and moderate risk acuity levels

7.6 Denials

Claims may be denied for administrative or medical necessity reasons. An administrative denial example could be when a service provided didn't get notification before the service, or the notification came in too late. Denial for medical necessity example could be when the level of care billed wasn't approved as medically necessary. If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

- **Duplicate claim:** This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information:** Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. This type of claim can be resubmitted with the correct information.
- **Eligibility expired:** Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware.
- **Claim not covered by the Plan:** Procedures are not covered.
- **Time limit expired:** The claim is not sent in time.
- **Prior Authorizations:** Not obtaining Prior Authorizations for required services.
- **Non-Contracted Services:** Services provided by a non-contractor without appropriate prior authorization.

7.6.1 Denial Process

Covered services provided by FBHP must be Medically Necessary, consistent with generally accepted standards and guidelines of medical practice. Services must be provided at the appropriate level of care setting for the Member's clinical condition.

Services must not be provided solely for the convenience of the Member, Member's family, or the Provider. Services shall not be provided to improve the Member's condition beyond normal variations of individual development or aging.

FBHP may request medical records when the case requires a review of the records to determine if the case is medically necessary and appropriateness. Services that do not meet these requirements shall be denied by FBHP.

7.6.2 Denial Appeal Process

FBHP will accept and process any Medicare Prescription Drug Plan (PDP) or Medicare Advantage appeal from a member/provider or an authorized representative expressing dissatisfaction with Farm Bureau Health Plans' adverse determination. In addition, Farm Bureau Health Plans will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

FBHP will identify and remove any communication barrier that might impede member/providers or representatives from effectively making appeals. FBHP will facilitate the request to file an appeal for a member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- A TTY line for the hearing impaired
- A translation service unable to speak English
- Additional accommodations for any member with special needs who is unable to follow the standard process.

FBHP will provide a full and fair review of the appeal, including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the member/provider can demonstrate good cause. Medicare Advantage Plans: Notification of the decision will be issued within the following time frames from the date the request is received (with the exception of Medicare Part B drugs):

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Preservice – As expeditiously as required based on the member's health, but no later than 30 calendar days
- Post service – 60 calendar days from the receipt of the request

The time frames for Medicare Part B drugs are:

- Expedited – No later than 72 hours (no extensions permitted)
- Standard Preservice – No later than seven days (no extensions permitted)

Time frames for decisions might be extended for expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension
- Farm Bureau Health Plans justifies the necessity for additional information and documents, in the best interest of the member

The extension notification to the member must occur prior to the expiration of the decision time frame and must include the right to file an expedited grievance if the member disagrees with the extension.

Medicare Prescription Drug Plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Standard – Seven calendar days If the initial determination is upheld during the appeal process, the resolution letter from Farm Bureau Health Plans will provide additional information on next-level appeals.

7.7 Continuity of Care (COC)

Continuity of care is an approach to ensure that the patient-centered care team is cooperatively involved in ongoing healthcare management toward a shared goal of high-quality medical care. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost effective medical care.

7.8 Services Requiring Prior Authorization

The services requiring Prior Authorizations are kept current and posted on the FBHP website at:

https://fbhealthplans.com/mapd-provider/

7.8.1 Submission Process for Prior Authorization

Prior authorizations with supporting documentation are submitted via:

- Provider Portal - https://fbhealthplans.com/mapd-provider/

- Mail: Farm Bureau Advantage
P. O. Box 303
Columbia, TN 38402
- Telephone: (800) 608-2667
- Fax Number: (844) 263-1928

Case reviews are based on:

- Case specifics
- Completeness of the information received
- CMS requirements
- State or federal requirements

7.9 Services Exempt from Prior Authorization

If services are not listed in the addendum in back of manual or on the up-to-date prior authorization list maintained on the FBHP website, they do not require Prior Authorization. This may be verified by checking a requirement at https://fbhealthplans.com/mapd-provider/.

7.10 Utilization Management Timeliness

FBHP will comply with Utilization Management Timeliness Standards as described in CMS Managed Care Manual. All timeline templates, documentation, and reporting elements will follow standards as directed by CMS. FBHP strives to avoid delays in care by making

determinations as quickly as possible. Providers can expedite this process by using the provider portal to make requests and by including all requested documentation with your request.

7.11 Concurrent Review

Concurrent Review is the assessment used to determine medical necessity or clinical appropriateness of services as the services are being rendered. Concurrent review is used for the assessment of the need for continued inpatient or ongoing care.

7.12 Second Opinion Review

The second opinion program provides Members and Providers with the ability to validate the need for specific procedures.

7.13 Discharge Planning

Through our continuum of care efforts, Members will be evaluated for discharge planning needs that identifies services FBHP will provide as the Member transitions from one care setting to another based upon their benefit design. The goal of discharge planning for FBHP is to reduce hospital length of stay and readmission to the hospital and improve the coordination of services for our Members.

7.14 Reserved

7.15 Hospice Services

Hospice services are provided by the Medicare Hospice benefit. FBHP members will be covered by the Medicare Hospice benefit.

7.16 Supplemental Services

Farm Bureau Advantage does cover Supplemental services (vision, hearing, dental and fitness) services. See the supplemental benefits listed in section 1.2.

Chapter 8 – Quality Improvement (QI)

8.1 Quality Assurance and Performance Improvement (QAPI) Program Overview

The QAPI Program helps to define structure and processes to ensure access to health care and services with reviews to improve quality and safety of clinical care services. Continuous Quality Improvement (CQI) encourages all health care team Members to continually identify activities to improve Member care. Steps for CQI may include assessments, action plans, implementation, and re-evaluation. Strategies and techniques in this process help to define our goals of best-in-class care for our Members.

These strategies include:

- Oversee and review types of care and services given.
- Define quality and efficiency of health care delivered against goals and principles.
- Establish clinical guidelines and service standards.
- Monitor clinical services delivered to our Members for quality, appropriateness, and medical necessity.
- Review consideration for cultural and linguistic needs.
- Ensure medical qualifications of participating health care Providers and their cooperation with quality initiatives.
- Consistent standards are enforced as required by contractual agreements, regulatory agencies, industry guidelines and community standards.
- Promote health education to Provider and Members
- Maintain well credentialed network of Providers following Credentialing Plan
- Awareness of Member safety and confidentiality for protected health information
- Resolve quality issues timely, track and document.

8.2 Provider Responsibility

To fulfill CMS mandated risk adjustment and quality improvement initiatives, FBHP will work with your practice to obtain clinical data and access medical records. As stated in the Provider agreement in the Risk Adjustment, Quality and Utilization Management section, Provider agrees to participate in and cooperate with FBHP designee's Risk Adjustment, Quality, and Utilization Review Programs which include, but are not limited to: (a) compliance with referral procedures as referenced herein and in the Policies and Procedures, and; (b) provision of data and access to medical records for the Plan's quality management, Healthcare Effectiveness Data and Information Set (HEDIS), the Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) studies and risk adjustment. Provider agrees to participate in any quality improvement efforts needed to satisfy local, state or federal requirements.

8.3 Quality Improvement Committee

The TRH Board of Directors oversees the QI program. The Chief Medical Officer (CMO) is accountable for QI operations. The CMO and Director of Health Services lead the QI program and collaborate with interdepartmental teams. The Manager of Clinical Quality is responsible for

communication throughout the organization regarding all QI initiatives. Annually the Quality Assurance and Performance Improvement Committee reviews data, reports, and performance measures to evaluate activities to assess the QI program. This information is then submitted to the TRH board for oversight and additional input.

This evaluation includes but not limited to:

- Review of program activities and any audits.
- Trending of performance measures.
- Capture inconsistencies in health care delivery.
- Assessment of the Member's confidentiality.
- Identify Provider network quality of care and service issues.
- Seeks opportunities for process improvement.
- Analysis of potential or current barriers, issues, non-compliance through quantitative and qualitative data.
- Update policies as needed.
- Tracks and documents all activities.

This committee will suggest QI activities based on a review of all factors that may contribute to changes in performance or impact quality measures. The committee will create and implement an action plan with the collaboration of appropriate FBHP departments.
Data sources that will be used to measure progress toward the goal may include, but are not limited to:

- Claims
- Health Effectiveness Data Information Set (HEDIS®)
- Health Risk Assessment (HRA) Tools
- Care management intervention data
- Medical Records
- Surveys (enrollee, beneficiary satisfaction, other)
- Part D performance data

This forum allows for the teams to investigate, discuss, and take action on these cases.

QI committee communication for initiatives that impact Providers will be posted in several areas-newsletters, Provider Manual, Provider Portal (https://fbhealthplans.com/mapd-provider/) and during Provider visits or webinars.

8.4 Clinical Measures

The following subsections describe metrics for assessing, observing, identifying, and reviewing outcomes of our Members.

8.4.1 Healthcare Effectiveness Data and Information Set (HEDIS)

One of FBHP clinical performance measures are captured through the Healthcare Effectiveness Data and Information Set (HEDIS). CMS requires HEDIS measure reporting which is one of health care's most widely used performance tools and FBHP requests that the network of

Providers assist in continuously improving these measures. FBHP expects cooperation from the Providers with annual HEDIS data collection efforts and medical record review.

8.4.2 Star Ratings Program

In its ongoing efforts to put "Patients First" and empower them to work with their Providers to make health care decisions that are best for them, CMS has developed a Stars Rating program. This program is a quality measurement endeavor for Medicare Advantage (MA) and Prescription Drug plans (PDPs or Part D plans) . The key to this empowerment is ensuring that Medicare beneficiaries and their families have access to meaningful information concerning quality, access, and cost so they can make an informed decision about their health care choice(s).

Reference: https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf

Star Quality Ratings consist of 3 primary domains:

- **Member Experience** –
  - This is the most heavily weighted of the 3 categories.
  - Information is gathered from an Annual Consumer Assessment of HealthCare Providers Systems (CAHPS) Survey of our members. E.g., how satisfied are members/patients with the care they receive? How easy is it to get appointments? What is the average wait time in-office?
- **Medical Care** –
  - How well is members' health managed by the plan providers?
  - How often does the care you provide meet CMS quality criteria (see below)? Does your documentation support that care?
  - FBHP expects providers to support the delivery of high-quality clinical care by adhering to CMS guidelines for quality gap closure.
- **Plan Administration**
  - How will is the plan run and administered?
  - How do members rate customer service?

Annually, CMS publishes the "Medicare Part C and D Star Ratings" for MA, MA-PD, PDP contracts that capture performance and experiences across 40+ metrics to assist MA beneficiaries in finding the best plan for their health needs. The overall performance ratings range from 1 Star (lowest) to 5 Stars (highest).

The Star Ratings program consists of 2 components – Part C (medical) and Part D (drug) for MA-PDs, Part C ONLY for MAs and Part D ONLY for PDPs. There are 4 core measure types across the 2 components:

1. Clinical Quality measures:
   a. HEDIS (Part C)
      i. Breast Cancer Screening
      ii. Colorectal Cancer Screening
      iii. Osteoporosis Management in Women Who had a Fracture

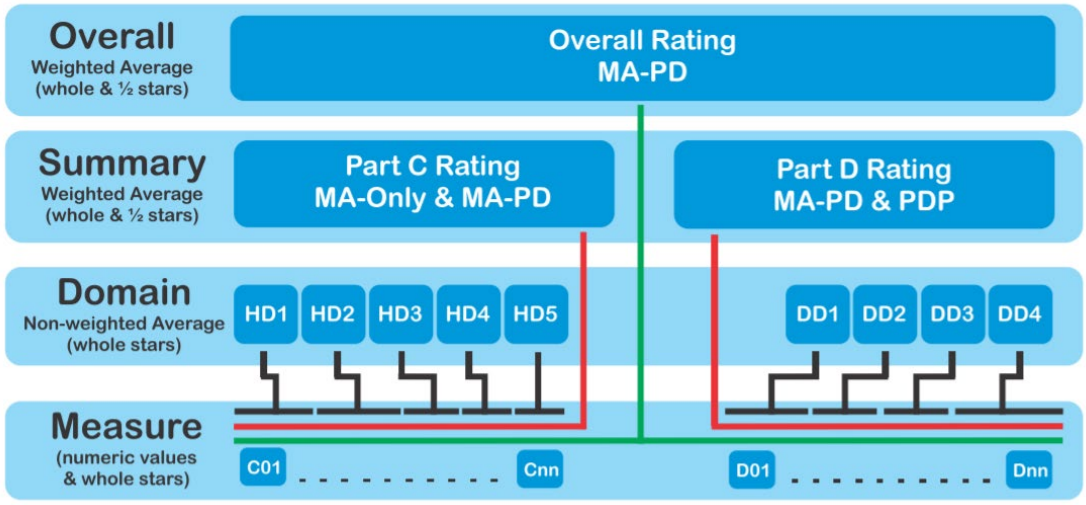
iv. Statin Therapy for Patients with Cardiovascular Disease
v. Medication Reconciliation Post-Discharge
vi. Improving Bladder Control
vii. Annual Flu Vaccine
viii. Monitoring of Diabetic Patients
    1. Blood sugar control
    2. Kidney Health Evaluation
    3. Eye Exam
ix. Care for Older Adults – Medication Review
x. Care for Older Adults – Pain Assessment
xi. Monitoring of Physical Activity
xii. Fall Risk Reduction
xiii. Rheumatoid Arthritis Management
xiv. Transition of Care Management
xv. Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions

b. Pharmacy (Part D)
    i. Medication Adherence for Cholesterol (Statins)
    ii. Medication Adherence for Diabetes Medications
    iii. Medication Adherence for Hypertension
    iv. Statin Use in Persons with Diabetes
    v. Comprehensive Medication Review for members enrolled in Medication Therapy Management

2. Beneficiary Perception measures (Part C and D)
3. Administrative measures (Part C and D)
4. Quality Improvement measures (Part C and D)

These measures serve as an individual unit of measurement then roll-up across domains in each of two program components.

