

Medicare Advantage Plans

Regence MedAdvantage is offered as an alternative to the Medicare Parts A and B program and Medicare supplement plans. Regence MedAdvantage is a Medicare Advantage plan that provides the same benefits available as traditional Medicare, plus some additional benefits.

Regence MedAdvantage provides incentives for members to seek services from physicians, other health care professionals and facilities contracted with the Regence MedAdvantage Preferred Provider Organization (PPO) network. Services provided by in-network providers are reimbursed at the in-network benefit level with low copayment and coinsurance amounts, while services provided by out-of-network providers are subject to higher copayment and coinsurance amounts.

When medical care is needed, we encourage members to contact a Regence MedAdvantage participating provider. If specialty care is needed, providers should direct members to participating Regence MedAdvantage specialists and facilities. Written or telephone referrals are not required for specialty care. Please refer to our online Regence MedAdvantage provider directory to identify participating in-network physicians, other health care professionals and facilities on our *Provider Web Site* at www.or.regence.com/provider/directory.

Pre-authorization is required for some services. Physicians and other health care professionals are responsible for pre-authorizing all services listed on the *Medicare Products Pre-authorization List*. The most current list is available in the Care Management section of our *Provider Web Site* under Medical Pre-authorization.

The Regence MedAdvantage service area includes Benton, Clackamas, Clatsop, Columbia, Coos, Curry, Douglas, Hood River, Jackson, Josephine, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill counties in Oregon and Clark County in Washington.

Medicare Advantage Requirements

With the introduction of Medicare Advantage plans in 1999, the Centers for Medicare & Medicaid Services (CMS) implemented a significant number of regulations and requirements for health plans as well as their contracted network of providers.

As a participating provider with Regence MedAdvantage, you are required to comply with these regulations and requirements, including the laws and regulations related to the prevention of fraud, waste and abuse. To assist with this effort, Regence provides training to network providers to inform you and your employees about relevant Medicare rules and regulations.

Some of the regulations to be aware of are:

- Medicare Advantage plans allow members to be out of the service area for up to 12 months before being disenrolled.
- Medicare requires all members of Medicare Advantage plans to complete a *Health Risk Assessment* within 90 days of enrollment. Regence will send all newly enrolled Regence MedAdvantage members a *Health Risk Assessment*. Regence will assist physicians with enhanced case management for their patients who have complex or serious medical conditions. Case managers will work with physicians and other health care professionals to assess health status and establish and implement a treatment plan.
- Providers may not deny, limit or apply conditions to the coverage or furnishing of covered services to members enrolled in Regence MedAdvantage on the basis of any condition related to the member's current health status.
- Providers may not impose any cost-sharing to Regence MedAdvantage members for influenza or pneumococcal vaccine.
- Neither Regence, nor any provider shall make any specific payment, directly or indirectly, to another physician or physician group as an inducement to reduce or limit medically necessary services furnished to a Regence MedAdvantage member.
- Providers agree to furnish all encounter data necessary to characterize the context and purpose of each encounter with a Regence MedAdvantage member. Providers agree that all encounter data will be used by Regence in validating its rates with CMS and that all encounter data and other information submitted to Regence and ultimately CMS is accurate, complete, truthful, and is based on the provider's best knowledge, information and belief. Providers acknowledge that misrepresentations about the accuracy of encounter data may result in federal civil action and/or criminal prosecution.
- Providers agree not to bill Regence MedAdvantage members for covered services (except for deductible, copayments or coinsurance) if payment has been denied because the provider has failed to comply with the terms of the agreement between the provider and Regence BlueCross BlueShield of Oregon (Regence BCBSO). Providers must notify the Regence MedAdvantage member of his or her financial obligation for non-covered services.
- Physicians, other health care professionals and facilities and entities delegated by them to perform administrative services are covered entities under federal and state privacy laws. To the extent required by law, providers, Regence and their contracted business associates will keep all medical records containing patient-identifiable information confidential and will not disclose any patient-identifiable information to any third party without the prior written consent of the member.
- Providers shall ensure services rendered are documented and incorporated into the member's primary care medical record. It is important for specialty physicians and other health care professionals to advise the referring physician when follow-up care is necessary.
- Providers will make individual medical records available to patients or their legally designated representative upon request.

