
Signature Advantage Plan & Signature Advantage Community (HMO ISNP)

**January 1, 2025**

# Provider Manual

Customer Support 1-844-214-8633

Welcome aboard!

Signature Advantage Plan (SAP), an Institutional Special Needs Plan (ISNP), would like to thank you for choosing us as your partner. Our ISNP began enrolling new members in 2016 and currently serves institutionalized long-term residents throughout Kentucky and Tennessee. Collaborating with our providers to offer quality health care to plan members is our highest priority. Good communication with providers and members has been a key component to our success.

This Provider Manual serves as a reference guide. It is one of our multiple methods of communication and compliments our Model of Care provider training. We ask that you review the Provider Manual carefully.

We have created a Signature Advantage Website page should you have any specific questions or concern. The Signature Advantage page is available at www.signatureadvantageplan.com.

We are proud to have you as one of our provider choice options and look forward to working closely with you to serve our institutionalized members.

Sincerely,
Heather Kennedy, Chief Executive Officer

# Contents

# About Signature Advantage

Signature Advantage HMO ISNP and Signature Advantage Community HMO I-SNP Equivalent ("health plan" or "Plan") are Medicare Advantage Institutional Special Needs Plans designed to improve the care for residents of Long Term Care Facilities, Nursing Facilities, Assisted Living, Independent Living and Continuous Care Retirement Communities in Kentucky and Tennessee. Signature Advantage's target population is a Medicare beneficiary who resides or is expected to reside in a Signature Advantage contracted facility for 90 days or longer. This includes those individuals residing in Nursing Facilities (NF), Assisted Living Facilities (ALF), Independent Living and Continuous Care Retirement Communities in Kentucky and Tennessee.

# MODEL OF CARE

Signature Advantage's Model of Care organizes best practices and industry innovations such as the PCP/Nurse Practitioner care team providing onsite, facility-based primary health care support; a risk- assessment tool designed for a geriatric, nursing home patient population; a comprehensive history and physical assessment that drives an Individualized Care Plan (ICP); that is utilized by the Interdisciplinary Care Team (ICT) to ensure effective coordination of care; a care management platform that helps identify needed preventive health/HEDIS services, ensures the use of evidence based guidelines, and facilitates care team communications for care coordination; and frequent face-to-face member and caregiver/family member interactions that identify member care preferences and allow time for important care decision discussions and counseling. Providers should go to the Signature Advantage Website to access the Model of Care Training.

The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs, and the coordination of care to improve members overall health. Signature Advantage's Institutional Special Needs Plan (I- SNP) Model of Care has the following goals:

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

Importantly, the Model of Care focuses on the individual I-SNP member. I-SNP members receive a comprehensive health risk assessment initially and annually thereafter. Based on this assessment, an individualized care plan is developed. An interdisciplinary care team, which includes practitioners of various disciplines and specialties based on the needs of the member, is responsible for care management. The member may participate in this process, as may all their healthcare providers. The individual care plan is stored centrally so that it can be shared with all members of the interdisciplinary care team, as indicated. All providers are

encouraged to participate in the I-SNP Model of Care and interdisciplinary care teams.

Signature Advantage uses a data-driven process for identifying the frail/disabled, multiple chronic illnesses and those at the end of life. Risk stratification and protocols for intervention around care coordination, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the needs of Plan members, a specialized provider network is available to assure appropriate access to care, complementing each member's primary care provider.

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

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

All members are required to choose or designate a PCP at enrollment. Signature Advantage members can choose their PCP from the list of contracted PCPs maintained and published by Signature Advantage. Members can change their PCP at any time. The PCP change will become effective on the first day of the following month. PCPs contracted and available to be chosen as a primary care provider with Signature Advantage are clearly identified in Signature Advantage's member materials, including the Provider Directory as credentialed at time of publication.

**Signature Advantage's evidenced-based Model of Care includes the following components:**

- The clinical team provides integrated health care management with a strong primary and preventive care focus to treat acute and chronic conditions.
- All members receive a comprehensive history and physical exam and care plan within 90 days of enrollment and comprehensive visits at least once a month, thereafter.
- Nurse Practitioners utilize a health risk assessment tool that rates each member's medical condition as low, moderate, or high.
- Risk scores dictate the Nurse Practitioner's clinical visit/monitoring schedule.
- A risk score framework is used at each clinical visit/monitoring and tracked over time.
- An individualized plan of care having goals and measurable outcomes specific to the targeted special needs of each member is developed.
- An interdisciplinary care team is formed for each member.
- Access to a specialized provider network having expertise pertinent to the targeted special needs of the member population.
- A medication therapy management program.
- Demonstrated cultural competency among staff and providers.
- Members and their caregivers/family's engagement in decision making.
- Member and caregiver/family participation in Plan policy and operations through surveys and formal feedback.

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

# MEMBER INFORMATION

### *Member Identification & Eligibility*

All participating providers are responsible for verifying a member's eligibility every visit. Please note that membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) retroactively terminates members for various reasons. When this occurs, the Signature Advantage claim recovery unit will request a refund from the provider.

The provider should then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question.

Signature Advantage has continuous enrollment each year under the Special Needs Plan designation, eligible members moving into a contracted facility can choose to enroll at any time.

Each member is provided with an individual membership identification card. Noted on the ID card is the member's identification number, plan code, co-payment, and effective date. If the member does not have an ID card, you must verify eligibility as listed below.

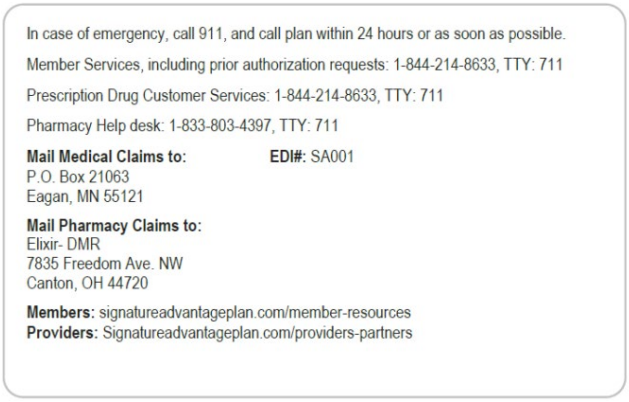
Providers should always verify member eligibility prior to the appointment. Signature Advantage should have the most current eligibility information. You can verify member eligibility through the following ways:

- Member ID Card: Note that changes do occur, and the card alone does not guarantee member eligibility.

- Telephonically: Please call the Member Services Department at (844) 214-8633.
- Signature Advantage Website via the Eligibility portal
- Other commercially available means

Signature Advantage ID Cards Examples:






### *Maximum Out-of-Pocket (MOOP)*

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

### *Member Hold Harmless*

Participating providers are prohibited from balance billing Signature Advantage members including, but not limited to, situations involving non-payment by Signature Advantage, insolvency of Signature Advantage, or Signature Advantage's breach of its Agreement. Providers shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than Signature Advantage, acting on behalf of members for Covered Services provided pursuant to the participating Provider's Agreement. The provider is not, however, prohibited from collecting co-payments, co-insurances or deductibles for covered services in accordance with the terms of the applicable member's Benefit Plan.

### *Member Confidentiality & Privacy*

At Signature Advantage, we know our members' privacy is extremely important to them and we respect their right to privacy when it comes to their personal information and health care. Access to Protected Health Information (PHI) allows Signature Advantage to closely work with providers, like yourself, to determine whether a service is a Covered Service and pay your clean claims for Covered Services using the members' medical records.

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

### *Member Rights and Responsibilities*

Members have the right to be treated with dignity, respect, and fairness always. Signature Advantage must obey laws against discrimination that protect members from unfair treatment. These laws say that Signature Advantage cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

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

There are federal and state laws that protect the privacy of member medical records and personal health information. Signature Advantage keeps members' personal health information private as required under these laws. Signature Advantage provides members with a notice that tells them about rights and explains how Signature Advantage protects the privacy of their health information.

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

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

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

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

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

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

### *The right to use advance directives (such as a living will or power of attorney)*

Members have the right to ask someone, such as a family member or friend, to help them with decisions about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If a member wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them, if they ever become unable to make decisions for themselves. Members also have the right to give their doctors written instructions about how they want to handle their medical care if they become unable to make decisions for themselves. The legal documents that members can use to give their directions in advance of these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living wills" and "powers of attorney for health care" are examples of advance directives.

If members know in advance, they are going to be hospitalized they should take a copy to the hospital. If members are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If members have not signed an advance directive or do not have a

signed copy with them during the admission, the hospital will have forms available and will ask if the member wants to sign one.

Remember, it is a member's choice whether he/she wants to fill out an advance directive including whether they want to sign one if they are in the hospital. According to the law, no one can deny them care or discriminate against them based on whether they have signed an advance directive. If members have signed an advance directive and they believe that a doctor or hospital has not followed the instructions in it, members may file a complaint with their State Board of Medicine or appropriate state agency. This information can be found in the member's EOC.

### *The right to make complaints*

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Signature Advantage must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. To obtain information relative to appeals, grievances or concerns and/or coverage determinations, members should be directed to contact our Member Services Department.

### *The right to get information about their health care coverage and cost*

The EOC tells members what medical services are covered, and what the member must pay for. If members need more information, they should be directed to contact our Member Services Department. Members have the right to an explanation from Signature Advantage about any medical services not covered by Signature Advantage. Signature Advantage must tell members in writing why Signature Advantage will not pay for or allow them to get a service and how they can file for an appeal to ask Signature Advantage to change the decision. If asked, staff should inform members on how to file an appeal and should direct members to review their EOC for more information about filing an appeal.

### *The right to get information about Signature Advantage, plan providers, drug coverage, and costs*

Members have the right to get information about the Signature Advantage Plan and operations. This includes information about the Plan's financial condition, the services provided, and Signature Advantage's health care providers and their qualifications. Members have the right to find out from the Plan how doctors are paid. Members should be directed to call the Member Services Department for information. Member also have the right to get information from Signature Advantage about their Part D prescription coverage and the network pharmacies. Staff should instruct members to call our Member Services Department.

### *The right to obtain more information about members' rights*

Members have the right to receive information about their rights and responsibilities. If members have questions or concerns about their rights and protections, they should be directed to contact our Member Services Department. Members can also get free help and information from their State Health Insurance Assistance Program (SHIP). In addition, the Medicare program has written a booklet titled Members Medicare Rights and Protections. To get a free copy, members should be directed to call 1-800-MEDICARE (1- 800-633-4227). TTY users should call 1-877-486- 2048. Members can call 24 hours a day, 7 days a week. Or members can visit www.medicare.gov on the web to order the booklet or print it directly from their computer.