Figure 1: The Four Levels of Star Ratings



*Reference: https://www.cms.gov/files/document/2023-star-ratings-technical-notes.pdf

Individual measures are assigned weights ranging from single-weighted (e.g., process measures), triple-weighted (e.g., intermediate outcome and outcome measures), quadruple-weighted (e.g., experience measures), and quintuple-weighted (e.g., Quality Improvement measures) with higher weighted measures influencing the overall performance. Certain comorbidities that are prevalent in these demographics are captured across multiple measures (e.g., Diabetes and Hypertension). Member experience measures are the highest weighted (i.e., quadruple weighted) in the program and contribute over 50% of performance thus aligning with the guiding principle of the program (i.e., Patients Voice/ Member First).

8.4.3 Chronic Care Improvement Program (CCIP)

In compliance with CMS requirements, FBHP will conduct CCIP initiatives. The intent of this program is designed to promote effective chronic disease management and improve the care and health outcomes for the Member with chronic conditions.

The CCIP is intended to achieve the following objectives:

- Support CMS Quality Strategy found in CMS guidelines:cms.gov/medicarequality-initiatives-patientassessment-instruments/qualityinitiativesGenInfo/legacy-quality-strategy.html;
- Include interventions that are above and beyond FBHP inherent care coordination role and overall management of enrollees.
- Engage enrollees as partners in their care.
- Increase disease management and preventive services utilization.
- Improve health outcomes.
- Be universally applicable to FBHP.
- Facilitate development of targeted goals, specific interventions, and quantifiable, measurable outcomes.
- Guard against potential health disparities
- Produce best practices.

FBHP methodology will address the objectives, develop criteria, and identify the Members with multiple or sufficiently severe chronic conditions who would benefit for participating in the CCIP program.

Some of these diagnostic groups may include:

- Asthma
- Behavioral Health conditions
- Cardiac conditions
- Cancer
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Dementia

- Diabetes
- HIV/AIDS
- Hypertension
- Parkinson's Disease

8.4.4 Additional Measures

Additional measures are monitored by collecting variety of data from multiple sources to understand areas of potential improvement for service delivery.

These sources consist of:

- Member satisfaction
- Member complaints
- Appeals and grievances
- Access and availability to care
- Provider satisfaction
- Network monitoring of Providers
- Health outcome data
- Call center responsiveness
- Member safety component
- Provider utilization
- Critical Incidents

8.5 Reporting

FBHP uses multiple sources of tracking and reporting for QI programs, improvements, and opportunities.

Some of these resources are documented as:

- The use of quantitative measurement tools (e.g., scorecards, dashboard reports, key performance indicators) to report, and track and compare.
- The use of monitoring to track and review open/closed corrective action plans and the details of the activities for each.
- The use of tracking for training programs and pass or fail rates for staff, Providers when applicable.
- The implementation of new or updated Medicare requirements including documentation of the updates in FBHP information, policies and procedures and quality control measures to confirm.
- Logging and trend of number of complaints from employees, Members, Providers, through customer service calls or other sources.
- Identifying and tracking non-compliance.
- Critical incident monitoring and documentation.

Methods to communicate reporting information may include physical postings of information, email distributions, internal websites, and individual and group meetings. The dissemination of

information from the QI Committee must be made within a reasonable time and to all appropriate parties.

8.6 Beneficiary Safety Program

FBHP follows quality improvement guidelines to review some or all of the professional activities of our Providers and health care practitioners to ensure beneficiary safety.

This includes the following requirements from Section 1154 of the Social Security Act:

A. Services and items are or were reasonable and medically necessary.
B. The quality of such services meets professionally recognized standards of health care; and
C. Determine if services could be effectively provided more economically on an outpatient basis or an inpatient health care facility of a different type.

Chapter 9 – Credentialing

9.1 Overview

The Centers for Medicare & Medicaid Services (CMS) regulations require that all Medicare Advantage (MA) organizations offering coordinated care plans, network-based private fee-for-service plans, network-based medical savings account plans, as well as section 1876 cost organizations, maintain a network of appropriate Providers and facilities that is sufficient to provide adequate access to covered services to meet the needs of the population served. This includes oversight of developing standards for credentialing to ensure they all meet the qualifications and competency to join the network of health care delivery and comply with the published laws and regulations for Medicare Advantage. CMS requires this process be reviewed by peers through an established process with policies and procedures in place to support the credentialing and re-credentialing process. CMS requires a plan to ensure applicants are notified if any action is to be taken by FBHP that may result in notification to proper authorities. Providers are also entitled to understand the Fair Hearing and appeals process. Requirements for continual assessment of the quality of the credentialing and recredentialing process to ensure Member care is provided by qualified Providers is included in the policy.

9.2 Plan Process

Farm Bureau Health Plans (FBHP) maintains a credentialing and re-credentialing process to meet all applicable laws and regulations as it relates and defined by Centers of Medicare and Medicaid (CMS) and National Committee for Quality Assurance (NCQA). This plan includes the peer review oversight and compliance to requirements that ensure Providers are qualified and competent to provide care and facilities are appropriately revied by applicable regulatory agencies. The process addresses continuous evaluation to identify opportunities for improvement to the process to maintain the most qualified Providers to care for the Members.

Additionally, the plan establishes a structured range of actions that may be taken against a Provider with a mechanism to notify Providers of their rights. Included are actions for Fair Hearing process, appeals rights and notice to authorities. Provider notification for determinations for disciplinary actions, terminations, or suspension, denial into the network, reporting to authorities or other decisions are part of the structured range of actions within the credentialing and recredentialing plan.

FBHP is electing to utilize the services of a National Committee for Quality Assurance (NCQA) certified Credentialing Verification Organization (CVO) to provide verification and/or ongoing monitoring of credentialing and re-credentialing elements.

9.3 The Chief Medical Officer

The Chief Medical Officer is responsible for the administration of the credentialing process and oversight for activities as defined in this section in coordination with the CVO. The Chief Medical Officer will have the responsibility of; oversight of the Credentialing Program of FBHP, shall serve as the Chairman of the Credentialing Committee, review and approve Provider files

meeting the baseline credentialing requirements, and participation in the decision-making process of the Credentialing Committee.

9.4 The Credentialing Committee

The Credentialing Committee has the responsibility to; conduct scheduled meetings to review applications and documents from Providers, to interpret the information against the standards set forth in the credentialing policies and procedures, provide professional advice and expertise affecting the onboarding of network Providers while making any necessary professional decisions regarding acceptance or denial about the Providers. The Credentialing Committee will then submit any required reports.

The Credentialing Committee is a multi-disciplinary committee with representation of the various types of Providers and specialties represented by the FBHP clinical staff. By utilizing a multi-disciplinary committee, FBHP will have access to Providers who can convey their expertise on current practices in the medical community, including technical knowledge. The Credentialing Committee is chaired by the FBHP Chief Medical Officer, or a designated physician.

The Credentialing Committee will exercise its responsibility by:

- Evaluating the education/training, current competency, and qualifications of the Providers applying to or affiliating with FBHP.
- Making recommendations regarding credentialing decisions guided by the approved Policies and criteria.
- Receiving reports from the Chief Medical Officer or designated physician of Provider files that were previously approved in the interim of Credentialing Committee meetings.
- Reviewing, revising, and creating policies and procedures at a minimum, on an annual basis.
- Acting in the capacity of a professional review body that will conduct oversight and monitor corrective action plans related to credentialing and the delivery of care to Members.
- Acting in the capacity of a professional review body that will conduct appellate and hearing activity.
- Ensuring and maintaining non-discriminatory practices.
- Ensuring and maintaining confidentiality of credentialing documentation; and
- Credentialing Committee will report all final decisions, recommendations, and actions to the Executive Management Team
- Ad hoc meetings for credentialing can be exercised at the discretion of the committee.

Members of the Credentialing Committee with either a vested interest and direct involvement or knowledge of any Providers who do not meet the credentialing baseline standards shall recuse themselves from contributing to the final decision regarding those Providers.

The Chief Medical Officer and the Credentialing Committee will also participate in the analysis of Provider data to identify opportunities for quality improvement in the credentialing process to

maintain competent and qualified Providers to care for Members. These procedures will be structured in accordance with the NCQA, CMS, state and federal laws.

9.4.1 Credentialing Committee Meetings

The Credentialing Committee shall meet at least 8 times annually, or as necessary. These meetings may be held virtually (by telephone or webinar) or in-person. They cannot be held via email.

The Credentialing Committee shall conduct meetings when required for peer review, appellate requests, fair hearing, and professional review purposes as in the Ongoing Monitoring section of this policy.

All activity and discussion by this Committee shall be recorded in a set of minutes and signed by the Chairperson upon approval of the information recorded and submitted at the following meeting. However, the final decision date shall stand as the date of the actual Credentialing Committee meeting.

9.5 Requirements

CMS states that credentialing is required for:

- All physicians who provide services to the MA organization's enrollees, including Members of physician groups; and
- All other types of health care professionals who provide services to the MA organization's enrollees, and who are permitted to practice independently under state law

Types of Providers that require credentialing may include but not limited to;

- Allopath's (MD)
- Ambulatory Surgery Centers
- Certified Nurse Midwives (CNM)
- Chiropractors (DC)
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Centers
- Dentist (DMD, DDS)
- Federally Qualified Health Clinics (FQHC)
- Home Health Agencies
- Hospices
- Hospitals
- Licensed Clinical Professional Counselors (LCPC)
- Licensed Clinical Social Workers (LCSW)
- Nurse Practitioners (NP)
- Oral Surgeons
- Osteopaths (DO)
- Outpatient Physical/Occupational/Speech Therapy Centers
- Physician Assistants (PA)

- Podiatrists (DPM)
- Psychologists (PsyD, PhD)
- Rural Health Clinics (RHC)
- Skilled Nursing Facilities

Credentialing is not required for:

- Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.
- Hospital-based health care professionals who provide services to Members incident to hospital services, unless those health care professionals are separately identified in enrollee literature as available to Members; or

- Students, residents, or fellows.

9.6 Provider Rights

Providers who are in the initial credentialing phase of selection and evaluation will be notified of their rights through network Provider application process.

9.7 Right to Review Information

FBHP notifies Providers of their right to review information it has obtained to evaluate their credentialing application, attestation, or CV that may include information obtained from external sources, except for references, recommendations or other state or federal peer review protected information.

9.8 Right to Correct Erroneous Information

When credentialing information from other sources differs from or does not support information provided by the Provider, the Provider has the right to correct the erroneous information or information creating the discrepancy. The process of correction includes:

- A notification of discrepancy or error within 14 calendar days of receipt of application via telephone, email, fax, or certified mail will be sent by a Member of FBHP.
- The Provider shall respond to the Member of FBHP with corrected documentation or information within 14 calendar days of receipt of notification; and
- If the Provider requests a copy of the documentation provided by the external source, the request for the release must be written and signed by the Provider.
    - The documentation released will be sent via certified or registered mail to the practitioner; and
    - Corporate counsel will have approved the type of information or documentation to be released.
- Corrected information or documentation will be submitted to Credentialing Committee with the completed application if the Provider does not meet baseline credentialing requirements
- The practitioner will then be notified of the final decision in accordance with this policy

9.9 Right to be Informed of Application Status

Providers may request the status of their application by telephone, fax, email, or U.S. mail by contacting the FBHP. The FBHP will respond to the application status request within three business days of the request.

Farm Bureau Health Plans
Attn: Medicare Advantage Plans
P. O. Box 313
Columbia, TN 38402-0313
Phone: (877) 874-8323

9.10 Provider's Responsibility

The Provider is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that FBHP would consider in making a reasonable Credentialing decision. Provider must inform Credentialing Committee of any material change to the information on the Application including but not limited to: any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, imposition of an Office of Inspector General (OIG) sanction, General Services Administration (GSA) debarment, or Material Restrictions on licensure. Failure to inform Credentialing Committee of a status change is a violation of this Credentialing process and may result in delay or denial from the Network.

9.11 Non-Discrimination Policy

FBHP will not discriminate, in terms of Contract or contractual relationship against any health care professional who is acting within the scope of his or her license or certification under state law, solely based on the license or certification. FBHP will not discriminate against any Provider due to race; color; national or ethnic origin; age; religion; disability; sex; sexual orientation; gender; gender identity and expression, including a transgender identity; genetics; veteran status; retaliation; and any other characteristic protected under applicable federal or state law, herein called "protected categories." In addition, FBHP will not discriminate against Providers based on the population they serve or Providers that specialize in conditions that require costly treatment.

Monitoring activities to ensure non-discrimination during the credentialing process will include:

- Applications will be processed in the order of receipt or in order of expected Contract start date, if received in the allotted timeframe for processing;
- All elements of the application are reviewed to ensure the Provider meets FBHP's credentialing criteria prior to processing;
- Date of Birth (DOB) requested on applications, shall be used only for querying the National Practitioner Data Bank (NPDB);
- Practitioner rights to review application data, request status of application, and to correct erroneous information or to address discrepancies are available to all applicants;
- If FBHP denies a given Provider or group of Providers in its network, it must furnish written notice to the affected Provider(s) stating the reason for the decision.
- All Credentialing Committee decisions are recorded in the minutes; and

- A Member of the Compliance Department or their designate to ensure that the practitioners were not discriminated against will conduct:
    - Periodic audits of denied applicants;
    - Periodic audits of Provider grievances to determine if there are any grievances alleging discrimination; and
- Annual sampling of the initial credentialing and recredentialing applications of Providers approved by the Medical Director and Credentialing Committee

9.11.1 Confidentiality

To ensure confidentiality of the data and documentation collected during the initial credentialing and recredentialing process, the following mechanisms have been implemented:

- Provider files are secured within the CVO system with secure access electronically and in accordance with the Information Technology Department's Security Policies
- Any hard copy documentation is locked and secured in file cabinets in a secured area with access limited to FBHP employees;
- Providers' access to their credentialing information is outlined and defined previously in **Section: Primary Provider Rights-Right to review information**;
- Confidentiality statements are signed annually by the Credentialing Committee and the FBHP staff affirming they will protect, during and after Contract or affiliation with the organization, any confidential information they handle
- The FBHP staff is trained annually and up to date with compliance requirements as well as in the protection of credentialing documentation and patient health information (PHI)
- All new FBHP employees will be oriented to their roles in securing credentialing information, policies regarding confidentiality, password protection, physical security of files (not to be left unsecure on a desk), electronic security (computers put to sleep when away), and authorization levels for those who may have access to credentialing information
- Access to all systems is terminated upon employee's departure
- The handling of credentialing data is restricted to an authorized staff. If a third party requires access to credentialing information, refer to Corporate Counsel for guidance to ensure release of information adheres to The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, FBHP Confidentiality Policies and Procedures, FBHP PHI Policies and Procedures, local, state and/or federal laws.
- Periodic database reports will be generated to track employee access to credentialing files to ensure no unauthorized access has occurred
- Intermittent and consistent back-up of all credentialing data exists for the protection, archiving, and recovery of data. This service is provided through the CVO
- It is not the intent or practice of the credentialing process to collect PHI. However, should PHI be included in any documents collected to complete the credentialing process, this information shall be either returned to the Provider or destroyed in the shredder if it has no bearings on recommendations by the Credentialing Committee.