- At all reasonable times, providers will grant Regence, CMS, the Comptroller General of the United States, and their duly authorized representatives the right of access to its facilities and to its financial and medical records which are directly pertinent to Regence MedAdvantage members in order to monitor and evaluate cost, performance, compliance measures reporting, quality improvement activities, appropriateness, and timeliness of services provided.
- In the event Regence BCBSO terminates its Medicare Advantage contract with CMS, providers agree to continue to furnish health care services to Regence MedAdvantage members for:
 1. The duration of the period for which premiums have been paid, and
 2. If the member is hospitalized on the date of termination or in the event of insolvency, through date of discharge from the hospital.
- The payments that providers receive from Regence MedAdvantage are, in whole or in part, federal funds. We comply with all laws and regulations applicable to entities receiving federal funds.
- Claims for Regence MedAdvantage members must be approved or denied no later than 60 calendar days from the date of receipt or as outlined in your Agreement.
- Providers are responsible for the education and training of all individuals working within their medical practice to ensure that procedures outlined in this Administrative Manual are followed correctly. An online workshop is available in our *Provider Web Site* in the Educational Tools section. You may also contact Provider Services to request additional staff training.
- Providers are responsible for the annual Medicare compliance training of all individuals working within their medical practice for detection, correction, and prevention of fraud, waste and abuse. An online workshop is available in the Educational Tools section of our *Provider Web Site* to assist in this training requirement.

CMS Guidelines for Provider Activities and Materials

Providers may engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.

Providers are permitted to make available and/or distribute plan marketing materials as long as they do so for all plans with which they participate. Additionally, providers may display posters or other materials announcing their contractual relationships.

Providers cannot accept enrollment applications or offer inducements to persuade beneficiaries to join plans. Providers are advised to refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, **www.medicare.gov**, or 1 (800) MEDICARE as providers may not be fully aware of all Medicare plan benefits and costs.

Provider Affiliation Information

Providers may announce new provider network affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., publicity, radio, television). An announcement to patients of a new provider network affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail and/or email. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Affiliation banners, displays, brochures, and/or posters located on the premises must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plans and only lists plan names and/or contact information do not require CMS approval.

To obtain CMS approval for materials which promote or market your Regence network affiliation, please send materials to Regence to ensure the content is appropriate. Regence will review the materials, make necessary corrections, and forward them to CMS for approval. To initiate this process, contact Nan Forster at (503) 587-3327. Please be advised that the CMS review process may take as long as 45 days.

Comparative and Descriptive Plan Information

Providers may distribute printed information to their patients comparing the benefits of different plans (all or a subset) with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution. Providers may not health screen when distributing information to their patients.

Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party.

Providers/Provider Group Web Sites

Providers may indicate Web site links to plan enrollment applications and/or provide downloadable enrollment applications. If so, the Web site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

Educational Events

Providers may not distribute plan marketing materials or distribute or collect plan applications at educational events. Educational events are intended to provide objective information about the Medicare program and/or health improvement and wellness.

Educational events must be identified with the disclaimer, "This event is only for educational purposes and no plan specific benefits or details will be shared."

Regence MedAdvantage Benefit Summary

This section includes a summary of covered benefits for Regence MedAdvantage. Contact Regence MedAdvantage Provider Customer Service at 1 (877) 508-7362 or access the Provider Center for complete and current benefit information.

Regence MedAdvantage features low copayments and low out-of-pocket expenses for members who receive services from in-network (participating) providers. Services rendered by out-of-network (non-participating) providers are reimbursed at the out-of-network benefit level with higher copayment and coinsurance amounts. Please confirm through the Provider Center or with Regence MedAdvantage Provider Customer Service the amount of the copayment or coinsurance. All copayments should be collected from the member at the time of service.