### *The right to take action if a member thinks they have been treated unfairly or their rights are not being respected*

If members think that they have been treated unfairly or their rights have not been respected, there are options.

- If members think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, members should be encouraged to let Signature Advantage know immediately by calling the Member Services Department. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, members should be encouraged to call our Member Services Department. Members also can get help from their SHIP.

### *Signature Advantage Member Responsibilities*

Along with certain rights, members of Signature Advantage also have responsibilities. Members are responsible for the following:

- To become familiar with their Signature Advantage coverage and the rules they must follow to get care as a member. Members can use their Signature Advantage EOC and other information provided to them to learn about their coverage, what Signature Advantage must pay, and what rules they need to follow. Members should be encouraged to call our Member Services Department if they have questions or complaints.
- To advise Signature Advantage if they have other insurance coverage.
- To notify providers when seeking care that they are enrolled with Signature Advantage and to present their plan enrollment card to providers unless it is an emergency. To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Members must be encouraged to ask questions and communicate any concerns with their doctors and other providers whenever the member has them.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their plan premiums and any other co-payments or coinsurance they may have for the Covered Services they receive. Members must also meet their other financial responsibilities that are described in their EOC.
- To let Signature Advantage know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage and/or Signature Advantage operations.
- To notify Signature Advantage and their providers of any address and/or phone number changes as soon as possible.
- To use their Signature Advantage Plan only to access services, medications, and other benefits for themselves.

### *Advanced Medical Directives*

The Federal Patient Self-Determination Act ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the CMS, HEDIS requirements, and the Plan's own policies and procedures, Signature Advantage requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act. All providers contracted directly or indirectly with Signature Advantage may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and Signature Advantage. Signature Advantage and the PCP and/or treating provider will arrange for a transfer of

care.

Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, Signature Advantage conducts periodic patient medical record reviews to confirm that required documentation exists.

### *Benefits and Services*

All Signature Advantage members receive benefits and services as defined in their EOC. Signature Advantage encourages its members to call their PCP to schedule appointments. However, if a Signature Advantage member calls or comes to a provider's office for an unscheduled non-emergent appointment, please attempt to accommodate the member and explain to them your office policy regarding appointments. If this problem persists, please contact Signature Advantage.

### *Emergent and Urgent Services*

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

- **Emergency medical condition** is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part."
- Emergency medical condition status is not affected if a later medical review found no actual emergency present.
    - Emergency services are "covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."
    - Urgently needed services are "covered services that are not emergency services as defined above but are:
        - Medically necessary and immediately required as a result of an unforeseen illness, injury, or condition.
        - Provided when the member is temporarily absent from the plan's service area; or under unusual and extraordinary circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible; and
        - Given the circumstances, it was not reasonable to wait to obtain the services through the Plan network."

The Signature Advantage network includes multiple hospitals, emergency rooms, and providers able to treat the emergent and urgent conditions of Signature Advantage members twenty-four (24) hours a day, seven (7) days a week. For urgent and emergent issues that occur onsite in the member's facility or in the service area, the PCP is responsible for providing, directing, or authorizing a member's urgent or emergent care— including urgent or emergent services provided onsite in their facility (known as "Skill in Place.") The PCP or his/her designee must

be available 24 hours a day, 7 days a week to assist members needing emergent or urgent services.

Emergent or urgent issues requiring services or expertise not available onsite in the member's facility will be addressed with transfer of the member to a Signature Advantage contracted acute care hospital or emergency room able to provide the needed care. The PCP, working with the Plan's Nurse Practitioner, is responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members have a co-payment responsibility for outpatient emergency visits unless an admission result.

While most members remain in the service area, Signature Advantage members may receive emergency services and urgently needed services from any provider, regardless of whether services are obtained within or outside the Signature Advantage authorized service area and/or network and regardless of whether there is a prior authorization for the services. For emergency services outside the service area, Signature Advantage will pay reasonable charges for emergency services received from non-participating providers, if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a co- payment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

In cases where ambulance services are dispatched through 911 or a local equivalent and the ambulance provider is not contracted with Signature Advantage, the Plan follows Medicare rules on coverage for ambulance services as set forth in 42 CFR 410.40.

### *Continuing or Follow-Up Treatment*

Continuing or follow-up treatment, except by the PCP, whether in or out of service area, is not covered by Signature Advantage unless specifically authorized or approved by Signature Advantage. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the member can reasonably be transported to a participating hospital or returned to the care of the PCP.

### *Member Inquiries, Complaints, and Grievance & Appeals*

Telephone inquiries and complaints (not grievances as described below) received by Signature Advantage's Member Services Department will be resolved on an informal basis. Inquiries and complaints may include but are not limited to questions such as whether a specific service is covered or a request for a member identification card. Inquiries and complaints do not include grievances or 'appealable' issues. In situations where a member or the member's appointed representative remains dissatisfied with the resolution of their inquiry or complaint, the member or the member's appointed representative must submit, in writing or verbally, a request for reconsideration of that resolution. Those inquiries received by Signature Advantage will be logged in the Plan's tracking system and automatically placed within either the appeal or grievance process, whichever is appropriate.

Signature Advantage members or their appointed representative also have the right to file a grievance about problems they observe or experience with the plan. A grievance is an expression of dissatisfaction with any aspect of Signature Advantage's operations, activities or behavior while providing health care services, items, or prescription drugs. Situations for which a grievance may be filed include but are not limited to:

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

In addition, Signature Advantage members and their appointed representatives may appeal any decision about Signature Advantage's failure to provide what they believe are benefits contained in the basic benefit package. These include:

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

***Appealable issues will be placed in either the expedited or standard appeals process.***

A member or their appointed representative may also appeal any decision to discharge them from the hospital. In this case, a notice will be given to the member or their appointed representative with information about how to appeal and the member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to the Signature Advantage EOC for additional information.

***Continuity and Coordination of Care***

Continuity of Care is essential to maintain member stability. As a part of the care transition process, the Plan's Nurse Practitioner will be the primary advocate in ensuring the member's well-being across multiple care settings and across the health spectrum. The Plan's Nurse Practitioner will work with the PCP to ensure that the highest quality of health care will be delivered to the member in each of the health care settings.

The Signature Advantage Nurse Practitioners understand how coordinated health care improves the care of this vulnerable membership, and will work to ensure coordinated care by:

- Providing members and caregivers/families one accountable point of contact – the assigned Nurse Practitioner.
- Following members across care settings during transitions (i.e. admission to a hospital).
- Educating members and caregivers/families on member diagnoses.
- Setting goals that promote coordinated care.
- Making and keeping specific tasks/appointments, follow up items with members.
- Coordinating care within and across treatment settings between external and internal stakeholders.
- Creating a process through which health care providers can communicate with one another about the member's care.
- Making member preferences known and accessible to all health care providers.

Signature Advantage's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves Signature Advantage's network and a member is in an active course of treatment, Signature Advantage will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, Signature Advantage will work to transition a member into care with a Participating Provider or other provider within Signature Advantage's network. Signature Advantage is

not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

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

Signature Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the PCP evaluates the member and establishes a new plan of care.

# PROVIDER INFORMATION

Signature Advantage provides a PCP-driven care model engaging dedicated medical providers physically located at the contracted facilities to enhance and provide care management and coordination.

The PCP is supported by Plan's Nurse Practitioners with appropriate certification and qualifications for the population to be managed.

### *Providers Designated as Primary Care Providers (PCPs)*

Each Signature Advantage member must select a Signature Advantage participating primary care provider at the time of enrollment. Signature Advantage members will be able to choose their primary care provider from the list of contracted providers maintained and published by Signature Advantage.
Members will be able to change their primary care provider at any time. Providers contracted as PCP and available to be chosen as a primary care provider with Signature Advantage will be clearly identified in Signature Advantage's member materials, including the Provider Directory.

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

### *The Role of the Primary Care Provider (PCP)*

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

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

- Manage the health care needs of Signature Advantage members who have chosen the provider as their PCP.

- Ensure that members receive treatment as frequently as is necessary based on the member's condition.
- Develop an individual treatment plan for each member.
- Submit accurate and timely claims and encounter information for clinical care coordination.
- Comply with Signature Advantage's prior authorization and referral procedures.
- Refer members to appropriate Signature Advantage participating providers.
- Comply with Signature Advantage's Quality Management and Utilization Management programs.
- Participate in Signature Advantage's Comprehensive Exam and Health Risk Assessment.
- Use appropriate designated ancillary services.
- Comply with emergency care procedures.
- Comply with Signature Advantage access and availability standards as outlined in this manual, including after-hours care.
- Submit claims to Signature Advantage on the CMS 1500 or successor claim form or electronically in accordance with Signature Advantage billing procedures.
- Ensure that, when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Comply with Preventive Screening and Clinical Guidelines.
- Adhere to Signature Advantage's medical record standards as outlined in this manual.

### *The Role of the Specialist Physician*

Each Signature Advantage member is entitled to seek care from Specialist Physicians for certain required services for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a Signature Advantage member as follows:

- Provide specialty health care services to members as needed.
- Collaborate with the member's Signature Advantage PCP to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician in a timely manner.
- Comply with access and availability standards as outlined in this manual including after-hours care.
- Comply with Signature Advantage's prior authorization and referral process.
- Comply with Signature Advantage's Quality Management and Utilization Management programs.
- Submit claims to Signature Advantage on the CMS 1500 claim form in accordance with Signature Advantage's billing procedures and other Medicare approved claim forms.
- Ensure that, when submitting claims for services provided coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Refer members to appropriate Signature Advantage participating providers.
- Submit encounter information to Signature Advantage accurately and timely.
- Adhere to Signature Advantage's medical record standards as outlined in this manual.

### *Administrative, Medical and/or Reimbursement Policy Changes*

From time to time, Signature Advantage may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific Signature Advantage policies and procedures may be obtained by calling the Plan's Network Operations Department: (844) 214-8633.

Signature Advantage may communicate policy changes to providers through our website or written notifications. . Upon receipt of such notices, providers are responsible for reviewing the policy updates in the Provider Manual

and complying with these changes.

### *Communication Amongst Providers*

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

### *Provider Marketing Guidelines*

The below is a general guideline to assist Signature Advantage providers, who have contracted with multiple Medicare Advantage plans and are accepting Medicare fee-for-service patients, in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions.

