scan

2024

Provider Operations Manual

Arizona, Nevada, New Mexico, and Texas

Summary of 2024 Changes

SCAN updates its Provider Operations Manual (POM) every year.
Below is a summary of changes for the Arizona, Nevada, New Mexico, and Texas 2024 POM edition.

Chapter 1: Benefit Plans – Special Needs Plans – Language added to provide new guidance regarding: Institutional Special Needs Plan (I-SNP)

Chapter 2: Transportation – Language added for clarification purposes and to provide additional guidance.

Chapter 4: **Medicare Wellness Assessment** – Language added to provide new guidance.

Post Hospitalization Visit – Transitions of Care – Language updated for clarification purposes.

Chapter 5: **Timeline for Re-Credentialing** – Language added for clarification purposes.

Provider Changes (Additions, Terminations, Panel Closures) – Language updated to provide new guidance regarding Termination of Primary Care Physician (PCP) or Behavioral Health Provider.

Member Notification (Provider Terminations) – Language added for clarification purposes and to provide additional guidance.

Out of Area/Network Services v. Directed Care/In Area Initiated Care – Language added to provide additional guidance.

Specialty Care – Language added to provide additional guidance.

Access to Care Standards and Hours of Operation – Language added for clarification purposes and to provide additional guidance regarding Accessibility Standards.

Provider Training and Education – Language added to provide additional guidance.

Member Rights and Nondiscrimination – Language added to provide additional guidance.

Disruptive Member Issues – Language added for clarification purposes and to provide additional guidance.

FDR and Compliance Program Requirements – Language added to provide additional guidance regarding 1) General Compliance Training 2) Fraud, Waste and Abuse (FWA) Training 3) Submission of all required attestations to demonstrate compliance.

Chapter 6: **Prior Authorization** – Language added to provide additional guidance.

Timeliness of Pre-Service Organization Determinations (Part C) – Language added to provide additional guidance regarding: To Render Decision and Notify Member and Provider (from Receipt of Request)

Notice Requirements – Language updated and added for clarification purposes and to provide additional guidance regarding: 1) To Member (or Physician) After Denial of Medical Coverage 2) To Member (or Physician) Where Group is Not Responsible for Services

Chapter 8: **Patient Experience** – Language added to provide additional guidance.

Chapter 10: Audit Summaries – Language added for clarification purposes and to provide additional guidance.

Summary of 2024 Changes

SCAN updates its Provider Operations Manual (POM) every year.
Below is a summary of changes for the Arizona, Nevada, New Mexico, and Texas 2024 POM edition.

Chapter 11: Part D Formulary – Language added to provide additional guidance.

Part D Vaccines – Language added to provide additional guidance.

Part B Prescription Drugs – Language added to provide new guidance.

Chapter 12: Provider Payment – Language added to provide guidance to individual providers directly contracted with SCAN.

Chapter 13: Claims – Language updated and added for clarification purposes and to provide additional guidance.

Definition of Clean Claim – Language added to provide additional guidance.

Claims Submission – Language updated and added for clarification purposes and to provide additional guidance.

Overpayment and Recovery – Language added to provide additional guidance.

Coordination of Benefits – Language updated and added for clarification purposes and to provide additional guidance.

Rejected v. Denied Claims – Language added to provide additional guidance.

Payment – Language updated for clarification purposes.

Provider Claims Disputes and Appeals – Language added to provide additional guidance.

Guidance for Providers Delegated for Claims Activities – Language updated and added to provide additional guidance.

Chapter 16: Privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Language updated and added for clarification purposes and to provide additional guidance.

Note: Throughout the SCAN Health Plan 2024 Provider Operations Manual – Arizona, Nevada, New Mexico, and Texas:
Network Management – NetworkMgmt@scanhealthplan.com has been replaced with
Network Relations – NetworkRelations@scanhealthplan.com

Contents

About SCAN

*Our **mission** is simple: Keeping Seniors Healthy and Independent. That's been our mission since we were founded in 1977.*

It started when a group of senior activists in Long Beach, California got together, determined to improve access to the care and services they needed so they could stay as independent as possible. They brought together experts in medicine, gerontology, psychology, and social services and formed the Senior Care Action Network, a not-for-profit health plan for people with Medicare.

Now known as SCAN, we are still not-for-profit. And we are still dedicated to helping our Members live how and where they choose, with the assistance they might need as they get older.

To learn more about SCAN, please visit our website:

https://www.scanhealthplan.com

Chapter 1: Welcome and Overview

Welcome

Congratulations and welcome to a new year with the SCAN family! We look forward to working with you to meet high quality of care standards and provide and manage cost-effective health care for our Members.

About this Manual

This manual outlines your responsibilities as a provider participating in the SCAN network of providers. As indicated in your provider contract with SCAN, you are obligated to comply with the terms of this manual.

This manual is updated annually and is available on our website at *https://www.scanhealthplan.com*.

The use of the term "provider" in this manual refers to individuals and entities contracted with SCAN to provide health care or ancillary services to Members, "provider" shall also mean any subcontractor contracted with a "provider" to provide services to Members. The use of the term "group" or "medical group" or "provider group" in this manual refers to a provider that is a medical group or IPA. All capitalized terms are defined in accordance with Medicare rules unless a different definition is stated in this manual or in your contract with SCAN.

Non-Interference

Nothing contained in this manual is intended or shall be construed to interfere with the professional relationship between a Member and his/her physician(s), including the physician's ability to discuss treatment options with the Member or advocate for the Member in his or her Grievances relating to services. Providers likewise may not prohibit Members from completing SCAN surveys and/or otherwise expressing their opinion regarding services received from providers.

Medicare Advantage

SCAN is a Medicare Advantage Organization (MA Organization) subject to the requirements of the Medicare Advantage (MA) Program as administered by the Centers for Medicare & Medicaid Services (CMS). SCAN benefit plans also include Medicare Part D prescription drug

coverage (also referred to as “MA-PD Plans”). All providers are subject to Medicare Advantage plan requirements including Part D requirements. In order to be a SCAN provider, you must be eligible for payment by Medicare. This means that to be in the SCAN network you cannot be excluded from participation in any federal health care program and that you have not opted out of the Medicare program. See *Appendix A: Select CMS Requirements* for select requirements.

Benefit Plans

All SCAN products include the full benefits of Original Medicare (Part A and Part B) and pharmacy drug (Part D) coverage. Products may also include additional benefits beyond Original Medicare. These additional benefits are Supplemental Benefits. Supplemental Benefits include Medicare Mandatory Supplemental Benefits and Optional Supplemental Benefits. Examples are vision and hearing coverage. See *Chapter 4: Physician Responsibilities* for section entitled Additional Supplemental Benefits.

Benefit Plans - Special Needs Plans

SCAN offers Special Needs Plans (SNPs), which are Medicare Advantage coordinated care plans specifically designed to provide targeted care and limit enrollment to special needs individuals. See *https://www.cms.gov///SpecialNeedsPlans/html*.

SCAN offers the following SNP plans:

- Chronic Condition Special Needs Plans (C-SNP) serving Members with specific severe or disabling chronic conditions including cardiovascular disorders, chronic heart failure, diabetes mellitus, and end-stage renal disease (requiring any mode of dialysis).
- Institutional Special Needs Plan (I-SNP) serving Members who live in institutions or are institutional equivalent (living in the community, i.e., in Assisted Living) and require an institutional level of care. Members must meet nursing facility level of care criteria and reside in designated counties.

Each SNP type has a Model of Care (MOC) that outlines the SNP population, care coordination provided, provider network, quality measurement and performance to ensure that each member’s unique needs are identified and addressed through the plan’s care management practices. ***Annual SNP Model of Care (MOC) training is a regulatory requirement for all providers who serve SNP members.***

For a summary of SNP MOC requirements visit *https://snpmoc.ncqa.org.* Other references include: Medicare Managed Care Manual Chapter 5 - Quality Assessment and Chapter 16b – Subchapter B - Special Needs Plans at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326* and CMS Model of Care (MOC) at *https://www.cms.gov////SNP-MOC.html*

Review the applicable Summary of Benefits, Evidence of Coverage (EOC), and formulary documents available online at *https://www.scanhealthplan.com//plan-materials* for more information.

Participation in Benefit Plans
Providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com*

Chapter 2: Key Contacts Resource Guide

<table>
<tr><th colspan="2">SCAN Resources for Providers</th></tr>
<tr><td colspan="2">SCAN website includes, but is not limited to, the following information/resources:</td></tr>
<tr><td colspan="2">https://www.scanhealthplan.com</td></tr>
<tr><td>

Access and enroll in the SCAN Provider Portal
Provider Quick Reference Guide (Eligibility/Benefits/Claims information)
Processed Claim Inquiry
Provider Disputes and Appeals information and form (Claims)
Claim Payment and Electronic Remittance Advice (ERA)
Claims Overpayment and Recovery information and form
Claim Submission
Provider Claim Talking Points and FAQs
Eligibility and Benefit Verification
Clinical Guidelines
Clinical Tools
Community Connections
Formulary Drug (search)
General Compliance and Fraud, Waste, and Abuse (FWA) Training
Evidence of Coverage (EOCs)
Plan Materials
Case Management Programs

</td><td>

General Information for Office Staff

SCAN CMS Approved Letter Templates
SCAN Case Management Program Fact Sheets
Privacy Policy

Health Education

Cultural Competency Training Resources
Care and Communication Tips
Patient Handouts

Pharmacy (Benefits and Information)
Provider Directory
Multi Cultural Resources and Interpreter Services
Provider Compliance Resources

Code of Conduct
Report a Compliance Issue

Provider Operations Manuals
Report Fraud, Waste and Abuse
SNP Model of Care Training
SNP Plan Codes
Quality Improvement Program

</td></tr>
<tr><td colspan="2">SCAN Provider Portal* includes, but is not limited to, the following information/resources:</td></tr>
<tr><td colspan="2">https://www.scanhealthplan.com/providers</td></tr>
<tr><td>

Encounters Module (Encounter Data Portal)
Eligibility Module:

Verify Member Eligibility and Benefits. Also print Member eligibility with confirmation date

</td><td>

Resources and Guidelines Module:

Annual SCAN Benefit Grids
Provider Quick Reference Guide (Eligibility/Benefits/Claims information)
Processed Claim Inquiry

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</table>

SCAN Resources for Providers	

• **Eligibility Module Cont. from previous page:**
  ○ Obtain maximum out of pocket (MOOP) amount and if MOOP has been met
  ○ Obtain appropriate address to submit claims
  ○ Member Benefits Services FAQs
  ○ Eligibility Inquiry Guide
• **Claims Module:**
  ○ Lookup claim status for claims processed directly by SCAN
  ○ Claim Inquiry Guide
• **Delegated Entities Reports if applicable:**
  ○ 5 Star Risk adjustment and HCC
  ○ Capitation
  ○ Eligibility and New Member
  ○ PCPASAP/IHA ASAP
  ○ Pharmacy
  ○ Risk Pool
	• **Resources and Guidelines Module Cont. from previous page:**
	  ▪ Ask questions about claim processed directly by SCAN
	  ▪ Obtain MOOP Accumulator amount
	  ○ Provider Disputes and Appeals information and form (*Claims*)
	  ▪ Check status of Provider Dispute or Non-Contracted provider appeal
	  ○ Claim Payment and Electronic Remittance Advice (ERA)
	  ○ Claim Overpayment and Recovery information and form
	  ○ Provider Claim Talking Points and FAQs
	  ○ General Office Staff Trainings
	  ○ Health Education Resources
	  ○ Provider Operations Manual (POM)
	  ○ SCAN Provider Newsletter

** For SCAN contracted delegated entities. If you are an employee of a SCAN direct-contracted delegated entity,* ***please contact your provider group administrator to grant access or contact SCAN portal admin to confirm group administrator at*** *providerportal@scanhealthplan.com* **Delegated entities are required to notify SCAN when there is a change in Portal Administrator. Please submit request to change Portal Administrator to NetworkManagementAdministration@scanhealthplan.com.*	
Network Relations Contact	
*NetworkRelations@scanhealthplan.com**	
• Access/availability questions • How to become a provider • Delegation/delegation oversight • Contracting questions	• Assistance with in-network specialists, Medicare-approved facilities, or other providers • Delineation of Financial Responsibility (DOFR) for services
**Email requests for corporate changes and to add/terminate providers to ProviderUpdates@scanhealthplan.com*	

<table>
<tr><th colspan="2">SCAN Resources for Providers</th></tr>
<tr><td colspan="2">Provider Information Line</td></tr>
<tr><td colspan="2">(877) 778-7226</td></tr>
<tr><td>• Verify eligibility and/or benefit information via IVR, automatic voice response and/or faxback*
• *Submit Alternative Format Selection for Members</td><td>• Hospital Authorizations
• Interpreter services (24/7)
• Virtual Remote Interpretation (VRI) (See Chapter 5: Network Standards)</td></tr>
<tr><td colspan="2">*For immediate assistance, log into the SCAN Provider Portal (to create an account see the SCAN Provider Portal section in this chapter) and/or use Electronic Data Interchange (EDI).</td></tr>
<tr><td colspan="2">Care Management</td></tr>
<tr><td colspan="2">(855) 649-7226 and Fax (562) 989-5212</td></tr>
<tr><td>• Refer a Member*</td><td>• Case management Questions/Support</td></tr>
<tr><td colspan="2">* Referrals may be emailed to CMReferral@scanhealthplan.com</td></tr>
<tr><td colspan="2">Medical Management and Utilization Management</td></tr>
<tr><td colspan="2">(800) 250-9048 (Option 2) and Fax (800) 411-0671</td></tr>
<tr><td>• Organization Determination/Coverage guidance
• DOFR/Risk clarification
• Authorizations for services to SCAN contracted entities (Refer to Informational Letter – Carve Out)</td><td>• Report an admission
• Hospital Authorizations
• Report an event (See Chapter 5: Network Standards)</td></tr>
<tr><td colspan="2">Claims</td></tr>
<tr><td colspan="2">• Verify claims status via SCAN’s Provider Portal. Register at www.scanhealthplan.com/providers
• Request copies of a remittance advice, confirm payments of a check, electronic, or virtual card payment, or set up payment preference, please visit https://www.providerpayments.com or call (888) 984-5025
• Submit claims electronically by signing up with SCAN’s electronic clearinghouse, Office Ally, directly at (360) 975-7000 (Option 1) or visit https://cms.officeally.com/
• For all other claims questions see Chapter 13: Claims</td></tr>
</table>

Encounter Data Team	
Encounters_Operations@scanhealthplan.com	
• Submit Health Industry Collaboration Effort (HICE) Alternative Submissions • Encounter data portal questions	• Audit, data reconciliation and error resolution issues and questions • Risk Adjustment Processing System (RAPS) and Encounter Data Processing System (EDPS) Questions
Pharmacy Benefits	
Express Scripts (Pharmacy Benefits Manager (PBM))	
For Coverage Determinations, 24/7:	(844) 424-8886; Fax (877) 251-5896 TTY (800) 716-3231
For mail order prescriptions:	(888) 327-9791 Fax (800) 837-0959 Address: Express Scripts Mail Pharmacy Service, PO Box 66566, St. Louis, MO 63166-6566
To request to add a drug to the SCAN Part D Formulary:	Mail request to: SCAN, Attn: Sr. Director, Pharmacy and Formulary Operations, 3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806
Enroll in the Mail Order Program	
Online at: *www.StartHomeDelivery.com* or mail a completed application (available from Member Services) to: Express Scripts, Mail Pharmacy Service at PO Box 66566, St. Louis, MO 63166-6566.	
Report Fraud, Waste, or Abuse	
By phone:	(877) 863-3362 (anonymous)
By email:	*FraudWaste&AbuseProg@scanhealthplan.com*
Online:	*https://www.scanhealthplan.com/scan-resources/report-an-issue/fraud-information-and-resources*
Report a HIPAA Breach	
By phone:	(877) 863-3362
By email (preferred):	*PrivacyOffice@scanhealthplan.com*
By certified mail:	SCAN, Privacy Office, 3800 Kilroy Airport Way, Ste 100 Long Beach, CA 90806
Initiate an Appeal on Behalf of a Member	
By phone:	(855) 650-7226
Online (Part D only):	*https://www.scanhealthplan.com///file-an-appeal*

SCAN Resources for Members	
Member Services • **Arizona: (855) 650-7226** • **New Mexico: (855) 826-7226** • **Nevada: (855) 827-7226** • **Texas: (855) 844-7226**	
• Resolve service issues or claims issues • Assistance with the Grievance or Appeal Process • Get a Member ID card • Questions and information • Address and phone number changes • Supplemental Benefit Information • Benefits and co-payments • Pharmacy benefits	• Provider directory • Select a physician or request to transfer physicians • Translation/interpreter services • Virtual Remote Interpretation (VRI) (See *Chapter 5: Network Standards*) • Caregiver support • Community resource assistance • Information regarding clinical trials
Transportation	(844) 714-2218
SCAN's routine transportation service is a supplemental benefit and not covered by Original Medicare. The primary purpose of routine transportation is to provide non-emergency transportation to medically necessary services. All transportation, including wheelchair and gurney/stretcher transports, must meet SCAN criteria. The routine transportation benefit is not available to all SCAN plans. Refer to applicable SCAN Evidence of Coverage (EOC) to determine if routine transportation is covered. Each one-way trip may not exceed 75 miles for eligible Medicare passengers. **Non-Medical Transportation (NMT)** is available in taxis, sedans, and ride share vehicles for ambulatory passengers. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated. **Non-Emergency Medical Transportation (NEMT)** covers transportation provided in wheelchair vans, gurney/stretcher transports, and Basic Life Support (BLS) vehicles. **To schedule transportation:** To ensure timely access, transportation arrangements must be made no less than twenty-four (24) hours in advance (not including weekends) for a passenger vehicle and no less than forty-eight (48) hours in advance for wheelchair service (not including weekends). Rides requiring door-to-door service or gurney/stretcher vehicles require no less than seventy-two (72) hours in advance (not including weekends). Transportation from an acute care setting, i.e., inpatient hospital, skilled nursing facility, inpatient psychiatric facility must be provided within a three (3) hour time frame from the time of discharge. Rides must be cancelled in advance if the transportation is no longer needed. If a ride is not cancelled before the driver has been dispatched, the ride will be counted towards annual ride limit. For curb-to-curb, door to door, and other available services please refer to Member's Evidence of Coverage (EOC) available online at: *https://www.scanhealthplan.com//plan-materials* for more information.	

SCAN Resources for Members
"Will Call" Rides: "Will Call" rides are scheduled when a pick-up time is not provided at the time of the reservation. This is usually done for medical appointment return pickups as appointments may run longer than expected. When the Member is ready for pick-up, call **"SCAN Transportation" at 1-844-714-2218** to schedule the pick-up for the ride home. Will call rides may take up to **one (1) hour** for the ride to reach the pick-up location. Successful pick-ups require Members to be waiting **curbside at the front main entrance** of the address unless other directions were provided at the time of reservation. Note: To check on an already scheduled ride or if the driver does not arrive in 10 minutes from the time of your scheduled pick up, please call SCAN Transportation at **1-844-714-2218** to dispatch another driver. A new pick-up time will be provided.

Chapter 3: Enrollment and Eligibility

To enroll in a SCAN product, individuals must meet all eligibility requirements and complete the SCAN application process during a valid enrollment election period.

Medicare Eligibility Requirements
To enroll, an individual must:
• Have Medicare Parts A & B and continue paying Part B premium,[1] • Live in the benefit plan's service area, [2] and • Be a United States citizen or otherwise be lawfully present in the United States, See *Chapter 1: Overview*.
[1] Includes those under age sixty-five (65) and qualified by Social Security as disabled. [2] Member must continuously reside within the service area for six (6) months or more.

Open Enrollment, Lock-in, and Disenrollment

CMS requires MA Organizations to have an Annual Enrollment Period, which currently runs from October 15 to December 7 of each year. Usually, this is the only time when MA health plans and prescription drug plans are open and accepting new Members, other than those who are newly eligible or qualify for Open Enrollment Period or special election.

MA Organization Members are "locked-in", meaning Members can only switch MA plans during open enrollment unless they qualify for a special election enrollment or switch to a 5-star health plan. Special election situation examples include, but are not limited to, a Member moving outside the service area of their current plan, turning/recently turned sixty-five (65), moving to a new service area, has Medicaid, losing retiree health coverage, being diagnosed with a qualifying disability, etc. Other special election situations may exist, as determined by CMS.

Members also have a Medicare open enrollment period in which they may enroll or voluntarily disenroll, typically between January 1 and March 31, of each calendar year and have the choice to switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage).

SCAN must disenroll a Member when:

1) **Member does not retain Medicare Coverage Parts A and B,**
2) **Member is deceased,**
3) **Member no longer meets SNP status requirements,**
4) **Member permanently moves out of SCAN's service area or is outside of SCAN's service area for more than six (6) continuous months,**
5) **Member is not lawfully present in the United States, or**
6) **CMS requires SCAN to disenroll a Member**

SCAN also must disenroll Members when SCAN's contract with CMS is terminated or SCAN reduces its service area. SCAN may pursue disenrolling a Member if the Member fails to pay applicable monthly plan premiums, or provides fraudulent information or the

misuse of your membership identification card. For optional disenrollment, SCAN's discretionary decision shall be final. All covered services must continue to be provided until the disenrollment effective date.

The plan cannot ask you to leave our plan for any health-related reason.

Identifying a Patient as a SCAN Member

Member identification cards are intended to identify the Member, the type of plan the Member has, and provide important/relevant information regarding copayments, etc. Cards for various products may have different looks, but the general information displayed on the identification card is similar to the example below: (Note for AZ and NM the SCAN logo on the Member ID card will appear slightly different e.g., AZ: SCAN Desert Health Plan, NM: SCAN Health Plan New Mexico.)

Applicable Claims address will appear on Member's ID card.