- If a breach occurs of information containing patient health information (PHI), a written notification to the Providers whose files were compromised, the patients whose information was breached, and the delegated entity to which a delegated arrangement is in place shall be sent within 60 days of the discovery. The written notification must include details consistent with FBHP's Policies regarding HIPAA Guidelines.

9.12 Documentation Process

9.12.1 Professional Practitioners

To demonstrate qualifications to join the network, each Provider must complete an application that includes the following information;

Application Requirements	
Completed, signed, and dated application for participation with an attestation date no greater than 180 calendar days prior to submission for final approval	Valid Federal Drug Enforcement Administration (DEA) certificate for the state of TN Department of Financial & Professional Regulation Controlled Substance Registration;
Attestation of history of loss or limitations of license and/or clinical privileges;	Evidence of current malpractice insurance;
Attestation of disciplinary actions, and/or felony convictions;	Proof of education and training, to include board or professional certification, if appropriate. This would entail proof of graduation from an accredited professional or medical school or proof of completion of an accredited residency program, or proof of Board or Professional Certification, if reported by a physician, oral surgeon, podiatrist or healthcare professionals, including nurse practitioners and physician assistants;
Attestation of history of present or past chemical, substance and/or alcohol abuse;	Status of current hospital privileges;

Attestation to mental and physical competence to perform the essential duties of the profession;	Work history for the most recent five years of relevant health care Contract experience. The timeframe should include beginning and ending month and year, unless the continuous Contract exceeds five years, then beginning and ending year will suffice;
Attestation to the correctness and completeness of the application;	Educational Commission for Foreign Medical Graduates (ECFMG) certification or equivalent, if practitioner is a foreign medical graduate;
Signed and dated Release of Information form;	History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner for the most recent five years, or that are still pending professional liability actions;
Current unrestricted license to practice in the State of TN	Provider's unique National Provider Identifier (NPI);
	Physician Collaborative Agreement for non-physician practitioners who are required by state law to affiliate with a supervising physician.

9.12.2 Facility Application Requirements

To demonstrate qualifications to join the network, each facility must complete an application that includes the following information;

Note that application criteria is subject to change.

Application:

- Facility name
- Facility address
- Facility contact information
- Credentialing contact information

- Facility administration contact information
- Legal business name (as reported to the IRS)
- Federal Tax Identification Number (TIN)
- DBA (if applicable)
- National Provider Identification (NPI) for facility
- Corporate address
- Name and mailing address of where Provider can be contacted directly
- Facility type (1 per application)
- List all clinical areas of interest for which the facility currently provides
- List all languages spoken fluently by facility staff and indicate if interpreter services and/or sign language services are available
- Health care licensure (include cope of each license for the facility)
    - License number, state or city, licensing agency, initial issue date, renewal date, expiration date
- Medicare status
- Medicare number

HOSPITALS ONLY:

    - Indicate if the hospital is designated by CMS as a Sole Community Provider
    - Indicate if hospital is a Critical Access Hospital
- Accredited facilities:
    - Indicate accredited facilities
    - Attach copies of current accreditation certificate or letter
- Non-Accredited facilities:
    - Indicated if this facility has had an onsite licensing survey by the Department of Health or CMS within the past 36 months
    - Attach copy of most recent onsite government agency survey along with your Corrective Action Plan(s), if deficiencies were cited, OR attach letter from government agency stating facility is in substantial compliance with most recent survey standards
- Staffing:
    - Indicate if the facility validates and verifies, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services?
        - If yes, indicated how the facility conducts the credentialing process for each practitioner
        - If no or other, explain
- A copy of the facility's insurance certificates that includes:
    - Insurers affording coverage
    - Amounts of coverage
    - Policy number
    - This facility as covered by the policy
    - Effective date and expiration date

    - Name/phone number of issuing policy
- Is facility covered by Commercial General liability insurance in the amount of $1 million per occurrence and $3 million aggregate, at a minimum?
    - If no, please obtain the above minimum amount of required coverage before submitting application.
- Is facility covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate, at a minimum? Must be a facility/organizational policy, not Individual-only policy.
    - If no, please obtain the above minimum amount of required coverage before submitting application.
- Has this facility's Commercial General or Professional liability insurance ever, for any reason, been denied, cancelled, non-renewed, or initially refused upon application?
    - If yes, explain.
- Attestation: (If facility is accredited this section can be left blank) answer the following questions yes or no and provide a detailed explanation on a separate sheet, including dates, for any questions answered yes.
    - Has this facility had or currently has pending legal actions in last 10 years?
    - Has this facility ever been convicted of a crime?
    - In the last 10 years has this facility ever been named in a complaint based on allegations of professional negligence or professional misconduct or has this facility ever received notice of an intent to commence litigation of that type? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.
    - Regarding any suit in the last 10 years, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.
    - Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business in last 10 years?
    - At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility in the last 10 years, or are any actions which may lead to such conclusions now underway?
    - At any time has this facility/organization been assessed a penalty or fined by a government agency or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?
    - In the last 10 years has at any time any third-party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issues, or for any other reason?
    - Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?

- In the last 10 years has this facility, under any current or former name or business identity, ever had its accreditation revoked or suspended, or placed conditions upon?

Malpractice Claim Information Sheet:

- Will be completed for all claims within the last 10 years unless the facility is past accreditation:
  - Facility name
  - Patient name
  - Diagnosis
  - Facility involvement in case
  - Allegations
  - Case summary
  - Patient outcome
  - Other pertinent details
  - Date of incident
  - Date filed
  - Date closed
  - Resolution of case (dismissed, settled, etc.)
  - Settlement amount paid on your behalf if any
  - Professional liability insurer involved
    - Name of insurer
    - Address of insurer
    - Policy number

*FBHP accepts and uses the CAQH application.

9.13 Submission Process for Verification for Credentialing

FBHP is electing to utilize the services of a Credentialing Verification Organization (CVO) to provide verification and ongoing monitoring of these elements of credentialing. The CVO credentialing process is a 36-month cycle. The application and supporting documents will be collected by the CVO team and reviewed for accuracy and completion. The network team and the CVO will work in collaboration to support the collection of required credentialing documents in a timely manner.

CMS states some information may be verified from a primary source and some information may be verified from secondary sources. A “primary source” is an organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys. Primary source verification may be achieved through the use of industry-recognized verification sources. The nationally recognized accrediting organizations specify which sources they consider to be appropriate primary sources for verifying credentials. In some instances, except for licensure, a secondary source will be considered acceptable provided that the secondary source verifies the information from the originator. If FBHP or CVO uses one of the

primary sources identified by one of these nationally recognized accrediting organizations, CMS will consider that source acceptable. If questioned, FBHP and CVO will be able to reference which organization identified that source. These sources are:

- Current, unrestricted state license to practice is primary source verified through the applicable state licensing board in TN if license is required to practice
- Current Drug Enforcement Administration (DEA) registration is primary source verified through one of the following methods, if DEA is required to practice: The DEA Diversion website, NTIS or the certificate itself.
- Current Controlled Dangerous Substance Registration (CDS), if required to practice, must be primary source verified through the state of TN Department responsible for Controlled Substance Registration
- Education or board certification must be primary source verified through one of the following methods for MDs, DOs, or DDS applicants:
    - American Board of Medical Specialties (ABMS) or its related products (Certificates, Board Certified Docs) or the board certifying institution;
    - American Medical Association (AMA) Profile;
    - American Osteopathic Association (AOA) Profile;
    - Hospital or educational institution that provided the education or training; or
    - State licensing board or agency whose policy is to primary source verify the highest level of education (copy of current policy or annual primary source verification letter that must be annually reviewed, obtained, and maintained.)
- Education or professional certification must be primary source verified through one of the following methods for advanced practitioner applicants, such as nurse practitioners and physician assistants:
    - Professional certifying organizations specific to their specialties, if they claim to be certified and if this certification will be listed in the directory of a managed care organization granting FBHP delegation for credentialing purposes;
    - American Medical Association (AMA) Profile for physician assistants;
    - Hospital or educational institution that provided the education or training; or state licensing board or agency whose policy is to primary source verify the highest level of education (copy of current policy or annual primary source verification letter must be annually reviewed and maintained.)

National Practitioner Data Bank (NPDB) must be queried directly from its website.

- History of malpractice claims settled, or judgments paid within the last five years may be obtained by:
    - Querying the NPDB; and/or
    - Querying the malpractice insurance carrier
- OIG will be queried through the Office of Inspector General's website to determine if there are any Medicare/Medicaid specific exclusions
- For determination if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities, the System for Awards Management (SAM) website, formerly EPLS, will be queried

- The state report of exclusions based on fraud, convictions, loss of license, patient abuse and other reasons occurring within the NY state Provider Sanction List should be queried
- The Social Security Administration's Death Master File (SSADMF) must be searched at the time of initial application to ensure that Medicaid is not being billed in the name of a deceased Provider
- To confirm no history of felony or other criminal conduct, the FBHP shall obtain clearance utilizing a Criminal Background search from its CVO, upon notification of the Provider's hire date

Note: All new applicants will be added to the ongoing monitoring service lists upon receipt of application to ensure the latest sanction, exclusions, or opt-out reports are available prior to the approval process.
Primary source verification is not required for all data elements in the application process. These elements may be provided by the Provider or may be verified through primary source or secondary source (Via Attestation): These elements not requiring primary source verification are:

- Confirmation of hospital privileges in good standing to ensure accurate FBHP directory information may be confirmed through at least one of the following methods, if hospital privileges are relevant to profession:
    - Copy of online directory information provided by the hospital's website;
    - A letter from the hospital indicating practitioner's affiliation;
    - Verification obtained through the Practitioner Hospital Data Bank (PHDB); or
    - NAMSS PASS
    - Attestation of the Credentialing application
- Confirmation of hospital admitting arrangements to ensure patients have access to a participating hospital setting may be confirmed through at least one of the following methods:
    - Utilizing the same process for secondary verification of hospital privileges for the covering or collaborative Provider, if applicable. (Some Providers may elect not to affiliate with a hospital.)
- A copy of the face sheet of the professional malpractice coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, except for federal coverage through the Federal Torts Claims Act, or evidence of compliance with state regulations
- Work history of five years with no gaps greater than six months
    - A copy of the curriculum vitae; or
    - A written explanation

If the work history gap is greater than 60 days, a written explanation from the practitioner is required.

- Required physician collaborative agreements for non-physicians may be verified utilizing:

    - Individual agreements completed by collaborative physician and non-physician, and approved by the practice or hospital setting
- Office site visits shall be completed by the Quality and Performance Improvement Department for all Providers affiliated with FBHP

9.13.1 Clean File Criteria

The Chief Medical Officer is responsible for the approval of Providers whose files meet the baseline standards, in accordance with this policy. The criteria established for clean files include the following:

- No history of malpractice claims settlements or judgments as reported by the National Practitioner Data Bank (NPDB-HIPDB) or by self-attestation within the most recent five years;
- No history of exclusions, sanctions, revocations, involuntary relinquishments, terminations, suspensions, or limitations within the most recent five years and no related unresolved issues greater than five years for:
    - Licensure
    - Drug Registration
    - Clinical Privileges
    - Participation in Managed Care Organization Networks
    - Medicare/Medicaid
    - Board Certification
    - Professional Certification
    - Malpractice Insurance
- No history of criminal or felony convictions; and
- No history of substance abuse or an incomplete substance abuse program within the most recent five years. Completed programs must be accompanied by a letter of advocacy from the appropriate agency.

Exception: A noticeable pattern or trend that may be greater than the most recent five-year period will be submitted to the Credentialing and Professional Review Committee for review.

9.13.2 Unclean File Criteria

The Credentialing Committee is responsible for the approval of Providers whose files do not meet the baseline standards, in accordance with this policy. The criteria established for unclean files include the following:

- History of malpractice claim settlements or judgments as reported by the National Practitioner Data Bank (NPDB-HIPDB) or by self-attestation within the most recent five years;
- History of malpractice claim settlements or judgments exceeding a total of $1,000,000 as reported by the National Practitioner Data Bank (NPDB) or by self-attestation within the most recent ten years;

- History of exclusions, sanctions, revocations, involuntary relinquishments, terminations, suspensions, or limitations within the most recent five years and/or related unresolved issues:
    - Licensure
    - Drug Registration
    - Clinical Privileges
    - Participation in Managed Care Organization Networks
    - Medicare/Medicaid
    - Board Certification
    - Professional Certification
- History of criminal or felony convictions; and
- History of substance abuse or an incomplete substance abuse program

Exceptions: Issues not described above may be reported or detected during the credentialing process. These issues will be submitted to the Credentialing Committee for discussion, recommendations, and decisions.

9.13.3 Notification of Decision

A formal notification letter will be sent to the Provider indicating the final credentialing decision within 10 calendar days of the decision date. If a Provider's initial application was denied, the notification will be sent via Certified Mail listing the reason for denial, in accordance with Fair Hearing and Appeal within this credentialing plan. Denials based upon failure to meet the baseline criteria will require only a notification. Should the denial be based upon quality-of-care issues, a report to the appropriate authorities will be required as indicated in the Fair Hearing and Appeals section.