Providers Can:

- Mail/call their patient panel to invite patients to general Signature Advantage sponsored educational events to learn about the Medicare and/or Medicare Advantage program. This is not a sales/ marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.
- If agreed upon by both parties' providers may announce a new or continuing affiliation with Signature Advantage made through direct mail, email, telephone, or advertisement according to 42 CFR §§ 422.2262(a), 422.2268, 423.2262(a), 423.2268.
- Have additional mailings (unlimited) to patients about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify patients, in a letter, of a decision to participate in a Signature Advantage sponsored program.
- Utilize a provider/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a Signature Advantage area to advise patients of Signature Advantage information.
- Provide objective information to patients on specific plan formularies, based on a patient's medications and health care needs.
- Refer patients to other sources of information, such as the State Health Insurance Assistance Program (SHIP), Signature Advantage marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Display in areas other than those where patients receive medical care and distribute in provider offices Signature Advantage marketing materials, excluding application forms. The office must display or agree to display materials for all participating Medicare Advantage plans when requested.
- Notify patients of a provider's decision to participate exclusively with Signature Advantage for Medicare Advantage or to close panel to original Medicare fee-for-service patients if appropriate.
- Display promotional items with the Signature Advantage logo.
- Allow Signature Advantage to have a room/space in provider offices separate from where patients receive health care services, to provide Medicare beneficiaries with access to a Signature Advantage sales representative.

### *Providers Cannot:*

- Quote specific health plan benefits or cost share in patient discussions.
- Urge or steer towards any specific plan or limited set of plans.
- Collect enrollment applications in provider offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Mail notifications of health plan sales meetings to patients.
- Call patients to invite patients to sales and marketing activity of a health plan.
- Advertise using Signature Advantage's name without Signature Advantage's prior consent and potentially CMS approval depending upon the content of the advertisement.

### *Member Assignment to New PCP*

Signature Advantage PCPs have a limited right to request a member be assigned to a new PCP. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening, or uncooperative to the extent that his/her membership seriously impairs Signature Advantage's or the provider's ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment or coinsurance for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/provider relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

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

A member also may request a change in PCP for any reason. The PCP change that is requested by the member will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

# PROVIDER PARTICIPATION

Providers must be contracted with and credentialed by Signature Advantage or the entity under contract to perform credentialing services. Signature Advantage's Credentialing Program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), CMS and State regulations as applicable.
Signature Advantage takes ultimate responsibility for all services provided by contracted entities, terms of the contract, and fulfillment of all terms and conditions of its contract. Signature Advantage may agree to delegate credentialing to a provider organization so long as a) a Delegation Agreement is signed by both parties, and b) a delegation audit is conducted and found to be satisfactory.

### *Plan Notification Requirements for Providers*

Participating providers must provide written notice to Signature Advantage no less than 10 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to Signature Advantage by contacting your Network Support Representative at networksupport@signatureadvantageplan.com:

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

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory and claims process promptly. Please note, failure to provide up to date and correct information regarding your practice and the providers that participate may result in the denial of claims for you and your providers.

### *Closing Patient Panels*

When a Participating Primary Care Provider elects to stop accepting new patients, the provider's patient panel is considered closed. If a Participating Primary Care Provider closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Signature Advantage members by closing their patient panels for Signature Advantage members only, nor may they discriminate among Signature Advantage members by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify Signature Advantage's Network Support Department, in writing at Signature Advantage Plan ATTN: Network Support 805 N. Whittington Parkway Louisville, KY 40222 or by email at networksupport@signatureadvantageplan.com, at least 60 days before the date on which the patient panel will be closed.

### *Access and Availability Standards for Providers*

Signature Advantage has established written standards to ensure timeliness of access to care that meet or

exceed the standards established by CMS, to ensure that all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. Additionally, Signature Advantage requires that all providers offer standard hours of operation that (1) do not discriminate against Medicare enrollees and (2) are convenient for Signature Advantage members, the facilities where members reside, and facility staff who aid in member care.

### *Timeliness of Access to Care*

Signature Advantage members have access to care 24 hours a day, 7 days a week as medically necessary. Signature Advantage has the additional policies in place to make sure members have timely access to routine, preventive, and urgent care services.

- Primary care providers should provide:
  - Routine, preventive care and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as moderate or high risk.
  - Routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within 1 week (7 days) on-site at member's nursing facility residence.
  - Immediate urgent and emergent care on-site at member's nursing facility residence or in the provider's office or telephonically in coordination with the Nurse Practitioner.
  - 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted provider coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to routine care calls returned by the end of the day.
  - Specialists are required to be available for a consult or new patient appointment within 21 days of initial request and to be immediately available to primary care providers for an urgent or emergent consult regarding a member.
  - Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Signature Advantage Nurse Practitioners, Medical Director and Utilization Management staff, and nursing home facility staff):
    - Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately.
    - Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
    - Routine care calls, both weekdays and after-hours calls, will be returned by the end of the day or the following morning.
    - All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

### *Network Access Monitoring and Compliance*

Using valid methodology, Signature Advantage will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. In addition to regularly scheduled performance measurement, Signature Advantage will regularly review utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access of care (provider or after hours) are collected through the Signature Advantage the Member Services Department line. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Practitioners or sites identified for access improvement opportunities are contacted in a timely manner regarding survey or measurement results, and follow-up inquiries and measurements may be scheduled. All contracted providers are informed of this policy in the Provider Manual. The policy is also included on the Signature Advantage website.

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

# PROVIDER RIGHTS AND RESPONSIBILITIES

### *Provider Rights*

Signature Advantage encourages your feedback and suggestions on how service may be improved within the organization.
Payment will be based on contracted rates and/or Medicare fee schedules. Contracted providers may dispute claims submissions you feel have not been paid according to medical policy or in keeping with the level of care rendered. You may request to discuss any referral request with the Plan Medical Director at various times in the review process before a decision is rendered or after a decision is rendered. The timeframe for a provider dispute submission must be within 60 days from the processing of the claims and/or issue. A resolution will be provided within 60 days of receipt of the request.

**Dispute Request Address:**
SIGNATURE ADVANTAGE CLAIMS
PO Box 21063
Eagan, MN 55121
**Dispute Request Fax Number:**
ATTENTION: APPEALS DEPT
(800) 880-3263
**Inquire on the Status of Your Dispute:**
(844) 214-8633

### *Provider Information*

Specialists are required to coordinate the referral process (i.e. obtain authorizations) for the further care they recommend. This responsibility does not revert back to the Primary Care Provider while the care of the member is under the direction of the Specialist. In the event a provider is temporarily unavailable or unable to provide patient care or referral services to a Signature Advantage member, he/she must arrange for another provider to provide such services on his/her behalf. This coverage cannot be provided by an Emergency Room.

- Each provider has agreed to treat Signature Advantage members the same as all other patients in his/her practice, regardless of the amount of reimbursement.
- Each provider has agreed to provide continuing care to participating members.
- Each provider has agreed to utilize Signature Advantage's participating providers/facilities when services are available and can meet the patient's needs. Approval prior to referring outside of the contracted network of providers may be required.
- Each provider has agreed to participate in Signature Advantage's peer review activities as they relate to the Quality Management/Utilization Review program and engage in the plan's grievance processes.

A provider may not balance bill a member for providing services that are covered by Signature Advantage. This excludes the collection of standard co-pays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.

### *Credentialing and Recredentialing Process*

Credentialing is a key part of our network process. The credentialing process helps ensure our members have access to quality care. The Credentialing process is required to meet state and federal guidelines. Our preferred method of application data is the Council for Affordable Quality Healthcare (CAQH). Please ensure that your information is current and accurate, and all attestations are complete with CAQH. During the credentialing process our staff will perform verification accessing your CAQH application or contact you directly for completion if you do not use CAQH. We may also query the National Practitioner Data Bank.

The credentialing process generally takes up to ninety (90) days to complete but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the Practitioner will be notified of their participation effective date. To maintain participating status, all practitioners are required to recredential at least every three (3) years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information in advance of their three-year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request. Practitioners who fail to return recredentialing information prior to their recredentialing due date will be notified in writing of their termination from the network.

### *Application Process*

1. Submit a completed State Mandated Credentialing application, CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.
2. If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information and explanations.
3. Provide appropriate clinical detail for all malpractice cases that are pending or resulted in a settlement or other financial payment.
4. Submit copies of the following:
    - All current and active State Medical Licenses, DEA certificate(s) and state-controlled substance certificate as applicable.
    - Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
    - Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
    - If a provider, current and complete hospital affiliation information on the application. If no hospital privileges and the specialty warrants hospital privileges, a letter detailing the alternate coverage arrangement(s), or the name of the alternate admitting provider should be provided.

### *Office Site Evaluations*

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue and/or as otherwise mandated by state regulations.

Practitioner offices will be evaluated in the following categories:

1. Physical Appearance and Accessibility
2. Patient Safety and Risk Management
3. Medical Record Management and Security of Information
4. Appointment Availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit, if necessary, to ensure that the corrective action has been implemented.

### *Provider Rights*

- Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations, or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the Plan's offices.
- Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the provider. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.
- Right to be informed of the status of their application upon request. A provider may request the status of the application either telephonically or in writing. The Plan will respond within two business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

### *Organizational Provider Selection Criteria*

When assessing organizational providers, Signature Advantage utilizes the CAQH & CMS Criteria such as:

- Must be in good standing with all state and federal regulatory bodies.
- Has been reviewed and approved by an accrediting body.
    - If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other Plan criteria.
- Maintains current professional and general liability insurance as applicable.
- Has not been excluded, suspended, and/ or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

### *Organizational Provider Application and Requirements*

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc.).
3. Proof of current professional and general liability insurance as applicable.

4. Proof of Medicare participation.
5. If accredited, proof of current accreditation. Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high-tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
6. If not accredited, a copy of any state or CMS site survey that has occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

### *Organizational Site Surveys*

As part of the initial assessment, an on-site review may be required on any hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within thirty (30) days and may be re-audited, at a minimum within sixty (60) days, to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards, even after re-auditing, will not be eligible for participation.

### *Credentialing Committee / Peer Review Process*

All initial applicants and recredentialed providers are subject to a peer review process prior to approval or reapproval as a participating provider. Providers who meet all of the acceptance criteria may be approved by the Plan Medical Director. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of contracted primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and recredentialing process must be obtained and verified within one hundred eighty (180) days prior to presentation to the Medical Director or the Credentialing Committee. All providers must be credentialed and approved before being assigned a participating effective date.

### *Non-Discrimination in the Decision-Making Process*

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

### *Provider Notification*

All initial applicants who successfully complete the credentialing process are notified of their plan effective date. Providers are advised to not see Signature Advantage members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee will be notified via a letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

### *Appeals Process & Notification of Authorities*

If a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include a) the reason(s) for the action, b) outlines the appeals process or options available to the provider, and c) provides the time limits for submitting an appeal. All appeals will be reviewed by a panel of peers. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

### *Confidentiality of Credentialing Information*

All information obtained during the credentialing and recredentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies.

Confidential provider credentialing and recredentialing information will not be disclosed to any person or entity except with the written permission of the provider or as otherwise permitted or required by law.