Members are instructed to use a temporary ID card if services are needed prior to the receipt of the permanent identification card, similar to the example below:

Verifying Member Eligibility

Providers are responsible for verifying eligibility each time a Member receives care. Possession of a Member identification card does not guarantee eligibility. SCAN offers the following options to verify Eligibility and Benefits.

Electronic Eligibility and Benefit Inquiry & Response (EDI 270/271)
EDI 270/271 is the most efficient option, to obtain SCAN Member eligibility and benefits information. To establish connectivity with SCAN, providers should contact their Clearinghouse and Practice Management System (PMS) vendor or Hospital Information System (HIS) vendor to provide **SCAN's Payer ID# 10178.** SCAN's EDI 270/271 clearinghouse vendor is **FinThrive** (formerly TransUnion). Contact them for testing and connectivity questions by email: *TUPrtnrSupt@finthrive.com* or call (877) 732-6853
SCAN's Provider Portal
Providers can self-register at *https://www.scanhealthplan.com/providers* and gain immediate access to check Member eligibility status, view benefit plan information including PCP information, print eligibility/benefit confirmation and access Plan Evidence of Coverage (EOC).
SCAN's Provider Automated Interactive Voice Response (IVR)
Providers can verify member eligibility/benefits and request a faxback via SCAN's IVR. No registration is required. Call (877) 778-7226, available 24/7.

Additionally, each medical group receives a monthly eligibility report that includes all Members assigned to that medical group.

Member Eligibility
Help us help the Member – Verification is based on the data available at the time of the request. Subsequent changes in eligibility may occur or may not yet be available, therefore, verification of eligibility **is not** a guarantee of coverage or payment.

Enrollment Area and Primary Care Physician Selection

Upon enrollment, Members are asked to select a Primary Care Physician (PCP) and medical group. SCAN encourages, but cannot require, a Member to select a PCP within thirty (30) minutes or thirty (30) miles of their residence. If a Member does not select a PCP and medical group on the enrollment form, SCAN will assist with selection or assign

a default PCP and medical group within thirty (30) minutes or thirty (30) miles of the Member's residence.

Continuation Area

A Member may elect a SCAN benefit plan if he/she permanently resides in the benefit plan service area. A temporary move into a benefit plan's service area does not enable the Member to elect that benefit plan – therefore, SCAN must deny such election. SCAN, however, may offer a continuation of enrollment option to local benefit plan Members when they no longer reside in the benefit plan service area, but permanently move into a SCAN designated continuation area local plan. (See 42 CFR 422.54(b)).

Member Requests to Change PCP

A Member may change their PCP and/or medical group or Independent Practice Association (IPA) for any reason, at any time. If a Member wishes to change their PCP within their contracted medical group or IPA, this change will be effective on the first of the following month. If Member wishes to change their PCP to one affiliated with a different contracted medical group or IPA, the Member's request must be received on or before the twentieth (20th) of the month. The change will then be effective the first (1st) of the following month. Change requests received after the twentieth (20th) of the month will be processed and effective for the first (1st) of the second month after the change request.

Dates of Coverage

A Member's effective date is the first day of the month, and a Member's termination date is the last day of the month. Coverage begins at 12:00:01 a.m. (PST) on the effective date and ends at 11:59:59 p.m. (PST) on the termination date. Members typically become effectively enrolled on the first (1st) day of the month after completing an enrollment application. Members may be enrolled for future effective dates (ninety (90) days in advance) when they are approaching the age of sixty-five (65) and become eligible for Medicare Parts A and B in future months. SCAN refers to these "future effectives" as "Age-Ins".

Chapter 4: Physician Responsibilities

Physicians participating in the SCAN network have certain responsibilities based upon their roles as PCPs and/or specialist physicians. Contracted medical groups and directly contracted physicians are responsible for ensuring that their physicians comply with SCAN requirements as set forth in this POM including the requirements set forth in this Chapter. This responsibility extends to clinical and non-physician staff responsible for supporting physicians; therefore, all uses of "physician" shall be understood to extend to such staff.

Participation in Benefit Plans
Providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com.*

PCPs and Specialist Physicians

A PCP is a family physician/family practitioner, general practitioner, internist, or other specialist allowed by the Member's benefit plan, selected by the Member to be responsible for supervising, coordinating, and providing care to the Member. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member's health care needs (from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services). PCPs are also responsible for maintaining the Member's medical records, including documentation for all services provided to the Member. Members may also choose to see a Nurse Practitioner or Physician's Assistant who supports the PCP.

A specialist physician is a physician credentialed to provide certain specialty care outside the expertise of the PCP.

Annual Exams

Contracted medical groups are required to ensure that PCPs perform preventive visits and yearly wellness exams to assess acute chronic conditions and preventive health care needs. Additionally, SCAN strongly recommends that Members are seen as often as their condition(s) require.

Note: Annual wellness visit must include a review of the Member's current opioid prescriptions and screening for potential substance use disorders, including a referral for treatment as appropriate.

Please refer to the following for more information:
https://www.uspreventiveservicestaskforce.org/
https://www.medicare.gov//preventive-visit-and-yearly-wellness-exams.html

Medicare Wellness Assessment

SCAN requires PCPs to conduct a Medicare Wellness Assessment for Members within ninety (90) days of the Member's enrollment effective date.

Comprehensive Welcome to Medicare Assessment and Health Exams must include but are not limited to the following:

- Complete history and physical (including, but not limited to)
    - Present and past illness(es) with hospitalizations, operations, medications
    - Physical exam including review of all organ systems
    - Height, weight, body mass index (BMI), blood pressure (BP), cholesterol screening
    - Preventive services per the United States Preventive Services Task Force (USPSTF) A and B Guidelines for 65-year old (including age appropriate assessments such as tuberculosis screening, clinical breast exam, allergy, colon cancer screening, mammogram, pap smear, etc.)
    - Review of the beneficiary's current opioid prescriptions and screening for potential substance use disorders, including a referral for treatment as appropriate.
- Medication Review
- Pain Assessment
- Mental health evaluation/Screening for depression
- Social history
    - Current living situation
    - Marital status
    - Work history
    - Education level
    - Sexual history
    - Use of alcohol, tobacco, and drugs
- Assessment of risk factors and development of behavioral risk health education – to include assessment of:
    - Nutrition
    - Functional status (including activities for daily living/instrumental activities for daily living (ADL/IADLs)
    - Physical Activity
    - Risk of falling (including history of fractures/Osteoporosis)
    - Urinary Incontinence
    - Environmental Safety
    - Dental/Oral Health
- An assessment of need for preventative screens and services
- Diagnoses and plan of care

Post Hospitalization Visit – Transitions of Care

Contracted medical groups are required to follow post hospitalization best practices to ensure PCPs perform post hospitalization visits within seven (7) – ten (10) days of discharge. The post-hospital follow-up visit presents an ideal opportunity for the PCP to

prepare the Member and family caregiver for self-care activities, make sure the discharge instructions are documented and being followed, medications are reconciled and to head off situations that could lead to readmission.

Additional Supplemental Benefits

SCAN Members may be entitled to additional benefits beyond Original Medicare, including Supplemental Benefits. Some examples of Supplemental Benefits are prescription drug coverage, vision coverage, and hearing coverage.

Advance Directives

PCPs are required to educate and should encourage each Member to complete an advance directive and document this in the Member's medical record. Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)). SCAN supports and recommends the following resource: 'Prepare for your Care' *https://prepareforyourcare.org/en/welcome*

For additional information see: *https://www.scanhealthplan.com/caregivers-and-family/advance-care-planning*

Referrals

PCPs and specialist physicians must provide referrals for Members timely and appropriately. Providers are expected to direct Members to in-network health professionals, hospitals, laboratories, and other facilities unless appropriate specialty care is not available within SCAN's network. In circumstances where out-of-network services are needed, authorization is required except in the case of Emergency Services.

In-Network Services and Medicare-Approved Facilities: Help us Help the Member
Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* for assistance determining financial responsibility for services, locating in-network specialists, or a Medicare-approved facility. Providers may also go to *https://www.scanhealthplan.com* to locate participating providers.

Referrals shall **not** be required for:

- Routine women's healthcare, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as received services from a network provider (See 42 CFR 422.100(g)(1));
- Influenza vaccine and pneumococcal vaccine received from a network provider. Co-pays may not be charged (See 42 CFR 422.100(g)(2));
- Emergency Services from network providers or from out-of-network providers;
- Urgently Needed Services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible;
- Kidney dialysis services that the Member gets at a Medicare-certified dialysis facility when the Member is temporarily outside the plan's service area;
- Any other services specified in the applicable EOC; and
- Mental and Behavioral Health services.

Out of Area Dialysis Services: Help us Help the Member

PCPs should advise Members to contact SCAN Member Services before they leave their benefit plan service area so that SCAN can help arrange for maintenance dialysis while the Member is away.

Behavioral and Mental Health Referrals

PCPs must screen Members for mental and behavioral health needs using validated screening tools at each visit and, when appropriate, initiate a mental health or substance use referral to Member's assigned medical group. Refer to the SCAN Evidence of Coverage (EOC) for available Mental and Behavioral Health benefits.

Referrals for mental and behavioral health services must be:

- Made within-network; and/or
- To a vendor who is contracted with the medical group to provide behavioral health or substance use services for the medical group (unless otherwise specified in the agreement between the medical group and SCAN).

Validated screening tools include:

Behavioral Health Disorders	Validated Screening Tools
Depressive Disorders	PHQ2, PHQ9, GDS
Anxiety Disorders	GAD2, GAD7
Bipolar Disorders	MDQ
Psychosis	PQ-B
PTSD	PC-PTSD
Substance Use Disorders	CAGE-AID

Opioid Treatment Program Services: Medicare Part B Benefit

Section 2005 of the SUPPORT for Patients and Communities Act establishes Opioid Use Disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a **Medicare Part B benefit**, including necessary medications, counseling, therapy, and testing.

Standing Referrals

PCPs may allow standing referrals where a Member requires continuing specialty care over a prolonged period of time (e.g., Member has a life-threatening, degenerative or disabling condition that requires coordination of care by a specialist instead of PCP). PCPs and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period of time during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a Member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and

disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, when authorized by the medical group.

Second and Third Opinions

Second and third opinions are covered even if the service is determined not to be covered. PCPs must provide referrals to another network physician when a second or third opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinion referrals are for consultation only and do not imply referral for ongoing treatment. (See Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Services.)

Chimeric Antigen Receptor (CAR) T-cell Therapy

CAR-T immunotherapy is a covered service when the CMS National Coverage Determination criteria are met. See *https://www.cms.gov/medicare-coverage-database*. Inpatient administration is included in Hospitalization responsibility. Outpatient administration is included in Outpatient Facility and Part B Covered Drugs responsibility.

Transplants

Transplant evaluation and services **must** be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety.
See *https://www.cms.gov///MedicareApprovedFacilitie/index.html*.

When a delegate refers a Member for transplant evaluation and the Plan has financial risk for transplant services, per the DOFR, the Plan will render a transplant evaluation authorization, which may be performed concurrently with medical management of an inpatient event. Transplant (and transplant evaluation) related professional, facility and diagnostic services must be billed separately from other services. All other services not directly related to transplant services remain the financial responsibility of the entity at risk for inpatient care.

Medical groups are **required** to notify SCAN and review ***all*** transplant requests for collaboration. Please refer to your DOFR for further information.

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the referred provider. The referral, as well as denial or acceptance of the referral needs are to be documented in the Member's medical record by both the referring provider and referred provider. Specialists must provide the referring PCP informative reports on care rendered in a timely manner.

Members on Hospice

The PCP remains responsible for Members receiving Medicare certified hospice care to ensure non-hospice care and services are provided. Refer to the Member's EOC at *https://www.scanhealthplan.com//plan-materials* for more information.

Member elects Hospice*			
Type of Services	**Member Coverage Choice**	**Member Cost-Sharing**	**Payments to Providers**
Hospice	Hospice Program	Original Medicare cost-sharing	Original Medicare
Non-Hospice Parts A&B	In Network/Medical Group	SCAN cost-sharing	Original Medicare
Non-Hospice Parts A&B	Out of Network	Original Medicare cost-sharing	Original Medicare
Non-Hospice Part D	SCAN Part D	SCAN cost-sharing	SCAN
Supplemental	SCAN	SCAN cost-sharing	SCAN

***For more information, please refer to SCAN Medical Policy available on the SCAN Provider Portal.

Hospice Medication Management

Drugs and biological products paid for under the Part A per-diem payments to a Medicare hospice program are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis and four categories of drugs that relieve common symptoms during the end of life, regardless of terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety.

For Members enrolled in Hospice, SCAN has Member-level Prior Authorization requirements on the following four categories to determine their coverage under Part A versus Part D benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.

- For these drugs, Hospice-affiliated providers must provide a supporting statement of whether the prescribed drug is unrelated to the Member's terminal illness or related condition for Part D coverage.

Refer to Hospice and End Stage Renal Disease (ESRD) Part D Exclusions (See *Chapter 11: Pharmacy*).

Out of Area Hospitalizations

When SCAN is financially responsible for out of area hospitalizations, SCAN will coordinate care and services in collaboration with the out of area providers until the Member is discharged or stable for transfer and repatriation into the contracted network. Medical Groups are required to notify SCAN when they become aware of an out of area admission. PCPs and Medical Groups are expected to work collaboratively with SCAN to safely transfer the Member into the contracted network and continue coordinating the Member's transition of care. (See *Chapter 5: Network Standards*)

Out of Country Hospitalizations

SCAN will coordinate care and services in collaboration with the out of country providers until the Member is discharged or stable for transfer and repatriation into the

contracted network. PCPs and Medical Groups are expected to work collaboratively with SCAN to safely transfer the Member into the contracted network and continue coordinating the Member's transition of care.

Continuity of Care

Continuity of care is the continuous coordinated care afforded to all Members by a practitioner involved in their care and treatment. This care is a collaborative effort between providers and SCAN. Physicians are responsible for working with SCAN to ensure continuity of care. (See *Chapter 6: Utilization Management*)

Clinical Trials

SCAN Members may participate in a Medicare-approved clinical trial and stay enrolled in SCAN to continue to get care not related to the trial through their assigned Medical Group/PCP. Authorization is not required.

Clinical trial providers should bill Original Medicare for clinical trial related services. These services are not carved out to SCAN, though SCAN may offer assistance in determination of Medicare approved clinical trials. For additional information, refer to the Member's applicable EOC at *https://www.scanhealthplan.com//plan-materials* as well as the Medical Policy > BCG0111 - Clinical Trials, Experimental Procedures and Items, and Investigational Devices, available on the Provider Portal.

Providers may also refer Members to Medicare at 1-800-MEDICARE (1-800-633-4227) for more information.

Clinical Trials: Help us Help the Member
Members do not need SCAN's permission to participate in a clinical trial. Providers should direct Members to SCAN Member Services for all clinical trial information. See *Chapter 2: Key Contacts Resource Guide* (Member Services).

Access Requirements

Maintain and monitor a ***network of appropriate providers*** *supported by written agreements and sufficient to provide adequate access to covered services to meet the needs of Members*

Demonstrate that providers are appropriately ***credentialed***

Ensure plan services are available ***24 hours a day, 7 days a week*** *and are provided in a* ***culturally competent manner***

Ensure appropriate ***ambulance services, Emergency and Urgently Needed Services, and post-stabilization care services*** *coverage*

Establish ***written standards for timeliness of access to care*** *and Member services that meet or exceed established standards,* ***continuously monitor*** *these standards, and take* ***corrective action*** *as necessary*

Ensure ***continuity of care*** *and* ***integration of services***

See 42 CFR 422.111-114; Title 28, Section 1300.67.2.1

Chapter 5: Network Standards

Ensuring access to care is a collaborative effort between SCAN and SCAN's provider network and is accomplished through establishing and maintaining standards that apply across SCAN's provider network. All network providers are responsible for abiding by these network standards.

Credentialing

To be eligible to participate in the SCAN network, all providers must be able to demonstrate that they meet SCAN credentialing requirements including, but not limited to, the following:

- In good standing with all state and federal regulatory bodies;
- Approved by an accrediting body or, if not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other plan criteria;
- Maintains current general, professional, workers compensation liability insurance, and other insurance types as applicable;
    - SCAN must be listed as the 'additional insured' under the General Liability insurance.
- Not been excluded, suspended, and/ or disqualified from participating in Medicare, Medicaid, or any other government health related program; and
- Enrolled in Medicare and Medicaid, as applicable.

Delegation of Credentialing Functions

SCAN typically delegates credentialing functions. Entities that have been delegated to perform credentialing functions on behalf of SCAN must comply with all requirements applicable to SCAN, including the requirements set forth in this section. See also *Chapter 10: Delegation Oversight*.

Credentialing Process and Nondiscrimination

The SCAN Credentialing Committee is responsible for the development and maintenance of a comprehensive credentialing and re-credentialing process, to make credentialing and re-credentialing decisions, monitor quality of care and services, provide guidance for continuous quality improvement to meet NCQA, CMS and applicable state requirements. Credentialing decisions are made on a fair and impartial basis according to predetermined criteria related to

professional conduct and competence, not based on an applicant's race, gender, age, ethnic origin, sexual orientation, or type of patients or procedures in which the provider specializes.

The credentialing process consists of three parts: information gathering, information review, and decision. All providers are expected to provide full, accurate, and timely information. Failure to do so could result in delay or a determination not to credential the provider. If unfavorable information about a provider is discovered during the credentialing process (e.g., professional liability settlements, sanctions, or other adverse information, etc.), SCAN or a delegated entity may decide not to credential the provider. Applications that are incomplete or that do not meet standards for review will not be accepted and are not subject to appeal.

Timeline for Re-Credentialing

All providers must complete the credentialing process prior to becoming a SCAN participating provider and must complete the re-credentialing process every thirty-six (36) months. Any new provider will be considered an out-of-network provider until the credentialing process is complete and will not be listed in the SCAN provider directory. Health Delivery Organizations (HDOs) that have fewer than three (3) stars under the CMS 5-Star Quality Rating System will be given a provisional credential of one (1) year (with an additional two (2) years granted if improvement is shown).

American Board of Medical Specialties Board Certification

SCAN requires groups to obtain Board Certification status from the American Board of Medical Specialties (ABMS) of all network and contracted physicians. For Non-Board Certified physicians, highest education attained must be primary source verified. ABMS Board Certification demonstrates a physician's exceptional expertise in a particular specialty and/or subspecialty of medical practice and provides a trusted credential that is important to patients and relevant to physician practice. ABMS Board Certification is peer-developed, externally validated program that reflects the critical core physician values of compassion, patient-centeredness, and a passion for education. Patients, physicians, health care providers, insurers, and quality organizations look for these markers as the best measure of a physician's knowledge, experience, and skills to provide quality health care within a given specialty. (See *http://www.abms.org/board-certification/.)*

Provider Appeals

Providers will be notified in writing of any decision to limit, suspend, or terminate participation in the SCAN network. Notification will include the reasons for the action, the appeals process or options available to the provider, and 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, if reportable, will be reported to the appropriate licensing boards, National Practitioner Data Bank (NPDB), or other appropriate disciplinary bodies. See 42 CFR 422.202(d)(1)-(4) for applicable requirements.

Provider Changes (Additions, Terminations, Panel Closures)

Providers and provider groups are responsible for timely notifying SCAN of requests for provider additions, provider terminations, address changes and panel changes. Unless otherwise stated in the contract between the provider or provider group and SCAN and for all products except provider sponsored plans, requests are processed per the following timelines. Notification is to be emailed to *ProviderUpdates@scanhealthplan.com*.

Provider Change
Termination of Primary Care Physician (PCP) or Behavioral Health Provider
Provider shall make best efforts to deliver notice to SCAN seventy-five (75) calendar days prior to the effective date of termination, or as soon as the group is notified by the provider, in order for SCAN to notify Members of these changes timely. In the event a PCP is terminated with less than seventy-five (75) calendar days' notice, then the group is to provide SCAN with written notice within five (5) business days of becoming aware of the termination. Terminations will become effective the 1st of the month following the expiration of the notice period unless SCAN is able to process the request earlier. In the event of a PCP termination, the group must also provide SCAN with a replacement PCP to whom to transfer the Members. The replacement PCP must be affiliated with SCAN and accepting Members.
Adding New Providers
Requests must include a complete profile for the new provider or a file containing all the required data elements. Incomplete requests will be returned with details regarding deficiencies and/or notice of action needed. SCAN will notify the provider or provider group if the Add request is declined and provide the reason. (Reasons for declining an Add request may include: provider is no longer practicing at locations requested, provider's specialty is one which SCAN does not load, provider has quality management issues and is closed to new site affiliations, requested site affiliation has a corrective action pending, or that contract limitations exist (e.g. provider is located outside of SCAN's market or the delegated entity contracted service area, etc.)).
Panel Closures
Notice to be received by SCAN at least sixty (60) calendar days in advance of any PCP who will no longer be able to accept Members. If the delegated entity is unable to meet this requirement because a PCP has failed to give the delegated entity notice of a closure, the delegated entity shall provide SCAN notice within five (5) business days of first learning of the closure. Unless otherwise stated in the contract between SCAN and the delegated entity, in no event shall a delegated entity ever have more than twenty percent (20%) of its PCP panel closed to Members at the same time.
Notice to SCAN of Adverse Actions
Provider and Provider Groups are required to immediately notify SCAN upon discovery of any contracted providers who have an adverse action against their medical/clinical license such as an accusation, probation, or other disciplinary action imposed by the Medical Board and/or any applicable licensing body. Notification is to be submitted to *credentialing@scanhealthplan.com* • Delegates are required to review healthcare practitioners who have an accusation adverse action against their license declared by the applicable licensing body. Review should include, as appropriate, but is not limited to: ▪ Discussion of the accusation ▪ Discussion of complaints and Grievances concerning quality of care ▪ Review of prescribing practices (if applicable) ▪ Implementing appropriate interventions if there is concern of poor quality that could affect Member safety (e.g., panel closure, monitoring of practitioner, termination, etc.) • Delegates are also required to monitor healthcare practitioners who have adverse action decisions (e.g., public letter of reprimand, probationary terms, etc.) against their license declared by the appropriate state licensing board. Monitoring should include, as appropriate, but is not limited to: ▪ Grievances concerning quality of care ▪ National Practitioner Data Bank (NPDB) queries ▪ Appropriate state licensing board communications (emails or website) ▪ Other applicable licensing board, as appropriate ▪ Practitioner's registration and/or completion of required courses

Member Notification (Provider Terminations)

Following state and federal requirements, SCAN is required to make a good faith effort to provide written notice of the termination of a contracted specialist provider at least thirty (30) calendar days before the termination effective date to all Members who are patients seen on a regular basis by that provider (See 42 CFR 422.111(e) and 42 CFR 438.10(f)). The phrase "patients seen on a regular basis" means Members who are assigned to, currently receiving care from, or have received care within the past three (3) months from a specialist provider or facility being terminated. SCAN is required to make a good faith effort to provide written notice and make at least one attempt at telephonic notice of the termination of PCP and Behavioral Health Providers at least forty-five (45) calendar days before the termination effective date to all Members who are assigned to or currently receiving care from that PCP and to Members who have been patients of that PCP or Behavioral Health Provider within the past three (3) years. Providers and Provider Groups are responsible for identifying and notifying impacted Members who accessed the terminating specialist (including but not limited to Behavioral Health Providers) or hospital in the prior three (3) months and/or who accessed the terminating Behavioral Health Provider within the past three (3) years. The content of provider termination notices shall comply with the model communications material and all applicable requirements (See 42 CFR 422.2267(e)(12)).