Regence offers these Medicare Advantage plans:

- Regence MedAdvantage (stand-alone medical plan without prescription drug coverage)
- Regence MedAdvantage + Rx Classic (medical plan with standard prescription drug benefit as required by CMS)
- Regence MedAdvantage + Rx Enhanced (medical benefits and enhanced prescription benefits)

Regence MedAdvantage reimbursement and coding guidelines follow Medicare rules whenever possible. In particular, please note the following:

- Regence BCBSO Correct Code Editor (CCE) and CMS' National Correct Coding Initiative (NCCI) rules are applied as for all other Regence products.
- Diagnosis codes must reflect all digits to the full extent of the code indicated in the *International Classifications of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding manual.

Regence applies our standard multiple procedure fee reductions when reimbursing multiple endoscopic procedures rather than applying Medicare's endoscopic family of codes payment methodology. In most cases, this results in a higher level of reimbursement.

2010 Summary of Benefits

Benefit Element	Regence MedAdvantage and Regence MedAdvantage Enhanced		Regence MedAdvantage Classic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	\$0	\$50 Applies to Medicare covered services only	\$50 Applies to Medicare covered services only
Out-of-Pocket Maximum	\$2,000	\$3,500	\$2,500	\$4,000
Inpatient Hospital (unlimited days)	\$125 per day, up to a maximum of \$625 per benefit period, no limit to the number of days	\$225 per day, up to a maximum of \$1,125 per benefit period; no limit to the number of days	\$175 per day, up to a maximum of \$875 per benefit period, no limit to the number of days	\$250 per day, up to a maximum of \$1,250 per benefit period, no limit to the number of days
Inpatient Mental Health Care	\$125 per day, up to a maximum of \$625 per benefit period, 190 day lifetime maximum	\$225 per day, up to a maximum of \$1,125 per benefit period, 190 day lifetime maximum	\$175 per day, up to a maximum of \$875 per benefit period, 190 day lifetime maximum	\$250 per day, up to a maximum of \$1,250 per benefit period, 190 day lifetime maximum
Skilled Nursing Facility (no 3-day hospital stay requirement)	No copay Days 1-100 (no benefits after 100 days)	\$25 per day; Days 1-100 (no benefits after 100 days)	\$10 per day Days 1-100 (no benefits after 100 days)	\$30 per day Days 1-100 (no benefits after 100 days)
Home Health Care	No copay	10% coinsurance	10% coinsurance	20% coinsurance
Doctor / Specialist Office Visit	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Chiropractic Services (manual manipulation to correct subluxation)	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Podiatry Services	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Mental Health Care	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Substance Abuse Care	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Services / Surgery	\$100 copay	\$200 copay	\$200 copay	\$300 copay
Ambulance Services	\$100 copay	\$100 copay	\$100 copay	\$100 copay

Benefit Element	Regence MedAdvantage and Regence MedAdvantage Enhanced		Regence MedAdvantage Classic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Worldwide Emergency Care	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)
Urgently Needed Care (billed/coded from Urgent Care Facility only)	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Rehabilitation Services	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
DME and related supplies	No copay	10% coinsurance	10% coinsurance	20% coinsurance
Prosthetic Devices and related supplies	No copay	10% coinsurance	10% coinsurance	20% coinsurance
Diabetes Self- Monitoring Training and Supplies	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2
Lab Services	No copay	No copay	No copay	No copay
Diagnostic Tests and Radiology	No copay	10% coinsurance	10% coinsurance	20% coinsurance
Bone Mass Measurement	No copay	No copay	No copay	No copay
Colorectal Screening Exams	No copay	No copay	No copay	No copay
Immunizations (Medicare- covered)	No copay	No copay	No copay	No copay
Mammograms	No copay	No copay	No copay	No copay
Pap Smears/Pelvic Exams	No copay	No copay	No copay	No copay
Prostate Cancer Screening Exams	No copay	No copay	No copay	No copay
Dental Services	Medicare covered dental care - \$10 copay; Preventive services, no copay, up to \$500.	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500.	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500.	Medicare covered dental care - \$35 copay; Preventive services, no copay, up to \$500.