### *Ongoing Monitoring*

Signature Advantage conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned are subject to review by the Plan Medical Director or the Credentialing Committee who may elect to limit, restrict, or terminate participation. Any provider whose license has been revoked or has been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid or any other government health related program or who has opted out of Medicare will be automatically terminated from the Plan.

### *Provider Directory*

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

## CLAIMS

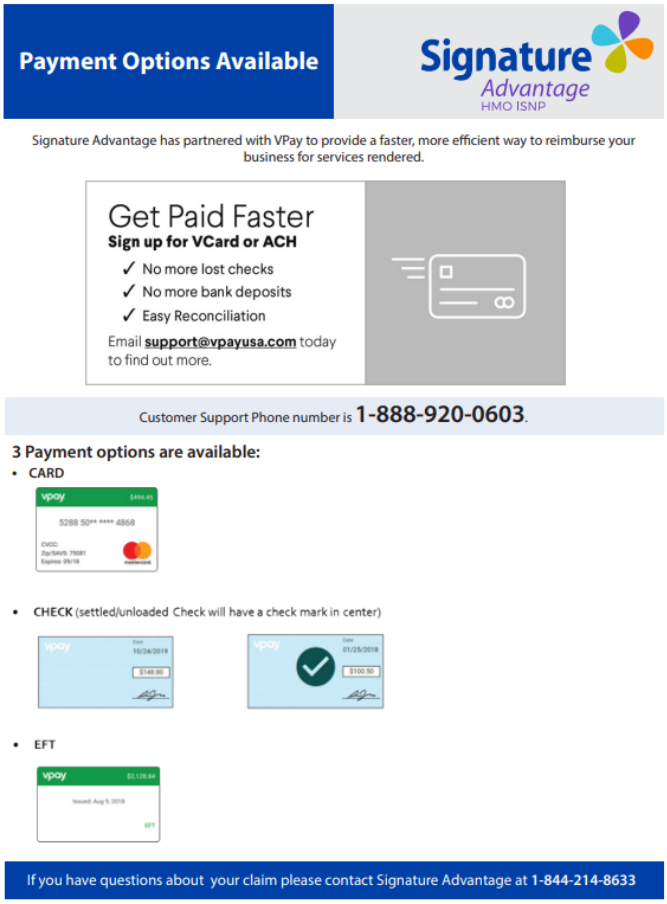
### *Claims Submission*

Signature Advantage strongly encourages providers to submit claims electronically and to check the status of claims electronically. While Signature Advantage prefers electronic submission of claims, both electronic and paper claims are accepted. The benefits of electronic claims submission and status inquiry include the following:

1. Less staff time spent on phone calls;
2. Increased ability to conduct targeted follow-up; and
3. More accurate and efficient processing and payment of claims.

Providers will need to sign up to submit claims electronically and for electronic remittance. Once enrolled, providers can submit claims directly through a clearinghouse or through their current system and receive payments electronically. Providers can contact customer support at 1-844-214-8633.

**EDI NUMBER: SA001**
**CLEARING HOUSE: CLAIMS NET**




For those providers submitting paper claims, all completed claims forms should be forwarded to the address noted below:

**SIGNATURE ADVANTAGE CLAIMS**
**PO Box 21063**
**Eagan, MN 55121**

### *Timely Filing*

As a Signature Advantage participating provider, you have agreed to submit all claims within 180 days from the date of service or based on your contracted terms.

### *Claim Format Standards*

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

Signature Advantage can only pay claims which are submitted accurately. The provider is always responsible for

accurate claims submission. While Signature Advantage will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

### *Claim Payment*

Signature Advantage pays clean claims according to contractual requirements and CMS guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, but is not limited to, lack of data fields required by Signature Advantage or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for nonparticipating providers and suppliers, or circumstances requiring special treatment that prevents timely payment from being made on the claim. Clean claims should be processed within 30 days from receipt. Payment will be based on contracted rates and/or Medicare fee schedules. Non contracted providers will be paid based on plan rules and CMS guidelines.

Overpayment and with-holds – If an overpayment is identified by Signature Advantage, the Signature Advantage will notify the provider in writing about the overpayment. Providers will be asked to submit the refund within 30 days from the date of receipt of the notification. If a refund is not received in the specified time period, with-holds will be applied to any future payments until the refund is fully recouped. If the provider questions any overpayment recovery action, the provider may dispute the amount of the refund request within 30 days of the date of notice by submitting a letter to PO box 21063 Eagan, MN 55121 or call customer service at 1-(844)-214-8633 TTY 711.

### *Pricing*

Original Medicare typically has market adjusted prices by code (i.e. CPT or HCPCS) for services that traditional Medicare covers. However, there are occasions where Signature Advantage offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, Signature Advantage will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid.

Signature Advantage will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. Signature Advantage will also follow guidelines put forth by the AMA CPT, and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by Signature Advantage is subject to the grievance, appeals, and clinical review policies and procedures outlined in this manual.

### *New or Non-listed Codes*

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

Signature Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, Signature Advantage shall make every effort to load the new code with approved pricing at current published Medicare rates, subject to all applicable copayments, deductibles, and cost-sharing amounts. In the event a provider submits a code and the Signature Advantage claims system does not recognize it as a payable code, or does not have a contracted allowance, the following process will occur:

1. Signature Advantage retains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. This would include, but is not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS;
2. Provider may then dispute the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and
3. Signature Advantage shall pay for any such services that include proof of payment by Original Medicare within the past six (6) months at the current Medicare rates less all applicable copayments, deductibles, and cost-sharing.

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

All codes/services submitted for payment and not recognized by the claims system shall be subject to verification of medical necessity. Providers should call for pre-certification of any procedure/service/or code for which they have concerns about coverage.

Providers in the same group practice who are in the same specialty will be paid as though they were a single provider. For example, only one evaluation and management service may be paid unless a different specialty within the same group is providing a separate service.

### *Claims Encounter Data*

Providers who are being paid under capitation must submit claims within the same timely filing limit required for fee-for-service or non-capitated claims in order to capture encounter data as required per your Signature Advantage Provider Agreement.

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

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

### *Non-Payment / Claim Denial*

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

Obtaining pre-services review will reduce denials and the need for post service clinical review with possible denials, however pre-service review does not guarantee payment.

### *Processing of Hospice Claims*

When a Medicare Advantage (MA) member has been certified as hospice AND the premium Signature Advantage receives from CMS is adjusted to hospice status, the financial responsibility for that member shifts from Signature Advantage to Original Medicare. While these two conditions exist, Original Medicare covers all

Medicare–covered services related to the hospice condition rendered. The only services Signature Advantage is financially responsible for during this time include any benefits Signature Advantage offers above Original Medicare benefits that are non-hospice related, non- Medicare covered services such as; routine vision, audiology, prescription drug claims, etc.

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

# COORDINATION OF BENEFITS AND SUBROGATION GUIDELINES

### *General Definitions*

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

A plan will be determined to have Primary or Secondary responsibility for a person's coverage as defined below with respect to other plans by applying the NAIC rules.

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

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

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

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

### *Basic NAIC Rules for COB*

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

The following Medicare.gov websites serve as a guide:

- https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
- https://www.medicare.gov/publications/11546-Medicare-Coordination-of-Benefits-Getting-Started.pdf
- https://www.doi.gov/sites/doi.gov/files/migrated/flert/training/upload/Medicare-Guide-to-Who-Pays-First.pdf

### *Basic Processing Guidelines for COB*

For Signature Advantage to be responsible as either the primary or secondary carrier, the member must follow all HMO rules (i.e. follow appropriate referral process).

**When Signature Advantage is the secondary insurance carrier:**

- All Signature Advantage guidelines must be met in order to reimburse the provider (i.e. precertification, referral forms, etc.).
- The provider only requests payment for member cost sharing required.
- Once payment and/or EOB are received from the other carriers, submit the claim with the EOB to Signature Advantage for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

**When Signature Advantage is the primary insurance carrier:**

- Submit the claim to Signature Advantage first.
- Be sure to have a copy of the signed "assignment of benefits" on file and available if requested.
- Once payment has been received from Signature Advantage, submit a copy of the claim with the remittance advice to the secondary carrier for adjudication.
- The provider collects the co-payment required under the member's Signature Advantage Plan.

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

### *Worker's Compensation*

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

### *Subrogation*

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

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by the Signature Advantage Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

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

**For claims related questions, please contact your local Signature Advantage Network Provider Services Department at: (844) 214-8633.**

## PROVIDER APPEALS

A non-contracted provider appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Your appeal will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee that your request will be approved, or your claim paid. The appeal decision may still be to

uphold the original decision. All non-contracted providers are required to submit a Waiver of Liability form (WOL) with all requests for post service claim appeals.

An appeal must be submitted to the address/fax listed below within 60 days from the original decision notification date. You must include the following with your appeal request: a copy of your denial including the specific claim ID and line item being appealed, the members name, member health plan ID, name of person/party requesting the appeal, any medical records that would support why the service is needed, if for a hospital stay, a copy of the insurance verification done at time of admission, good cause explanation if provider did not follow prior authorization process, and contact information for the appellant.

**Appeal Request Address:**
SIGNATURE ADVANTAGE CLAIMS
PO Box 21063
Eagan, MN 55121
**Appeal Request Fax Number:**
Attention: Appeals Dept
(800) 880-3263
**Inquire on the Status of Your Appeal:**
(844) 214-8633

# HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS (a standardized data set) is developed and maintained by NCQA, an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include measures such as Comprehensive Diabetes Care, Care of Older Adults, Adult Access to Ambulatory and Preventive Care, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

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

All records are handled in accordance with Signature Advantage's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Signature Advantage's HEDIS results are available upon request. Contact the health plan's Quality Improvement Department to request information regarding those results. HEDIS® is a registered trademark of NCQA.

### *Behavioral Health*

Signature Advantage provides comprehensive mental health and substance abuse services to its members. Its goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality. Signature Advantage's network is comprised of mental health and substance abuse services and providers who identify and treat members with behavioral health care needs.

Integration and communication among behavioral health and physical health providers is most important. Signature Advantage encourages and facilitates the exchange of information between and among physical and behavioral health providers. Member follow-up is essential. High risk members are evaluated and encouraged to participate in Signature Advantage's behavioral health focused Case Management Program where education, care coordination, and support is provided to increase member's knowledge and encourage compliance with treatment and medications. Signature Advantage works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

### *Behavioral Health Services*

Behavioral Health services are available and provided for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

- Access to Signature Advantage's Member Services Department for orientation and guidance

- Routine outpatient services to include providers such as: psychiatrist, addictionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
- Initial evaluation and assessment
- Individual and group therapy
- Psychological testing according to established guidelines and needs
- In-patient hospitalization
- Inpatient and out-patient detoxification treatment
- Medication management
- Partial hospitalization programs

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

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

### *Responsibilities of the Primary Care Provider*

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

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

### *Access to Care*

Members may access behavioral health services as needed:

- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice.
- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Members and providers may call Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations at (844)214-8633.