Plan Notification (Member Events)

In order to ensure prompt and appropriate payment of claims, providers are required to notify SCAN timely of the following Member events when SCAN is financially responsible:

Event	Notification Timeframe
Admissions (Planned or Unplanned)	
Acute Inpatient (in/out of area)	Within twenty-four (24) hours of admission
Outpatient Observation Stay	Within twenty-four (24) hours of admission
Skilled Nursing Facility	Within twenty-four (24) hours of admission
Long Term Care Facility	Within twenty-four (24) hours of admission
Authorizations	
Acute Rehabilitation Unit/Long Term Acute Care (LTAC)	Prior to admission (at time of request)
Elective inpatient procedures (planned transition)	Within one (1) business day of Admission
Transplants	
Solid Organ & Bone Marrow Transplants	Prior to transplant pre-evaluation
Fax notifications to SCAN Medical Management at (800) 411-0671 or call (800) 250-9048.	

Out of Area/Network Services v. Directed Care/In Area Initiated Care

In general, SCAN only covers services that are delivered by providers that are in the SCAN contracted network and in the plan service area (e.g., that are delivered "in network" and "in area"). Delegated entities are responsible for ensuring that referrals to out of network and/or out of area providers are appropriate per the terms of the Member's EOC and may retain financial responsibility for those referrals. (i.e., referring a Member to an out of network or out of area provider for care that is non-urgent and non-emergent and/or is available from an in network provider). It is also important that providers

understand that not all care that is delivered outside the service area constitutes “out of area” services for purposes of determining financial responsibility. Delegated entities remain responsible for out of network services when a provider, advertently or inadvertently, refers a Member to an out of network provider (“directed care”) or transfers a Member out of network for care that was initiated by an in network provider (“in network initiated care”). This includes situations where a provider directs a Member to an out of area provider based on a standing instruction, no bed availability in network facilities or because care is not available in the service area. In the case of both directed care and in area initiated care, all subsequent services related to that episode of care, including but not limited to diagnostics, admissions to acute or non-acute facilities, and consults are considered in area for purposes of determining financial responsibility.

For Transplant related care/services refer to *Chapter 4: Physician Responsibilities*.

Providing Information

All providers are expected to cooperate timely with SCAN’s requests for information in order for SCAN to, among other regulatory requirements, meet disclosure obligations required by CMS and other regulatory agencies, all information necessary to: (1) administer and evaluate the program; and (2) establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (See 42 CFR 422.64(a), 422.504(a)(4)). This information includes but is not limited to, SCAN quality and performance indicators for benefits including, disenrollment rates for Medicare enrollees electing to receive benefits through SCAN for the previous two (2) years, information on Medicare enrollee satisfaction, information requested to support organization determinations, and information on health outcomes. See 42 CFR 422.504(f)(2)(iv)(A)-(C). See *Chapter 14: Encounter Data* for requirements specific to encounter data.

Access and Availability

CMS has established access to service and related rules to ensure that all covered services, including supplemental services, are available and accessible to Members for the duration of the benefit year (for hospitalized Members hospitalized on the termination date or, in the event of an insolvency, through discharge) and are provided in a manner consistent with professionally recognized standards of care. See 42 CFR 422.112, 422.504(a)(3)(iii).

Provider Network

SCAN contracts with a network of providers to ensure that all covered services, including supplemental services, are available and accessible. To accomplish this, SCAN maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are used in the network as PCPs, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. See 42 CFR 422.112(a)(1)(i).

Specialty Care

Delegated Medical Groups are responsible for providing and arranging for necessary specialty care. Delegated Medical Groups are also responsible for allowing Members direct access to certain routine and preventive health services, including mental and behavioral health services. The Medical Group arranges for specialty care outside of the provider network when network providers are unavailable or inadequate to meet a Member's medical needs. If needed, SCAN can assist in arranging this care. See 42 CFR 422.112(a)(3).

Provider Directory

SCAN is mandated to have accurate provider data. To that end SCAN relies on all providers and provider groups to provide real-time provider roster information. SCAN is required to audit and validate provider network data and provider directories on a routine basis. SCAN requires any provider updates to be reported immediately, but in no event more than five (5) business days from the time the provider or provider group is aware of changes to provider roster.

In addition, SCAN conducts a quarterly roster verification process which ensures that each provider network is accurately recorded in SCAN's provider data system. SCAN's validation efforts may include reaching out to providers using a vendor partner. Outreach to providers may include the use of fax, email, and phone calls. Providers are required to provide timely responses to such communications.

Roster information includes, but is not limited to: additions, terminations, ability to accept new patients, street address, phone number, and any other changes that affect availability to Members. Any changes to provider rosters should be timely submitted to SCAN's dedicated mailbox *ProviderUpdates@scanhealthplan.com*.

Finding Providers: Help us Help the Member

Members can access SCAN's online searchable provider directory at *https://www.scanhealthplan.com* and request a hardcopy provider directory from SCAN's Member Services department or the SCAN website.

Access to Care Standards and Hours of Operation

CMS requires that SCAN employ written standards for timeliness of access to care and services, make these standards known to all providers, continuously monitor its provider networks' compliance with these standards, and take corrective action as necessary. These standards must ensure that the hours of operation of SCAN's network are: (1) convenient to, and do not discriminate against Members and are no less available than hours offered to other patients; and (2) available 24/7 to provide Covered Services, when Medically Necessary. See 42 CFR 422.112(a)(6)(i) and 42 CFR 422.112(a)(7)(ii) and Medicare Managed Care Manual (MMCM), Chapter 4, Section 110.1.1.

To ensure network access standards are met and network adequacy in accordance with federal and state requirements, SCAN has established the following accessibility standards for all contracted providers:

Accessibility Standards	
Services	**Standard (Measured From Time of Request)**
Urgent/Emergent	
Emergency Services*/Urgent Care	Immediately 24/7
Urgent Care Appointment: PCP	Forty-eight (48) hours if no prior authorization required for PCP
Urgent Care Appointment: Specialist	Ninety-six (96) hours if prior authorization is required
Post stabilization services**	One (1) hour
Dental	Seventy-two (72) hours
* 1 or more physicians and 1 nurse on duty at all times	
** Contracted delegated entities must provide 24/7 access to providers for prior authorization of Medically Necessary post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by the delegated entity within one (1) hour or the service is deemed approved. Upon stabilization, additional medical-necessity assessment should be performed to assess the appropriateness of care and assure that care is rendered in the appropriate venue.	
Non-Urgent/Non-Emergent	
Ancillary services	Fifteen (15) business days
Specialty Care	Fifteen (15) business days
PCP or Behavioral Health Services appointment	Seven (7) business days
Routine and preventive care (PCP) (BH)	Thirty (30) business days
Preventive Care (Dental)	Forty (40) business days
Telephone Triage or Screening	Thirty (30) minutes
Other	
Interpreter services	24/7
Dental (non-preventive)	Thirty-six (36) business days

Providers must also maintain procedures for: (1) follow-up on missed appointments to monitor waiting times in physician's offices, telephone calls (to answer and return), and time to obtain appointments; and (2) for triaging Members' calls, providing telephone medical advice (if it is made available), and accessing telephone interpreters.

For list of Telehealth services see *https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes*

Cultural Competency and Interpreter Services

Providers are responsible for ensuring that all services are provided in a culturally competent manner and are accessible to all Members including those with limited English proficiency (LEP), low literacy levels, hearing, sight, or cognitive impairment, or those with diverse cultural and ethnic backgrounds. See 42 CFR 422.112(a)(8), MMCM, Chapter 4.

To this end, providers are expected to ensure that:

- Referrals are made to culturally and linguistically appropriate community services and agencies, when indicated (See *Chapter 2: Key Contacts Resource Guide*)
- Interpreter services are available 24/7 at no charge to the Member either directly or through SCAN resources
- Members are to use interpretive services instead of using family and friends, especially minors, as interpreters (Section 1557 of the Patient Protection and Affordable Care Act)
- Trained and fluent bilingual staff are used in medical interpreting; *Source: Health Industry Collaboration Effort (HICE) Tips for Communicating Across Language Barriers; *http://www.iceforhealth.org/*

- Visible signage is displayed to assist Members in requesting an interpreter
- The Member's primary spoken language and any request or refusal of interpreter services is recorded in their medical record: and
- Language assistance written and/or alternative format communication must meet the appropriate regulatory requirements.
    - Centers for Medicare & Medicaid Services (CMS) eighth grade level

For additional tools and resources, please see below:

- Multi-Cultural Toolkit - *https://www.scanhealthplan.com/providers/multi-cultural-resources-and-interpreter-services*
- Health Equity Tip Sheet - *https://www.scanhealthplan.com//////health-equity-tip-sheet_v5.pdf*
- U.S. Department of Health and Human Services (n.d.). The Office of Minority Health. *https://minorityhealth.hhs.gov*
- Office of Disease Prevention and Health Promotion, Healthy People 2030 *https://health.gov/healthypeople*
    - Topics include, but are not limited to:
        - *Older Adults*
        - *Access to Health Services*
        - *Disability and Health*
        - *Lesbian, Gay, Bisexual, and Transgender Health*
        - *Social Determinants of Health*

Interpreter Services: Help us Help the Member

SCAN provides free interpreter services to Members. To access services, call the Provider Information Line, twenty-four (24) hours a day at (877) 778-7226 (TTY User: 711) and select the Interpreter Services option when prompted.

You can also access SCAN Virtual Remote Interpretation (VRI) at *https://scan.cqfluencyvri.com*, enter access code: scan and select language.

VRI requires no prior scheduling, offers professional interpreters in ASL and 170 languages, reduces wait times and provides high quality care in minutes.

Health Education

Providers must implement and maintain an easily accessible Member health education program. (See 42 CFR 422.112(b)(5)). It is the responsibility of each delegated entity to conduct annual review and evaluation for all health education programs, as well as provide annual staff education on the availability of health education programs.

The program must include:

- Policies and procedures describing the health education program;
- Designation of an individual responsible for implementing and overseeing the health education program;
- Health education material must be:
    - Obtained from credible and reliable sources;
    - Meet appropriate levels of readability and suitability for an older adult population;
    - Meet appropriate CMS plain language and written communication requirements;

- Available in threshold languages and alternative formats, based on Member population including availability of interpreter services (Interpreters, American Sign Language, and TTY/TDD);
- Inventory of health education program components including, but not limited to:
  Education interventions (e.g., classes, webinars, telephonic) based on educational strategies appropriate for Members, at least some classes are offered free of charge, and are available for the following topics either directly or by referral (e.g., affiliated hospital, contracted agency, community based) – tobacco use and cessation, alcohol and drug use, fall or injury prevention, weight control/nutrition/physical activity, and self-care and management of health conditions including asthma/COPD, diabetes, hypertension, and Congestive Heart Failure (CHF)

Provider Training and Education

SCAN supports provider partners by regularly offering training and education on a variety of topics including, clinical protocols, evidenced-based practice guidelines, claims and billing, and cultural awareness and sensitivity instruction for Members. Provider participation is encouraged. Medical groups are responsible for providing additional training, to ensure best practices are integrated into their organizations.

Appeals, Grievances, and Payment Disputes

SCAN does not delegate Member Appeals and Grievances functions to its contracted providers. See *Chapter: 9 Member Appeals and Grievances* for more information.

In order to meet regulatory requirements, SCAN requires its providers to:

- Instruct Members to contact SCAN to file all Appeals and Grievances;
- Forward all Grievances and/or Appeals to SCAN on the day of receipt;
- Respond timely to requests for information and records from SCAN; and
- Effectuate overturn decisions in a timely manner and provide proof of timely effectuation. (See, e.g., 42 CFR 422.618(b)(2) and (c)).

Member Appeals and Grievances are time-sensitive procedures that require the timely collaboration between health plans and their provider organizations. Untimely responses to requests for medical records or other lack of cooperation may result in a favorable Member determination against the provider organization. Failure to timely effectuate overturn decisions may also result in adjustments to reimbursement.

Marketing and No Steering Rule

SCAN is responsible for any comparative/descriptive material developed and distributed on SCAN's behalf by providers and, as such, SCAN must ensure that providers (and subcontractors) comply with CMS marketing rules. See Medicare Communications and Marketing Guidelines (eff 02/09/2022 and subsequent updates) (MCMG); 42 CFR 422.2260 and 422.2262.

Providers may **not**:

- Offer sales/appointment forms or accept enrollment applications;
- Direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests;
- Mail marketing materials on behalf of SCAN;

- Distribute marketing materials/applications in areas where care is being delivered, except in common areas;
- Offer anything of value to induce SCAN Members to select them as their provider;
- Offer inducements to persuade beneficiaries to enroll in a particular plan;
- Health screen when distributing information to patients;
- Accept compensation directly or indirectly from SCAN for enrollment activities; or
- Steer, or attempt to steer, an undecided potential enrollee toward a plan, or limited number of plans, based on the financial interest of the provider or its subcontractors. Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions

Providers may:

- Provide the names of plans with which they contract and objective information on all benefits based on a particular patient's medications and health care needs;
- Make available or distribute plan marketing materials, display posters for all plan sponsors being offered;
- Refer their patients to other sources of information such as CMS's website or phone number; and
- Use SCAN's logo, or engage in co-branding, with SCAN's prior written consent.

Member Rights and Nondiscrimination

All new and existing Members receive communications regarding rights and responsibilities in their annual EOC. To ensure these rights, providers must:

- Treat the Member with fairness and respect at all times;
- Ensure that the Member gets timely access to covered services and drugs;
- Protect the privacy of the Member's PHI;
- Support the Member's right to make decisions about care;
- Allow the Member the right to make complaints and to request reconsideration of decisions made;
- Advise the Member what to do if the Member believes he/she is being treated unfairly or rights are not being respected; and
- Advise the Member how to get more information about their rights.

Providers may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status including, but not limited to, the following: medical condition including mental as well as physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, potential third-party liability for payment for the service, or disability. (See 42 CFR 422.110(a)). Providers further may not differentiate or discriminate against any Member as a result of their enrollment in SCAN or another managed care organization, because they are a Medicare or Medicaid beneficiary, because they filed a complaint, grievance, or lawsuit, or because of sex, race, color, creed, religion, ancestry, national origin, ethnic group identification, income level, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, identification with any other persons or groups defined in Penal Code 422.56, or on the basis of any other protected class or

characteristic under applicable laws. Providers must also ensure equal access to health care services for limited English proficient (LEP), limited reading skills, hearing incapacity and speech impaired Members through provision of high quality interpreter and linguistic services.

Safeguard Privacy and Maintain Records Accurately and Timely

For any medical records or other health and enrollment information maintained with respect to Members, providers must establish policies that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. (See 42 CFR 422.118).

Providers must further:

- Safeguard the privacy of any information that identifies a particular Member and have procedures that specify: (1) for what purposes the information will be used within the organization; and (2) to whom and for what purposes it will disclose the information outside the organization;
- Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas;
- Maintain the records and information in an accurate and timely manner;
- Ensure Member timely access to records and information that pertain to them; and
- Timely report breaches of PHI (See *Chapter: 16 Privacy and HIPPA*).

Disruptive Member Issues

There are situations in which a Member's behavior can place a strain on the provider and/or the Provider Organization. CMS generally does not permit the involuntary termination of a Member except in very specific circumstances. SCAN will work with providers to find a way to meet the needs of the Member while addressing the concerns of the affected providers. Under no circumstances should providers refuse to continue to provide and arrange care of a Member. All efforts should first be made to resolve the issue at the practice level.

Disruptive behaviors may include abusive, harassing, or derogatory comments to staff, including yelling or profanity, threats of violence, threats of lawsuits, and inappropriate public behavior.

If a Member is violent or is threatening violence, law enforcement should be notified immediately. In addition, promptly notify SCAN via your assigned Network Relations Specialist or email *NetworkRelations@scanhealthplan.com* and include any supporting details and documentation.

Providers ***may not*** end a relationship with a Member because of a Member's medical condition, the cost and type of care/treatment required, or for the Member's failure to follow treatment recommendations.

Providers ***may not*** refuse to continue to coordinate care as long as the Member is assigned to the Provider.

A member ***may not*** be involuntarily transferred to a new provider or medical group without the approval of SCAN.

Each provider organization must have a documented Disruptive Member procedure approved by SCAN. If all efforts have been exhausted, SCAN will work with Provider to transfer Disruptive Members to another provider for repeated, continuous, and unabated disruptive behavior by the Member that prevents the provider from providing services to the Member.

Refer to Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment, Section 50.3.2 – Disruptive Behavior *https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf.*

Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* for more information.

FDR and Compliance Program Requirements

Providers that have contracted with SCAN to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program are considered first tier or downstream entities of SCAN (also referred to as "FDRs" for "first, tier downstream, and related entities"). CMS requires that FDRs fulfill specific Medicare compliance program requirements which are outlined below and further specified in each provider contract. (See also MMCM Chapter 21, Medicare Prescription Drug Benefit Manual (PDBM) Chapter 9, and 42 CFR 422.503, 423.504.)

Compliance Program Requirements	
Written Standards	
FDRs must have written standards, that may be stated in a separate Medicare-specific stand-alone document or be within a corporate Code of Conduct, which describe at a minimum the FDR's:	
• Mission and commitment to compliance with law and to the highest ethical standards; • Procedures to avoid and address conflicts of interest; • Procedures for fraud, waste and abuse prevention, detection and correction; • Policy of non-intimidation and non-retaliation;	• Method and frequency by which provider distributes standards of conduct to employees and downstream entities (required within 90 days of hire, upon update and annually); • System for routine monitoring and identification of compliance risks; and • Compliance officer and high level oversight.

General Compliance Training	
FDRs may utilize CMS's standardized training available on the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo, or equivalent training. FDRs may use CMS's standardized general compliance training, or equivalent training, or incorporate the CMS general compliance training materials or equivalent. Training must include:	
• Review of compliance policies and procedures, and commitment to business ethics and compliance with all Medicare requirements; • Overview of how to ask compliance questions; training should emphasize confidentiality, anonymity, and non-retaliation; • Requirement for contractor to report to the sponsor actual or suspected Medicare and/or Medicaid program noncompliance or potential Fraud Waste and Abuse (FWA); • Examples of reportable noncompliance;	• Review of the disciplinary guidelines for non-compliant or fraudulent behavior; • Attendance and participation in compliance and FWA training programs annually; • Training must be made part of the orientation for new employees; • Overview of HIPAA, CMS Data Use Agreement (if applicable), and the importance of maintaining the confidentiality of PHI; • Overview of monitoring and auditing process; and • Review of the laws that govern employee conduct in the Medicare program.
Fraud, Waste and Abuse (FWA) Training	
FDRs may use CMS's standardized FWA training, or equivalent training, or incorporate the CMS FWA training materials or equivalent. FWA training must include:	
• Laws and regulations related to MA and Part D FWA; • Obligations of FDRs to have appropriate policies and procedures to address FWA; • Processes for employees to report suspected FWA to the sponsor directly or to their employer who then must report it to the sponsor; • Protections for FDR employees who report suspected FWA;	• Types of FWA that can occur in the settings in which FDR employees work; • Requirement for training to occur within ninety (90) days of hire and annually; and • Effective ways to communicate information from the compliance officer to others including physical postings of information, e-mail distributions, internal websites, and individual/group meetings with compliance officer.
Offshore Subcontracting (CMS issued guidance 08/15/2006 and 07/23/2007; and 2008 Call Letter.)	
FDRs that engage in offshore subcontracting (CMS issued guidance 07/23/2007, *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/memooffshoremodule_08.26.08_68.pdf* and *https://www.hhs.gov/guidance/document/offshore-subcontractor-data-module-hpms) must have policies that:*	
• Ensure that PHI and other personal information remains secure; • Appropriately limit subcontractor's access to Medicare data;	• Allow for immediate termination of the subcontractor upon discovery of a significant security breach; and • Include language that requires compliance with applicable laws and regulatory guidance.
Exclusion Screening, Oversight, and Records	
FDRs must have policies that:	
• Ensure that no persons or entities are excluded or become excluded from participation in federal programs. See Social Security Act 1862(e)(1)(B), 42 CFR 422.752(a)(8), 423.752(a)(6), 1001.1901.	• Describe oversight of FDRs and process to monitor and audit FDRs; and • Specify retention of compliance related records for ten (10) years, or longer if required by applicable law.