If a Provider's application was tabled for additional information, a letter requesting additional information will be sent to the Provider within 14 calendar days requesting a response within 14 calendar days. If the requested documentation is not received in the appropriate timeframe, a follow-up telephone call is made. If no response or no documentation is submitted prior to the next Credentials and Professional Review Committee date, the application may be considered withdrawn should the Committee deem not enough information to recommend. The applicable Department will be notified that no further credentialing efforts will be made on behalf of FBHP, in accordance with the Fair Hearing and Appeals section. If an application remains incomplete and is not submitted for approval due to insufficient data after three attempts over a period of 45 calendar days, the applicable Department will be notified that the Provider's non-compliance has placed his application in a withdrawn status. Upon confirmation from the applicable Department not to pursue further, the Provider is then notified by certified letter of his withdrawn status.

9.13.4 Authority

The final credentialing decision dates of the Chief Medical Officer and the Credentialing and Professional Review Committee designate the approval dates for each individual Provider. Records of these approvals will accompany each individual file, whether it is in an approval

document, a copy of the notification letter, or a copy of the minutes or Medical Director approved listing.

The FBHP Executive Management Team has delegated to the Chief Medical Officer and the Credentialing a Committee the implementation, oversight, and final decision for all credentialing functions.

9.14 Recredentialing

FBHP has adopted the CVOs 36-month recredentialing cycle period. Providers who apply for re-credentialing and who shall be re-enrolled in FBHP network or on a hospital staff shall be resubmitted for approval every 36 months. The recredentialing process will follow the credentialing process with the inclusion of Provider performance.

The recredentialing appraisal may include consideration of practitioner specific performance data which may not be limited to Member grievances and triggered office site evaluations. Additional items from the following sources below may be (not required) considered in the decision-making process as applicable:

- Utilization management data
- Medical record audits
- Patient satisfaction surveys
- Identified adverse events
- Sanctions
- Corrective Action Plans

If unable to recredential a Provider due to military leave, maternity leave, or sabbatical, the relationship with FBHP remains in place and the Provider will be recredentialed upon his/her return. FBHP will be required to document the reason for this delay in the Provider's file. At a minimum, the recredentialing must be completed within 60 calendar days of when the Provider resumes practice.

For any Provider who experiences a break in the credentialing cycle less than 30 calendar days, whether for termination due to administrative reasons such as failure to return documentation or the end of a contractual relationship with FBHP which is then reinitiated, the Provider may be recredentialed with appropriate documentation in file stating the reason for break. If the break is greater than 30 calendar days, the Provider will be processed as an initial applicant.

9.14.1 Recredentialing Exceptions

Education and work history will not be required unless additional education has been obtained to change the specialty affecting clinical services offered. Confirmation and attestation of FBHP's credentialing profile based upon initial information collected may be sufficient for the recredentialing process. Notification of recredentialing status or approval is not required.

9.15 Method of Documentation

FBHP maintains an electronic copy of the credentialing applications, attestation, checklist, and documentation to support the credentialing process within the delegated CVO web-based portal system. Electronic documentation will be permissible, if criteria are met, and the database or system used can assign a unique electronic identifier. Each document verified or collected must be either date stamped and initialed by a Member of the FBHP delegated CVO or identified electronically.

9.16 Ongoing Monitoring, Performance and Sanctions

On a continuous basis during the interval between initial verification and re-verification of credentials of each Provider, monitoring for possible sanctions and adverse actions will be conducted by FBHP or its delegated CVO. Information from multiple sources will be reviewed within 30 calendar days of its release for evidence of notifications regarding FBHP Providers. For reporting entities that do not publish sanction information on a set schedule, FBHP or CVO will query for this information monthly. Issues identified will be reported via the web-based portal provided by the CVO monthly. Resource sites include: System for Awards Management (SAM), Office of Inspector General (OIG), Medicaid Opt-Outs from regional Medicare administrator, National Government Services (NGS), state of TN Provider Sanction list from Department of Healthcare and Family Services.

Adverse results or incidences of potentially poor patient care delivery found on any of these reports will be directed to the Health Services Department, investigated, and subject to peer review and subsequently submitted to the Credentialing Committee for recommendation. Providers who have opted-out or who are not participating in Medicaid or Medicare are not eligible for reimbursement through contracted insurers and may not be eligible to be employed by or affiliated with FBHP. The applicable departments will be notified immediately of their ineligibility to participate.

The National Practitioner Data Bank Continuous Query service is considered an acceptable source for licensure, Medicare and Medicaid sanctions, and claims history. CAQH Sanctions Track is an acceptable source for licensure, state and federal Medicare and Medicaid sanctions, and Medicare Opt-Outs. The CVO provides full Provider Sanction monitoring.

Performance measures, Member complaints or any incident of questionable quality of care may be evaluated by FBHP to ensure the continuous delivery of safe, high quality Member care. These measures can be reviewed through the quality performance reviews from the clinical or quality team that identifies trends, patterns, safety issues, Member grievances that are collected, aggregated and analyzed. These may include:

- Office or site visits
- Member complaints
- Member Satisfaction Surveys
- Sensor Reporting
- Clinical performance-based outcomes
- Medical records

- Utilization reports
- Billing and claims

9.17 Site Visits

FBHP will establish a set of standards for conducting site visits. This frequency will be established as 1 time during the credentialing cycle within every 36 months after initial credentialing has been established. FBHP ‘s site visit process will include procedures for detecting deficiencies and have mechanisms in place to address those deficiencies. The initial credentialing site visits of the offices of primary care practitioners, obstetrician-gynecologists, or other high-volume Providers, will be conducted as part of the site visit process. High-volume Providers are defined under utilization patterns of Member care and may change from time to time depending on historical claims data.

- The site visit assessment will include an evaluation of the site’s:
- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped
- Physical appearance to provide a safe clean environment for patients, visitors, and staff
- Adequacy of waiting room space to accommodate the average number of patients seen
- Adequacy of exam room space including provisions for privacy during examinations or procedures
- Availability of appointments if applicable
- Adequacy of medical/treatment record-keeping
- The Credentialing Team/Network will conduct an assessment of the medical record-keeping practices on all Provider types as specified by applicable law or regulation. A medical record-keeping assessment of one medical record will be reviewed to address the extent to which medical record-keeping practices support the following:
- Confidentiality of the record
- Consistent organization of the record

Based on the severity of the identified issue, any failed site visit will have a period of time to correct the reason for the failure. This time period will be determined by the significance of the issue by the Chief Medical Officer and Credentialing Committee.
Depending on the severity of the issue, an Administrative Suspension may be issued by the Medical Director. Failure to correct the issues after this period will result in loss of credentials with potential re-application only after documented correction has been achieved.

9.18 Credentialing Quality Improvement

To maintain continual review process, five percent of approved files completed by FBHP will be audited for accuracy, completeness, and timeliness prior to submission for approval. Documentation of date of review, auditors’ signature and a copy of the audit will be included with the file and tracked for reporting purposes.

In addition to file audits, database logs will be maintained to audit the document collection and processing time to identify staff productivity or consistency improvement opportunities. The

targets for each stage of the collection, review, submission, approval and notification will be established. The processing times will be reviewed with staff, Chief Medical Officer, Credentialing Committee to analyze and identify barriers or obstacles. Plans will be implemented for corrective actions as needed.

9.19 The Health Care Quality Improvement Act (HCQIA)

HCQIA leaves largely undefined the types of acts or omissions that relate to "competence or professional conduct." The Act, however, makes it clear that certain factors, such as membership in a professional society, fees, advertising practices, competitive acts intended to solicit or retain business, or support for allied health professionals do not relate to professional competence or conduct. Failure to attend staff meetings or to complete medical records are not viewed as related to competence or professional conduct unless they reach the point of adversely affecting the health or welfare of patients. The legislative history of the Act indicates that felonies or crimes of moral turpitude, illicit transactions involving drugs, serious sexual offenses, violent behavior and other similar acts are activities that could adversely affect patients. The database for reporting adverse actions offers some additional guidance by listing adverse action classification codes for certain types of activities.

The HCQIA requires health care entities to report to the National Practitioner Data Base (NPDB) certain professional review actions ("Adverse Action Reports") with a copy of the NPDB report required to be filed with the applicable licensing board. Health care entities are required to report such actions for physicians and dentists. Health care entities may report such actions on other health care practitioners. FBHP will file NPDB reports, as appropriate and as required by HCQIA in accordance with the reportable actions:

- A professional review action based on the professional competence or professional conduct that adversely affects his or her clinical privileges for a period of more than 30 days
- Acceptance of the surrender or restriction of clinical privileges (1) while the Provider is under investigation or (2) in exchange for the health care entity not conducting an investigation relating to possible professional incompetence or improper professional conduct.
- Suspension of clinical privileges for a period of more than 30 days based on potential imminent threat to patient safety
- Revisions to any such actions described above

9.20 Range of Actions

The Chief Medical Officer will investigate matters to determine if sanctions, adverse actions, or quality of care issues identified in accordance with credentialing procedures warrants restrictions, suspension or termination of a Provider from the network.

The investigation should reach a conclusion as to whether the Provider network privileges will be affected due to non-compliance with credentialing requirements, practitioner's competency, professional conduct, or immediate actions for harm to patient health, fraud or other actions of breach of contract.

If immediate action is not warranted, the matter will be presented to the Credentialing Committee for final decision. All actions taken by FBHP to suspend, revoke, or terminate a Provider will afford the Provider the right to appeal.

The suspend, revoke or termination of a Provider may include but not limited to the following activities:

- Provider is under investigation by a state or federal authority for willful misconduct
- Provider is non-compliant with credentialing/recredentialing requirements
- Provider fails to meet quality standards as set by FBHP
- Provider has supported allegations regarding Member safety against them (with substantiated documentation)
- Provider has lapse, revocation, suspension, termination or sanctions for license, certifications or Medicare/Medicaid eligibility
- Provider has serious documented clinical quality deficiencies
- Provider has criminal or felony convictions
- Provider has provided medically unnecessary care, utilizing health care resources inappropriately, demonstrated poor judgement which jeopardized the health of Member

9.21 Notice to Providers

Any suspensions, terminations, non-renewals will take effect immediately and Providers will be notified as outlined below. A notification indicating Providers who have been suspended or terminated will be disseminated to all appropriate internal department staff to ensure a seamless transition of Members to new Providers.

9.21.1 Notice of Administrative Suspension

Written notification of the effective suspension date will be mailed to the Provider via certified mail within 3 business days of the determination. Notice will include reason for actions, requirements, and timeframe for resolution;

- The practitioner will be given 30 calendar days from notification to correct any administrative issues or to provide adequate documentation of investigation showing evidence it does not affect the welfare of the FBHP patient or delegating entities' Members and/or the Provider's license to practice or eligibility to accept Medicare or Medicaid funds.

9.21.2 Notice of Termination

Written notification will be mailed via overnight express to Provider within 24 hours of the determination, no less than one business day. Notice will include reason for the actions, requirements, and if relevant, standards used to evaluate Providers, in addition to timeframe for appeals process;

- The practitioner will be given 30 calendar days from notification to correct any administrative issues or to provide adequate documentation of investigation showing

evidence it does not affect the welfare of the FBHP patient or delegating entities' Members and/or the Provider's license to practice or eligibility to accept Medicare or Medicaid funds.
- The Provider will be given 30 calendar days from the date of notification of termination to request an appeal;

A summary of the appeal rights and process will be included in the notification.

9.21.3 Notice of Non-Renewal

Written notification will be mailed to the Provider within 10 calendar days of the final credentialing decision. Notice will include reason for the actions, requirements, and if relevant, standards used to evaluate Providers, in addition to the timeframe for re-application or resolution.

- The Provider will be given 30 calendar days from the date of notification of termination to request an appeal;

A summary of the appeal rights and process will be included in the notification.

9.21.4 Notice to Authorities

Actions taken to suspend or terminate the Provider from FBHP network based upon professional conduct, competency, or sanctions shall be reported via certified or express mail to CMS, National Practitioner Data Bank, State of TN Department of Financial and Professional Regulations within 30 calendar days.

9.22 Appeal Rights

The Provider has the right to appeal FBHP's decision to suspend, revoke or terminate the Provider from the FBHP network. The appeal rights and process allow the Provider to:

- Submit a written request to the Chief Medical Officer for a hearing within 30 calendar days after notification of the adverse decision;
- Be represented by an attorney or another representative of their choice;
- Receive notice of scheduled hearing's location, date, time, composition of the hearing panel, and a list of witnesses or consultants, if expected; and
- Receive written notification of the appeal decision which will contain the specific reason for the decision

If a Provider does not request a hearing, FBHP will finalize the termination or suspension procedures by notifying the applicable FBHP departments and appropriate authorities. In accordance with this policy, a Provider is entitled to only one hearing if all criteria are met.

9.23 Fair Hearing Process

The Fair Hearing process is a structured range of actions that may be taken against a provider with a mechanism to notify providers of their rights. Included are actions for Fair Hearing process, appeals rights and notice to authorities. Provider notification for determinations for

disciplinary actions, terminations, or suspension, denial into the network, reporting to authorities or other decisions are part of the structured range of actions.

FBHP is electing to utilize the services of a NCQA certified Credentialing Verification Organization (CVO) to provide verification and/or ongoing monitoring of credentialing and recredentialing elements.

- To ensure FBHP complies with state and federal rules and regulations governing Medicare Advantage for provider credentialing and recredentialing process.
- To ensure FBHP complies with state and federal rules and regulations governing Medicare Advantage Fair Hearing and appeals process.
- To establish a Credentialing Committee to maintain continual oversight of decisions made for credentialing, recredentialing and any issues related to the provider's qualifications, competency, or adverse actions.
- To establish and maintain a system for set standards for provider network criteria that meets CMS and NCQA compliance.
- To establish and maintain a system for provider notification of actions against the provider and advise provider of their rights to Fair Hearing and appeals.
- To protect MA members with qualified and competent providers.
- To develop a process in collaboration with CVO vendor for credentialing and recredentialing activities.
- To document and report all network activities regarding credentialing, recredentialing, Fair Hearing and appeals.