### *Medical Record Documentation*

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-IV multi-axial classification system and document a complete diagnosis. The provision of behavioral health services requires progress note documentation that corresponds with day of

treatment, the development of a treatment plan, and discharge plan as applicable for each member in treatment.

### *Continuity of Care*

In the best interest of our members and to promote positive healthcare outcomes, Signature Advantage encourages continuity of care and coordination of care between medical providers and behavioral health providers.

# UTILIZATION MANAGEMENT

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

Signature Advantage UM staff base their utilization-related decisions on the clinical needs of members, the Member's Benefit Plan, InterQual's evidence-based clinical guidelines, the appropriateness of care, Medicare National and Local Coverage Guidelines, health care objectives, and evidence-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other such relevant information.

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

Departmental Functions:


### *Prior Authorization*

The PCP or Specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a member for an elective admission, and outpatient service. Signature Advantage recommends submitting a request at least seven (7) days in advance of the scheduled admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. To request a prior authorization go **HERE** or navigate to the Signature Advantage Plan Homepage → Providers and Partners → Request for Authorization.

To inquire on the status of your authorization providers should call: 1 (844) 214-8633. For Part D Prescription Drug Coverage requests go to Elixir-Home (elixirsolutions.com) or use CoverMyMeds, Surescripts, Online Coverage Determination (PromptPA). Services requiring prior authorization are listed in Table below and on Signature Advantage's website.

## Signature Advantage PAR Provider Prior Authorization Table

| Service Request Type (Source: Sig Advantage Plan 2025 PBP - Evidence of Coverage) | Applies to Sig Adv Plan (SAP), Sig Adv Community (SAC), or Both | Prior Authorization Required (Yes / No) | Notification within 24-hours Following Admission Event (Yes / No) | Continuation of Services Approval Required (Yes/No) | Pre-claim Retrospective Review Allowed (Yes/No) | 2024 to 2025 Change? |
|---|---|---|---|---|---|---|
| **Ambulance Services (Non-emergent)** | Both | Yes | No | NA | No | No |
| **Ambulatory Surgical Centers (ASC) Services** | Both | Yes | No | NA | No | No |
| **Cardiac & Pulmonary Rehab Services** | Both | Yes | No | Yes | No | No |
| **Chiropractic Services** | SAP | Yes | No | Yes | No | No |
| **Chiropractic Services** | SAC | No | No | Yes | No | No |
| **Diabetic Supplies and Services / Diabetic Therapeutic Shoes and Inserts** *(*Auth Required for billed charges in excess of $250)* | Both | Yes* | No | Yes | No | No |
| **Durable Medical Equipment (DME)** *(*Auth Required for billed charges in excess of $250)* | Both | Yes* | No | Yes | No | No |
| **Emergent/Urgent Services (USA territories only)** | Both | No | Yes | NA | Yes | No |
| **Home Health Services** | Both | Yes | No | Yes | No | No |
| **INN Specialist Referrals** | Both | No | No | No | No | No |
| **Inpatient Hospital - Acute** **Unplanned admissions do not require prior authorization however, the plan must receive notification of admission per CMS requirements and will perform a retro and concurrent review on unplanned admissions. Planned/scheduled admissions do require authorization prior to the service being rendered.* | Both | Yes* | Yes | Yes | Yes* | No |
| **Inpatient Hospital - Psychiatric** **Unplanned admissions do not require prior authorization however, the plan must receive notification of admission per CMS requirements and will perform a retro and concurrent review on unplanned admissions. Planned/scheduled admissions do require authorization prior to the service being rendered.* | Both | Yes* | Yes | Yes | Yes* | No |
| **Opioid Treatment Program Services** | Both | Yes | Yes | Yes | No | **No** |
| **Other Part B Drugs** *(*Auth Required for billed charges in excess of $250)* | Both | Yes* | No | Yes | No | No |
| **Outpatient Blood Services (Transfusions)** | Both | No | No | No | No | No |
| **Outpatient Diagnostic High tech Radiological Services (e.g. MRI, MRA, PET, CTA, CT Scans, and SPECT)** **No authorization required for general X-ray Services.* | Both | Yes* | No | NA | No | No |
| **Outpatient Diagnostic Procedures, Tests, and Lab Services** *EXCEPTION: *Please contract the UM department via fax at (800) 880-3263* | Both | Yes* | No | NA | No | Yes |
| **Outpatient Hospital Services** | Both | Yes | No | NA | No | No |
| **Outpatient Observations** | Both | Yes | Yes | Yes | No | No |
| **Outpatient Psychiatric Services** | Both | No | No | No | No | No |
| **Outpatient Substance Abuse Services** | Both | No | No | No | No | No |
| **Part B Chemotherapy Drugs** *(*Auth Required for billed charges in excess of $250)* | Both | Yes* | No | Yes | No | No |
| **Part B Drugs -** *Initial Chemotherapy Only* | Both | Yes | No | Yes | No | No |
| **Partial Hospitalization** **Unplanned admissions do not require prior authorization however, the plan must receive notification of admission per CMS requirements and will perform a retro and concurrent review on unplanned admissions. Planned/scheduled admissions do require authorization prior to the service being rendered.* | Both | Yes | No | Yes | No | No |
| **Physician Specialist Consultation Medical/Behavioral** | Both | No | No | No | No | No |
| **Podiatry Services** (Routine Foot Care) | Both | No | No | NA | No | No |
| **Prosthetics / Medical Supplies** *(*Auth Required for billed charges in excess of $250)* | Both | Yes* | No | Yes | No | No |
| **Renal (Kidney) Dialysis** | Both | No | No | No | No | No |
| **Skilled Nursing Facility Admission** | Both | Yes | Yes | Yes | No | No |
| **Therapeutic Radiology Services** | Both | No | No | NA | No | Yes |

| | | | | | | |
|---|---|---|---|---|---|---|
| ***Authorization required for high tech radiological services only: MRI, MRA, PET, CTA, CT Scans, and SPECT** | | | | | | |
| **Therapy Services (PT/OT/ST - Capped per facility contract)** | Both | No | No | No | No | No |
| **Additional Telehealth Services** *( Part B: PCP, Physician Specialist, Individual & Group Sessions for Psychiatric Services, Dialysis, Kidney Disease Education, Diabetes Self Management Training)* | Both | No | No | No | No | No |
| **Supplemental Benefit Over-the-Counter (OTC) Items (including Incontinence Supplies):** **(SAP $400/Quarter SAC $300/Quarter).** Must use Preferred Provider. | Both | No | No | No | No | Yes |
| **Supplemental Benefit Dental Services:** *Preventive (2 Oral exam visits; 2 Dental x-rays; and 2 prophylaxis/cleaning visits) per plan year.* *Comprehensive (Non-routine, Diagnostic, Medicare-covered Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery)* *Note: Comprehensive dental benefits are limited to a total maximum plan benefit of $2000 allowed (Plan paid amount) for the plan year.* | Both | No | No | No | No | No |
| **Supplemental Benefit Vision Services:** *SAP One (1) Routine Eye Exam and $275 toward eyewear cost* *SAC One (1) Routine Eye Exam and $325 toward eyewear cost* | Both | No | No | No | No | Yes |
| **Supplemental Benefit Remote Access Technology (Web/Phone-based technologies):** Members have the option to receive medical consultations with board certified licensed physicians through either phone or web-based video. Physicians can diagnose common health issues, recommend therapy, and if necessary and appropriate, write non DEA controlled prescriptions. This benefit is designed to handle non-emergent medical problems and members should not use this benefit if they are experiencing a medical emergency. To access services, members must register online or over the phone and provide their basic medical history. Appointments are available 24 hours a day, 365 days per year. Members may access services by phone (smartphone not required), computer, or tablet for their appointment. | Both | No | No | No | No | No |
| **Supplemental Benefit Home-Based Palliative Care:** Supportive Care (SC), a home based palliative care program puts the member at the center of decisions about their health, coordinating medical services consistent with their goals of care. This approach has shown improvement in symptom management, improved quality of life, and lower acute care utilization. SC supports members with an advanced illness that meets SC admission requirements. Members receive comfort-directed care, while continuing to receive curative treatment. •Coverage is limited to 250 calendar days of services in a 12 month period that begins the first day SC services are provided. | SAP | Yes | No | No | No | Yes |
| **Supplemental Benefit Foot Care:** *Plan covers an additional 6 Podiatry visits per year.* | SAC | No | No | No | No | No |
| **Supplemental Benefit Foot Care:** *Plan covers an additional 12 Podiatry visits per year.* | SAP | No | No | No | No | No |
| **Supplemental Benefit Hearing Services:** *One (1) Routine Hearing Exam and Hearing-aid Fittings* *(Plan pays up to $4000 every two years)* | Both | No | No | No | No | **Yes** |
| *NOTE: Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary. For benefits verification, please refer to Member's Evidence of Coverage posted at: www.signatureadvantageplan.com; or call Member Services at 844-214-8633.* | | | | | | |

The presence or absence of a service or procedure on the list does not determine coverage or benefits. Call our Customer Services Department to verify benefits, coverage, and member eligibility at 844-214-8633.

The UM Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with Signature Advantage at the time of the request for authorization and on each date of service.
- Verification that the requested service is a covered benefit under the member's benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Verification that the service is being provided by the appropriate provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The UM Department documents and evaluates requests utilizing Medicare benefits policies as well as nationally accepted criteria, processes the authorization determination in accordance with CMS guidelines, and notifies the provider of the determination. Examples of information required for a determination include, but are not limited to:

- Member Name, Date of Birth, and Health Plan Identification Number
- Name and Location of Service
- Primary Care Provider name
- Servicing/Attending provider name
- Diagnosis
- Service/Procedure/Surgery description and CPT, HCPCS, and Revenue Codes
- Authenticated Medical records including but not limited to Progress Notes, Lab and Radiology Results, and Physician Orders supporting the need for the service to be rendered.
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- ICD Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location
    - Inpatient
        - Acute hospital
        - Skilled nursing
        - Hospice
        - Long-term acute care
        - Rehabilitation
        - Behavioral health
    - Outpatient
        - Telehealth
        - Office
        - Home
        - Off-campus outpatient hospital
        - On-campus outpatient hospital

    - Ambulatory surgery center
    - Observation
- Referral
    - Office
    - Off-campus outpatient hospital
    - On-campus outpatient hospital
    - Ambulatory surgery center
    - Other
- Type of authorization – inpatient or outpatient
- Tax ID Number (TIN) and National Provider Identifier (NPI) number of requesting provider
- TIN and NPI of treatment facility where service is being rendered
- TIN and NPI of the provider performing the service
- Name and telephone number of all providers indicated
- Attending physician's telephone number
- Discharge plans

### *Initial Decision-Making Time Frames*

| Review Type | Plan's Notification Timeframe |
|---|---|
| Standard/non-urgent pre-service medical services | Within 14 calendar days of the request |
| Standard/Non-urgent pre-service Part B drug services | Within 72 hours of the request |
| Expedited/Urgent pre-service medical services | Within 72 hours of the request |
| Expedited/Urgent pre-service Part B drug services | Within 24 hours of the request |
| Post-service/Payment | Within 30 calendar days of the request |

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

**Routine** – If all information is submitted at the time of the request, Signature Advantage strives to make a determination within 1-3 days. CMS mandates the health plan render a determination within 14 calendar days.