SCAN providers acknowledge that compensation by SCAN is contingent on full and ongoing compliance with their agreement with SCAN and this manual, including submission of all required attestations to demonstrate compliance. In the event a SCAN provider fails to timely provide SCAN any such attestation, SCAN may impose corrective action, including, but not limited to, financial penalties related to noncompliance.

Disclosure of Ownership and Control Interest and Management Statement

SCAN Providers must fully comply with all state and federal requirements for disclosure of ownership and control, interest and management, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare and Medicaid programs. See 42 CFR 422.500, 42 CFR 422.222, and 42 CFR 455 (as applicable).

A full and accurate disclosure of: (1) direct or indirect ownership in the disclosing entity and/or (2) ownership interest in an obligation of the disclosing entity, is required and must be reported to SCAN if it equates to an ownership interest of five percent (5%) or more in the disclosing entity or at least five percent (5%) of the value of the property or assets of the disclosing entity, respectively.

Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* for more information.

Chapter 6: Utilization Management

The role of utilization management is to ensure the consistent delivery of high-quality health care services to SCAN Members. At SCAN, utilization management is a collaborative and cooperative effort between SCAN and its provider and provider groups. We work together to ensure that Members receive covered services that are Medically Necessary, appropriate to the Member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Delegation of Utilization Management

SCAN typically delegates utilization management functions to its contracted delegated entities for most items and services. The entities that have been delegated to perform utilization management activities on behalf of SCAN must comply with all requirements applicable to SCAN, including but not limited to, the requirements set forth in this Chapter.

Where items or services are not delegated and remain SCAN's responsibility, providers should send authorization requests to SCAN Medical Management. See also *Chapter 10: Delegation Oversight* for more information.

Organization Determinations

An Organization Determination is any decision made by an MA Organization, or its delegated entity, regarding receipt of or payment for a managed care item or service, the amount SCAN requires a Member to pay for an item or service, or a limit on the quantity of items or services. Organization Determinations include, but are not limited to, prior authorizations, concurrent review, retrospective review, and requests for continuity of care. Should SCAN receive a request for an Organization Determination where the responsibility for making the determination has been delegated, SCAN will refer the request to the appropriate delegated entity.

Organization Determinations must be made by health care professionals, who have appropriate clinical expertise in treating the Member's condition or disease, in accordance with currently accepted medical or health care practices, taking into account any special circumstances that may require deviation from National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or other criteria. Organization Determinations are always based on Member eligibility and appropriateness of care/service. SCAN does not reward providers or other individuals for approving or issuing denials of authorizations.

When an entity delegated to make Organization Determinations does not have all of the information it needs to make a determination, the delegated entity must make reasonable and diligent efforts to obtain all necessary information in accordance with CMS guidelines. See *https://www.cms.gov////ORGDetermin.html.*

Delegated entities are expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, including those that result from CMS's NCDs and LCDs.

Members must be provided all the basic benefits covered under original Medicare Part A and Part B. In general, Medicare coverage and payment is contingent upon a determination that:

- A service is in a covered benefit category;
- A service is not specifically excluded from Medicare coverage by Title XVII of the Social Security Act (the "Act"); and
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body member, or is a covered preventive service.

See *MMCM Chapter 4 – Benefits and Beneficiary Protections Section 20.4* for Medicare Managed Care Enrollee Grievances, Organization Determinations, and Appeals guidance.

Prior Authorization

SCAN typically delegates the responsibility for prior authorizations to its delegated entities, depending on the Provider's contract with SCAN.

Prior authorization is never required for Emergency Services, including behavioral health services necessary to screen and stabilize Members.

Prior authorization is always required for planned out of area services that are not Urgent or Emergent.

Refer to Timelines of Pre-Service Organization Determinations (Part C) discussed below.

All SCAN providers and provider groups must follow Medicare Guidelines including, but not limited to:

- *Medicare National Coverage Determinations (NCD)*
- *Medicare Local Coverage Decisions (LCD)*
- *Local Coverage Articles (LCAs) (Active/Retired)*
- *Medicare Manuals (Internet Only Manuals (IOM))*

In the absence of Medicare guidelines:

- In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals, an MAO may adopt the coverage policies of other MAOs in its service area
    - Reference: *Medicare Managed Care Manual (MMCM) Chapter 4, Section 90.5 Creating New Guidance*
- Nationally recognized evidence-based guidelines/criteria: e.g.,
    - National Comprehensive Cancer Network (NCCN)®
    - American Diabetes Association (ADA)®
    - American Heart Association (AHA)®
    - InterQual® or Milliman Care Guidelines (MCG)® in conjunction with the clinical judgement of a qualified health professional

- Contact SCAN Medical Policy (*medicalpolicy@scanhealthplan.com)*

NOTE: The guidelines are to be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards of care. Flexibility in coverage can be applied in coverage determination that allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria when clinical benefits are highly likely to outweigh any clinical harms.

Timeliness of Pre-Service Organization Determinations (Part C)

This section applies to Part C pre-service Organization Determinations only (i.e., determinations with respect to the provision of medical services/items). Please see *Chapter 11: Pharmacy* for Part D Coverage Determinations.

A Member or his/her physician may seek pre-service Organization Determination from SCAN or, where applicable, its delegated entities. The Member or his/her physician may request that an Organization Determination be expedited when he/she believes that waiting for a decision under the standard time frame could place the Member's life, health, or ability to regain maximum function in serious jeopardy. Time frames for Part C pre-service Organization Determinations are:

To Render Decision and Notify* Member and Provider (from Receipt of Request)	
Standard	• **Fourteen (14) calendar days with possible fourteen (14) day extension** • **Seventy-two (72) hours after receiving the request for Part B drugs and cannot be extended**
Expedited	• **Seventy-two (72) hours with possible extension, not to exceed fourteen (14) calendar days** • **Twenty-four (24) hours after receiving the request for Part B drugs and cannot be extended**
To Provide Notice* of Denial of Request to Expedite	
Prompt oral notice and subsequent written notice **within three (3) calendar days**	
*See the Notice Requirements section of this Chapter for details regarding the form of notice required	

See *https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG//Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf*

Supplemental Benefits

Delegated entities may request coverage guidance from SCAN by sending an email to *medicalpolicy@scanhealthplan.com* or contacting SCAN's Utilization Management Department at (800) 250-9048, Option 2.

Concurrent and Retrospective Review

SCAN typically delegates the responsibility for concurrent review to its delegated entities. When delegated for concurrent review, Delegated Entity must follow guidelines outlined in *Chapter 10: Delegation Oversight* and refer to the Delegated Entities Delegation of

Responsibilities (DOR) for more information. When concurrent review is not delegated, SCAN performs inpatient (including continued stay review, discharge planning, and discharge review) and outpatient concurrent reviews. For inpatient stays, SCAN performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge and/or transition of care arrangements have been made.

SCAN also typically delegates the responsibility for retrospective review to its delegated entities. When delegated for retrospective review, Delegated Entity must follow guidelines outlined in *Chapter 10: Delegation Oversight* and refer to the Delegated Entities DOR for more information. When retrospective review is not delegated, SCAN conducts retrospective medical record review as may be required for health care services that were provided without formal prior authorization and medical necessity screening. Regardless of delegation, a retrospective review can be triggered by claims/encounter data where services are denied for failure to obtain prior authorization or pre-defined focused reviews such as diagnosis related grouping (DRG) validation, short stay, readmission reviews, etc.

Notice Requirements

Delegated entities are responsible for ensuring that all Member notifications are provided in a culturally competent manner. SCAN requires member-facing materials to be written in appropriate levels of readability and suitability for an older adult population, understanding that there may be exceptions.

Language assistance, written, and/or alternative format communication must also meet the applicable regulatory requirements, including:

- CMS - eighth grade level

Member notices must be complete and accurate, including adequate rationale specific to the decision, written in a manner easily understandable to Members, and not subject to interpretation. Notification of denial must include citation of criteria used, rationale, and recommendations for alternative and/or follow up with physician/provider. Notices must not use acronyms or technical/clinical terms unless an explanation/definition is provided.

Delegated entities performing utilization management functions must use SCAN-approved notices. These templates have been designed to meet CMS notice requirements, translations into SCAN threshold languages and are available at: *https://www.scanhealthplan.com///scan-cms-approved-letter-templates*

SCAN Provider Readability Guidelines are available at:
https://www.scanhealthplan.com///////provider-partner-readability-guidelines

Delegated Entity must follow guidelines outlined in *Chapter 9: Member Appeals and Grievances.* See also 42 CFR 422.624, 422.626, 489.27, and *Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance*.

Notice	When Required
To Member (or Representative) After Request for Prior Authorization	
Notice of Authorization letters (Facility and Services)	Issue when service/item/stay is authorized
Notice of Dismissal of Pre-Service Request	Issue when: • Request lacks valid appointment of representative form or written equivalent or valid authorization • Service/item requested already been received
To Member (or Physician) After Denial of Medical Coverage See *https://www.cms.gov////MADenialNotices.html*	
Notice of Denial of Medical Coverage (NDMC)	Issue when denying a request for medical services. • **Pre-Service Denials – Standard or Expedited** • **Exhaustion of Skilled Nursing Benefit Denials** • **Psychiatric Facility Exhaustion of Benefits Denials** • **Refusal to Transfer** *Note: Not to be used for Post Service Denial of Payment* *https://www.cms.gov/medicare/medicare-general-information/bni/downloads/integrated-denial-notice-instructions-cms-10003.pdf*
Extension Needed for Additional Information	Issue when an extension is needed for additional information in the interest of the Member *Note: Use when requesting additional information from NON-CONTRACTED providers, NOT to pend the decisions while waiting for medical records from contracted providers.*
Services Do Not Meet Expedited Criteria	Issued when the Member has requested an expedited initial decision and the request does not meet Expedited Initial Organization Determination (EIOD) criteria
To Facility	
Denial of Coverage for Inpatient Hospitalization	Issue when a reviewing physician denies an inpatient facility stay/extension of an inpatient stay
To Hospital Inpatients See *https://www.cms.gov////hospitaldischargeappealnotices.html*	
Important Message From Medicare (IM)	Issue to inform of hospital discharge appeal rights *Note: Must be delivered in person within two (2) calendar days of admission and not more than two (2) calendar days prior to discharge and the patient must sign that they received and understand* *https://www.cms.gov/medicare/medicare-general-information/bni/downloads/important-message-english-and-spanish.zip*
Detailed Explanation of Non-Coverage (DENC)	Issue when the Member has filed an appeal with the CMS Quality Improvement Organization (QIO) for denied covered skilled nursing services (including home health, comprehensive outpatient rehabilitation and hospice) *Note: Must be delivered no later than close of business of the day of the QIO notification*
Detailed Notice of Discharge (DND)	Issued **by the acute hospital** when the Member appeals the hospital discharge (with the QIO). Delegated entities are responsible for the oversight of their contracted facilities. *Note: Must be delivered to the inpatient before noon of the day after notification by QIO of the appeal. The hospital must provide all documents/information requested by QIO.*
To Hospital Observation Patients See *https://www.cms.gov////hospitaldischargeappealnotices.html*	
Medicare Outpatient Observation Notice (MOON)	Issued when Member is in an outpatient setting receiving observation services and is not inpatient at a hospital or critical access hospital (CAH). *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/MOON-FAQs.docx*

To Member (or Physician) Where Group is Not Responsible for Services	
Informational Letter to Beneficiary And Or Provider Physician (Carve Out)	Issue when the Member has requested services that the group does not have responsibility for providing or authorizing (e.g., acupuncture and chiropractic services, hearing aid services, non-Medicare covered podiatry, non-emergent transportation, non-medical vision, home delivered meals, over the counter items)
To Members Whose HH, SNF, Hospice, or CORF Services Are Ending See *https://www.cms.gov////FFS-Expedited-Determination-Notices.html*	
Notice of Medicare Non-Coverage (NOMNC)	Issued when there is a termination of: • SNF • HH (including psychiatric home health) • CORF • Hospice (delivered by Hospice Provider) *Note: Must be delivered two (2) calendar days OR the second to last day of service if care is not being provided daily, prior to termination of services unless exception applies and must be delivered in person. Member must sign and receive a copy.*
Optional Form to Document Alternate Delivery	Utilized to document the issuance of the NOMNC when the Member and/or Member's representative is unable or refuses to sign the NOMNC *Note: If Member is unable to make decisions for him/herself, contact Member's representative on the day of NOMNC issuance and mail the Optional Form on the day of contact*
Detailed Explanation of Non-Coverage (DENC)	Issued when the Member has filed an appeal with the QIO for services denied for SNF, HH, CORF, Hospice *Note: Must be delivered no later than close of business of the day of the QIO notification*
Reinstatement of Coverage	Issued when skilled level of care is reinstated after receipt of NOMNC *Note: Letter advises the Member there will be no lapse in coverage. If Member's condition changes, this letter can be issued prior to QIO decision. New NOMNC must be issued for notification of discharge at least two (2) calendar days prior to last covered day.*

Delegated Entities for Utilization Management: Let us Help You

SCAN is available to answer questions regarding required notices and to provide on-site in-service education. Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* for information.

SCAN CMS approved letter templates are available on the SCAN website *https://www.scanhealthplan.com///scan-cms-approved-letter-templates*

Continuity of Care

SCAN, in collaboration with the assigned delegated entity, will coordinate care and services for Members who are newly enrolled, transitioning to a new PCP and/or medical group, or where there is potential for disruption in services, to ensure uninterrupted care and safe transition. Criteria for continuity of care includes, but is not limited to: outpatient mental health/chemical dependency treatment; current acute or SNF hospitalization; chemotherapy, radiation therapy or nuclear medicine; complex chronic condition requiring continued care and ongoing services; DME (e.g. oxygen, hospital bed); terminal illness requiring continued care and ongoing services; and pending authorized surgery/procedure scheduled within one hundred eighty (180) days.

Continuity of care decisions are made in collaboration with the Member's new PCP and/or medical group. For timing requirements and financial responsibility with respect to continuity of care, please refer the provider's contract with SCAN.

The delegated entity is responsible for the continuity of care, including but not limited to a provider being terminated from the SCAN network due to a quality of care concern, a provider no longer providing services in SCAN's service area, or if sanctioned by Medicare and/or the medical board.

Chapter 7: Care Management

Delegation of Care Management

SCAN delegates certain activities to contracted providers, and contracted providers must perform these activities according to the contract and in compliance with all applicable state and federal laws, including, but not limited to, Medicare laws and regulations, and CMS guidelines. SCAN, however, remains ultimately responsible for the performance of all delegated activities. (See 42 CFR 422.504(i); 42 CFR 422.202(b); and 422.504(a)(5)).

Providers should refer to their Delineation of Responsibilities (DOR) Grid for additional information.

SCAN monitors and audits all delegated activities to ensure that they are performed satisfactorily. Refer to *Chapter 4: Physician Responsibilities* and *Chapter 10: Delegation Oversight* for additional information.

This Chapter focuses on Care Management programs that SCAN has implemented to maintain high quality care.

SCAN Care Management Programs

SCAN integrates the person-centered care approach in developing programs and activities to ensure optimal clinical outcomes for Members. SCAN offers telephonic case management programs for Members at high risk for poor health outcomes identified through predictive modeling and referrals. The goals of SCAN's programs include preventing unnecessary admissions/readmissions, facilitating access to care/services, supporting providers by reinforcing adherence to treatment plans, assisting Members in navigating the health care system, facilitating goals of care discussions and completion of advanced care directives, increasing Member satisfaction, improving self-management skills by educating to evidence-based guidelines, and addressing gaps in care and care giver support.

Program Description	Staffing
Complex Case Management (CCM) Program	
Telephonic case management for Members identified as high-risk for poor health outcomes and hospitalizations. Program services focus on the social determinants of health (SDOH) as well as supporting adherence to the treatment plan and preventive health care. • Additional focus on Members transitioning from a care setting to home (hospital or skilled nursing facility to home), Members with advanced illness, and/or behavioral health needs.	Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists All supported by a Board Certified Geriatrician

Disease Management (DM) Program	
Telephonic disease management for Members diagnosed with: • Congestive Heart Failure (CHF), • Chronic Obstructive Pulmonary Disease (COPD) and/or • Diabetes Disease management services include education and coaching following evidence-based guidelines for the management of the condition. Additional focus on social determinants of health, medication management, signs and symptoms of an exacerbation and action planning, preventive care, and adherence to the treatment plan.	Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists All supported by a Board-Certified Geriatrician
Medication Therapy Management Program (MTMP)	
Based on the CMS guidelines, Members identified receive Comprehensive Medication Reviews (CMRs) and Targeted Medication Reviews (TMRs). If care management needs are identified, Members are connected to Care Management for follow up.	Clinical Pharmacists RNs
Medication Advisor Program	
High-touch Member outreach program using motivational interviewing techniques to discover barriers and offer individualized solutions to Member with medication adherence issues.	Care Navigators
Care Coordination	
Primarily focused on the Special Needs Plan (SNP) population to support the following: • Health Risk Assessments (HRA) • Coordination of benefits • Identification benefits • Identification of unmet needs • Care planning and care management	RNs Non-clinical staff

For more information regarding these programs including full eligibility requirements, please refer to *Chapter 2: Key Contacts Resource Guide* for contact information.

Chapter 8: SCAN's Quality Improvement (QI) Program

CMS Requirements

MA Organizations must have a ***Quality Improvement Program*** *to ensure the necessary infrastructure to coordinate care, and to promote quality, performance, and efficiency on an ongoing basis.*

MA Organizations must:

Develop and implement a ***chronic care improvement program*** *and* ***quality improvement projects****;*

Develop and maintain a ***health information system****;*

Encourage providers to ***participate in CMS and HHS QI initiatives****;*

Implement a program review process for ***formal evaluation of the impact and effectiveness of the QI Program*** *at least annually;*

Correct all problems *that come to its attention through internal surveillance, complaints, or other mechanisms;*

Conduct the ***Medicare CAHPS® satisfaction survey****;*

Measure performance *and report using standard CMS measures; and*

Develop, compile, evaluate, and report *certain measures and other information to CMS, its Members, and the public.*

See 42 CFR 422.152.

SCAN does not delegate Quality Management (QM), however, SCAN network providers are required to meet quality standards and comply with SCAN's Quality Improvement Program, which includes, but is not limited to, the following requirements:

- Maintaining a Quality Improvement Program;
- Routine reporting of delegate data (i.e., HEDIS, ODAG, ODR);
- Providing access to documents, medical records, data and/or information required as part of quality of care and quality improvement activities; and
- Allowing access to office site(s) and medical record keeping and documentation

SCAN's Quality Improvement Program is designed to objectively and systematically evaluate and improve the quality of care and/or services in collaboration with the contracted provider network. The program ensures that meaningful and relevant programs based on nationally recognized research, evidence, and best practices are implemented to improve member experience and outcomes.

The Quality Improvement Program encompasses both clinical and non-clinical care and services for all SCAN Members in all SCAN contracts. The program activities apply to:

- All medical and mental health care and services, both clinical and non-clinical, provided to Members through the health plan and contracted providers and vendors;
- All Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

SCAN has adopted the Aims established by the Institute for Healthcare Improvement (IHI) in connection with SCAN's Quality Improvement (QI) goals. SCAN's quality initiatives are in pursuit of these aims:

- Improve the patient experience of care (including quality and satisfaction);
- Improve the health populations; and

- Reduce the per capita cost of health care.

In conjunction with the IHI Aims, SCAN has adopted the IHI Health Equity Framework. The framework includes:
- Make health equity a strategic priority;
- Make increasing equity core to our business;
- Develop clinical and operational data and processes to support health equity;
- Deploy specific strategies that have a direct impact on equity;
- Decrease institutional racism within the organization;
- Leverage partnerships with providers and community organizations to support health equity;
- Advocate for public policies that promote health equity for older adults; and
- Develop partnerships with community organizations to improve health and equity.

SCAN believes that members are the architects of their care and vital to the healthcare team. By partnering with members, their families, and providers we build a foundation for successfully achieving quality outcomes. Safety is integrated into all components of member enrollment, health care delivery and oversight. These activities are aimed at improving safety for our members and include the following intended outcomes:
- Reduced sentinel events
- Reduced medication errors
- Reduced use of high-risk medications
- Appropriate levels of utilization
- Increased compliance with standards of care
- Services/Care provided by a quality network of contracted facilities

SCAN is person-centered and adheres to the Institute of Medicine definition of patient-centered care as “care that is respectful of, and responsive to, individual patient preferences, needs, and values” and ensures that the member experience is excellent through programs like the Program for Advanced Illness (PAI) and Customer Experience. SCAN focuses on the following outcomes:
- Improved member experience related to the delivery of culturally and linguistically appropriate services
- Improved member experience related to end-of-life care and adherence to end-of-life care decisions
- Attainment of member-centered goals
- Improved member experience with the health plan

Health Outcomes
Effective Care Coordination matches populations with appropriate care and services to ensure positive health outcomes. Care Management and Care Transitions programs are the primary population-based interventions SCAN uses to ensure effective care coordination. SCAN also conducts specific member quality interventions when there are barriers to effective care coordination. While these interventions are applied to all SCAN populations, the Special Needs Plans have specific requirements which are articulated in the SCAN Models of Care. These activities result in the following outcomes:

- Reduction in readmission rates year over year
- Reduced admissions for ambulatory care sensitive diagnoses
- Timely access to needed care
- Improved communication among providers
- Improved continuity of services
- Improved coordination between medical and behavioral health

Patient Experience

In order to achieve improved health outcomes, physicians and office staff should:

- Schedule all patients for an annual wellness visit to evaluate and manage chronic conditions and close care gaps
- Ensure timely access to care to address acute symptoms (i.e same day appointments, telehealth, clinical triage and guidance)
- Manage chronic conditions, including medication management and regular testing, to ensure conditions are well controlled.
- Engage with patients after emergency department visits.
- Manage care transitions between inpatient and outpatient settings by engaging with patients and reconciling medications post hospitalization
- Assess and provide treatment options for common geriatric conditions like fall risk, urinary incontinence, and maintaining physical activity
- Assess and provide treatment for mental health
- Collaborate with specialists and other clinicians to ensure patients receive timely access to care
- Assist patients to navigate and coordinate their care, such as assisting with appointment scheduling with specialists and engaging patients in their treatment plan
- Reconcile patient medications and ensure patients understand their prescriptions, and reduce barriers to non-adherence

SCAN and providers/provider groups can work together to achieve these outcomes by:

- Sharing data and reports including gaps in care, encounter submissions, and performance data, and taking action as needed
- Collaborating to exchange ideas, successes, failures, and constructive feedback on best practices
- Participating in SCAN's Office Staff Training (OST) program to learn best practices for 5 Star Measures
- Providing documentation and patient records as requested by SCAN

SCAN provides the 5 Star Guidebook intended for provider groups and physicians looking for guidance on how best to improve their performance against a number of measures that CMS uses to evaluate and reward successful implementation of best practices in healthcare. For additional information related to CMS 5 Star measures, see *Part C and D Performance Data | CMS*

Access and Affordability

At SCAN, we focus on improving affordability by monitoring for appropriate utilization, benefit design, working to improve health thereby preventing costly hospitalizations, and implementing programs to detect and prevent fraud, waste, and abuse. These efforts are balanced by a grievance and appeals process and quality investigation process to ensure access to care. Quality outcomes related to affordability include:

- Utilization metrics within accepted benchmarks
- Maximum out of pocket costs in accordance with Medicare regulations
- Reduced ambulatory care sensitive admissions
- Reduced readmissions
- Medication adherence

QI activities are communicated to network providers through Quality Committees, individual provider performance reporting, provider E-Newsletters, and the SCAN Website. The QI Program is available upon request. For more information, please contact your Network Compliance Auditor.