9.23.1 Hearing Committee

The Chairman of the Credentialing Committee shall appoint a Hearing Committee of at least three FBHP Providers who will have the requisite expertise to ensure an efficacious and fair hearing. This Hearing Committee may include Members of the Credentialing Committee. The Hearing Committee Members shall be impartial, shall not have actively participated in the formal consideration of the matter at a previous level, and shall not be in direct economic competition or in the position of financial gain. An external peer review organization may be used should a conflict of interest be identified negating the effectiveness and the unbiased act of decision-making.

9.23.2 Hearing Officer

The FBHP Chief Medical Officer will be responsible for appointing a Hearing Officer who will be the Presiding Officer during the hearing. The Hearing Officer may be an attorney at law with experience in the professional peer review proceedings. The Officer appointed shall not be biased for or against the Provider. The Officer may participate in the deliberation and act as a legal advisor but shall not be entitled to vote. The Officer shall have the responsibilities to:

- Ensure all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence;
- Ensure proper decorum is maintained and that evidence is presented in an efficient and expeditious manner;

- Determines the order of the procedure for presenting evidence argument during the hearing;
- To rule on discovery requests, requests for continuances, questions, and/or disputes;
- To exercise discretion over the hearing process to ensure it is consistent with legal proceedings;
- To ensure the proceedings and documents submitted are recorded in the minutes of Hearing Committee meeting; and
- To ensure compliance with these policies and procedures

9.23.3 Decision

The decision of the Hearing Committee shall be based on the evidence produced at the hearing and any written statements submitted to the Hearing Committee. A quorum of 50% of the Hearing Committee must be present to render a final decision. The Hearing Committee will forward the rendered decision that contains the specific reasons for the decision to the Credentialing and Professional Review Committee who will be responsible for notifying the Provider of the final decision.

9.23.4 FBHP Rights

FBHP reserves the right to attorney representation and the right to consult with an external or internal peer review counsel.

Chapter 10 – Provider Network Management

10.1 Overview

This section includes an overview of general Provider information that CMS requires for participating Providers to assist them in the understanding and compliance with written rules of participation, notice of resources and contacts, material procedures and Provider's responsibility in participation.

CMS has defined adequacy for Medicare Advantage plans (Medicare Part C) for each county a Part C plan applies for. The adequacy requirements include:

- A list of 29 provider specialties that must be covered in each county the plan had applied for,
- A list of 13 facility requirements that must be covered in each county the plan has applied for,
- These provider and facility services must be maintained on and ongoing basis to assure the plan members have continuous access to these services,
- Each county is assigned a county designation (CEAC, Rural, Micro, Metro and Large Metro) which determines the volume of provider and facility services in each county based on the county population,
- County designations are assigned and also determined by a time and distance factor per designation classification. Large Metro designation identifies highly populated areas and CEAC constitutes the least populated or underserves areas.
- The Plan utilizes the services of Quest Analytics to test and measure the adequacy requirements CMS has identified require.
- Quest Analytics tests each of the Plan's counties on a quarterly basis to ensure the Plan maintains the adequacy CMS requires for the Plan's members.

10.2 Provider Obligations

Providers will render Covered Services to Members pursuant to the terms of the Agreement which are within the scope of his, hers, or their license, certification, and expertise. These services will be rendered only at those locations listed in the exhibit within the Provider Agreement and with the roster of Providers included in the agreement. Provider shall notify FBHP with any changes to the exhibit within the agreement with at least 30 days written notice or days stated in agreement. Additional information is within the body of the Provider Agreement and FBHP Credentialing Plan.

10.2.1 Accessibility

Provider agrees to provide Covered Services to Members during normal business hours maintained by Provider. The Provider shall maintain an answering service that provides direct communication with a person able to assist Member in obtaining necessary medical care. In the event that the Provider is unable to provide Covered Services to a Member, the Provider shall arrange for a Participating Provider to provide services to the Member on the Provider's behalf.

10.2.2 Member Verification

Prior to providing Covered Services to Members, the Provider shall verify the Member's eligibility with FBHP. The Providers' can contact FBHP by:

- Phone: **(833) 999-0135**
- Portal: https://fbhealthplans.com/mapd-provider/

10.2.3 Closed Panel

Providers may only cease to accept new Members in the event that (i) Provider has ceased to accept any new patients due to Provider's capacity to provide care, and (ii) Provider has given at least 30 days' prior written notice to FBHP of its intent to do so.

10.2.4 Referrals

In the event that any Provider is not a primary care Provider, Provider shall, except in the case of Emergency Services, provide Covered Services to Members only upon the referral of such patient by a primary care Provider if a referral is required under such Member's Benefit plan for such Covered Services.

10.2.5 Participating Providers

All Providers agree to refer and/or admit or arrange for the admission of Members only to Participating Providers unless the referral or admission to a non-Participating Provider is either (i) approved by FBHP prior to the referral or admission, (ii) necessary, in Provider's reasonable professional judgment, or (iii) specifically requested by the Member.

10.2.6 Non-Covered Services

All Providers agree that when a non-Covered Service is provided to a Member, Provider will inform the Member in advance that he or she will be financially responsible for the cost of the non-Covered Service and obtain the Member's consent to such service. Provider shall document in the Member's medical record that Provider has informed the Member that he or she will be responsible for the cost of the non-Covered Service. If this information is not documented when a non-Covered Service is rendered and the Member alleges that he or she was not informed of his or her financial liability, the Provider may be held responsible for the cost of such services.

For services not covered by the Plan, an Advanced Notice of Non-Coverage (ABN) must be given to the Member to identify the absence of coverage and the Member's financial responsibility for the service(s).

10.2.7 Provider Coverage

All Providers shall arrange for coverage in their absence during substantially the same times which Provider typically offers services. Such coverage must be provided by another Participating Provider.

10.2.8 Language and Cultural Proficiency

All Providers shall provide information to Members regarding treatment options. Included in these options are;

- Consideration to those Members with limited English proficiency or reading skills
- Diverse cultural and ethnic backgrounds, physical or mental disabilities
- Effective communication to assist Member in making decisions regarding treatment options
- Educate Members regarding health needs
- Share findings of examinations
- Side effects of treatment, medications
- Management of symptoms

10.2.9 Non-Discrimination

All Providers shall not, deny, limit or condition coverage for the furnishing of health care services/benefits to all Members based on health factors, such as medical condition, claims experience, receipt of health care, medical history, genetic information, race, color, ethnicity, national origin, religion, sex, age, sexual orientation, gender identity or presentation, evidence of insurability, or disability.

10.2.10 No Charge/No Recovery for Covered Services

With the exception of Cost Share, a Provider shall not bill a Member directly for Covered Services rendered by Providers where the Providers did not submit the claim within the time limit period or for Covered Services. Provider also agrees to look solely to FBHP for payment for Covered Services furnished to Members unless otherwise specified with body of the Provider Agreement.

10.3 Joining the FBHP Network

FBHP welcomes community Providers that wish to join the network to care for valued Members. Providers have options in requesting to participate in the FBHP network. The application process and the credentialing process are two separate procedures. The application process can start by:

- Contacting Provider Network at
    - Email – ProviderNetwork@fbhp.com
    - Phone – (931) 560-0041, ext. 6450, or toll free (866) 477-0722, ext. 6450
- The Plan will contact you to discuss the plan and the steps to b contract with the Plan and become an in-network provider
- Supply the Plan with Provider's Council for Affordable Quality Healthcare (CAQH) identification number
- Emailing or phoning the Provider Network contacts will connect providers to resources to begin the contracting and credentialing process to participate in the Farm Bureau Advantage network.

- For Facilities and for Provider's that do not have a CAQH number, completing a credentialing application found at:
    - https://fbhealthplans-dev.azurewebsites.net/mapd-provider/
- Allow up to 60 days to complete the contract and credentialing processes

10.4 Contracting and Credentialing

10.4.1 Provider Contracting

The FBHP Team for Provider contracting is responsible for developing and negotiating financially sound Provider agreements with all types of Providers to ensure comprehensive coverage for health care services for FBHP Members. Provider agreements are consistent with state and federal rules and regulations for required language.

10.4.2 Provider Credentialing

As stated in the Provider Agreement, the Provider agrees to cooperate, comply with, and assist FBHP in its credentialing and recredentialing processes of medical staff in fulfillment of FBHP's obligations for all National Committee for Quality Assurance (NCQA) standards. The Provider agrees that neither he, she, or it, nor any Group Provider, is eligible to render Covered Services to Members under the Agreement until Provider and/or Group Provider has been credentialed by FBHP or its designee.

All credentialing criteria, policies and procedures are defined in the FBHP Credentialing Plan. The provider can access the Provider Manual at:

- The Medicare Advantage Provider Resources portal,
    - https://fbhealthplans.com/mapd-provider/

10.5 Provider Portal

The provider portal can be found at (https://fbhealthplans.com/portal-access/). Provider resources for the Farm Bureau Advantage plan can be found at (https://fbhealthplans.com/mapd-provider/).

Providers are required to register for portal access. Providers will need their tax identification number and NPI number to register. The registration confirmation is based on verification of the tax ID and NPI numbers. This verification process can take up to seven (7) days before access is granted to the provider(s).

You will be able to do the following in the Provider Portal:

- View and download forms,
- Request to update your information,
- View patient benefits & eligibility,
- View claims and payment information,
- Submit a claims reconsideration request if necessary,
- View a member's medical & prescription history,
- View formulary options,

- Search a Provider Directory,
- Access FAQs and Provider Services when needed.

10.6 Provider Education and Training

This section applies to FBHP Medicare Advantage Program.

Provider education and training is implemented by FBHP Team for all Provider types. FBHP will establish goals, objectives, curricula, and implementation guidelines for Provider education and training programs consistent with any state or federal guidelines.

The FBHP Team provides specialized training options for the Provider network with the goal of improving the delivery of services to Members. By providing a variety of forums for Provider training, the team will assist the Provider network in becoming informed on federal and state regulations, rules, required courses, topics of interest, and references available. The trainings will also establish an understanding of FBHP Member needs to impact clinical measures, Member interactions and administrative management navigation. The interdisciplinary teams within FBHP will work in collaboration to develop curriculum with oversight, guidance and approval of the Chief Medical Officer and/or Chief Medical Officer, compliance officer, or other influencers to ensure consistent information.

10.7 Education and Training Materials

All contracted Providers will receive on-going comprehensive education and training as stipulated in the Provider Manual, Provider Agreement, and required by applicable regulatory bodies. FBHP also requires its contracted network to meet the training requirements of the National Committee for Quality Assurance (NCQA).

10.7.1 Orientation Sessions and On-Site Visits

Provider orientation sessions will be conducted by FBHP to provide an in-service training on the Provider Manual and to conduct additional training, as needed, for newly contracted Providers and programs are attempted to be scheduled within three (3) business days of the contract being countersigned and sent back to the provider. Annual training sessions for newly contracted providers are being attempted to be scheduled within three (3) days of the notification of the fully executed contract being sent back to the provider when possible.

The training may include, but is not limited to:

- Authorization, claims and Member eligibility verification processes for hospitals, skilled nursing facilities and ancillary Providers
- Balance Billing
- Cultural Sensitivity
- Customer Service
- Case Management
- Disenrollment Process
- Medical Management Delegation & Payment Responsibility
- Prior Authorizations

On-site visits may also consist of in-service educational opportunities or informational notifications. These visits will focus on policy updates and program updates as required by the Centers for Medicare and Medicaid Services (CMS).

Additional on-going education programs may be conducted in venues such as:

- Joint Operating Committees
- Lunch and Learns
- Provider Councils
- Town Halls
- Webinars

The provider portal (https://fbhealthplans.com/mapd-provider) has a Medicare Advantage Provider Resources page that has training information that includes:

Provider Manual
Quick Reference Guide
Prior Authorization Procedure Codes List
Medicare Manual
Quick Tips for the Provider Portals
Provider Training
Inflation Reduction Act Provider Letter
Fraud, Waste and Abuse information
FAQ's
Professional and Facility Roster Templates

For more information about joining our Medicare Advantage network please contact us at ProviderNetwork@fbhp.com or call (833) 999-0135, option 2.

10.7.2 Provider Notifications (Bulletins and Newsletters)

FBHP will publish and distribute Provider notifications bulletins and/or newsletters at least semi-annually. The notices will provide relevant and timely information concerning applicable standards, services available to Members, quality improvement activities, updates, and other pertinent issues related to the delivery of health services to Members.

10.8 Provider Manual

The FBHP Provider Manual provides important information and resources for our network Providers as well as assists in navigating our health plan procedures. The content addresses policies, procedures, state and federal regulatory requirements. Also included in this manual are phone numbers, websites, and links for additional references. Educating a new Provider on how to locate the Provider manual on the Provider Portal/ website will meet the Provider Manual distribution regulatory requirement. The Provider Manual can be found on the FBHP website at (http://fbhealthplans.com/mapd-provider) this will direct providers to the Medicare Advantage Provider Resources page where the Provider Manual can be found.

10.9 Provider Directories

FBHP produces a Provider Directory for the Medicare Advantage (MA) product line. The directory is a listing of all the contracted PCPs, specialists, ancillary, hospitals, and other care Providers that serve our Members. Upon request, a directory will be sent to the requesting Provider. The Provider's contact information is updated on the FBHP website in real time for Members to access. On-line directories are available at (https://fbhp.healthtrioconnect.com/public-app/consumer/provdir/entry.page).

10.9.1 Provider Data Integrity and Maintenance

Ensuring that Provider's practice data is accurate will help Members find network Providers and can help increase visibility for Provider's practice. Providers can update their information:

- By emailing roster information to ProviderNetwork@fbhp.com.
- By going to the Medicare Advantage Provider Resources page on the FBHP website and downloading the appropriate (facility or provider) roster template and emailing it to ProviderNetwork@fbhp.com.
- Utilizing their area Provider Engagement staff to assist the provider to submit changes to the plan.
- Mailing the provider's changes to:
  Farm Bureau Advantage
  P. O. Box 303
  Columbia, TN 38402
- By calling the plan at (833) 999-0135, option 2.