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

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

### *Emergency Services*

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

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

Signature Advantage must be notified of all admissions within twenty-four (24) hours of admission (or the next business day). Please be prepared to discuss the member's condition and treatment plan with Signature Advantage's UM staff.

**Emergency -** Authorization is not required

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

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

### *Referral Process*

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

In-network Specialist visits do not require a referral. The specialist, however, is required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Out-of-network approval must be obtained prior to services being rendered. No retro-authorizations of out- of-network services will be accepted. Please note that we value the PCP role in taking care of our Signature Advantage members and that the PCP has a very important role in directing the member to the appropriate specialist based on your knowledge of the patient's condition and health history. It is also preferred that members are directed to participating providers when appropriate. In order to ensure this, please refer to our online Provider Directory for participating Specialists.

### *Self-Referrals*

Please refer to Signature Advantage's website to view the current Provider Directory for participating Specialists. If a member has a preference, the PCP should accommodate this request if possible. The only exceptions where the member may self-refer are:

- To a participating Gynecologist for annual gynecological exam and to see a non- participating OB/GYN. The PCP may perform the annual exam if agreed upon by the member.
- Mental health referrals to Signature Advantage's Behavioral Health Care.
- Vision Exams – Members who have a Vision benefit may self-refer to a participating provider.
- Dental Coverage – Members who have a Dental benefit may self-refer to a participating Dental provider.

### *Retrospective Review*

Retrospective review is the process of determining coverage for clinical services by applying guidelines/criteria to support the claim adjudication process after the opportunity for prior authorization or concurrent review timeframe has passed, generally as part of the contract Provider Dispute process. After confirming the member's eligibility and the availability of benefits at the time the service was rendered, contract providers should submit an explanation for why a prior auth was not obtained and all supporting clinical documentation (medical records) with the claim for dispute review. Providers can submit claims and documentation directly through a clearinghouse or through their current system:

**EDI NUMBER: SA001**
**CLEARING HOUSE: CLAIMS NET**

For those providers submitting paper claims, all completed claims forms and supporting documentation should be forwarded to the address noted below:

**SIGNATURE ADVANTAGE CLAIMS**
**PO BOX 21063**
**Eagan, MN 55121**

In most cases, if the requesting contracted provider failed to provide timely notification or obtain preauthorization of services, the member must be held harmless regardless of the Plan's dispute decision.

### *Concurrent Review*

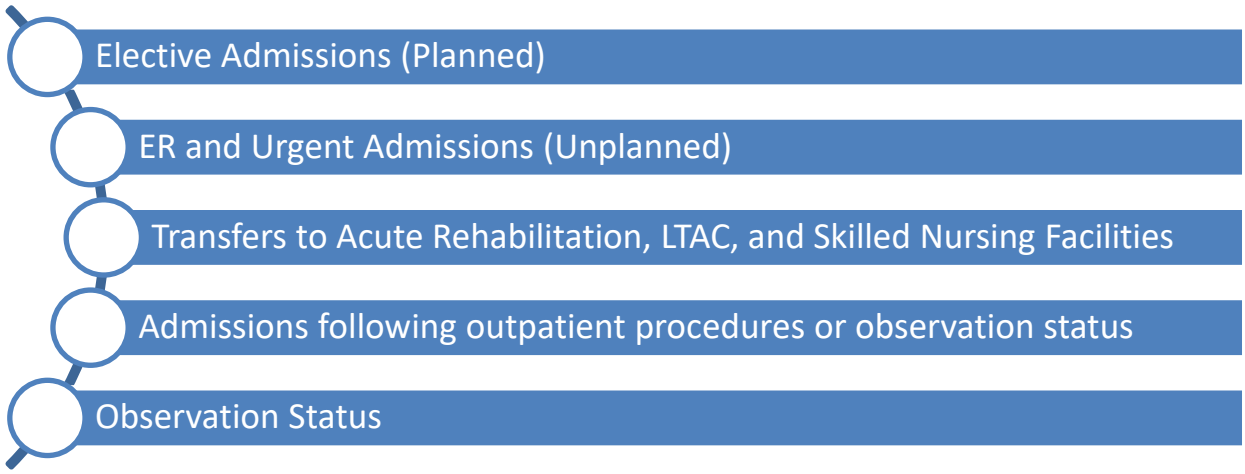
Concurrent Review occurs following an initial assessment. This includes the continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission, SNF admission, or other inpatient admission in order to ensure:

- Covered services are being provided at the appropriate level of care.
- To assist and facilitate transfer/Discharge planning.
- Services are being administered according to the individual facility contract.

Providers are required to deliver all CMS notices.

***Admission Notifications:***

In addition to prior authorization requirements, Signature Advantage requires notification within 24 hours for




the following services:

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

Signature Advantage's Utilization Management Department complies with individual facility contract requirements for concurrent review decisions and timeframes. Signature Advantage's UM nurses, utilizing Medicare Benefits policies and InterQual clinical care guidelines, will conduct medical necessity reviews. In the event the UM Nurse reviewer is unable to approve requested services, the nurse reviewer will refer the request to Signature Advantage's medical director for determination. The facility must provide all requested clinical updates and documentation by faxing Signature Advantage's UM fax line at (800) 880-3263. If sufficient clinical information is not received timely (within 24 hours of admission time or last covered day), the case will be reviewed for medical necessity with the information Signature Advantage has available.

Review is not required for readmission back to the referring Nursing Facility (the member's primary residence nursing facility); however, if the patient is transitioning to a skilled level of care, the SNF is required to request authorization of skilled services within 24 hours of transfer. All out- of-network SNF reviews should also be faxed to (800) 880-3263. Signature Advantage will render a determination within 24 hours of receipt of complete clinical information. The UM nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a timely determination. Clinical update information should be received within 24 hours of the last covered day,

A Signature Advantage Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made please call (502) 200-0217. The provider is also encouraged to contact Signature Advantage's

Medical Director for Peer-to-Peer discussion regarding the request. The telephone number to contact our Medical Director for the discussion is (502) 200-0217. Following the Peer-to-Peer discussion, the Medical Director will make a final determination to either authorize or deny the requested service.

Signature Advantage may issue facility denials when any inpatient facility fails to provide requested clinical records and updates as required. A facility denial may also be issued if a member who is already receiving care in an Inpatient Hospital or Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care, Signature Advantage will issue a written facility denial notification. The provider cannot balance bill the member when a facility denial is issued.

***Special Requirements for SNFs, HH Agencies, and CORFS:***

Signature Advantage also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines to Skilled Nursing Facilities (SNFs), Home Health (HH) Agencies, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). This notice will be sent by fax to the SNF and delivered to the member within 2 days of the last covered day. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative, or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and his/her signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:

- The member's last day of covered services and the date when the beneficiary's liability is expected to begin
- The member's right to appeal a coverage termination decision
- A description of how to request an appeal by a QIO
- The deadline to request a review, as well as what to do if the deadline is missed
- The telephone number of the QIO to request the appeal.

The date when the information is verbally communicated is considered the NOMNC's receipt date. The facility/Provider must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical record, mailed to the representative the same day as the telephone contact, and faxed to Signature Advantage Utilization Management department.

The NOMNC includes information on a members' rights to file a fast-track appeal with CMS' designated Quality Improvement Organization (QIO). When notified by Signature Advantage UM that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

• Provide medical records and documentation to Signature Advantage and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.

• Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Signature Advantage to the member or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can appeal through Signature Advantage's appeals department. For more information about notification of termination requirements, practitioners can visit the CMS website. Examples have been provided below and include:

| Notice | Primarily Issued By | Delivered to the Member or Member Representative By | Type of Notice | Provider Type | Purpose |
|---|---|---|---|---|---|
| Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123) | Signature Advantage | Facility/Provider | Expedited Determination Notices | HHAs, SNFs, Hospices, and CORFs | Informs beneficiaries of their discharge when their Medicare covered services are ending. |
| Detailed Explanation of Non-Coverage (DENC, Form CMS-10124) | Signature Advantage | Facility/Provider | Expedited Determination Notices | HHAs, SNFs, Hospices, and CORFs | Given only if a beneficiary requests an expedited determination. Explains the specific reasons for the end of covered services. |
| Important Message from Medicare (IM, Form CMS-10065) | Hospital | Hospital | Hospital Discharge Appeal Notices | Hospitals | Informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. |
| Detailed Notice of Discharge (DND, Form CMS-10066) | Signature Advantage | Hospital | Hospital Discharge Appeal Notices | Hospital or MA Plan | Given only if a beneficiary request expedited review of a discharge decision. Explains the specific reasons for the discharge. |
| Integrated Denial Notice (IDN, Form CMS-10003) | Signature Advantage | Facility/Provider | Denial Notices | Medicare Health Plans | Issued upon denial, in whole or in part, of an enrollee's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment. |
| Medicare Outpatient Observation Notice (MOON) | Hospital | Hospital | Hospital notice of observation services and are not inpatients | Hospital or MA Plan | Issued to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). |

### *Special Requirements for Hospitals*

Medicare beneficiaries and providers have certain rights and protections related to financial liability and appeals under the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers:

- MA Denial Notices (MA Denial Notices)
- MA Expedited Determination Notices (MA Expedited Determination Notices)
- Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) (Hospital Discharge Appeal Notices)
- Medicare Outpatient Observation Notice (MOON)
- Notice of Medicare Non-Coverage (NOMNC)

### *Hospital Discharge Rights for Medicare Advantage Members*

The CMS requires that hospitals deliver the Important Message from Medicare (IM) to all Medicare beneficiaries, including Medicare Advantage (MA) plan members who are hospital inpatients. Hospitals are required to provide the IM to the MA member upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM are on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/BNI. The IM informs hospitalized MA beneficiaries about their hospital discharge appeal rights and their right to request an "immediate review" by the QIO when Signature Advantage, along with the hospital and physician, determines that inpatient care is no longer necessary.