Chapter 9: Member Appeals and Grievances

CMS require SCAN to establish and maintain meaningful procedures for timely resolution of Member Appeals and Grievances on both a standard and expedited basis.

SCAN does not delegate Member Appeals and Grievance functions to providers. Members should be directed to contact SCAN Member Services. See *Chapter 2: Key Contacts Resource Guide* (Member Services).

Help us Help the Member
Should the provider receive a Member grievance, the provider should report to SCAN Member Services immediately. See *Chapter 2: Key Contacts Resource Guide* (Member Services).

The following table describes the difference between Appeals and Grievances and provides a summary of the relevant timeframes:

Appeal	**Grievance**
An Appeal is a review of an adverse Organization Determination, including Part D Coverage Determinations. The first step of the Appeals process is a "Request for Reconsideration" (Redetermination for Part D)	Any complaint or dispute (other than of an Organization Determination) expressing dissatisfaction with the manner in which a health plan, provider, or delegated entity provides health care services, regardless of whether any remedial action can be taken
Examples	
• Reconsideration of pre-service denial • Reconsideration of determination of co-payment amount • **Part D:** Redetermination of drug denial based on medically accepted off label use	• Problems getting an appointment • Disrespectful or rude behavior by doctors, nurses, or other staff • **Part D:** General complaint about a drug being excluded from Part D coverage
Who May File	
Enrollees, their representatives (appointed or authorized), and certain providers, see below	Enrollees and their representatives (appointed or authorized)
Time Frames (All timeframes are calendar days, unless stated otherwise)	
To Request	
Sixty (60) days from receipt of denial (extension may be granted)	Sixty (60) days from date of event
To Render Decision and Notify Member and Provider (from receipt of request)	
Standard	
Pre-Service: Thirty (30) days (fourteen (14) day extension may be allowed) **Payment:** Sixty (60) days **Part D:** Seven (7) days	Thirty (30) days (fourteen (14) day extension may be allowed)
Expedited	
Pre-Service and Part D: Seventy-two (72) hours **Payment Requests:** Cannot be expedited	Twenty-four (24) hours (where criteria are met)

Further Levels of Review	
Second Level: Independent Review Entity (IRE) **Third Level:** Administrative law Judge (ALJ) Hearing **Fourth Level:** Medicare Appeals Council **Judicial Review:** Federal District Court	Enrollee may file a complaint with the QIO in addition to or in lieu of a Grievance

The foregoing is a resource only. Different rules may apply depending on whether the Appeal and/or Grievance falls under Part C or Part D. For information regarding Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, please see *https://www.cms.gov/////Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf*:

Requesting Reconsideration/Redetermination on Behalf of a Member

Part C: Normally, the right of Appeal for a denial of an Organization Determination belongs solely to the Member. However, CMS allows a physician who is providing treatment to a Member, upon providing notice to the Member, to request Reconsideration on the Member's behalf. In such a case, the physician is not required to submit proof that he/she is the Member's representative.

Part D: The Member's prescribing physician or other prescriber may request Redetermination of a Coverage Determination on behalf of the Member. Notice to the Member may be required depending upon the circumstances. See *https://www.cms.gov/////Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf* for CMS guidance.

To initiate a Request for Reconsideration/Redetermination on behalf of a Member under Part C or Part D, physicians can contact SCAN Member Services. See *Chapter 2: Key Contacts Resource Guide* (Member Services). For Part D, Physicians can also initiate a request for a Redetermination/Redetermination electronically on SCAN's website at: *https://www.scanhealthplan.com//medicare-part-d-benefits-file-an-appeal*.

Continuing Benefits While An Integrated Reconsideration Is Pending:
The Member, or a Member's representative or provider, may request that the Member continue to receive the previously authorized service or item at the previously authorized level while the integrated reconsideration is pending if:

- The request for continuation and the integrated reconsideration are both filed timely, that is, within ten (10) calendar days after the notice of the Organization Determination
- The service or item was ordered by an authorized provider,
- The integrated appeal involves the termination, suspension, or reduction of previously authorized services, and
- The period covering the initial authorization has not yet expired

Please refer to *Chapter 13: Claims*, for more information regarding provider disputes and appeals.

Chapter 10: Delegation Oversight

SCAN delegates certain activities to contracted providers, and contracted providers must perform these activities in compliance with all applicable state and federal laws, including, but not limited to, Medicare laws and regulations, and CMS guidelines. (See 42 CFR 422.504(i) and CFR 438.230). SCAN, however, remains ultimately responsible for the performance of all delegated activities. To ensure that delegated activities are performed satisfactorily, SCAN monitors and audits all delegated activities.

Delegation Determinations

Prior to delegation, SCAN evaluates and documents the entity's ability to perform the delegated activity in accordance with state and federal requirements and SCAN requirements. Upon delegation, each delegated entity is provided with a DOR document that describes in more detail the delegated entity's responsibilities and reporting requirements.

SCAN will send updated DORs when there are changes in delegation requirements or delegation status. Delegated entities should refer to their contract with SCAN and their most recent DOR for information related to delegated activities.

SCAN maintains the sole discretion to allow the delegation of activities to contracted providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities (e.g., sub-delegation) without prior written consent from SCAN. SCAN approved modifications for delegated activities may require additional reporting and auditing requirements, to ensure SCAN has full access to delegate data to execute or oversee regulatory activities, for example in the event of approved sub-delegation.

Performance of Delegated Activities

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, in accordance with all applicable laws, their contract with SCAN, this POM, and the DOR. Delegated entities may utilize their own policies and procedures to perform delegated activities, provided to the extent that such policies and procedures are consistent with SCAN's requirements. If the delegated entity's policies and procedures are inconsistent with SCAN requirements, SCAN requirements apply.

Delegated entities remain responsible for the performance of all delegated functions, even functions performed by subcontractors. Delegated entities are required to evaluate subcontractors' performance of delegated activities by monitoring and audits. Please see the provider contract with SCAN for subcontracting requirements.

Delegation Status, Revocation, and Resumption

SCAN will grant delegation to entities that have demonstrated the ability to perform delegated functions through pre-delegation and ongoing monitoring and audit activities. Delegated entities who fail to meet monitoring and/or auditing standards may be subject to corrective action and more frequent and/or focused audits. Delegation status to the delegated entity is subject to change, dependent on the entity's performance.

Per CMS regulations, SCAN may revoke delegated activities, or specify other remedies, in instances where CMS or SCAN determine that a delegated entity has not performed satisfactorily.

SCAN Oversight Committee Structure

Network Performance Committee

The Network Performance Committee (NPC) is responsible for: (1) establishing and maintaining a formalized, comprehensive oversight program for monitoring delegated functions and services provided by contracted health care providers including FDRs; (2) overseeing SCAN's network providers' compliance with contractual and regulatory requirements; and (3) overseeing efforts to correct identified deficiencies and/or non-compliance.

Credentialing Committee

The SCAN Credentialing Committee is responsible for establishing and maintaining a comprehensive credentialing and re-credentialing process, making credentialing and re-credentialing decisions, monitoring quality of care and services, and providing guidance for continuous quality improvement to meet NCQA, CMS and applicable state requirements. Credentialing decisions are made on a fair and impartial basis, according to predetermined criteria related to professional conduct and competence, not based on an applicant's race, gender, age, ethnic origin, sexual orientation, or type of patients or procedures in which the provider specializes.

Audits

In addition to ongoing monitoring, delegated entities are subject to annual audits, focused audits, re-audits, and exigent/ad hoc audits.

- **Annual Audits**: Annual audits are conducted on a routine, scheduled basis depending on delegation status.
- **Focused Audits or Re-Audits**: A focused audit or re-audit is usually conducted when some aspect of an annual audit reveals non-compliance or at the discretion of the NPC.
- **Exigent/*ad hoc* Audits**: An exigent or *ad hoc* audit is conducted when SCAN determines there is a reasonable need for a non-routine audit (e.g., SCAN becomes aware that a provider delegated for claims payment has experienced an event or series of events that might materially affect its ability to pay claims promptly). Exigent or ad hoc audits may be conducted without notice. However, to allow delegated entities to arrange for the necessary resources and staff, the audit team will notify the delegated entity one (1) hour prior to arriving on site.

Providers are required to submit reports to effectuate audit activities (e.g., quarterly, and annual financial statements in connection with the financial audit/monitoring). SCAN notifies Providers annually of the reporting requirements. Failure to submit required reports may result in increased oversight, corrective action, or other appropriate action.

SCAN's Delegated Oversight Unit (DOU) will work with the delegated entity to schedule an audit unless an exigent or ad hoc audit is required.

With the exception of unscheduled exigent/ad hoc audits, once an audit date is set, the delegated entity will receive an audit confirmation letter that includes information about the audit scope, how to prepare for the audit, and other information as may be necessary to conduct the audit. Failure to timely comply with audit requests may result in corrective action, de-delegation, or sanctions.

Audit Results and Corrective Action

Results of the audit and any requests for corrective action will be returned to the delegated entity within thirty (30) to forty-five (45) calendar days of the date of the audit. Corrective action may be

required in addition to other remedies or sanctions (e.g., placing the delegated entity on financial watch status). See Sanctions section, below in this Chapter. Corrective action required by SCAN is separate and distinct from corrective action that may be required by third parties. SCAN will consider corrective action by third parties as corrective action for noncompliance with a contractual or regulatory requirement, however SCAN is not required to accept such action.

Unless otherwise agreed to in writing, delegated entities have thirty (30) calendar days from the receipt of corrective action request to submit a completed corrective action plan (CAP) to SCAN. CAPs must include:

- A root cause analysis that describes the underlying causes that resulted in noncompliance and steps to prevent future noncompliance;
- The expected corrective actions entity will take to remediate and to prevent future noncompliance;
- The date(s) the corrective action is expected to be completed and timeframes for specific achievements;
- The ramifications for failure to implement the corrective action successfully; and
- The staff responsible for implementation of the corrective action.

The following are examples of deficiencies that may warrant corrective action:

- Provider is unable or unwilling to provide information needed to conduct the audit, or otherwise fails to cooperate with audit activities;
- Provider is unable or unwilling to take action to comply with legal or contractual requirements (e.g., pay claims in accordance with CMS requirements or reserve funds for Incurred but Not Reported (IBNR) claims);
- Provider lacks written policies and procedures sufficient to meet legal or contractual obligations (e.g., policy requiring that provider report potential fraud, waste, and abuse to SCAN); and
- Provider fails to maintain documentation sufficient to meet legal or contractual obligations (e.g., incomplete documentation for CMS required training and/or screening).

Failure to cooperate with a SCAN request for corrective action may result in further corrective action, de-delegation, or sanctions.

Sanctions

If a delegated entity fails to cooperate with audit/monitoring efforts or fails to complete a CAP, SCAN may institute sanctions which may include the following, unless expressly stated otherwise in provider's contract with SCAN:

- Termination of the provider contract with SCAN;
- Require a letter of credit and/or other proof that the organization has access to sufficient funds for the payment of claims for healthcare expenses; and
- Exclude the provider from the SCAN network.

Depending on the nature of the deficiencies, SCAN may apply sanctions without first requiring a CAP.

Audit Summaries

The following table provides an overview of delegation oversight activities. For further information, email *FDR_Oversight@scanhealthplan.com*.

<table>
<tr><td colspan="2">Credentialing Oversight (Providers delegated for credentialing activities)
• Delegated entities must meet all CMS requirements regarding credentialing. (See Chapter 5: Network Standards)
• SCAN uses the current HICE Audit Tool</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Annual audit</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
<tr><td>• Initial credentialing file review
• Recredentialing file review
• Credentialing policies, procedures, and committee
• Adverse actions monitoring & reporting
• Quarterly credentialing/recredentialing reports†
• Practitioner office site quality</td><td>• Ongoing monitoring
• Notification to authorities and practitioner appeal rights
• Assessment of organizational providers
• Delegation of credentialing
• Identification of AIDS/HIV Specialists
• Credentialing System Controls (including annual oversight reports)
• Additional information as may be required</td></tr>
<tr><td colspan="2">FDR Compliance Oversight (all delegated entities)
• Delegated entities must meet all CMS downstream requirements for first tier, downstream, and related entities (FDRs). See provider contract with SCAN for specific downstream requirements; See also the MMCM, Chapter 21 and the PDBM, Chapter 9.
• Corrective action is required for audits that result in score of less than 100%.</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Sub-set selected for annual audit based on internal risk assessment
• Annual compliance attestation component†</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
<tr><td>• Compliance policies and procedures, including detecting fraud, waste, and abuse (FWA)
• Standards of Conduct (aka Code of Conduct)
• General compliance and FWA training
• Exclusion screening
• Compliance Issue – Resolution and Reporting</td><td>• Monitoring and auditing of FDRs
• Offshore subcontracting
• Record retention policy
• Downstream provider contracts
• Additional information as may be required</td></tr>
<tr><td colspan="2">Financial Audit (Providers delegated for claims processing activities)
Information obtained by SCAN as part of its financial audit will remain confidential and will be used solely to comply with CMS Standards for financial solvency and risk based capital requirements.</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Quarterly financial review
• Audit performed based upon failure to meet financial solvency requirements</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
<tr><td>• Financial Audit Questionnaire
• Financial statement review
• IBNR claims review</td><td>• Stop loss insurance
• Claims Payable Report
• Additional information as may be required</td></tr>
</table>

Financial Review-Quarterly Statements and Annual Financial Reports

On a quarterly basis, SCAN will send a reminder via email for documents for quarterly review, including unaudited financial statements†. Please remit the documents to the email sender's address. Documents are due to SCAN on May 15th (for January 1 – March 31), August 15th (for April 1 – June 30), November 15th (for July 1 – September 30), and February 15th (for October 1 – December 31).

SCAN will review financial statements with supporting schedules and documentation: • Balance Sheets • Income Statements • Statement of Cash Flows	SCAN will also review the following ratios to evaluate an organization's financial status: • Debt to Equity • Days of Cash on Hand • Medical Loss • Acid Test

Monthly Review

If an organization is placed on financial watch, a monthly review of the financial status of the organization will be required. This monthly review may include monthly unaudited financial statements, an updated Provider Financial Questionnaire, Claims Payable Report, and other financial documents.

Claims Audit (Providers delegated for claims processing activities)

- Delegated entities must meet all CMS requirements regarding claims. (See *Chapter 13: Claims*, for more information regarding these requirements).

Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)

- Annual audit with monthly reporting component or semi-annual, if indicated based on annual risk assessment

Scope of Audit

• Inventory management reports • Reports of pended claims • Medicare Advantage claims processing policies and procedures • Training materials • Organizational structure • Information systems (IS) • HICE Operational Review Questionnaire • Claim and claim supporting areas • Testing of contracted provider status	• Claim adjudication review, which may include: ◦ Non-contracted provider paid claims ◦ Unclean Non-Contracted provider paid claims ◦ Contracted provider paid claims ◦ Unaffiliated provider denials ◦ Denied claims with Member liability* ◦ 1st level provider dispute resolution claims ◦ Reopened claims ◦ Direct Member Reimbursement Claims ◦ Misdirected claims • Attestations and supporting copies • Excluded providers • Additional information as may be required

* If the provider is placed in retrospective review status for claim denials, 100% of denials must be submitted weekly for review.

**In the event of contract termination. Provider Organization is required to promptly provide all claims data to SCAN upon request.

Monthly Reporting of Claims Processing Timeliness†

All delegated entities must report claims processing timeliness on a monthly basis, using the current version of the HICE Monthly Medicare Advantage Claim Timeliness Report. The report is available at: *http://www.iceforhealth.org/*. This report should be faxed/e-mailed in time to be received by the 15th of the month following the month being reported.

Quarterly Reporting of Misdirected Claims†	
All delegated entities must report claims that were received but determined to be payable by another entity (e.g., SCAN, another medical group, a capitated provider, etc.). The Misdirected Claims Log template (based on HICE template) will be provided by SCAN to each delegated entity and must be submitted to SCAN via email or SFTP by 15th calendar day following the end of each calendar quarter: January, April, July, and October.	
Utilization Management Audit (Providers delegated for utilization management activities) Delegated entities must meet all CMS requirements regarding utilization management. (See *Chapter 6: Utilization Management* for more information).	
Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)	
• Annual audit • Annual SNP component for providers delegated for SNP • Monthly, quarterly, semi-annual, and annual reporting components†	
Scope of Audit	
• Utilization management program description • Physician involvement • Behavioral health practitioner involvement • Annual evaluation • Consistency in applying criteria • Communication services • Appropriate professionals • Use of Board-certified consultants • Affirmative statement about incentives • Timeliness of decisions and notifications • Policies for Appeals • Emergency Services • Delegation • Adequate and appropriate access to care • Direct access to in-network women's health specialist for routine and preventative services • Arrangements for Specialty Care • Population Health Management • Legislative requirements • ODAG mail authorization process • Ambulatory case management	• Health education and cultural linguistics • Services are provided with cultural competence • Initial Health Appointment • Advance Directives • Nondiscrimination • Evidence of no prohibition on health care professional advice to patients • Adherence to Medicare Marketing Guidelines • Provider access during federal disaster or public health emergency declaration • Specialist termination notifications • Clinical practice guidelines • Continuity of care and coordination of care • Standing referrals • Continuing services by a terminated provider • U.S. Preventive Services Task Force • Quality management and improvement program Requirements • Out-of-network/out-of-area contractual agreements and denial process • Additional information as may be required
Scope of UM Service Denial Audit	
• Timely Organization Determinations • Timely notification to Members • Correct letter template • Appropriate criteria for denial • Relevant clinical information for decisions • Appeal rights provided	• Accuracy of notifications • Alternate treatment options provided to Members • Language (8th grade level definition of medical terminology, defined acronyms when used) • Additional information as may be required

Scope of SNP Audit (Providers delegated for SNP only)	
• Care management program description • Population assessment • Care management assessment process • Individualized Care Plan (ICP) • Interdisciplinary Care Team (ICT)	• SNP MOC training requirements • SNP Trigger Report • SNP Transition of Care (TOC) • Ongoing care management • Additional information as may be required
Organization Determinations, Appeals, and Grievances (ODAG) and Organization Determinations and Reconsiderations (ODR) (all delegated entities) • *Delegated entities must submit timely, complete, and accurate ODAG and ODR data for CMS submission. Corrective action required for audits that result in score of less than 100%.*	
Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)	
• ODAG audits are conducted quarterly† • ODR audits are conducted annually† • Expedited Organization Determinations (EOD) and Standard Organization Determinations (SOD) audits are conducted quarterly	
Scope of Audit	
• Accurate and complete universe data	

† Please see **SCAN Annual Reporting and Attestation Due Dates and Notification** for detailed instructions.

SCAN's P&T Committee

SCAN's Part D Formulary is reviewed and approved by SCAN's Pharmacy and Therapeutics (P&T) Committee that meets specific requirements with respect to membership, conflict of interest, P&T member disclosure to CMS, meeting administration, formulary management, formulary exceptions, and P&T committee role.

The SCAN P&T Committee is comprised of physicians and pharmacists that come from various clinical specialties and evaluate new drug therapies for placement on the SCAN Part D Formulary, drug utilization criteria, pharmaceutical management policies and procedures, as well as select treatment guidelines for major medical conditions.

The SCAN P&T Committee meets at least quarterly and its decisions regarding the placement of new medications on SCAN's Part D Formulary are distributed to contracted providers.

See www.scanhealthplan.com for more information.

Chapter 11: Pharmacy

SCAN contracts with CMS to provide Medicare Part D prescription drug coverage for SCAN Members and must comply with CMS's rules and regulations.

Pharmacy Benefits

Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* to request a current SCAN benefits grid. Benefits grids are also available on the SCAN Provider Portal at: *https://www.scanhealthplan.com/providers*.

Part D Formulary

SCAN's Part D Formulary is a list of covered Part D drugs reviewed and approved by the SCAN Pharmacy and Therapeutics (P&T) Committee and CMS. SCAN's Part D Formulary and the updates to the Part D Formulary are available at: *https://www.scanhealthplan.com//formulary/*.

Providers shall use SCAN's Part D Formulary and non-Formulary medications subject to the exercise of the prescribing provider's clinical judgement. In cases non-Formulary medications are warranted, Provider will work with SCAN by requesting non-Formulary drugs using the SCAN formulary exception process described in the Coverage Determination section below.