All health care professionals who are contracted with FBHP must attest to the accuracy of their demographic information at least quarterly to meet contract requirements and regulatory guidelines. The plan utilizes the services of Quest Analytics and their Better Doctor services and internal functions to have providers attest to the accuracy of information provided to the plan.

Federal and state guidelines require that we work with health care professionals to ensure practice data and demographic information is up to date.

Provider directories are updated after confirmation of:

- A contracting Provider is no longer accepting new Members or an individual Provider within a Provider group is no longer accepting new Members
- A Provider is no longer under contract
- A Provider's practice location or other information has changed
- A Provider group had added a Provider
- A Provider has retired or ceased to practice
- Any information that affects the content or accuracy of the Provider Directory

Providers should promptly notify FBHP with any changes to the above information to keep an accurate and updated Provider Directory in compliance with applicable laws and regulations.

Additional information that should be updated includes:

- Office addresses and hours,
- Phone, fax email address and websites,
- Provider accepting patients/panel status,
- Telehealth services,
- Hospital and group affiliations,
- Ages and genders serviced,
- Languages spoken,
- Specialties,
- Areas of Expertise,
- Provider date of birth,
- Additional Providers/deletion/TIN's,
- National Provider Identifier (NPI) number,
- Professional licenses and degrees.

In addition to the updates described above, FBHP will annually audit the Provider Directory for accuracy.

Members, potential Members, Providers, and others may identify and report possible inaccurate, incomplete, or misleading information currently listed in FBHP's Provider Directory by contacting the plan by email at ProviderNetwork@fbhp.com or by calling the plan at (833) 999-0135, option 2.

10.10 Providers with Medical Practitioners

The use of non-physician practitioners/Providers is designed to increase Members' access to appropriate primary care and specialty medical services, maximize the patient's health and well-being, and promote cost-effective care. PCPs, general medicine, family practice, internal medicine, obstetrics and gynecology and other specialties are allowed to use medical practitioners to support these efforts.

The delegation of specified medical procedures to non-physician practitioner/Providers does not relieve the supervising physician of ultimate responsibility for the welfare of the Member or the actions of the non-physician practitioner/Provider. Tennessee Physicians may supervise up to seven (7) Nurse Practitioners. Supervision must be in person monthly for the first three (3) years and four (4) times a year in person thereafter with continued monthly meetings via telecommunications.

A Scope of Practice Agreement that is signed by the non-physician practitioner/Provider and the supervising physician, as well as standardized procedures, must be filed and maintained at the medical practice site. The Scope of Practice Agreement must address the following elements:

- Chart review requirements
- Delegated responsibilities

- Disciplinary policies
- Method and frequency of physician supervision
- Monitoring and evaluation of the non-physician practitioner/Provider
- Term of the agreement/contract

10.11 Provider Disputes and Appeals

Provider clinical grievances will be handled through a centralized process for contracted providers. The providers must notify the Plan in writing of their dispute or appeal. Information included in the written notification should be documentation to identify why the dispute or appeal and supporting the provider's reasoning for the dispute or appeal.

- Provider disputes will be Level 1 appeals only,
- Must be filed within 60 calendar days from the date of the notice of the initial determination,
- Request should include: Name of the enrollee, information identifying which denial is being appealed, and contact information for the appellant. Unless the request is from a representative, for which proof of appointment is required, the plan cannot require additional information in a request (e.g., appellant signature),
- The dispute/appeal will be logged with the plan,
- The dispute/appeal will include documentation and/or supporting evidence for the dispute/appeal,
- Disputes/appeals requiring medical necessity review musty include the provider's supporting documentation to support their request to substantiate medical necessity,
- Providers should only submit individual disputes. Multiple disputes in a single submission will not be accepted by the Plan.

10.11.1 Communication of Formal Provider Disputes and Appeals

Providers must communicate their formal grievances directly to the plan and may be over the telephone, in person, on-line or in writing. If the Provider wishes to file a formal grievance, a FBHP Representative can provide the Provider detailed instructions for filing a grievance. The FBHP Representative can also assist Providers in filing grievances, including assistance with completing a grievance form, if applicable. The grievance will be recorded on the Provider grievance log. An acknowledgment letter will be sent to the Provider within thirty (30) business days.

Contact information:

- Email: ProviderNetwork@fbhp.com
- In Writing Address: Farm Bureau Advantage, P. O. Box 303, Columbia, TN 37402
- Telephone: (800) 608-2667

10.11.2 Resolution of Formal Provider Disputes and Appeals

All disputes/appeals will be resolved within thirty (30) calendar days. The Plan may take a fourteen (14) day extension to examine documentation to make a determination for the dispute/appeal. Written notice of the resolution/disposition will be delivered via certified mail.

10.11.3 Communication of Formal Provider Disputes/Appeals

The communication process includes:

- The Provider notifies the Plan in writing of a dispute/appeal,
- Provider must notify the Plan within 60 calendar days of the initial notification determination,
- The Provider shall include the reason for the dispute/appeal, including supporting documentation to substantiate the Provider's request,
- Once the Plan has had time to review the information regarding the dispute/appeal, a determination by the plan will be made,
- The Plan shall have thirty (30) days to review the information and make a dispute/appeal determination,
- The Provider will be notified in writing of the dispute/appeal determination.

10.12 Provider Engagement

The FBHP Provider Engagement and Contracting Team is responsible for the relationship between FBHP and the network of Providers.

Some of their responsibilities include the following:

- Assist in Provider grievance resolution
- Conducting comprehensive Provider related studies
- Conducting Joint Operations Meetings to build a stronger relationship between FBHP and large Provider groups/hospitals: improving Member care
- Coordinating closely with Provider Contracting, Member Services, Claims, Utilization Management, Prior Authorization, and other departments when necessary to resolve issues
- Delivering reports, metrics or value based contracting documents to Providers that combine information technology, Provider network information and statistical studies
- Oversight for the management, accessibility, and usability of Provider information
- Production of the Provider Directories
- Serving as key contacts for PCP's, hospitals, specialists, clinics, ancillary Providers, skilled nursing facilities, ambulatory surgery centers and other Providers to resolve operational service issues
- Training the network of Providers to inform them on FBHP procedures, protocols, navigation of website/portal so to ensure compliance or resource distribution

10.13 Provider Term and Termination

In the event a Provider wishes to terminate his/her participation in FBHP Medicare Advantage Plan, or FBHP wishes to terminate a Provider, the Provider Agreement serves as the governing rules for termination notification.

10.13.1 Term

The term of the Agreement will commence on the Effective Date and continue for a period of two years and will automatically renew on each anniversary of the Effective Date following the initial two-year term unless it is terminated or not renewed pursuant to Article 5 in the agreement. Either party may elect not to renew the agreement at the conclusion of the applicable term described, by giving the other party no less than 120 days' prior written notice of its intent not to renew. Some exceptions may be noted. The Provider Agreement will be the source of truth of any specific exceptions.

10.13.2 Termination for Cause by Plan

Immediate Termination: FBHP may terminate the Agreement, Provider participation under the Agreement, immediately upon the occurrence of the following:

- FBHP reasonably determines that Provider or Group Provider poses a threat of imminent harm to a Member;
- FBHP reasonably determines that Provider or Group Provider has committed fraud;
- Provider or Group Provider has been suspended or excluded from participation in the Medicare program or any other federal or state healthcare program
- Provider or Group Provider is subject to a final, non-appealable action by a state licensing board or other governmental authority, the result of which impairs Provider's or Group Provider's ability to provide Covered Services or; the initiation, pendency, or final disposition of any action taken by a hospital or other health care facility, review organization, professional society, or governmental body to restrict, limit, suspend or revoke Provider's or Group Provider's hospital or other facility staff privileges.

10.13.3 Termination upon Notice

FBHP may terminate the Agreement, no sooner than 30 days following notice to Provider of the following, in the event that Provider has not cured the applicable breach within such notice period:

- Provider's insolvency; the appointment of a trustee or receiver for any substantial part of the assets of Provider; an assignment by Provider for the benefit of creditors; or the commencement of any proceedings under bankruptcy or insolvency law by or against Provider; or
- Provider's or Group Provider's material breach of any of the terms of the Agreement

10.13.4 Termination for Cause by Provider

Provider may terminate the Agreement upon 120 days' prior written notice to FBHP in the event that FBHP has materially breached the terms of the Agreement and has not substantially cured the alleged breach during such notice period.

10.13.5 Termination upon Mutual Agreement

This Agreement may be terminated upon the mutual written agreement of the parties.

10.13.6 Effect of Termination of Agreement

Upon termination of the Agreement for any reason:

- **Transitional Care:** Except as otherwise required by applicable law, upon the effective termination of Agreement all rights and obligations of the parties under the Agreement shall immediately cease. Provider shall remain responsible for providing Covered Services under the terms of the Agreement to Members who are under the care of Provider or a Group Provider at the time of such termination for a period of up to 90 days from the date of termination or for such other period required by applicable law. FBHP will provide compensation for those Covered Services rendered prior to the termination date and during the foregoing transitional care period pursuant to the terms of the Agreement.
- **Notice to Members:** Following notice of termination or non-renewal of the Agreement by either party, FBHP is authorized to notify Members and prospective Members and Participating Providers, and other persons and entities that it deems to have an interest herein of such termination, of such termination.

10.14 Excluded and Precluded Providers

FBHP monitors appropriate sanction resource lists to identify Providers for whom claims should be denied for its Medicare businesses. The OIG website will be reviewed on a monthly basis to identify sanctioned Providers both to prevent payment for medical claims to ineligible Providers, and to support correct claim determination complying with Medicare regulations. Additionally, FBHP or designated vendor monitors the CMS website on a monthly basis to identify precluded Providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

10.15 Records and Access

All Providers will comply with FBHP Provider Agreement, federal rules and regulations and/or state requirements that support the applicable standards for maintaining and sharing Member medical records.

10.15.1 Maintenance of Member Medical Records

Providers will be required to prepare and maintain clear, accurate, and complete medical records in accordance with applicable laws, regulations, professional standards, the CMS Contract, and national accreditation organizations. Providers are required to maintain Member medical records for a period of not less than 10 years after the date of termination of the

Agreement or 10 years from the date of the last audit performed under the Agreement, whichever is later, unless another period is required by applicable law or the CMS Contract.

10.15.2 Government Access to Records

Upon reasonable prior notice and to the extent permitted by applicable state and federal law, Department of Health and Human Services (HHS), the Comptroller General, Government Sponsors, and other applicable regulatory agencies or any designees of the above entities shall have the right to inspect, evaluate and audit any contracts, books, documents, papers and records, both service related and financial or otherwise related to Members and the provision of and payment for services under the Agreement. Such access shall be granted for no shorter period than the time frame required by law. Provider shall make its premises and its records available during regular business hours and upon reasonable prior notice for purposes of conducting audits.

10.15.3 Access to Records

FBHP or their designee(s) shall have the right, upon no less than 30 days' prior written notice, to inspect, evaluate and audit any contracts, books, documents, papers and records, both service related and financial or otherwise related to Members and the provision of and payment for services under the Agreement. Such access shall be granted for no shorter period than the time frame required by law. FBHP shall provide Provider a report summarizing the findings of any such audit. Upon request by FBHP, the Provider shall provide FBHP with copies of records for audit purposes within 14 days such request is provided to Provider at no cost to FBHP. Records may be electronically remotely access upon prior written consent of the Provider. FBHP reserves the right to extrapolate any findings from such an audit from a statistically valid sample of records to all relevant records submitted by the Provider.

10.15.4 Medical Record Criteria

The medical record will be evaluated for the following criteria:

- Pages in the record contain the patient's name or ID number
- Allergies or lack of allergies, and adverse reactions are noted and displayed in a consistent location and easily identified
- All notation or entries, dictation into the medical record are legible, signed, and dated (telemedicine and patient phone calls should also be captured)
- Any illnesses, conditions or history events are documented
- A medication list is included and updated as needed
- History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings
- Laboratory tests, x-rays or other testing is documented when ordered
- Results of all testing is noted in the medical record
- Follow-up recommendations and/or noncompliance to care plan is captured
- Documentation of discussions of advance directive/Living Will/Power of Attorney will be part of the medical record for adult patients who are MA Members;

- Copies of the above documents are in the record
- PCP, Specialists or other collaborative professional will be referenced,
- Conversation about risk assessment, screenings or preventative services is documented

10.16 HIPAA/HITECH and State Confidentiality Law Compliance

FBHP and Providers agree to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and the implementing regulations under HIPAA and HITECH, as modified from time to time. This also includes compliance with applicable state laws relating to confidentiality of records. Further, FBHP and Providers agree to abide by all applicable state and federal privacy and security requirements, including the confidentiality and security provisions.

10.17 Confidentiality between FBHP and Providers

All records, reports, trade secrets, proprietary processes, data, data formats, and financial information, including but not limited to rates of compensation, and other documents or information pertaining to the Provider and/or FBHP, whether such information is written, transferred orally, visually, electronically or by other means, as well as all copies, abstracts, summaries, or analyses of such information, which are provided, made available, or otherwise disclosed are confidential and proprietary and may not be disclosed to any person or entity for any reason at any time during or subsequent to the term of the Agreement, except for the parties' attorneys, accountants, or other authorized representatives, and except as required by law.

Additional information can be found in Article 6 of the Provider Agreement.

10.18 Dispute Resolution

FBHP and Provider agree to meet and confer in good faith to resolve any controversies that may arise under the Agreement prior to commencing arbitration (see Section 7.3) in the agreement. In the event that a dispute arises, the aggrieved party shall send notice to the other party of such dispute. Within 30 days of such notice, the parties shall meet and engage in good faith negotiations between executive-level officers of the parties for no less than 30 days from the date of the first meeting.