If the hospital staff is unable to personally deliver the IM to the patient or his/her representative, then the hospital staff should call the patient or representative to advise him/her of a member's rights as a hospital patient, including the right to appeal a discharge decision. At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital.
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins.
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision.
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged.
- A description of the steps for filing an appeal.
- When (by what time/date) the appeal must be filed to take advantage of the liability protections.
- To whom to make the appeal to, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion.

The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. The hospital also is required to:

- Confirm the telephone contact by written notice mailed to the member's authorized representative on that same date.
- Place a dated copy of the notice in the member's medical record and document the telephone contact with either the member or his/her representative on either the notice itself or in a separate entry in the member's record.
- Ensure that the documentation indicates that the staff person told the member or

representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.

- Ensure that the documentation includes the name of the staff person initiating the contact, the name of the member or representative contacted by phone, the date and time of telephone contact and the telephone number called. When direct phone contact with a member or a member's representative cannot be made, the hospital must:
- Send the notice to the member or representative by certified mail (return receipt requested) or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical record and document the attempted telephone contact to the member or representative.

Ensure that the documentation includes:

- The name of the staff person initiating the contact.
- The name of the member or member's representative.
- The date and time of the attempted call.
- The telephone number called.

### *Right to Appeal a Hospital Discharge*

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-10065, to all Medicare beneficiaries who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A Detailed Notice of Discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge. If a member chooses to appeal a discharge decision, the hospital or Signature Advantage must provide them with the Detailed Notice of Discharge (DND). When the CMS Quality Improvement Organization (QIO) notifies the hospital and Signature Advantage of an appeal, the hospital is responsible for delivering the DND as soon as possible to the member or his or her authorized representative on behalf of Signature Advantage, but no later than noon local time of the day after the QIO notifies Signature Advantage or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Signature Advantage.

## ADVERSE DETERMINATIONS

### *Rendering of Adverse Determinations (Denials)*

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based on contractual terms, benefits, or eligibility. Every effort is made to obtain all necessary information, including pertinent clinical information from the treating provider to allow the Medical Director to make appropriate determinations.

Only a Signature Advantage Medical Director may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Signature Advantage notifies the facility or provider's office of the denial of service. Such notice is issued to the provider and the member, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

Signature Advantage employees are not compensated for denial of services. The PCP or Attending Physician may contact the Medical Director by telephone to discuss adverse determinations.

### *Notification of Adverse Determinations (Denials)*

The reason for each denial, including the specific utilization review criteria or benefits provision used in the determination of the denial, is included in the written notification, and sent to the provider and/or member as applicable. Written adverse notifications are sent in accordance with CMS requirements to the provider and/or member as follows:

| Review Type | Plan's Notification Timeframe |
|---|---|
| Standard/Non-urgent pre-service medical services | Within 14 calendar days of the request |
| Standard/Non-urgent pre-service Part B drug services | Within 72 hours of the request |
| Expedited/Urgent pre-service medical services | Within 72 hours of the request |
| Expedited/Urgent pre-service Part B drug services | Within 24 hours of the request |
| Post-service/Payment | Within 30 calendar days of the request |

Initial oral notification of the denial decision is provided with electronic or written notification sent no later than 3 calendar days after the oral notification

### *Clinical Practice Guidelines & Reference Material*

Signature Advantage has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Signature Advantage promotes the use of clinical practice guidelines to:

- define clear goals of care based on the best available scientific evidence
- reduce variation in care and outcomes
- provide a more rational basis for clinical management of some conditions
- comply with accreditation standards and regulatory expectations

Signature Advantage developed and maintains a Clinical Practice Guidelines policy, including, but not limited to, the following adopted and implemented guidelines:

| | | |
|---|---|---|
| Preventative Care | CDC | Adult Immunizations |
| | The US Prevention Taskforce | US Prevention Taskforce |
| Cardiovascular | Journal of the American College of Cardiology | Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults |
| | Journal of the American College of Cardiology | Coronary Artery Disease in Patients >80 Years of Age |
| | American Heart Association | Atherosclerotic Cardiovascular Disease |
| | SpringerLink | Statin Therapy in Cardiovascular Disease |
| | Journal of the American College of Cardiology | Statin Therapy in The Elderly |
| COPD | Global Institute for Chronic Obstructive Lung Disease | COPD Prevention, Diagnosis and Management |
| Depression | ICSI | Depression |
| Dementia | Alzheimer's Association | Dementia Care |

| | | |
|---|---|---|
| Diabetes | American Diabetes Association | Diabetes Medical Care |
| Kidney Disease | Journal of the American Medical Association | Kidney Disease |
| Tobacco Dependency | Agency for Healthcare Research and Quality | Tobacco Use and Dependence |
| Chemical Dependency | American Psychiatric Association | Substance Use Disorders |

Signature Advantage's guidelines have been adopted based on valid and reliable clinical evidence from available peer-reviewed, evidence-based standards. Signature Advantage will review, revise, and approve these guidelines, using nationally recognized, evidenced-based literature. NCQA HEDIS Best Practices and CMS Star Rating Methodologies are also adopted by the plan.

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

### *Quality Improvement Program Overview*

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

### *Quality Committee*

The Committee will monitor provisions of care, identify problems, recommend corrective action, and guide the education of providers to improve health care outcomes and quality of service. The Committee also will conduct peer reviews, assign severity levels, and make recommendations for corrective actions, as needed.

### *Continuous Quality Improvement Process*

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

- Determination of the relevance of the issue to the population.
- Evaluation of baseline measure(s).
- Analysis to identify an opportunity for improvement.
- Analysis to identify possible root cause or barriers.
- Planning and implementation of actions to eliminate possible root causes or barriers.

- Evaluation of performance and effectiveness of the interventions by re-measurement after implementing actions.
- Analysis to determine how actions impacted performance.
- Continued re-measurement to determine whether improvements are sustained.

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

### *Quality Improvement Projects*

Signature Advantage will conduct and/or participate in at least two (2) Quality Improvement Projects each year. In addition to plan-specific Quality Improvement Projects, Signature Advantage will also consider collaborative Quality Improvement Projects with CMS, through the QIO, and other health plans in a statewide collaborative.

### *Quality of Care Issues*

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues that are usually identified by the Utilization Management staff and referred to the Quality Improvement Department staff. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting that could be indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families, or providers that could indicate a potential problem in the provision of quality care and services.

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

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

**Quality complaints are categorized as:**

- Access to care
- Availability of services
- Clinical quality of care concerns
- Provider/staff concerns

All Quality-of-Care issues are reviewed and investigated. Quality often requests records from providers and facilities as part of the investigation. Quality of care issues are reviewed by the QIC. Any action taken is documented in the provider's record and reviewed by the Credentialing Committee at the time of recredentialing. Quality of Care issues are highly confidential all quality of care/service issues may be faxed to the QI Department at (800) 880-3263.

### *Utilization Reporting and Monitoring*

Over-and under-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. By utilizing data from providers, individual product lines, and the system, Signature Advantage monitors for under- and over- utilization, analyzes data to identify the causes, and takes action to correct any issues identified. Signature Advantage then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions.

# CARE MANAGEMENT

### *The Role of the Nurse Practitioner*

The Certified Nurse Practitioner in collaboration and consultation with PCP, physicians, staff RN's and other health care professionals, provides holistic, compassionate care to members and families. The Nurse Practitioner provides care coordination and care management activities on behalf of Signature Advantage. The Nurse Practitioner practices within the context of collaborative management with a physician(s) in diagnosing, managing, and preventing acute and chronic illness and disease, and promoting wellness. Nurse Practitioners provide independent nursing functions based on nursing standards of care and a role in medical management working within a collaborative agreement with a physician(s). The Nurse Practitioner's role includes:

- On-site primary care support, closing gaps in care, and assisting with health care maintenance.
- Assessment, care planning, and communication.
- Medication review and monitoring.
- Early identification and treatment of symptoms Signature Advantage's Nurse Practitioners offer:
    - Coordinated care and more personal attention.
    - One point of contact for communication with the member, their caregiver/family, the doctors, and nursing staff.
    - Frequent and reliable clinician visits at least once a month, but may be weekly, depending on the member's needs.
    - Frequent visits to help prevent unavoidable trips to the hospital.
    - Completion of tests and treatments in the nursing home that are normally done in the hospital. For example, Nurse Practitioners will help avoid hospitalizations because they can provide clinical oversight in the nursing home for treatments often done in the hospital (like IV diuretic therapy for congestive heart failure patients).

The Nurse Practitioner will function as an in-the-field case manager and provide protocol driven primary care medicine. Upon member enrollment into the Plan, the Nurse Practitioner will conduct a comprehensive face- to-face history and physical, develop a plan of care with interventions based on the member's acuity at that point in time, and collaborate with the Interdisciplinary Care Team (ICT). A regular presence in the nursing facility, the Nurse Practitioner, supported by the PCP and ICT, will actively monitor the member's condition and proactively treat chronic conditions.

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

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

### *Discharge Planning/Acute Care Management*

Discharge Planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Signature Advantage utilizes assigned Nurse Practitioners to coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. All contracted Hospitals, Nursing Homes, Rehab Hospitals, LTACHs, and other inpatient facilities are obligated to allow Signature Advantage Care Managers (usually the Nurse Practitioner) access to Signature Advantage members for purposes of case management and utilization management activities for Signature Advantage members.

### *Transitions of Care*

Each Member will be assigned a Nurse Practitioner who will be responsible for facilitating safe transitions. The Signature Advantage Nurse Practitioners understand how coordinated health care improves the care of this vulnerable Membership, and will work to ensure coordinated care by:

- Giving Members and families one accountable point of contact – the assigned Nurse Practitioner.
- Educating Members and caregivers on Member diagnoses.
- Setting goals that promote coordinated care.
- Making and keeping specific tasks/appointments, follow up items with Members.
- Coordinating care within and across treatment settings between external and internal stakeholders.

- Creating a process through which health care providers can communicate with one another about the Member's care.
- Making Member preferences known and accessible to all health care providers.

As a part of the care transition process, the Nurse Practitioner will be an advocate in ensuring the member's well-being across multiple care settings and across the health spectrum.

The Nurse Practitioner will ensure that the highest quality of health care will be delivered to the member in each of the health care settings. Signature Advantage is committed to ensuring a safe care transition process and our Nurse Practitioners will have the following focus:

**Member-Centered Care**

- The Nurse Practitioner as a key point of contact for communication with the member, their family, the doctors, and nursing staff. Transitions occurring with the member's and/or caregiver and family's input and understanding to the extent possible. The member, caregiver and family are engaged and educated as to the reason(s) for the transition, nature and severity of the condition(s) and goals.
- Transitions consistent with the member's care goals and advance care directives.
- Transitions including appropriate member and caregiver education.