Providers shall prescribe medications listed in the SCAN Part D Formulary for Part D covered indications only consistent with section 1927(d)(2) of the Social Security Act, for example, formulary medications when used for weight loss even for a non-cosmetic purpose (i.e., obesity) are excluded from Part D coverage by CMS and are not covered by SCAN.

Requests to Add Drugs to the Part D Formulary

Providers may request that drugs be added to SCAN's Part D Formulary. Providers may submit written requests to: SCAN, Attn: Sr. Director, Pharmacy and Formulary Operations, 3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806.

Finding a Network Pharmacy

SCAN's pharmacy network includes over sixty-six thousand (66,000) pharmacies, many of which have preferred cost-sharing. Providers can locate a network pharmacy, including a pharmacy with preferred cost-sharing, by using the pharmacy search tool on SCAN's website at: *https://www.scanhealthplan.com//pharmacy-search*. To find a pharmacy in a specific area, search options must be entered, which includes selection of the following options: a specific zip code; pharmacies within a certain mile radius; preferred pharmacies only; and/or pharmacies open 24 hours. Once results are returned, the "Details" section will advise if the pharmacy has preferred cost-sharing, open 24 hours, or dispenses a 100-day supply.

Specialty Pharmacies and Specialty Medications

SCAN provides clinical support, therapy management, counseling, and social services for Part D specialty medications through its contracted Specialty Pharmacy, Accredo. Members may also choose to use other network specialty and retail pharmacies to obtain Part D specialty medications. Coverage determinations for specialty medications follow the procedure described below under "Coverage Determination Process".

Mail Order Pharmacy Program

Members are encouraged to use SCAN's mail order pharmacy program, administered by Express Scripts, which allows Members to receive up to a 100-day supply for certain medications delivered at home. Express Scripts Pharmacy[sm] is our preferred mail order pharmacy. While Members can choose any mail order network pharmacies to fill their prescription medications, they may pay less at the preferred mail order pharmacy. Providers can fill mail order prescriptions at Express Scripts Pharmacy as set forth below:

- By phone: (888) 327-9791
- By fax: (800) 837-0959
- Electronically: software required, please contact Express Scripts

To avoid delays, all prescriptions must have three (3) forms of identification (e.g., Member name, ID number, date of birth, etc.). If the three (3) forms of identification are not listed, the processing of prescriptions will be delayed. When sending prescriptions for controlled substances, a handwritten signature must be on the prescription. For more information, visit: *https://www.scanhealthplan.com///order-prescriptions-for-home-delivery*

Coverage Determination Process

SCAN delegates Part D Coverage Determinations to Express Scripts. Providers may request Coverage Determinations from Express Scripts 24/7 as set forth below:

- Electronically (Preferred): By an electronic prior authorization process (e.g., CoverMyMeds, ExpressPAth, Surescripts, etc.) (see *http://lab.express-scripts.com//physicians* for more information)
- By phone: (844) 424-8886 (If complete information provided, decision will be given on the call)
- By fax: (877) 251-5896 (Completed forms only) Forms available at *https://www.scanhealthplan.com///prior-authorization-and-step-therapy-forms*

Incomplete forms or insufficient information may result in delay or denial. Providers must respond timely to requests for information from Express Scripts. See *https://www.scanhealthplan.com///part-d-coverage-determination-process* for more information and additional ways to request Coverage Determinations.

Part D v. Part B: Let Us Help You

For assistance determining whether a drug falls under Part D or Part B, call the Provider Information Line at (877) 778-7226. A SCAN Clinical Pharmacist will provide a response, usually within twenty-four (24) hours. Please note, this service is for informational purposes only and is not a Coverage Determination. Coverage Determinations are made by Express Scripts as described above.

Injectables, including intravenous and intramuscular drugs, that are typically not self-administered and furnished "incident to" a physician's or other practitioner's service are covered under Part B consistent with section 1861(s)(2)(A) or (B) of the Social Security Act. **Per the "incident to" guidelines, providers are not allowed to instruct patients to purchase a drug themselves and bring it to the provider's office for administration.**

Transition Policy

A new or continuing Member may be taking drugs that are not on SCAN's Part D Formulary or that are on SCAN's Part D Formulary but require prior authorization, step therapy, and/or quantity limits. In these circumstances, SCAN may cover a temporary 30-day transition supply during the first ninety (90) days of coverage. Members should talk to their prescribers to decide if they should switch to an appropriate drug that SCAN covers or request a formulary exception.

If a Member is a resident of a long-term care facility, SCAN may cover a temporary 31-day transition supply during the first ninety (90) days of coverage. After the first ninety (90) days, SCAN may provide a 31-day emergency supply unless the Member has a prescription written for fewer days.

If a Member has a level of care change, SCAN may cover a temporary 31-day transition supply for those Members who are moving from home or a hospital stay to a long-term care facility. SCAN may cover a temporary 30-day transition supply for those Members who are moving from a long-term care facility, or a hospital stay to home. See *https://www.scanhealthplan.com///transition-policy-documents*.

Medication Therapy Management (MTM) Program

CMS requires all Part D sponsors to implement a medication therapy management (MTM) program for Members who have multiple chronic diseases, are taking multiple medications, and are likely to incur annual costs for covered Part D drugs at a specified threshold and for Members who are at-risk beneficiaries (ARBs) under a Drug Management Program (DMP). The purpose of the MTM program is to optimize therapeutic outcomes through improved medication use by providing comprehensive medication reviews (CMRs) and targeted medication reviews (TMRs) to physicians. Members in the MTM program receive a CMR from a Clinical Pharmacist or other qualified provider and receive a Recommended To-Do List and Personal Medication List upon completing the CMR. Recommendations of drug therapy changes, if any, are sent to the

Member's prescriber(s). All eligible members of the MTM program will receive information about: safe disposal of prescription drugs that are controlled substances; drug take back programs; in-home disposal; and cost-effective means to safely dispose of medications. For more information about MTM program, see: *https://www.scanhealthplan.com/scan-resources/pharmacy/2024-medication-therapy-management-mtm-program*

Opioids

The CMS finalized opioid policies for Medicare drug plans effective January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The policies include improved opioid safety alerts (pharmacy claim edits) when opioid prescriptions are dispensed at the pharmacy and drug management programs for Members determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs. As of January 1, 2022, all part D sponsors are required to have a drug management program for Members who are at-risk due to obtaining opioids from multiple prescribers and/or pharmacies or obtaining opioids with history of opioid related overdose. Providers shall cooperate with SCAN and provide necessary information concerning the use of opioids by a Member or Members as part of SCAN's drug management program. Residents of long-term care facilities, those in hospice care, Members receiving palliative or end-of-life care, Members with sickle cell disease (SCD), and Members being treated for active cancer-related pain are exempt from these interventions. These policies do not impact access to medication-assisted treatment, such as buprenorphine. For more information on opioid safety alerts, drug management program, and medication-assisted treatment, see: *https://www.scanhealthplan.com/scan-resources/pharmacy/programs-to-help-member-manage-medication-safety/drug-utilization-management*.

Part D Vaccines

SCAN encourages Members to obtain Part D-covered vaccines through a retail pharmacy if the vaccine is recommended by their PCP. Pharmacies will dispense and administer the vaccine under protocol. In such a case, the pharmacy submits the vaccine claim to Express Scripts with the drug cost and administration fee. Pursuant to the Inflation Reduction Act of 2022, Section 11401 (Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D), SCAN Members will have access to Part D-covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to SCAN Members. The effective date of the $0 copay for a new adult vaccine recommended by the ACIP will align with the date on which the CDC Director adopts the respective recommendation, as published on the CDC website, or the date after the last day of the ACIP meeting at which the recommendation was approved, if no date is published on the CDC website. Some covered Part D-covered vaccines include, but are not limited to, Shingrix (shingles), M-M-R II (measles), and T-DAP (whooping cough) vaccines. Providers can find a complete list of the Part D-covered vaccines SCAN covers in SCAN's Part D Formulary. For more information, see *https://www.scanhealthplan.com///part-d-vaccines*

Insulin

Consistent with the Inflation Reduction Act of 2022, Section 11406 (Appropriate Cost-Sharing for Covered Insulin Products Under Medicare Part D), SCAN members won't pay more than $35 for a one-month supply of each insulin product covered by SCAN, no matter what cost-sharing tier it's on. Providers can find a complete list of the insulin products SCAN covers in SCAN's Part D Formulary.

Part B Prescription Drugs

Pursuant to the Inflation Reduction Act of 2022, Section 11101, beginning April 1, 2023, SCAN Member coinsurance for Part B drugs will be reduced if the drug's price has increased at a rate faster than the rate of inflation. CMS publishes the adjusted beneficiary coinsurance for each Part B drug in the quarterly pricing files posted on the CMS website. SCAN members pay $0 - 20% of the Medicare-approved amount for Medicare Part B prescription drugs.

Consistent with the Inflation Reduction Act of 2022, Section 11407, beginning July 1, 2023, SCAN members pay no more than $35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump.

Hospice and End Stage Renal Disease (ESRD) Part D Exclusions

Medicare specifies that a drug prescribed to a Part D eligible Member cannot be considered a covered Part D drug if payment for such drug is available (or would be available) under Part A or B for that Member. Two examples of drugs covered under Part A or B are: (1) drugs and biological products related to the terminal illness or related conditions for Members who have elected the Medicare hospice benefit - these drugs should be covered under the Part A payment to a hospice provider; and (2) drugs used for ESRD beneficiaries receiving renal dialysis services - these drugs are included in the Part B bundled payment to an ESRD dialysis facility. It is important Providers understand these requirements.

Hospice Medications

PCPs remain responsible for Members receiving Medicare certified hospice care to ensure non-hospice care and services are provided.

- Drugs and biological products paid for under the Part A per-diem payments to a Medicare hospice program are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis and four categories of drugs that relieve common symptoms during the end of life, regardless of their terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety.
- For Members enrolled in Hospice, SCAN has Member-level Prior Authorization requirements on the following four categories to determine their coverage under Part A versus Part D benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.
- For these drugs, hospice-affiliated providers must provide a supporting statement of whether the prescribed drug is unrelated to the Member's terminal illness or related condition for Part D coverage.

PCPs should:

- Understand CMS guidelines for the management of Members in hospice
- Demonstrate use of SCAN guidelines
- Implement intervention to manage hospice Members including:
  - Monitoring patient status
  - Ensuring care transition support
  - Ensuring non hospice care needs are met
  - Managing medications (Hospice vs. Medical Group coordination)
- Explain care responsibilities for Members that transition into and out of hospice

End Stage Renal Disease (ESRD) Prospective Payment Program

CMS applies a bundled prospective payment system (PPS) for renal dialysis services provided by an ESRD dialysis facility that includes drugs used in the treatment of ESRD. CMS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment including supplies and equipment used to administer dialysis, drugs, biological, laboratory testing, training, and support services. As a result, drugs used for ESRD Members receiving renal dialysis services are excluded from Medicare Part D as these drugs are included in the Medicare Part B bundled payment to an ESRD dialysis facility. CMS has identified four (4) categories of drugs that will always be considered renal dialysis drugs when furnished to an ESRD Member and used as specified in the table below:

Intended Use	Drug Category
Access Management	Drugs used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and provide anesthetic for access placement
Anemia Management	Drugs used to stimulate red blood cell production and/or treat or prevent anemia
Bone and Mineral Metabolism	Drugs used to prevent/treat bone disease secondary to dialysis
Cellular Management	Drugs used for deficiencies of naturally occurring substances needed for cellular management

Part B vs. Part D edits will apply at Point of Service (POS) for ESRD Members for drugs that are considered to be “always” ESRD-drugs.

Sensipar® (cinacalcet) is included in the ESRD PPS and is not payable under the Part D benefit when used for the provision of renal dialysis services (Part B vs. Part D edit will apply to cinacalcet at Point of Service (POS) for ESRD Members).

Chapter 12: Provider Payment

This section provides general information regarding provider reimbursement. Non-contracted providers and contracted providers paid on a fee-for-service basis should refer to *Chapter 13: Claims* and/or their contract with SCAN for more information. Contracted capitated providers should refer to their contract with SCAN for capitation rates and other specific details, including the Division of Financial Responsibility (DOFR). Capitation is paid on or about the fifteenth (15th) day of each month. Capitation reports are available in the SCAN Provider Portal. Exceptions may be considered for individual providers directly contracted with SCAN. Providers may contact Network Relations Specialist at *NetworkRelations@scanhealthplan.com* for more information.

Corporate Information Changes

Providers must notify SCAN of any corporate information changes to ensure that payments are made correctly. Corporate information includes, but is not limited to, organization name and/or dba, organization ownership, tax identification number (TIN), and payee name and address. To notify SCAN of corporate information changes, please email the following documentation to *NetworkRelations@scanhealthplan.com*:

- A letter on provider letterhead signed by an officer;
- A copy of Provider's Statement of Domestic Stock Corporation document, Articles of Incorporation, or Service Agreement;
- A Fictitious Name Permit if the request is to a "dba"; and
- A W-9 if the request includes a TIN change.

Wire Transfers (Capitated Providers Only)

To request that payments be made via wire transfer, please email the following documentation to *NetworkRelations@scanhealthplan.com*:

- A letter on provider letterhead signed by an officer that includes a written statement approving the wire transfer of capitation funds and the following information:
  - ✓ Account Number
  - ✓ Routing Number
  - ✓ Bank Name
  - ✓ Bank Contact Person
  - ✓ Bank Phone Number
  - ✓ Bank Fax Number
  - ✓ Destination Address
  - ✓ Beneficiary Names
  - ✓ TIN
- An electronic funds transfer Form (EFT Form) signed by an officer;
- A W-9; and
- A copy of Provider's Statement of Domestic Stock Corporation document, Articles of Incorporation, or Service Agreement.

Physician Incentive Plans: Requirements and Limitations

CMS does not allow specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services. Indirect payments may include, but are not limited to, offerings of monetary value (e.g., stock options, waivers of debt) measured in the present or future. Additionally, if a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, SCAN must ensure that all physicians and provider groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys. SCAN is required to provide all information requested by CMS. (See 42 CFR 422.208).

CMS Requirements

MA Organizations and their delegated entities, must make ***correct claim determinations****, which include developing the claim for additional information when necessary for:*

- *Services obtained from a non-contracted provider;*
- *Ambulance services dispatched through 911;*
- *Emergency services;*
- *Urgently needed services;*
- *Post-stabilization care services; and*
- *Renal dialysis services.*

MA Organizations, and their delegated entities, must also provide reasonable reimbursement for the foregoing services as well as services for which coverage has been denied but found to be services the Member was entitled to upon appeal.

See 42 C.F.R. 422.100(a) and (b)(1); 422.132; 422.504(g)(1); Manual Ch. 4 – Section 10.2.

Chapter 13: Claims

SCAN processes claims for reimbursement for services rendered in accordance with all applicable regulatory requirements, including CMS requirements. These claims are for services provided to SCAN members at both contracted and non-contracted providers. SCAN will only process, and if appropriate, pay, claims for which SCAN is financially responsible, dependent on any delegated risk arrangements. Delegates with claim payment responsibilities on behalf of SCAN must also comply with requirements applicable to SCAN including the requirements set forth in this Chapter.

SCAN may review and audit claims on a pre and post payment basis for appropriateness and accuracy in accordance with prevailing Correct Coding Initiatives (CCI) Edits, regulatory requirements, and proper billing validation. SCAN may conduct these audits internally or through a third-party vendor. Providers are required to cooperate with SCAN's audits of claims and payments by providing access to requested claims information, all supporting documentation, including but not limited to itemized bills, medical records, and other related data. See *Chapter 10: Delegation Oversight*.

Definition of Clean Claim

Unless defined otherwise in a provider's contract with SCAN, a "clean" claim means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. (See 42 U.S.C. 1395u). SCAN reviews claims for correct coding including National Correct Coding Initiative (NCCI) edits, National Coverage Determination (NCD) edits and Local Coverage Determination (LCD) edits. Claims which do not meet the coding requirements may be rejected.

Claims Submission

SCAN accepts claims in an EDI format through SCAN's clearing house, Office Ally. Electronic claims submission is no cost to the provider. EDI claims submission

improves timely disposition of claims in accordance with CMS requirements.

Electronic claims must be submitted via a clearinghouse using the HIPAA Compliant 837 Version 5010 transaction set format. Providers can use their preferred clearinghouse, provided that the clearinghouse can complete transactions with Office Ally. If providers do not have a clearinghouse or have been unsuccessful in submitting claims to a provider's clearinghouse, please contact your clearinghouse or Office Ally directly at (360) 975-7000.

Providers can also contact Office Ally directly to establish electronic claims submissions connectivity with SCAN. To contact Office Ally, call (360) 975-7000 Option 1 or visit *https://cms.officeally.com/*.

SCAN accepts paper claims where electronic submission is not feasible. Claims must be submitted on current CMS standard forms: UB-04 (CMS-1450), or CMS HCFA 1500.

Paper claims may be submitted to: SCAN Claims Department, P. O. Box 22698, Long Beach, CA 90801-5616.

All claims must conform to CMS clean claim requirements and claim submission guidelines, including those set forth in the Medicare Claims Processing Manual and in accordance with prevailing Correct Coding Initiatives (CCI) Edits.

Claims submitted without all required information will be rejected through the clearing house or returned with a cover letter indicating the claim is incomplete. In order to have a claim considered for payment, provider will have to resubmit the claim with the correct and complete claim information.

SCAN may request additional information to facilitate claims processing, such as medical records or an itemized bill. Providers should submit requested documentation within forty-five (45) days for reconsideration of the claim. Information received after forty-five (45) days will be considered based on regulatory requirements.

Providers must submit claims for services rendered within one (1) year of the date of service or discharge, unless otherwise stated in a Provider's contract. SCAN encourages providers to submit all claims as soon as possible. Claims received after one (1) year from the date of service/discharge will be denied as untimely.

SCAN will provide payment or denial determinations for clean claims in accordance with CMS regulations. Providers can find claim determination periods in their contract. For non-contracted providers, claim determinations will comply with CMS regulations.

Claim Payments

Provider payments are produced by SCAN's vendor partner, Change Healthcare, and their partner ECHO Health. Providers are encouraged to register with Change Healthcare/ECHO Health as soon as practicable, to request copies of a remittance advice, confirm payments of a check, electronic, or virtual card payment, check tracer options, or to set up payment preference.

Electronic payment options:

1. **EFT (Electronic Funds Transfer) / ACH (Automated Clearing House)** – Automatic Direct Deposit
2. **Virtual Card (vCard)** – Virtual Visa Debit Transaction (This is the default option. Providers must call ECHO to make a change)
3. **Paper Check**

Providers will be able to review payments, remittance advice documents, configure payment preferences, and request check tracers and duplicate remittance advice documents following registration.

To enroll please visit *ECHO New User Registration for Provider Payments Portal* and provide SCANs ePayment Enrollment ID: 72261

- For all enrollment, technical and payment questions, please contact ECHO at *www.providerpayments.com* or call (888) 984-5025.

Overpayment and Recovery

Providers are required to report any payments made to them by SCAN to which they are not entitled as well as to return any overpayment to SCAN no later than sixty (60) days after the date on which the overpayment was identified and to notify SCAN in writing of the reason for the overpayment.

If SCAN determines that it has made an overpayment to a provider, it will make a claim for such overpayment by sending written notification to the provider that has received the overpayment. Providers have sixty (60) days from the date of the notice of the overpayment to contest or reimburse the overpayment.

Under existing regulation 42 CFR §405.374, providers and other suppliers will have fifteen (15) days from the date of this notification/revised demand letter to submit a statement of opportunity to rebuttal, including a statement and/or evidence stating why recoupment should not be initiated. The rebuttal is not an appeal of the overpayment determination, and it will not delay recoupment before a rebuttal response has been rendered; however, the outcome of the rebuttal process could change how or if payment is recouped.

Providers can request immediate recoupment instead of waiting for the recoupment process to begin. Submission of the immediate recoupment form in the provider portal is required. If immediate recoupment is not requested, and provider does not submit repayment within thirty (30) days of the date of the overpayment notice, deductions from future payments will begin at day forty-one (41).

Whether the provider is notified of an overpayment by SCAN or discovers such overpayment independently, the provider must mail the refund check along with a copy of the notification or other supporting documentation to the following address:

SCAN
P.O. Box 22698
Long Beach, CA 90801-5616

Coordination of Benefits

Coordination of Benefits is the procedure used to process health care payments for a Member with one or more insurers providing coverage. SCAN, and delegated entities for claims payment, must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. (See 42 CFR 422.108 and MMCM, Chapter 4, Section 130).

Prior to claims submission, providers must identify other payers who have primary responsibility for payment and bill that payer prior to billing SCAN (or its delegate). When a balance is due after receipt of payment from the primary payer, a claim may be submitted to SCAN (or its delegated entity) for payment consideration.

The claim must include information verifying the payment amount received from the primary payer as well as a copy of the primary payer's explanation of payment statement. Upon receipt of the claim, SCAN (or its delegate) will review its liability using the coordination of benefits rules and/or the Medicare/Medicaid "crossover" rules—whichever is applicable.

Where a member has a dual plan (Medicare and Medicaid), the Medicaid plan may cover any remaining balance, out of pocket or authorized services not covered under Medicare. Medicaid is always the payer of last resort, therefore all other insurance coverage must be processed before the Medicaid benefits are applied.

Third-Party Liability

Members who experience injury or loss due to another person or entity will have all claims processed by the third-party liability (TPL) vendor. Claims paid on behalf of a Member by SCAN or a SCAN delegated entity will be submitted to the respective payers TPL insurer for reimbursement. Most TPL claims are initiated by a member through an insurer or attorney, who will notify SCAN of the claim. SCAN will refer TPL claims to the SCAN TPL vendor for claims paid by SCAN. SCAN will refer any TPL claims to a SCAN delegated entity where the delegated entity paid the Member's claims.