10.18.1 Arbitration

If the parties are unable to resolve any dispute informally within 30 days of the initial meeting, either party may submit the matter to final and binding arbitration performed pursuant to the rules of the American Arbitration Association for Payor-Provider Disputes. For any dispute that has a total claim value of $300,000 or less, the parties agree that such arbitration will be before a single arbitrator acceptable to both parties and that neither party will be entitled to discovery. For any dispute that has a total claim value that exceeds $300,000, the parties agree that such arbitration shall be before a panel of three arbitrators. The Arbitration will take place in Maury County, Tennessee unless otherwise agreed upon. The parties agree that the arbitrator(s) will not be permitted to consolidate cases or to certify any class for purposes of a class action nor

shall the arbitrator be permitted to award punitive or exemplary damages. The cost of any arbitration will be borne equally by the parties and the parties will each bear their respective attorneys' and related fees. This provision will survive the termination of the Agreement regardless of its cause.

Chapter 11 – Claims, Encounters, and Payment

11.1 Overview

Farm Bureau Health Plans (FBHP) has a process for submitting claims for services. This section specifies guidelines for reimbursement for services rendered, claims processing, and other claims-related areas for contracted Providers.

11.2 Provider Responsibility

FBHP has entered into agreements with contracted Providers to divide the financial responsibility of adjudicating claims. Within the terms of the Participating Provider's Agreement, FBHP requires all Providers to make the best effort to submit all claims and/or Member encounters electronically.

Electronic Data Interchange (EDI) is the preferred method of claim submission for participating physicians and health care Providers.

EDI is the electronic interchange of business information using a standardized format; a process which allows one company to send information to another company electronically rather than with paper. Many business documents can be exchanged using EDI but one of the most common are claims between Providers and a health plan due to the ability of the standardize format of information.

EDI improves accuracy by eliminating the need for copying information from one document/system to another and reduces cost of overhead by reducing staff for manual operations. Information is received in "real time" thereby improving customer service with responses of questions and concerns more effectively.

For information on EDI claim submission methods please contact:

- Change Healthcare, (the Plan's clearinghouse), , https://www.changehealthcare.com/
- Register for access to the Plan on Change Healthcare's website,
- Provider will need their basic demographics,
- Provider will need Farm Bureau Advantage's
    - Payor Identification, **62045**
    - EID number, **RP061** (R, P, zero, 6, 1)
- Providers can:
    - Submit claims,
    - Check claim status,
    - Receive remittance advices,
    - Set up Electronic Funds Transfer (EFT).

Paper claims should be mailed to:

Farm Bureau Health Plans
PO Box 981602
El Paso, TX 79998-1602

11.2.1 Farm Bureau Portal

Provider should also register for the FBHP portal (Health Connect). The provider can go to https://fbhp.healthtrioconnect.com/app/index.page? to find the registration page. The Provider will need the following information in order to complete their registration.

On this screen, the user may enter the following information:

- First Name – the office manager's name
- Middle Initial – the office manager's middle initial
- Last Name – the office manager's last name
- Title – the office manager's title
- E-Mail – the office manager's email address
- Confirm E-Mail – re-enter the office manager's email address
- Office Phone – the office phone number
- Extension # – the office phone's extension number, if applicable
- Office Fax – the office fax number
- User Name – choose a username for login
- Password – choose a password for login
- Confirm Password – re-enter the password for login
- Security Question 1 – select a security question from the dropdown menu
- Security Answer 1 – enter an answer to the security question selected
- Security Question 2 – select a security question from the dropdown menu
- Security Answer 2 – enter an answer to the security question selected
- Security Question 3 – select a security question from the dropdown menu
- Security Answer 3 – enter an answer to the security question selected

On the Office Information screen, the user enters the following information:

- Organization Name – enter the organization's name
- Tax ID – enter the organization's tax ID number
- Address – enter the organization's address
- City – enter the organization's city
- State – enter the organization's state
- Zip Code – enter the organization's zip code

For assistance Providers can call (877) 814-9909.

11.3 Balance Billing

Federal law prohibits balance billing of beneficiaries in MA Plans.

Balance billing is the practice of billing a Member for the difference between what is reimbursed for a covered service and what a Provider feels should have been paid. It includes asking a beneficiary to enter into a private payment agreement or waive their balance billing protection and charging deductibles, coinsurance, co-pays or other administrative fees.

11.4 Claims Submission

Providers submit to FBHP Clean Claims for all Covered Services rendered by Provider to Members. Clean Claims will be submitted within 180 days of the applicable date of service. Claims submitted that are not Clean Claims, may be denied or partially paid by FBHP. If the claim is denied, the Provider will have the opportunity to rectify any errors and resubmit claim as a Clean Claim within 60 days of such notice. FBHP will pay Clean Claim as though it was timely submitted if resubmitted in such time period. FBHP will pay all Clean Claims for Covered Services submitted by Provider within 60 days of receipt and/or within required timeframes by applicable law, rule, or regulation, or the CMS Contract.

11.4.1 Timely Filing Deadline

The timely filing of a claim to FBHP will be within 365 days of the date of service. Contracted Providers please refer to your contract with FBHP for timely filing criteria.

11.4.2 Billing and Electronic Data Interchange Submissions

Providers must bill with the most current coding available.

11.4.3 Clearing House

Clearinghouses are electronic stations or hubs that allow electronic transmission between Providers and health plans in a secure environment.

The Plan utilizes the services of Change Healthcare (https://www.changehealthcare.com/).

See section 11.2 for additional information regarding registering and the services offered through Change Healthcare.

11.4.4 Clean Claim Submission

A clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements of encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

- Member’s name, address, gender, date of birth, relationship to subscriber (policy owner).
- Subscriber’s name
- Provider’s name, signature or representative’s signature, address where service was rendered,
- Provider “Remit to” address, phone number, NPI, taxonomy and federal TIN.
- Referring Provider’s name and NPI, as well as TIN (if applicable).
- Laboratory, DME, imaging and home health claims must include the referring care Provider’s name and NPI number
- Service information, including date of service(s), place of service(s), number of services (day/units) rendered,
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, with modifiers where appropriate,

- Current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. performed,
- Charge per service and total charges.
- Information about other insurance coverage.
- Information regarding job-related, auto or accident information, if available.

11.4.5 Incomplete Claims

Claims submitted with incomplete or invalid information may be returned to the submitter as an unclean claim. Examples include the following:

- **Unclean Claims:** Unclean claims include those with incomplete or missing required information.
- **Incomplete Information:** These claims include those with missing required or conditional information.
- **Invalid Information:** These claims include those with required or conditional information on a claim that is illogical, or incorrect.

Payment may also be denied for services provided that are determined by FBHP to be medically unnecessary. Provider may not bill a Member for medically unnecessary services with exception of written agreement for payment of those charges.

11.4.6 Paper Claims Submission

Paper claims should be submitted to:

Farm Bureau Health Plans
P. O. Box 981602
El Paso, TX 79998-1602

11.4.7 Claims Status Inquiries

Providers should register for claims status inquiries with Change Healthcare at:

http://changehealthcare.com
Phone: (866) 506-2830

You will need to supply your information and register for Farm Bureau Health Plans Medicare Advantage Plan with:

ID Number: **RP061 (R, P, zero, 6, 1)**
Payer Identification Number: **62045**

11.5 Electronic Funds Transfer

Providers should register for electronic funds transfers with Change Healthcare at:

http://changehealthcare.com
Phone: (866) 506-2830

11.6 Claims Adjudication

FBHP uses industry claims adjudication and/or clinical practices, state and federal guidelines, and/or our policies, procedures to adjudicate claims. We review data to determine appropriate

criteria for payment of claims. Every claim is subject to a comprehensive series of quality checks of edits and reviews. These quality checks verify and validate all claim information to determine if the claim should be paid, denied, or suspended for manual review. Edit checks may include:

- Data validity
- Procedure and diagnosis compatibility
- Provider eligibility on the date of service
- Recipient eligibility on the date of service
- Claim duplication
- Authorization requirements

The above is not an all-inclusive list.

11.6.1 Level-of-care Documentation and Claims Payment

Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care. For clarity, Level of Care documentation also requires Prior Authorizations. Although not every claim requires a Prior Authorization, it is imperative the Provider verify if a Prior Authorization is required and obtain the Prior Authorization prior to services being provided.

To track the specific level of care and services provided to its Members, we require care Providers to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes) and appropriate bill type.

11.7 Member Financial Responsibility

Verify the eligibility of our Members before you see them and obtain information about their benefits, including required copayments and any deductibles, out-of-pockets maximums or coinsurance that are the Member's responsibility.

11.8 Overpayments/ Underpayments

For recoupment of overpayment and rectification of underpayment, FBHP will provide 30 days' prior written notice to Provider before engaging in recovery of the overpayment of claims. FBHP may also offset any such amount against future payments owed to Provider only if Provider fails to repay such amounts within the 30-day notice period. The payment of the remaining balance of any underpayment will be within 30 days of discovery or notification of underpayment by Provider.

11.9 Retroactive Disenrollment

If a Member is retroactively disenrolled, FBHP will notify Provider within 60 days of receiving notice of retroactive disenrollment of Member. If there are paid claims for dates of service occurring after the effective date of retroactive disenrollment, recoupment monies from services paid to the Provider will be collected. No monies will be collected for services rendered more than one year prior to the date of notice.

11.10 Provider and Member Claim Disputes, Appeals, and Grievances

FBHP makes available to all Providers a fast, fair, and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contracts, non-contracted issues to the Providers. The dispute resolution mechanism is handled under applicable law and the Provider's Agreement.

11.10.1 Disputes

A Provider has a right to file a dispute in writing to FBHP Care within 365 days from the date of service.

A Provider dispute is a written notice to FBHP challenging or appealing or requesting consideration of a claim such as the following:

- Payment of a claim
- Denial of a claim
- Adjusted
- Seeking resolution of a billing determination

If a Provider disagrees with FBHP's reimbursement or denial of a claim, a dispute can be filed for reconsideration. Details to file a dispute are covered in Section10.11 Disputes of the Provider Manual.

11.11 Reimbursement to Non-Contracted Providers

Farm Bureau Health Plans (FBHP) will ensure that non-contracted physicians and providers will be compensated for services rendered when certain conditions are met.

Consequently, when a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for an enrollee, or could be covered only under specific conditions, the appropriate process is for the enrollee or provider to request a pre-service organization determination from the Plan.

If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral, the enrollee is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

If a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the Plan is not required to hold the enrollee harmless from the full cost of the service or item.

General requirements for all non-contracted providers:

For all non-contracted and/or non-credentialed providers (credentialing pending), the following are required prior to paying a claim:

1. The services requested must be covered by the Plan. If a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the Plan is not required to hold the enrollee harmless from the full cost of the service or item (Example: custodial care).
2. The services must be medically necessary.
3. The provider must not be on the CMS Exclusions List.
4. Medicare eligibility requirements must be met.

Prior authorization requests for care delivered by a non-contracted provider:

1. When a prior authorization request is received for care from a non-contracted provider, the member will be directed to a contracted provider if one is available within the member's service area.

2. Prior authorization is expected for all requests that are referred to non-contracted providers. Exceptions to this rule are allowed for radiology, anesthesiology, pathology, laboratory, and emergency services provided in conjunction with in-network facility care.

3. Providers will be educated that prior authorization is expected for all referrals to non-contracted providers. Prior authorization can be requested by either the referring or servicing (non-contracted) provider.

4. The provider network team will be notified of requests from non-contracted providers. They will attempt to contract with eligible non-contracted providers.

5. If the provider is a contracted provider not yet listed in the directory, they will be treated as an in-network provider.

6. If network contract negotiations are in process (90-day term limit with optional 30-day extension) and/or a bridge agreement is in process, the request will be treated as an in-network service.

7. When the request meets medical necessity and a contracted provider qualified to provide appropriate care to the member is not available within the member's service area, the plan will arrange a single case agreement with the non-contracted provider.

Claims from Plan Directed, Non-Contracted Providers:

1. Plan directed care occurs when a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan. In such cases, when submitted documentation supports plan directed care, and the request meets the general requirements, the non-contracted provider will be paid as an in-network service.

2. Claims for plan-directed care received from non-contracted providers for ancillary services such as radiology, anesthesiology, pathology, laboratory, or emergency services will be treated as an in-network service.

3. In all cases, when a contracted provider refers to a non-contracted provider and there is a contracted provider available within the member's service area, the provider network team will reach out to educate the contracted provider on the rules governing referrals to non-contracted providers.

4. The provider network team will be notified of claims from non-contracted providers. They will attempt to contract with eligible non-contracted providers.

Claims from Non-Plan Directed, Non-Contracted Providers:

Claims payments to Non-Plan Directed, Non-Contracted Providers will be paid when the provider satisfies the general requirements for non-contracted providers, AND:

1. The claim is due to a medical emergency, OR
2. The provider is within the first 90 days of contract negotiations, OR
3. The provider has a bridge agreement, OR
4. A contracted provider qualified to provide appropriate care to the member is not available within the member's service area.

Chapter 12 – Compliance

12.1 Goals and Objectives

The goal of Farm Bureau Health Plans (FBHP) Compliance Program is to ensure that all business operations are conducted in a manner that is compliant with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules pertaining to all product lines.

12.1.2 Reporting Fraud Waste and Abuse

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at www.fighthealthcarefraud.com If you suspect cases of fraud, waste, or abuse, you must report it by contacting the FBHealthPlan.EthicsPoint Hotline. This is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. FBHealthPlan.EthicsPoint Hotline telephone and web-based reporting is available 24 hours a day, seven days a week, and 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call FBHealthPlan.EthicsPoint Hotline, a trained professional at NAVEX Global will note your concerns and provide them to the FBHP Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to FBHealthPlan.EthicsPoint Hotline can be made from anywhere within the United States with telephone or internet access.

Under the terms of the contract between FBHP and the Provider, the Provider is required to report suspected cases of FWA.