**Communication**

- Peer to peer communication will be established across sites of care, including the exchange of reliable contact information, for problem-solving and optimization of care to meet the member's specific needs.
- Information about the member, including medication and care plans, will be collected prior, during and post care transition.

**Safety**

Safe transitions will rely on:

- Appropriate assessment of the member prior to transition.
- Prompt and consistent medication reconciliation at every transition point, as well as proper planning to ensure no discrepancies in administration of medication.

Safety will require accurate and timely transition of key information including but not limited to the following:

- Member's functional and cognitive status
- Plan of care and advance care directives
- Current problem list
- Current treatment regimen, including all necessary equipment needed
- Allergies
- Meal consistencies and preferences
- Recent labs, consultations, and diagnostic testing results

A member of the Interdisciplinary Care Team (ICT) will ensure the exchange of the member's Individualized Care Plan (ICP) and other relevant information is shared across the care sites. The Interdisciplinary Care Team will send the member's existing ICP within 24 hours of the transitional episode to the receiving care setting.

The ICP will contain information about the member that facilitates communication, collaboration, and continuity of care across the care sites. The Nurse Practitioner will work with the ICT to establish a discharge plan, including setting a discharge date and discharge planning goals that best suit the member's needs.

### *Case Management Services*

The Signature Advantage Case Management Program is an administrative and clinically proactive process that focuses on coordination of services for members with multiple comorbidities, complex care needs and/or short-term requirements for care. The Program is designed to work as a partnership between members, providers, and other care management staff. The goal is to provide the best clinical outcomes for members. The central concept is early identification and assignment of a designated Nurse Practitioner who provides education and measurement of compliance with standards of care. The assigned Nurse Practitioner strives to enhance the member's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost-effective outcomes. The assigned Nurse Practitioners have specific clinical expertise and provide support services and coordination of care in conjunction with the treating provider and other members of the medical support team.

### *Case Management Approach*

Signature Advantage strives to promote continuity and coordination of care, remove barriers to care, prevent complications and improve member quality of life. It is important to note that Signature Advantage treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity. In doing so, Signature Advantage can seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

When a member enrolls with Signature Advantage, they are assigned a Nurse Practitioner. The Nurse Practitioner meets with the member and/or their caregiver face to face and establishes themselves as the member's primary point of contact for all of their healthcare needs, including development of the Individualized Care Plan and coordinating all transitions in care.

Assigned Nurse Practitioners will utilize a Signature Advantage approved Health Risk Assessment Tool (HRAT) that is comprehensive, specialized for institutional patients, and administered in person as part of a Comprehensive Exam.

The Comprehensive Exam includes a full history and physical (H&P), the CMS required elements of an Annual Wellness Visit (AWV) for Hierarchical Condition Category (HCC) coding, and administration of the HRAT and occurs within 60 days of enrollment, and annually thereafter. Based on the results of the comprehensive assessment, the member will be assigned a total risk score and stratified as low, moderate, or high risk.

Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify members for case management intervention. The plan uses a streamlined operational approach to identify and prioritize member outreach and focuses on working closely with members and family/caregivers to close key gaps in education, self- management, and available resources.

Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Members continue to receive case management support while enrolled in the Signature Advantage Plan.

### *Coordination with Network Providers*

Signature Advantage offers members access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, mental health, and alcohol and substance abuse specialists, as well an ancillary care network. Each member has access to a Provider Directory annually and upon request, giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP, conditions under which out-of-area and out- of-network providers may be seen, and procedures for when the member's provider leaves the network. A toll-free Member Services Department telephone number is provided, and members with questions are asked to reach out to the Plan. Members also have access to a series of web- based provider materials.

The provider is a key member of the Interdisciplinary Care Team (ICT). Our assigned Nurse Practitioners will work with you and your staff to meet the unique needs of each member. Assigned Nurse Practitioners work with members and providers to schedule and prepare for member visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, the Nurse Practitioner will work closely with members to identify appropriate providers, obtain referrals, schedule visits, and secure transportation.

### *Communications*

Signature Advantage provides multiple communication channels to members. The Plan maintains a full-service inbound call program that allows members to inquire about all aspects of their relationship with the Plan. Member services and care management staff make outreach to our members to encourage them to participate in clinical programs and assessment activities provided as part of their health care benefit. In addition to telephonic touch points, the Plan regularly provides educational materials to members in response to identified care gaps and changes in health status.

### *Program Evaluation*

Signature Advantage continually monitors its Quality Program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the Program are made under two conditions: (1) changes must benefit members; and (2) changes must follow applicable regulations and guidance. Changes to the Program are accompanied by policy and procedure revisions and staff training as required. The Program operates under the umbrella of the plan's Quality Improvement Committee which reports to theBoard of Directors. It is reviewed and updated annually in collaboration with the Quality Improvement Department.

### *Confidentiality*

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

### *Continuity of Care*

Signature Advantage's policy is to provide continuity and coordination of care between medical and behavioral health services. Should a practitioner leave Signature Advantage's network and a member is in an active course of treatment,
our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.
In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, Signature Advantage will work to transition a member into care with a Participating Physician or another provider within Signature Advantage's network. Signature Advantage is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Signature Advantage also recognizes that as new members join our health plan and may have already begun treatment with a provider who is not in Signature Advantage's network. Under these circumstances, Signature Advantage will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Signature Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at (844) 214-8633.

# CORPORATE COMPLIANCE PROGRAM

### *Compliance Overview*

The purpose of Signature Advantage's Corporate Compliance Program is to articulate Signature Advantage's commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Signature Advantage's operations. Further, Signature Advantage's Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

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

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing Signature Advantage's lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

Signature Advantage has policies and procedures in place for coordinating and cooperating with NBI MEDIC (National Benefit Integrity Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. Signature Advantage also has policies that delineate that Signature Advantage will cooperate with any audits conducted by CMS, NBI MEDIC or law enforcement or their designees.

Call the anonymous Signature Advantage Compliance Hotline toll-free at (833) 742-6004.

### *Fraud, Waste, and Abuse*

Signature Advantage has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 C.F.R. § 422.503 and 42 C.F.R. § 423.504, and Signature Advantage has policies and procedures in place for cooperating with CMS and law enforcement entities.

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

- Anonymously by calling the toll-free Compliance Hotline at (833) 742-6004. The Compliance Hotline is a completely confidential resource that can be used by employees, contractors, agents, members, or other parties to voice concerns about any issue that may affect Signature Advantage's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at compliance@signatureadvantageplan.com.
- By mail at Signature Advantage, Chief Compliance Officer, 805 N Whittington Pkwy, Louisville, KY 40222
- Directly by phone at (502) 410-6859

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

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our members, Signature Advantage conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows Signature Advantage to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Signature Advantage will review your coding and may review medical records of providers who continue to show significant variance from their peers. Signature Advantage endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Signature Advantage's medical management efforts and our provider community. As a result, you may be

contacted by Signature Advantage's contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

To meet your FWA obligations, please take the following steps:

- Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

Complete the mandatory FWA online training at CMS' Medicare Learning Network per CMS' requirements You may request a copy of the Signature Advantage Compliance Program document by contacting Signature Advantage Network Operations at (844) 214-8633; or call the Signature Advantage Compliance Officer at (502) 410-6859 or compliance@signatureadvantageplan.com

### *Medicare Advantage Program Requirements*

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage Program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage Program. Such amendment shall not require the consent of provider or Signature Advantage and will be effective immediately on the effective date thereof.

1. Books and Records; Governmental Audits and Inspections. Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers, and accounts relating to provider's performance of the Agreement and transactions related to the CMS Contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.
2. Privacy and Confidentiality Safeguards. Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.
3. Member Hold Harmless. Provider shall not, in any event (including, without limitation, non-payment by Signature Advantage or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any member for any amount(s) that Signature Advantage may owe to provider for services performed by provider under the Agreement. This provision shall not prohibit provider from

collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.

5. Delegation of Activities or Responsibilities. To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement ("Delegated Activities"), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Signature Advantage; and (ii) in the event that the Signature Advantage or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable State and/or Federal laws and regulations and CMS instructions, then Signature Advantage shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of Signature Advantage. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by Signature Advantage, or (ii) provider's credentialing process will be reviewed and approved by Signature Advantage and Signature Advantage shall audit provider's credentialing process on an ongoing basis. Provider acknowledges that Signature Advantage retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that Signature Advantage maintains ultimate accountability under its Medicare Advantage contract with CMS.
6. Prompt Payment. Signature Advantage agrees to pay provider in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to Signature Advantage members. For purposes of this provision, a clean claim shall mean a claim for provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Signature Advantage.
7. Compliance with Signature Advantage's Obligations, Provider Manual, Policies and Procedures. Provider shall perform all services under the Agreement in a manner that is consistent and compliant with Signature Advantage's contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the Signature Advantage Provider Manual and all policies and procedures relating to the Benefit Plans.
8. Subcontracting. Signature Advantage maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Signature Advantage. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain Signature Advantage and member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing Signature Advantage and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to members or Benefit Plans upon request of Signature Advantage.
9. Compliance with Laws. Provider shall comply with all State and Federal laws, regulations, and

instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the Anti-Kickback statute (42 U.S.C. 1320) of the Social Security Act).

10. Program Integrity. Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify Signature Advantage immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in Signature Advantage shall be terminated if provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.
11. Continuation of Benefits. Provider shall continue to provide services under the Agreement to members in the event of (i) Signature Advantage's insolvency, (ii) Signature Advantage's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Signature Advantage, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.
12. Incorporation of Other Legal Requirements. Any provisions now or hereafter required to be included in the Agreement by applicable Federal and/or State laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Manual or elsewhere in your Agreement.
13. Conflicts. In the event of a conflict between any specific provision of your Agreement and any specific provision of the Manual, the specific provisions of this Manual shall control.

### *Dispute Resolution*

Any controversy, dispute or claim arising out of or relating to your Provider Agreement ("Agreement") or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against Signature Advantage, an Affiliate, provider, or any provider ("Defendant"), any cross-claim or third party claim by such Defendant against Signature Advantage, an Affiliate, provider, or any provider Facility shall not be subject to arbitration. In the event arbitration becomes necessary, such arbitration shall be initiated by either Party making a written demand for arbitration on the other Party.

The arbitration shall be conducted in the county where the majority of the services are performed, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The Parties agree to be bound by the decision of the arbitrator.

The Parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party. Notwithstanding this Agreement to arbitrate, Signature Advantage, an Affiliate, provider, or any provider Facility may seek interim and/or permanent injunctive relief pursuant to this Agreement in the county where the majority of the services are performed in any court of competent jurisdiction. With respect to disputes arising during the life of this Agreement, this Section shall survive the termination or expiration of the Agreement.