Maximum Out of Pocket (MOOP) Limit

CMS requires MA Organizations to have a MOOP limit, which refers to the limit on how much a Medicare Advantage Member pays out-of-pocket each year for medical services covered under Medicare Part A and Part B. Co-payments, co-insurance, and deductibles comprise Member expenses for purposes of MOOP. MOOP is in addition to the Member's Medicare Part B Premium. The MOOP limit is accumulated based upon claims paid by

SCAN and encounters reported to SCAN by delegated providers who process claims on SCAN's behalf.

Members who reach a point where they have paid the MOOP during a calendar year (coverage period), will not have to pay any out-of-pocket costs for the remainder of the year for covered Medicare Part A and Part B services. When the Member reaches this level, SCAN will no longer deduct any applicable Member out-of-pocket costs from the provider's reimbursement.

The MOOP can vary by benefit plan and may change from year to year. Please see the applicable EOC available at *https://www.scanhealthplan.com//plan-materials* for more information.

No Balance Billing

Member balance billing (MBB) is strictly prohibited. SCAN payments to providers are considered payment in full, less any copays, coinsurance, or deductibles – which are the financial responsibility of the Member. Providers are prohibited from seeking additional payment from Members for any other unpaid balances.

Providers that engage in balance billing may be subject to sanctions by SCAN, CMS, and other regulatory agencies.

Please note that providers may seek payment from a Member for a covered service that is NOT Medically Necessary or for a non-covered service ONLY IF provider obtains written informed consent stating financial responsibility for the specific services prior to services being rendered.

If a copayment, coinsurance, and/or deductible amount collected from a Member at the time of service exceeds the Member cost share, the provider is required to refund the overpaid amount within fifteen (15) calendar days. Providers shall not apply overpayments to outstanding balances.

Delegated providers who process claims on SCAN's behalf must have established systems and processes in place which tracks and accurately applies Member cost share. Delegated providers must also ensure timely billing practices for provider and downstream providers/subcontractors to prevent MBB. This process must include, but is not limited to, designated personnel that serves as a primary contact for MBB issues and provider notification to downstream providers regarding MBB requirements. Delegated Provider's process must comply with all requirements set forth by SCAN and federal/state regulators.

To ensure compliance with MBB restrictions, SCAN requires providers to investigate and resolve MBB cases within fifteen (15) calendar days of a request, whether from SCAN, a Member, or another party. Providers are also required to cooperate with SCAN to resolve any MBB issues that arise.

Claims Adjudication

Rejected v. Denied Claims

SCAN may reject claims which do not meet the definition of a "clean" claim due to missing or invalid required information. Rejected claims do not have Appeal rights. See *http://www.cms.gov/////clm104c01.pdf*. The provider must correct and resubmit the claim timely for further adjudication. If the provider resubmits the claim after one (1) year from the date of service or date of discharge, the claim will be considered untimely and will be denied.

SCAN will deny a claim if SCAN determines that all or some portion of the claim is not payable and, in such a case, no payment is applied to the denied claim item(s). Denied claims cannot be resubmitted for payment but may be appealed (see below).

SCAN may reject or deny claims which are received by SCAN for which a delegated entity is responsible for claims processing. A provider may see the denial on the remittance advice, however SCAN has forwarded the claim to the appropriate delegate for processing. Providers can find the correct billing address on the back of the Member's SCAN member ID card or by accessing the Member's eligibility information on the SCAN Provider Portal.

Payment

SCAN processes clean claims according to provider's contract and compliant with all federal and state regulatory requirements.

Special Rules for Non-Contracted Provider Claims

95% of "clean" claims from non-contracted providers must be paid or denied within thirty (30) days of receipt. (See 42 CFR 422.500; 422.520(a)(1); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). Non-contracted claims that do not meet the definition of "clean claims" must be denied within sixty (60) days of receipt. (See 42 CFR 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). If clean claims from non-contracted providers are not paid or denied within thirty (30) days, interest must be paid in accordance with 1816 (c)(2)(B) and 1842(c)(2)(B). (See 42 CFR 422.520(a)(2); Manual Ch. 11 – Section 100.2).

Checking Claims Status

Claims status can be checked on-line via SCAN's Provider Portal. To register, please go to *https://www.scanhealthplan.com/providers* and follow the registration process. See *Chapter 2: Key Contacts Resource Guide* (Claims) for more information. Providers should check the claim status in the Provider Portal before submitting a request for additional information.

Provider Claims Disputes and Appeals

Payment disputes and Appeals processes for contracted providers are governed by the terms of the contract between the provider and SCAN and the information below. Providers also can find information on to how to file disputes and appeals on the SCAN Provider Portal.

For disputes related to claims determinations made by SCAN, Provider must submit the following process before invoking any other dispute resolution and arbitration procedures. First, the provider must submit a provider dispute of that decision to SCAN within sixty (60) days of the last written determination. Provider claims disputes should be submitted to SCAN via the provider portal (preferred method) or by fax to 562-997-1835.

Provider's claims dispute should, at a minimum, identify in writing why provider contends the determination was in error, identify the evidence in the claim record that it contends supports its position, and provide any other applicable documentation necessary for SCAN to evaluate provider's dispute. SCAN will respond in writing to provider's dispute filed pursuant to this paragraph within sixty (60) days of receipt of the dispute unless otherwise indicated in the Provider's contract with SCAN. If Provider fully complies with SCAN's process and disagrees with SCAN's redetermination of Provider's claims, Provider may then proceed to the dispute process described further in the contract between Provider and SCAN.

Special Rules for Non-Contracted Providers

SCAN has established a Provider Payment Dispute Resolution (PDR) process by which non-contracted providers may dispute the amount paid for a covered service (e.g., the amount is less than or greater than the amount that would have been paid under Original Medicare, or SCAN paid for a different service or more appropriate code than what was billed ("down-coding"). The PDR process for non-contracted providers cannot be used to challenge payment denials that result in zero payment being made to the non-contracted provider. These matters must be processed as Appeals. The Appeals and PDR processes are summarized below.

Appeals (Denied Claims Only) – Non Contracted Providers
Provider may request an Appeal within sixty (60) calendar days of receipt of RA
The request must include: • A signed Waiver of Liability (WOL) form holding the Member harmless regardless of the outcome of the appeal and supporting documentation such as a copy of the original claim and any clinical records; and • Other documentation that supports the provider's request. NOTE: A copy of the WOL is available at: *https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms*. If the WOL is not received timely, the request for an appeal will be sent to MAXIMUS for dismissal and the provider will receive written notification of the dismissal directly from MAXIMUS.
• SCAN has sixty (60) calendar days to reconsider the denial • Upheld denials are automatically submitted to MAXIMUS for the next level of review • Provider will be advised regarding further appeal rights
1st Level PDR (Payment Dispute Resolution)
Within one hundred twenty (120) calendar days of receipt of RA to appropriate payer
• 1st level PDR is delegated to medical groups where the medical group is delegated for claims • SCAN, or the delegated medical group, has thirty (30) calendar days to reconsider the claims payment

2nd Level PDR Process (Payment Dispute Resolution)
May be submitted to SCAN within one hundred eighty (180) calendar days of receipt of upheld 1st level PDR via • ***Preferred by fax: (562-997-1835)*** • ***By mail: SCAN, Attention: Claims-2nd Level Appeal, P.O. Box 22698, Long Beach, CA 90801-56980***
• 2nd level PDR is not delegated to medical groups • SCAN has sixty (60) calendar days to render a decision

See *Chapter 5: Network Standards* for provider responsibilities with respect to Appeals, Grievances, and Payment Disputes.

Guidance for Providers Delegated for Claims Activities

This section provides additional guidance for providers delegated for claims activities to ensure that claims paid on SCAN's behalf are paid in accordance with CMS requirements and SCAN policies.

Guidance for Providers Delegated for Claims
Check Handling Delays
The number of days allowed to mail checks after they are printed should be documented in policies and procedures. The date the claim payment check is placed in USPS mail or equivalent for delivery must be used to define the end of the measurement time when measuring timeliness.
An intentional delay before mailing checks, and beyond the routine number of days it takes to audit or sign them, is a non-compliant process unless provider's reporting and timeliness compliance measurement has been adjusted to allow for the delay.
Claim Date Deficiencies
Each claim should be date-stamped with the date the claim is received.
Wrong Dates: If it is necessary to change a date stamp because a wrong date was stamped it should be done in accordance with the industry best practice. The industry best practice recommends that a line be drawn through the incorrect stamp, that the employee making the correction initials the correction, and that the correction is dated. The claim should then be stamped with the correct date received. Except for a situation where a date was accidentally stamped incorrectly, claims employees should not alter or change date stamps.
Double Dates: Claims submitted to SCAN or to the delegated entity, where the other party is responsible for claim payment, is deemed a "double date" claim. Claims will reflect the date the entities received the claim either by the submitter (first submission) or the entity (claim forwarded). While deemed "double date" claims, this process may occur more than twice. Once a claim is sent to the plan from the delegated entity and where the DOFR indicates the delegated entity is responsible for the claim, SCAN shall send the delegated entity a notice indicating their payment responsibility. In the event of double dated claims, the earliest date stamp must be used to measure the timeliness of the claim payment or denial (also see Misdirected Claims below). All date stamps are relevant date stamp(s) unless they can be shown to be impressed on a claim proof of loss by an entity that is not part of the delegated network.
Electronic Clearinghouses: Electronic claims which are transmitted directly to a clearinghouse by 5:00p.m. (or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m.) (according to the clearinghouse's time zone), must be considered as received on that day even if the delegated entity does not upload or process the data until a later date.
Misdirected Claims Deficiencies
Delegated entities must have a process for forwarding misdirected claims.
Triage and sorting processes must be established so that misdirected claims can be identified and forwarded within ten (10) calendar days of receipt to ensure that the payer has the necessary time required to adjudicate and pay the claim.

Delegated entities should instruct their physicians and downstream contracted providers on where to submit claims for services that are delegate risk. Correct billing address can be found on the Member's SCAN ID card or by accessing the Member's eligibility information on the SCAN Provider Portal.

Calculation of Federal Interest

Delegated entities must pay interest on clean claims that have not been paid within thirty (30) days of the earliest relevant received date stamp. Interest must be paid at the current rate beginning the 31st day from the receipt of the claim up until the date that the payment is placed in the USPS mail or equivalent.

To calculate the daily federal interest rate for senior claims, divide the current approved interest rate by three hundred sixty-five (365) (three hundred sixty-six (366) for leap years). The daily interest rate is then multiplied by the total days beyond the 30th and the total amount of the claim payment that is due. Always ensure the correct interest rate when paying prompt payment interest. The rate changes semi-annually, on January 1 and July 1, and is available at *https://fiscal.treasury.gov/prompt-payment/rates.html*.

Example 1: The payment due on a clean claim for a non-contracted provider is $1,200. It is being processed 53 calendar days after receipt and will take an additional 3 calendar days to verify, sign, and mail the check. The interest payment, which would be calculated based on 26 calendar delayed days (23+3 for check issuance, processing, and mailing), is 26 x $1,200 x (the current annual interest rate)/365 days.	**Example 2:** The amount to be paid for a non-contracted provider is $220. Today is the 32nd day after the receipt of the claim. The checks will not be printed, signed, and mailed 6 calendar days from today. Based on the delay of 8 calendar days (2 + 6 for check processing), the interest payment is 8 x $220 x (the current annual interest rate)/365 days.

CMS Approved Current Procedural Terminology (CPT) Codes with No Medicare Value

Delegates must have a process for pricing CMS approved CPT codes with no Medicare value.

If a new code appears, delegated entities must make every effort to determine whether the procedure, drug, or supply has a pricing history and profile. If there is a pricing history, map the new code to previous customary and prevailing charges, or fee schedule amounts, to ensure continuity of pricing. If there is no pricing history or coding implosion and explosion, delegated entities must make an individual consideration determination for pricing and payment of a covered service.

MOOP/Encounter Data

Delegates must have processes that ensure accurate data, including encounter data, used to accumulate the MOOP limit. (See *Chapter 14: Encounter Data*)

Providers are expected to have systems and processes in place to track MOOP amounts and to apply benefit limitations. Providers are also required to submit encounter data to the plan that includes MOOP amounts taken on claims. This information is required to avoid overcharging Member MOOP when SCAN pays claims that are the plan's responsibility under the DOFR.

1st Level PDR Process

Request for a 1st Level PDR may be made via phone or in writing but must be submitted to the delegated provider within one hundred twenty (120) calendar days from the notice of initial determination (i.e., Explanation of Benefits (EOBs), RA's, Letters). Provider must follow and include:

- EOB or RA used to transmit initial determination to a non-contracted provider
- Completed Payment Dispute Decision (PDD) form
- Appointment of Representative (AOR) form, if applicable.
- Claims Supporting documentation

2nd Level PDR Process

Delegated providers must notify non-contracted providers that they may seek 2nd level review directly from SCAN within one hundred eighty (180) calendar days from 1st level PDR decision notice by sending their request via:

- Preferred by fax: (562)997-1835
- By Mail: SCAN, Attention: Claims 2nd Level Appeal, P.O. Box 22698, Long Beach, CA 90801-5698.

Non-Contracted Provider Appeals

EOB or RA used to transmit a denial to a non-contracted provider must include the following information:

- Non-contracted providers have the right to request a reconsideration of the denial within sixty (60) calendar days from the remittance notification date;
- Non-contracted providers must include a signed WOL form holding the Member harmless regardless of the outcome of the Appeal;
- Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's Appeal; and
- Non-contracted providers can mail requests for reconsideration to: SCAN Non-Contracted Provider Appeal, P.O. Box 22644, Long Beach, CA 90801-9826.

All non-contracted provider Appeals must be sent to this address for reconsideration as soon as possible along with the original claim; a copy of the denial letter with Member liability if applicable; a copy of the RA or EOB and the reason for the denial, including any supporting documents

Delegated Claims Denial

CMS has strict requirements for the use, format, content, and delivery of the notice of a denial with Member liability (e.g., claim denial that results in a Member having liability for a medical service that would otherwise be the responsibility of the plan or the provider). Correspondence to Members regarding claims denials must meet CMS formal notice requirements including that they are sent in an envelope that states, on the outside, in a pre-printed format: "Important Plan Information About Your Enrollment".

- If the provider is placed in retrospective review status for claim denials, provider must submit copies of one hundred percent (100%) of claim denials with Member liability within one (1) business day after the date of the denial letter to SCAN for review. Denials may be submitted by mail to SCAN Delegation Oversight Unit, 3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806; by fax to (562) 989-5192; and by secure e-mail to *DelegatedCompliance@scanhealthplan.com*. If the entity has been de-delegated, prospective denials will need to be faxed to (562) 989-5192 for approval prior to issuance.
- Each denial should be accompanied by sufficient data to allow SCAN to verify that the decision to deny the claim and hold the Member liable is correct. The denials and all supporting documentation should be faxed to SCAN for review on or before the 55th day of claim aging. SCAN will review the denial(s) and approve, request additional information, or overturn the decision within two (2) business days of receipt.
- If SCAN overturns a denial, the delegated entity must pay the claim promptly. A copy of the check and EOB representing payment must be received within the timeframe set forth in the overturned decision notification. Failure to do so may result in deductions and/or recoupments from capitation payments.

CMS Requirements

MA Organizations must:

Submit full and complete data that ***conforms to CMS' requirements*** *for MAPD data equivalent to Medicare fee-for-service data, as well as other relevant national standards.*

Submit encounter data ***electronically to the appropriate CMS contractor.*** *Data must come from the provider, supplier, physician, or other practitioner that furnished the item or service. See 42 CFR 422.310(d).*

Submit ***medical records for the validation of encounter data****, as required by CMS. There may be penalties for submission of false data. See 42 CFR 422.310(e).*

Certify *(based on best knowledge, information, and belief) the* ***accuracy, completeness, and truthfulness*** *of all data submitted. 42 CFR 422.504(l)(3).*

Chapter 14: Encounter Data

Submission of timely, accurate, and complete encounter data is a collaborative effort and is crucial to appropriate care and reimbursement. MA Organizations are required to collect and submit encounter data to CMS that conforms to Medicare fee-for-service standards for all Medicare covered services and supplemental services that MA Organization providers perform. (See *422.310(d)(3)-(4), 422.504(d)-(e), (i)(3)-(4), (l)(3)).*

Provider Responsibilities

In order to meet CMS and other regulatory requirements, SCAN requires providers to:

Submit Complete and Accurate Encounter Data in the Proper Format

- Submit all encounters using the HIPAA Compliant 837 version 5010 transaction set format in conformance with SCAN Encounter Data Requirements:
- Medicare Providers must screen their encounter data for the presence of Provider Preventable Conditions (PPC) on a monthly basis.
- Submit encounters directly to SCAN (If authorized), or through a SCAN contracted clearinghouse.
- Submit all claim detail for adjudicated claims only, including all applicable billed amount, paid amount, MOOP amount, adjusted claims, and denied claims information
- Include all information necessary for SCAN to submit data to CMS in accordance with applicable CMS requirements
- Encounter data should reflect all procedures and applicable diagnoses that accurately reflect evaluation and treatment during the course of a single health care encounter
- Document the Member's conditions as specifically as possible (e.g., diabetic with secondary ophthalmologic and renal complications, should not be coded as "diabetes without complications" – complications should be clearly identified in documentation)
- All supplemental data, including chart review data and added or deleted diagnosis codes, submitted via the Alternative Submission Methodology (ASM) must be submitted in the ICE format and linked to an original 837 encounter. Unlinked supplemental data may not be accepted by CMS for EDPS submission. (See "Submission of Supplemental Encounter Data" below)
- Encounter data should accurately reflect the medical record stored at the provider office

Companion Guides: *https://www.csscoperations.com/internet/csscw3.nsf/DID/C1QB31Y8ZY*

Submit Timely Encounters

- Unless a longer period is expressly allowed in provider's contract with SCAN, all encounter data should be submitted to SCAN within three (3) months of date of service (DOS). Timeliness is critical to enable SCAN to comply with regulatory requirements, accurately capture data for medical programs, and to impact medical and financial performance. Failure to timely submit data may result in corrective action and/or penalties.
- Submit all encounter data for CMS sweep periods at least four (4) weeks prior to CMS deadlines. SCAN reserves the right to audit encounters for appropriateness of quantity and quality and take corrective actions as appropriate.
- Remediate any issue impacting CMS acceptance of the encounter data within one hundred eighty (180) days of notice, including, but not limited to, RAPS errors, 5010 errors, SCAN edits, CMS rejections, etc. Additionally, all rejections must be corrected at least four (4) weeks prior to the final sweeps submission deadline for the visit's DOS. All deadlines are subject to change at any time should CMS rules change.
- Refrain from resubmitting duplicate encounter data for CMS sweep periods. Only updated, corrected, or new encounter data will be accepted by CMS.
- Providers may reconcile encounter submissions at any time to ensure successful submission to SCAN and CMS (See "Reconciliation Process" below).
- Monthly rejection and reconciliation reports are available on the SCAN Provider Portal in the "HCC and Encounters" tab.

Cooperate with CMS and SCAN Audits

- Cooperation with all federal, state, and SCAN audits is mandatory (e.g., Risk Adjustment Data Validation (RADV) audits, Recovery Audit Contractor (RAC) audits, data validation audits, etc.), to ensure accuracy, timeliness, and completeness of submitted results. Providers must additionally provide requested data within specified timeframes. Failure to provide requested support for encounter data submitted to CMS may result in corrective action and/or other impacts and penalties from state and federal regulators.
- Providers must also cooperate with corrective action(s) requested by SCAN to resolve encounter data issues or errors.

Recommended Monthly Activities

- Perform monthly (but not less than quarterly) reconciliations using the production reports available on the SCAN Portal. A few of the most important reports include:
    - Hierarchical Condition Category (HCC) Monthly: contains all HCCs associated with the diagnosis codes for both EDPS & RAPS received during a given DOS
    - MAO-004 Monthly: contains a list of all diagnosis codes received during a given DOS
    - All Patient Control Number (PCN) Monthly: contains a list of all PCNs received during a given DOS
- Perform monthly corrections for all errors in SCAN Rejection Reports:
    - Rendering Entity (RPX): the national provider identifier (NPI) for the entity was incorrectly provided; correct by providing the NPI for the "individual" provider.
    - Provider Name Mismatch (PNM): the rendering NPI on the encounter is incorrect and/or does not match with SCAN provider name.
    - Full Encounter Data Reports (EDS): contains CMS rejection for EDS "Full Encounter" Data (See SCAN Resolution Guide for instructions on how to fix full encounter data rejections located on the Provider portal).

- Invalid DX: diagnosis code is invalid during the DOS, or the diagnosis code does not have the required level of specificity per CMS.
- Place of Service (POS) 21-23: professional encounter has invalid POS or is missing the corresponding Inpatient (21) or Outpatient (22 or 23) encounter. Either submit missing Inpatient or Outpatient encounters in the 837 format or correct professional encounter POS.
- ICE Pend**:** supplemental diagnosis codes submitted via ICE file (Alternative Submission Method (ASM)) are not rolling up to an existing 837 parent encounter or the *Member ID, From/Thru DOS, NPI, and Visit Type* on the ICE submission does not match the parent 837 encounter. Correct by submitting the parent 837 or ensure the ICE encounter matches with the five key data elements on the parent 837 encounter.
- Inconsistent Condition Data Validation (ICDV): medical conditions which are unlikely to be addressed outside of an acute setting. Correct by submitting subsequent hospital visit or medical record supporting the condition. If the code is truly invalid and should not be submitted to CMS, submit corrected 837 using the same claim ID as initial submission via your clearinghouse with the invalid code removed (do not submit an ICE file to delete the bad code).

Recommended Annual Activities

- Perform annual reconciliations using the production reports available on the SCAN Portal. A few of the most important reports include:
  - New Member Encounter Recon: SCAN provides the member list by February of each year. Submit historical ICE files for prior year's encounter by July of the existing year.