Examples of these types of suspected activities are:

- Changing, forging or altering a prescription
- Changing medical records
- Changing referral forms
- Letting someone else use their I.D. card to get medical services
- Misrepresentation of eligibility status • Identity theft
- Prescription drug diversion and inappropriate use
- Billing for services that were not done
- Double billing, upcoding, and unbundling
- Intentionally submitting false claims

To report FWA activities, Providers can contact:

Farm Bureau Health Plans

Compliance Hotline: (844) 208-2110

Mail: Farm Bureau Medicare Compliance Officer
P. O. Box 313
Columbia, TN 38402-0313

U.S. Office of the Inspector General
Hotline: (800) 447-8477, TTY: (800) 377-4950
Website: oig.hhs.gov/report-fraud/index.asp

Mail: U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

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

12.2 Authority and Responsibility

FBHP Compliance Program will ensure contracted Providers are following federal and state rules and regulations and in alignment with their contractual agreement with FBHP. The Compliance Program is to support the process that Members receive appropriate and quality health care services through the Provider network.

12.3 Audit and Oversight Activities

To ensure Members are receiving appropriate health care services, FBHP's Compliance Program will perform audit and oversight activities.

This may include, but are not limited to, the following activities:

- Monitoring and reporting of network compliance issues
- Provides oversight and ongoing monitoring of delegated responsibilities
- Assists in the implementation of corrective actions as needed concerning performance standards
- Includes Fraud, Waste, and Abuse investigation and resolve

12.4 Provider Compliance Responsibilities

Provider shall ensure all their related entities, contractors, subcontractors, and downstream entities involved in transactions related to FBHP product maintain and provide access to all pertinent contracts, books, documents, papers, and records (including records of education, training, and supporting documentation) necessary for compliance with state and federal requirements.

Provider shall conduct annual general and specialized compliance training for their employees.

Providers also agree to audits and inspections by CMS, and/or its designees, and to cooperate, assist, and provide information as requested as well as maintain records (including records of education, training, and supporting documentation) for a minimum of ten (10) years or longer, as may be required by law.

12.4.1 Policies and Procedures & Standards of Conduct

Providers will have written policies, procedures, and standards of conduct that outline the operation of the Provider's Compliance Program.

The following elements that should be included are:

- Provider's commitment to comply with federal and state standards
- Compliance expectations
- Guidance on dealing with compliance issues
    - Communication
    - Reporting
- Non-intimidation and non-retaliation policy for good faith reporting
- Provider expectations of ensuring their staff:
    - Conduct themselves in an ethical manner and that all issues of non-compliance and potential Fraud, Waste, and Abuse be reported through appropriate mechanisms and corrected
    - Trained in on policies, procedures, and standards of conduct within 90 days of hire, when there are updates, and annually

12.4.2 Training and Education

Providers shall establish, implement, and provide effective compliance training and education for their employees and downstream to related entities.

12.4.3 Site Visits

Provider shall comply with Site Visits performed at least annually by FBHP staff to meet the requirements established in the Medicare Managed Care Manual, chapter 4, section 60. Site Visits shall be performed on providers that are not delegated for credentialing or not accredited by a nationally accepted accreditation body. Other determining factors for a Site Visit or the frequency of the Site Visits are based on volume of the provider's FBHP member population, the overall size of the provider's panel, any deficiencies in meeting plan's requirements or the number of complaints and grievances submitted to the plan in a quarterly cycle.

Site Visits will evaluate the accessibility of the practice location, appearance of the practice location, that ir it clean, neat and uncluttered. Other evaluation points will also include meeting HIPAA requirements for FBHP members related to patient registration

in the practice office and recordkeeping. Safety issues will also be addressed regarding proper signage, emergency exit signage and safety equipment available in the practice location.

Site Visits can also be initiated on behalf of a member reporting a deficiency or issue to the plan.

12.4.3 Lines of Communication

Providers are responsible to establish and implement lines of communication for compliance related issues that are confidential and accessible.

12.4.4 Disciplinary Standards

Providers should have well-publicized disciplinary standards that encourage good faith participation in the compliance program.

12.4.5 Routine Auditing and Monitoring

An effective system for routine monitoring and identification of compliance risks should be established by Providers.

Ex: Work plan with dates of auditing activities, tracking mechanisms

12.4.6 Responding to Compliance Issues

Policies and procedures around promptly responding to compliance issues shall be established by the Provider.

12.5 Fraud, Waste and Abuse (FWA)

Under the terms of the contract between FBHP and the Provider, the Provider is required to report suspected cases of FWA.

Examples of these types of suspected activities are:

- Changing, forging or altering a prescription
- Changing medical records
- Changing referral forms
- Letting someone else use their I.D. card to get medical services
- Misrepresentation of eligibility status
- Identity theft
- Prescription drug diversion and inappropriate use
- Billing for services that were not done
- Double billing, upcoding, and unbundling
- Intentionally submitting false claims

To report FWA activities, Providers can contact:

Tom Tutaj
Medicare Compliance Officer
ttutaj@fbhp.com
(844) 223-3451

12.5.1 Reporting Fraud Waste and Abuse

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at www.fighthealthcarefraud.com

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the FBHealthPlan.EthicsPoint Hotline. This is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. FBHealthPlan.EthicsPoint Hotline telephone and web-based reporting is available 24 hours a day, seven days a week, and 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call FBHealthPlan.EthicsPoint Hotline, a trained professional at NAVEX Global will note your concerns and provide them to the FBHP Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to FBHealthPlan.EthicsPoint Hotline can be made from anywhere within the United States with telephone or internet access.

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• Misrepresentation of eligibility status
• Identity theft
• Prescription drug diversion and inappropriate use
• Billing for services that were not done
• Double billing, upcoding, and unbundling
• Intentionally submitting false claims

To report FWA activities, Providers can contact:

Farm Bureau Health Plans
Compliance Hotline: (844) 208-2110

Mail: **Farm Bureau Medicare Compliance Officer**
P. O. Box 313
Columbia, TN 38402-0313

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

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

12.5.2 Provider Compliance Responsibilities

Provider shall ensure all their related entities, contractors, subcontractors, and downstream entities involved in transactions related to FBHP product maintain and provide access to all pertinent contracts, books, documents, papers, and records (including records of education, training, and supporting documentation) necessary for compliance with state and federal requirements.

Provider shall conduct annual general and specialized compliance training for their employees.

Providers also agree to audits and inspections by CMS, and/or its designees, and to cooperate, assist, and provide information as requested as well as maintain records (including records of education, training, and supporting documentation) for a minimum of ten (10) years or longer, as may be required by law.

12.6 Health Insurance Portability and Accountability Act (HIPAA)

As covered entities, FBHP expects Providers to comply with applicable privacy and security requirements outlined by federal and state regulation and guidelines, including those set forth under the Health Insurance Portability and Accountability Act (HIPAA) Rules.

12.6.1 Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information (“ePHI”) it creates, receives, maintains, or transmits. If a Provider receives a misdirected communication from FBHP, the Provider must immediately notify FBHP by contacting:

Privacy Office Farm Bureau Health
Plans P.O. Box 313
Columbia, TN 38402-0313
Phone: (931) 560-0041, ext. 3115
E-mail: HIPPAconcerns@fbhp.com.

Providers should securely destroy misdirected communication.

It also requires entities to protect against any disclosures of such information that are not permitted or required by the Privacy Rule and ensure compliance by their workforce.

12.6.2 Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information and gives Members' rights under HIPAA. The Privacy Rule includes requirements to obtain a patient's permission before using or disclosing their Personal Health Information (PHI).

Including the Members':

- Right to access their PHI
- Right to request a restriction on certain uses and disclosures of their PHI
- Right to request changes to their PHI

12.7 Privacy and Information Security Related Resources and Websites

- U.S. Department of Health & Human Services- Office of Civil Rights (https://www.hhs.gov/ocr/index.html)
- Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/)
- U.S. Department of Health and Human Services, Administrative Simplification (https://aspe.hhs.gov/administrative-simplification)
- U.S. Department of Health and Human Services - Office of Civil Rights, HIPAA (https://www.hhs.gov/hipaa/index.html)
- Workgroup for Electronic Data Interchange (WEDI)
- (http://www.wedi.org)
- National Committee on Vital and Health Statistics (https://ncvhs.hhs.gov/)
- National Council for Prescription Drug Programs (http://www.ncpdp.org)
- Electronic Healthcare Network Accreditation Commission (https://ehnac.org/)
- Centers for Medicare & Medicaid Services (https://www.cms.gov/)

12.8 Transaction and Code Sets Standards

CMS sets forth requirements regarding information security and privacy. See following link for further information: (https://www.cms.gov/Medicare/Billing.ElectronicBillingEDITrans)

Electronic Data Interchange may include the following transactions:

- Claims and Encounter Information
- Payment and Remittance Advice
- Claims Status
- Eligibility
- Enrollment and Disenrollment
- Referrals and Authorizations
- Coordination of Benefits
- Premium Payment

Providers who engage in one of the identified transactions electronically must comply with the standard for that transaction.

Chapter 13 – Pharmacy

13.1 Overview

Farm Bureau Health Plans (FBHP) uses a pharmacy benefit manager (PBM) to administer the Members' pharmaceutical benefits. The FBHP prescription drug formulary is designed to support positive Member health outcomes through the administration of pharmacy benefits. The formulary is a preferred list of covered drugs, approved by FBHP with the goal to provide a covered pharmaceutical benefit that enhances the prescribing Providers the ability to deliver optimal drug therapy to Members. Additional information on pharmacy benefits can be found at: (https://www2.optumrx.com/)

13.2 Drug Selection

FBHP uses a drug classification system to develop the formulary for Members while considering the following criteria in the evaluation of drug selection:

- Drug safety profile
- Drug efficacy
- Drug effectiveness
- Comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications

The Formulary can be accessed at (https://www2.optumrx.com/member-resources.html)

13.3 Drug Utilization Review Program

FBHP and PBM will conduct drug utilization reviews to help ensure Members are getting safe and appropriate care. FBHP and their clinical system vendor will have oversight of Medicare Advantage (MA-PD) plan pharmacy issues and the PBM vendor will have oversight of the PDP plan.

13.4 Benefits Coverage/Limitations

FBHP sets benefit guidelines for pharmaceutical benefits.

- Quantity Limits: this may affect the number of prescriptions a Member can refill between Provider visits
- Prior Authorizations: some drugs may require prior authorizations from FBHP before the prescription can be prescribed.
- Updates to Formulary: from time to time, the formulary may have additions, deletions or changes based on FBHP classification system for drug selection to the formulary.
- Generic vs Brand: there may be rulings on pricing differences or generic drug use vs brand name drugs.
- Non-formulary drugs: FBHP will have outlines regarding non-formulary drugs; this may include financial impact to Member.
- Over the counter medication: FBHP may allow reimbursement for some over the counter medication.

- Exclusion: there may be drugs that are excluded on the formulary.

13.5 Medication Therapy Management (MTM)

The Medication Therapy Management (MTM) Program is a CMS required program that assists Members to ensure they are using appropriate medications to treat their medical conditions, offer advice on alternatives or options, educates, and informs.

FBHP adheres with the CMS requirements for Medication Therapy Management (MTM) Programs: Under 423.153(d), and has established a MTM program that:

- Ensures optimum therapeutic outcomes for targeted beneficiaries through improved
- medication use
- Reduces the risk of adverse events
- Is developed in cooperation with licensed and practicing pharmacists and physicians
- Describes the resources and time required to implement the program if using outside personnel and establishes the fees for pharmacists or others
- May be furnished by pharmacists or other qualified providers
- May distinguish between services in ambulatory and institutional settings
- Is coordinated with any care management plan established for a targeted individual under a chronic care improvement program (CCIP)

Each Part D Sponsor is required to incorporate a Medication Therapy Management (MTM) Program into their plans' benefit structure. Annually, Sponsors must submit a MTM Program description to CMS for review and approval. A CMS-approved MTM Program is one of several required elements in the development of a Sponsor's bid for the upcoming contract year.

Chapter 14 – Marketing

Providers may not develop or use any materials that market FBHP or the FBHP MA plan without FBHP prior written approval. Under MA program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the FBHP MA plans as long as the provider displays posters or notifications from all Medicare Advantage plans in which they participate.

14.1 Introduction

This section outlines Farm Bureau Health Plans (FBHP) approach to marketing which is guided by rules and regulations set forth by the Centers for Medicare and Medicaid Services (CMS).

14.2 CMS Marketing Regulations

To be compliant with regulatory guidelines, FBHP follows CMS guidelines. CMS defines marketing as communications materials and activities that meet the following standards for intent and content:

- Draw a beneficiary's attention to a MA plan or plans.
- Influence a beneficiary's decision-making process when making a MA plan selection.
- Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing).
- In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the MA organization's stated intent.
- Include or address content regarding any of the following:
- The plan's benefits, benefits structure, premiums, or cost sharing.
- Measuring or ranking standards (for example, Star Ratings or plan comparisons).
- Rewards and incentives

14.2.1 Submission of Marketing Materials to CMS

FBHP must submit all marketing materials, all election forms, and certain designated communications materials for CMS review.

14.2.2 CMS Review of Marketing Materials

FBHP will not distribute or otherwise make available any marketing materials or election forms unless one of the following occurs:

- CMS has reviewed and approved the material.
- The material has been deemed approved
- The material has been accepted under File and Use, as follows:

- FBHP may distribute certain types of marketing materials, designated by CMS based on the material's content, audience, and intended use, as they apply to potential risk to the beneficiary
- FBHP will certify that the material meets all applicable CMS communications and marketing requirements

14.3 FBHP Marketing Guidelines

Unless FBHP has granted the Provider written permission, FBHP does not allow Providers to use the FBHP name and logo along with other information, such as contact information, when the Provider sends out communications to their patients.

Marketing materials may not display the names or logos or both of Provider co-branding partners unless the materials clearly indicate via a disclaimer or in the body that “Other Providers are available in the network.”

14.4 Medicare Advantage (MA) Materials

For FBHP to achieve its goal of improving the health of the community, FBHP may request that Providers display and have Medicare Advantage materials available in their places of service. These requests will follow CMS guidance and are completely voluntary.

14.5 Failure to Comply

Providers are responsible to ensure their materials are compliant with both FBHP and CMS rules and regulations. FBHP team will be available to review marketing materials that Providers may distribute to their Members.

Appendix