Because providers are required to submit complete and accurate data to SCAN to meet SCAN's compliance obligation with CMS, any data in error or not reflected in SCAN reporting must be resubmitted prior to CMS and SCAN deadlines.

Encounter Data System (EDS) Edits Resources	
Reject Type	**Resource**
277 Edits	*https://www.csscoperations.com/internet/csscw3.nsf/DID/I9IQVMOVZR*
CMS Companion Guide	*https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSCAppendix_3A_MA_Companion_Guide10162020.pdf/$FILE/Appendix_3A_MA_Companion_Guide10162020.pdf*
SCAN Resolution Guide	See monthly EDS notification emails that include a SCAN Resolution Guide attachment

Reconciliation Process

Reconciliation of encounter data occurs between providers and SCAN and between providers and clearinghouses. Where provider organizations are working with clearinghouses for submission, each clearinghouse will supply reporting details directly to the providers on the total number of encounters received, accepted, and rejected. Encounters that are rejected at the clearinghouse are not sent to SCAN. For providers that submit encounters directly to SCAN, SCAN will supply the providers with similar reporting. Providers are responsible to review and remediate any rejections identified by the clearinghouse or SCAN error reporting.

Once the encounter has been accepted by the clearinghouse and sent to SCAN for processing, the results of the encounters will become viewable on the SCAN Encounter Data Portal (EDP), accessible at *https://www.scanhealthplan.com/providers*. The EDP will display the total number of encounters received, accepted, rejected, and sent to CMS, as well as show the results received from CMS (accepted and rejected). The EDP can also be used to modify or correct encounter data. Please note, error resolution completed on the EDP will be reflected within forty-eight (48) hours.

SCAN does not currently supply 999 or 277 reports to providers. All accepted and rejected encounter detail must be reviewed on the EDP or via the provider's clearinghouse portal.

Reconciliation reports are available monthly on the EDP, under the HCCs and Encounters modules, or by emailing the SCAN Encounter Data Team at *Encounters_Operations@scanhealthplan.com*.

Submission of Supplemental Encounter Data

All Providers that have submitted encounter data may send supplemental data through either the clearinghouse or directly to SCAN as outlined below.

<table>
<tr><th colspan="2">Clearinghouse Submissions</th></tr>
<tr><td colspan="2">Diagnosis codes in excess of twelve (12) per professional encounter and twenty-five (25) per institutional encounter may be submitted to the clearinghouse by:</td></tr>
<tr><td colspan="2">Submission of multiple v5010 encounters (duplicate of the entire encounter with the exception of the DX Codes). The following data is required to be identical to the original encounter to ensure "roll-up" of all diagnosis data into the appropriate visit:</td></tr>
<tr><td>• Member ID
• Start and End DOS</td><td>• Rendering Provider NPI
• Procedure Code</td></tr>
<tr><td colspan="2">Submission of multiple iterations of the 2300 Loop (includes service loop) within one encounter. Same requirements as above, plus:</td></tr>
<tr><td>• Use same PCN (CLM01 segment, 2300 Loop)
• 2nd Iteration of the 2300 Loop should differ only in diagnosis codes</td><td>• Keep service line (2400 Loop) in order between the 1st and 2nd iterations of the encounter the same</td></tr>
<tr><th colspan="2">ICE Alternative Submission</th></tr>
<tr><td colspan="2">Supplemental diagnosis data can also be sent using the SCAN modified ICE alternative submission format. The ICE alternative submission format is intended only to communicate adds or deletes of diagnosis codes for previously submitted encounter data through the clearinghouse to SCAN. Original encounter data should not be sent via the ICE alternative submission because CMS requires full encounter data format (CMS 5010). All supplemental data, including chart review data and added or deleted diagnosis codes, submitted via the ASM must be submitted in the ICE format and linked to an original 837 encounter. Unlinked supplemental data may not be accepted by CMS for EDPS submission.</td></tr>
<tr><td colspan="2">Enrolling for ICE Alternative Submission and Testing</td></tr>
<tr><td colspan="2">Email the SCAN Encounter Data Team at: Encounters_Operations@scanhealthplan.com. ICE files will not be accepted by SCAN until ICE file submission enrollment and testing is complete.</td></tr>
<tr><td colspan="2">ICE Alternative Submission File Specifications</td></tr>
<tr><td colspan="2">SCAN utilizes a modified version of the ICE standard format for alternative submission. All requirements for both professional and institutional ICE formats, including the file naming convention, must be strictly adhered to in order for files to successfully process.</td></tr>
</table>

Submitting ICE Production Files via the Encounter Data Portal
ICE alternative submission files should be uploaded through the File Transmission module on the EDP. These are 'fixed' file templates and if the specifications are not followed, files may be DENIED in the upload and will require a re-check to provider's file to confirm that it meets the specifications required. Note: ICE alternative submission "test" files should be submitted directly to provider's encounter data contact rather than through the EDP, which is for production file(s) only.
ICE Alternative Submission Hints, Tips and Notes
Ensure diagnosis codes and procedure code fields are formatted as text. If MS Excel is used as a working draft for correcting errors, then the cell containing a diagnosis and procedure code must be formatted as text. Otherwise, the leading zero may be deleted. Decimal points must be eliminated from diagnosis codes prior to submission in order to mirror CMS standard formatting.
At least one procedure code is always required on a professional encounter. On institutional encounters, either a procedure code and/or revenue code is required along with the bill type.
Be careful of any 'date' field. MBR_DOB, DOS_From, and DOS_Thru fields must include the leading zero and be in the format mm/dd/yyyy. Date field errors most often occur with /txt-direct submission files and CMS error files that are resubmitted for correction. Examples: 20230103 needs to be 01/03/2023 1032023 needs to be 01/03/2023 132023 needs to be 01/03/2023 1/3/23(DOS) needs to be 01/03/2023 1/3/23(DOB) needs to be 01/03/2023 1/03/2023 needs to be 01/03/2023
The Provider NPI is required. If the provider does not have an NPI or it is unknown, then the Tax ID and License number are required. If only the Tax ID is provided, it may not be enough to accurately identify the provider or institutional encounters; Tax ID may be entered into the MPN_NBR field. In order to link to the original 837 encounter, the Member ID, from date, thru date, and provider NPI from the ICE submission must be consistent with the original encounter

For more information, please contact the SCAN Encounter Data Team at: *Encounters_Operations@scanhealthplan.com*.

Chapter 15: Fraud, Waste, and Abuse

Providers must abide by all applicable fraud, waste, and abuse laws including laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (FCA) (31 USC 3729 et. seq.), and the Anti-Kickback Statute (section 1128B(b)) of the Act; 42 USC 1320a-7b(b)). (See 42 CFR 422.504(h)(1)).

In addition to federal and state statutes, SCAN and SCAN providers may be subject to other legal requirements concerning the reporting of credible fraud, waste, or abuse allegations (i.e., SUPPORT Act Section 6063 requires plans to submit information on investigations or other actions taken regarding providers who inappropriately prescribe opioids). This Chapter outlines provider obligations with respect to eliminating fraud, waste, and abuse and provides education and other resources for providers.

Examples of fraud, waste, and abuse include, but are not limited to:

- Billing for procedures not performed;
- Physician kick-backs for referrals;
- Authorizing and/or billing for services not medically necessary (i.e., acute inpatient instead of observation, advance life support ambulance services instead of basic life support ambulance services, etc.);
- Certifying terminal illness when criteria is not met;
- Obtaining benefits without medical necessity (i.e., glucose test strips, incontinence supplies, or enterals, etc.) and reselling;
- Billing for services that do not meet CPT/revenue code descriptions;
- Falsifying information in a medical record / claim;
- Improper bundling/coding of charges;
- Misrepresentation by a Member/provider to seek benefits;
- Unsupported risk adjustment data (including encounter data) submitted to CMS;
- Inaccurate Prescription Drug Event (PDE) and Direct/Indirect Remuneration (DIR);
- Incorrect Low Income Premium Subsidy for Employer Group Waiver Plans;
- Improper Opioid Prescription/Dispensing; and/or
- Incorrect enrollment into MA plans, Part D plans, and other government programs.

Investigation Process and Overpayment Recovery

SCAN reviews all reports of fraud, waste, and abuse. Allegations and investigative findings may be reported to appropriate regulatory and law enforcement agencies. In addition to reporting, SCAN may take corrective action, including but not limited to, recovery of overpayments. *Chapter 13: Claims* describes the overpayment recovery process for fee for service claims. In the case of capitated agreements, SCAN may also make adjustments to capitation payments necessary to affect recovery of an overpayment in accordance with 42 CFR 401.301-305 and 42 CFR 438.608(d).

Provider Responsibilities

In order to meet regulatory requirements, providers are required to:

Be Diligent and Immediately Report Suspected Fraud, Waste, and Abuse

- Watch for suspicious activity and red flags; and
- **Immediately** report suspected fraud, waste, and abuse that affects SCAN or SCAN Members, or retaliation for making such a report:

By Web:	*https://www.scanhealthplan.com/scan-resources/report-an-issue/fraud-information-and-resources*
By E-Mail:	*FraudWaste&AbuseProg@scanhealthplan.com*
By Phone:	(877) 863-3362 (may be made anonymously)

All reports will be kept confidential to the extent possible and in accordance with applicable law. Providers may also report directly to the Federal Department of Health and Human Services (HHS) or the Office of the Inspector General (OIG):

By Phone:	(800) HHS-TIPS ((800) 447-8477)
By E-Mail:	*HHSTips@oig.hhs.gov*
By Mail:	Office of the Inspector General HHS TIPS Hotline, P.O. Box 23489, Washington, DC 20026

Cooperate with SCAN Investigations, Resolve Issues, and Protect Your Employees from Retaliation

- Cooperate with SCAN's investigation of potential fraud, waste and abuse including timely responding to requests for medical records and other information;
- Cooperate with any corrective action requested by SCAN to resolve reports of potential fraud, waste, and abuse (including return of overpayments);
- Cooperate with referrals to law enforcement and/or regulatory agencies, and
- Do not retaliate against employees who act lawfully in furtherance of an action under the FCA, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under the FCA. Retaliation includes, but is not limited to, discharge, demotion, suspension, threats, harassment, or any other manner of discrimination against the employee in the terms and conditions of employment.

Training and Education

- Provide fraud, waste, and abuse, general compliance, and specialized training as required by CMS (See *Chapter 10: Delegation Oversight*);
- Require completion of training as a condition of employment or contracting;
- Participate in other fraud, waste, and abuse and compliance training opportunities; and
- Educate other providers, Members, and vendors when opportunities arise.

Compliant Policies, Procedures, and Practices

- Establish and maintain appropriate policies, procedures, and practices – update regularly to address trends in fraud, waste, and abuse (e.g., prescription drug abuse and hospice enrollment fraud);
- Strive for accuracy and excellence in service, coding, and billing;

- Document Member medical records properly and accurately (e.g., do not up-code, do not bill for services not rendered/not Medically Necessary, unbundle services, do not submit duplicate billing, etc.);
- Safeguard privacy; and
- Maintain records accurately and timely.

Monitoring and Oversight

All providers delegated to perform functions on behalf of SCAN are audited on a routine basis to determine compliance with CMS and other requirements related to eliminating fraud, waste, and abuse. (See *Chapter 10: Delegation Oversight* for specific information).

Fraud, Waste and Abuse Resource Sheet
Applicable Laws
Civil False Claims Act (FCA) (31 USC 3729 et seq.)
Allows a civil action to be brought against any person or entity who, among other things: (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee; (b) Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or (c) Conspires to defraud the government by getting a false of fraudulent claim allowed or paid.
Program Fraud Civil Remedies Act of 1986 (38 USC 3801 et seq.)
This statute amended the FCA, among other things, to extend liability to any person or entity that knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
Fraud Enforcement and Recovery Act of 2009 (FERA) (31 USC 3729)
This statute amended the FCA, among other things, to provide that FCA liability may attach whether or not there is intent to defraud the government (it is sufficient that the false statement is material to a false claim). Therefore, many types of innocuous overpayments could now potentially lead to FCA liability.
Patient Protection and Affordable Care Act and Health Care & Education Reconciliation Act of 2010 (PPACA) (42 USC. 18001 et seq)
PPACA, among other things, requires that: overpayments be reported and returned sixty (60) days after they are identified; items/services be prescribed by a Medicare-enrolled physician or other eligible professional; physicians have a face-to-face encounter with a patient before prescribing; and maintain and provide upon request documentation for certifications for DME or home health services. The PPACA increases civil monetary penalties (CMPs) for making false statements to federal health care programs or for delaying inspections, suspends payment during fraud investigations, and expands the RAC program to includes Part C & D.
The Deficit Reduction Act of 2010 (DRA) (42 USC 1396h(a))
The DRA, among other things, requires that any entity that receives or makes payments under the state Medicaid plan of at least five million ($5,000,000) per year provide certain information to its employees, contractors and agents concerning federal and state false claims act provisions, penalties, and protections.
Anti-Kickback Statute (42 USC 1320a-7b(b))
It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referral of items or services paid in whole or in part by a federal health care program. Remuneration includes transfer of anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.
Physician Self-Referral Prohibition Statute (42 USC 1395nn)
The “Stark Law” prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a Member of his or her family) has an ownership/investment, interest or with which he or she has a compensation arrangement, unless an exception applies.
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 (H.R.2028 Section 195, H.R.6, Section 6063)
Effective in 2022, the SUPPORT Act requires that plans implement drug management programs for at-risk beneficiaries (H.R. 2028 Section 195).

<table>
<tr><td colspan="2">Penalties</td></tr>
<tr><td colspan="2">Penalties for violating fraud, waste, and abuse laws include:</td></tr>
<tr><td>Employee subject to unlawful retaliation entitled to all relief necessary to make the employee whole including reinstatement with the same seniority status, 2x back pay and interest, special damages, litigation costs and reasonable attorneys' fees, and, where appropriate, punitive damages.</td><td>• Violation of the FCA is punishable by a civil penalty of not less than five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000) per claim*, plus 3x the damages the Government sustains
• Suspension of payment
• Potential criminal liability</td></tr>
<tr><td colspan="2">* Each separate bill, voucher, or other false payment demand constitutes a separate claim.</td></tr>
<tr><td>Penalties for violating Anti-Kickback Statute:</td><td>Penalties for violating Stark Law:</td></tr>
<tr><td>• Criminal: fines up to twenty-five thousand dollars ($25,000) per violation and up to a five (5) year prison term per violation
• Civil/Administrative: FCA liability, program exclusion, potential fifty thousand dollars ($50,000) CMP per violation, and civil assessment up to 3x amount claimed</td><td>• Overpayment/refund obligation
• FCA liability
• CMPs and program exclusion
• Potential fifteen thousand dollars ($15,000) CMP for each service
• Civil assessment of up to 3x amount claimed</td></tr>
</table>

Chapter 16: Privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

SCAN delegates various SCAN activities to certain providers that involve the use and disclosure of protected health information (PHI), making these delegated providers business associates of SCAN under HIPAA. Further, SCAN recognizes that providers, for the provision of medical services, are also covered entities and therefore have their own legal obligations related to HIPAA.

SCAN requires providers respect the privacy of SCAN Members (including SCAN Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Privacy and Security of Member and patient PHI should only be used or disclosed as permitted or required by applicable law.

Inadvertent Disclosures of PHI: SCAN may, on occasion, inadvertently misdirect or disclose PHI pertaining to SCAN Member(s) who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected SCAN Members in order to protect their privacy. The provider must not further use or disclose such PHI and will provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of SCAN.

HIPAA provides a floor for patient privacy. Where state law is more stringent than HIPAA, state law should be followed.

In addition to HIPAA, SCAN and SCAN providers may be subject to other legal requirements concerning the privacy of Member information. For example, SCAN is required to notify OCR of HIPAA breaches involving 500 or more Members, without unreasonable delay. By meeting the obligations in this Chapter, SCAN and its providers ensure that all HIPAA obligations are met.

HIPAA Requirements

Acquisition, access, use, or disclosure of PHI *in a manner not permitted under HIPAA is presumed to be a breach unless there is a low probability that PHI has been compromised, based on a multi-factored* ***risk assessment*** *that includes: (i) the nature and extent of the PHI involved, including types of identifiers and likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk has been mitigated.*

For ***breaches of PHI****,* ***notification*** *of the breach must be provided to* ***affected individuals****, the* ***HHS Secretary****, and, in certain circumstances, to other state agencies and the* ***media****.*

Generally, ***notification*** *must be provided* ***without unreasonable delay*** *and* ***in no case later than sixty (60) days*** *following the discovery of a breach.*

Pub. L. No. 104-191, 110 Stat. 1936 (1996); 45 CFR Parts 160, 162, and 164. For more guidance, see http://www.hhs.gov/hipaa/for-professionals/breach-notification/.

The business associate agreement (BAA) between SCAN and a delegated provider details the business associate's responsibilities with respect to Member PHI, including reporting PHI breaches to SCAN. While timeframes are set forth in each BAA, SCAN requests that providers notify SCAN of Member PHI breaches **immediately or as soon as possible** in order to meet strict regulatory incident notice expectations.

In order for SCAN to meet regulatory incident reporting expectations, prompt reporting, cooperation, and follow up from its business associates is critical. Therefore, in the event of a Member PHI breach, providers must do the following:

- Notify SCAN **immediately or as soon as possible** after the discovery of any breach, but no later than the time frame set forth in the provider's BAA. Notice should be addressed to the SCAN Privacy Office via email (preferred) or certified mail to:

  Email: *PrivacyOffice@scanhealthplan.com*
  Certified Mail: SCAN
  Attention: Privacy Office
  3800 Kilroy Airport Way, Ste 100
  Long Beach, CA 90806

- Promptly investigate all breaches and draft an initial incident report that includes, at a minimum:
  - An initial description of the nature and circumstances of the breach;
  - A description of the number of individuals involved;
  - A description of the types of PHI involved;
  - The date of the incident which caused the breach;
  - The date of discovery of the potential breach;
  - A list of affected Members involved in the breach, including their SCAN ID numbers;
  - Any efforts taken to mitigate harm to the individuals/Members; and
  - Sufficient information, including the investigative report, to allow SCAN to ensure that SCAN's obligations under HIPAA and other regulatory and contractual requirements are met.
- Cooperate with any SCAN investigation; including providing timely responses to SCAN inquiries regarding the breach;
- Collaborate with SCAN to determine which entity will provide any required notices;
- Work with SCAN to draft any required notices or obtain SCAN's approval for any notice sent on behalf of SCAN prior to distribution; and
- Ensure providers do not include SCAN's name in any notice to Members without SCAN's prior written approval.

For any questions about breach events, please contact SCAN's Privacy Office via email *PrivacyOffice@scanhealthplan.com*.

Appendix A: Select CMS Requirements

MMCM, Chapter 11 requires that MA Organizations include certain contract provisions in their downstream provider contracts. Additionally, MA Organizations must include certain MA-related provisions in the policies and procedures that apply to providers and suppliers that constitute the MA organizations' health services delivery network. The following table summarizes some of these provisions and where they can be found in this POM:

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS		
	Title 42 CFR §	**POM CHAPTER**
Safeguard privacy and maintain records accurately and timely	422.118	Chapter 5, Network Standards
Permanent "out of area" members to receive benefits in continuation area	422.54(b)	Chapter 3, Enrollment and Eligibility
Prohibition against discrimination based on health status	422.110(a)	Chapter 5, Network Standards
Pay for Emergency and Urgently Needed Services	422.100(b)(1)(ii)	Chapter 4, Physician Responsibilities Chapter 5, Network Standards
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)	Chapter 13, Claims
Direct access to mammography and influenza vaccinations	422.100(g)(1)	Chapter 4, Physician Responsibilities
No copay for influenza and pneumococcal vaccines	422.100(g)(2)	Chapter 4, Physician Responsibilities
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)(i)	Chapter 5, Network Standards
Direct access to women's specialists for routine and preventive services	422.112(a)(3)	Chapter 5, Network Standards
Services available 24 hrs./day, 7 days/week	422.112(a)(7)(ii)	Chapter 5, Network Standards
Adhere to CMS marketing provisions	422.2260, *et seq.*	Chapter 5, Network Standards
Ensure services are provided in a culturally competent manner	422.112(a)(8)	Chapter 5, Network Standards
Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary	422.112(b)(5)	Chapter 5, Network Standards
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)	Chapter 4, Physician Responsibilities
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)	Chapter 5, Network Standards
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)	Chapter 5, Network Standards
Payment and incentive arrangements specified	422.208	Chapter 12, Provider Payment
Responsibility over first tier, downstream and related entities	422.504(i)	Chapter 7, Care Management Chapter 10, Delegation Oversight

Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)(iv)(A)-(C)	Chapter 5, Network Standards
Must make good faith effort to notify all affected Members of the termination of a specialist provider contract 30 days before the termination by plan or provider and termination of a PCP or Behavioral Health provider at least 45 days before termination by the plan or provider	422.111(e)	Chapter 5, Network Standards
Written termination notice to Members regarding PCP, Behavioral Health or specialist providers must include required communication content and process in accordance with applicable requirements.	422.2267(e)(12)	Chapter 5, Network Standards
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)	Chapter 14, Encounter Data
Comply with medical policy, QI, and MM	422.202(b); 422.504(a)(5)	Chapter 7, Care Management
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)	Chapter 5, Network Standards
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)	Chapter 5, Network Standards
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)	Chapter 5, Network Standards
Notify providers in writing for reason for denial, suspension & termination	422.202(d)(1)-(4)	Chapter 5, Network Standards
Provide 60 days' notice (terminating contract without cause)	422.202(d)(1)-(4)	Chapter 5, Network Standards
Comply with federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)	Chapter 15, Fraud, Waste, and Abuse
Prohibition of use of excluded practitioners	422.752(a)(8)	Chapter 1, Overview Chapter 5, Network Standards Chapter 10, Delegation Oversight
Adhere to appeals/grievance procedures	422.562(a)	Chapter 9, Member Appeals and Grievances

Appendix B – Content Specific to State

State	POM Chapter and Section	Content Specific to State
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