Benefit Element	Regence MedAdvantage and Regence MedAdvantage Enhanced		Regence MedAdvantage Classic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing Services	\$10 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams	\$35 copay for diagnostic hearing exams
Routine Vision Exams	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Vision Exams related to diagnosis or disease	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Vision hardware	\$200 scheduled limit for eyewear every 2 years	\$200 scheduled limit for eyewear every 2 years	\$100 scheduled limit for eyewear every 2 years	\$100 scheduled limit for eyewear every 2 years
Routine Physical Exam	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Welcome to Medicare physical	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Dialysis	No copay	No copay	10% coinsurance	10% coinsurance

Pre-authorization

Refer to our *Medicare Products Pre-authorization List* for complete pre-authorization guidelines and requirements. The list is available on our *Provider Web Site*, in the Care Management section, under Medical Pre-authorization.

Contracted facilities including, but not limited to hospitals, skilled nursing facilities and rehabilitation centers are required to notify us of all inpatient admissions and discharges via phone at 1 (800) 824-8563 or faxed inpatient census log at 1 (800) 453-4341.

Pre-authorization is required for behavioral health and chemical dependency admissions via phone at 1 (800) 547-9718 or fax at 1 (800) 331-3505. Services and supplies provided by a psychiatric hospital are limited to a 190-day lifetime maximum.

When a physician admits a Regence MedAdvantage member to a participating hospital for acute care, the following is covered:

- Semi-private room and board
- Isolation, coronary or other special acute care units, when medically necessary
- Hospital services and supplies necessary for treatment and furnished by the hospital, such as operating and recovery rooms, blood and blood components, traction equipment and special diets.

Skilled Nursing Facility (SNF) Pre-authorization Requirements

When a hospital discharges a Regence MedAdvantage member to a skilled nursing facility (SNF), pre-authorization is required prior to the SNF admission. The hospital may initiate this process, but it is ultimately the responsibility of the SNF to ensure that the necessary pre-authorization is in place prior to admission.

- Contact our Medical Management team at 1 (800) 824-8563, option 3, to provide the admission date to the facility, as well as necessary additional information needed to confirm the length of stay and treatment plan. If a Medical Management coordinator is not immediately available, you may leave a message on the department's confidential voicemail with the details of the upcoming admission in lieu of speaking directly to a coordinator.

Note: Failure to obtain pre-authorization prior to admission will result in the SNF services being denied. These denied services are considered a provider write-off and may not be billed to our member. In the event a SNF fails to obtain pre-authorization prior to admission and/or the SNF services are denied for failure to obtain pre-authorization, the SNF may seek pre-authorization for future SNF services by following the process outlined above.

- CMS' regulatory guidelines in conjunction with *Milliman Care Guidelines*® will be used as the basis for determining medical necessity for all SNF admissions.

Identifying Regence MedAdvantage Members

Members are issued cards that list information necessary for claims submission. Member Customer Service and pre-authorization telephone numbers are listed on the back of the member card.

						www.myRegence.com	
A 01 JOHN PUBLIC		E M V RX Y Y Y		G Providers not contracted with Regence, send claims to your local Blue Cross and / or Blue Shield Plan.		H Customer Service 1 (800) 541-8981 TTY/TDD Line 711 Med Preauth 1 (800) 824-8563 Nurseline 1 (800) 267-6729	
B ID NO 999999999999		F Card Issue Date 02/18/09		"MEDICARE LIMITING CHARGES MAY APPLY"			
C REGENCE MEDADVANTAGE + RX CLASSIC (PPO)		BC/BS Plan 350 / 851 OV IN/OUT \$25/\$35		This card is for information only and does not certify eligibility or guarantee benefits.		I Submit Medical claims to: Regence PO Box 30805 Salt Lake City UT 84130	
D Group 440400002 RX BIN 610623 RX PCN 02100000 Issuer (80840)				Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association.		Submit RX Claims to: Pharmacy Services PO Box 12625 M/S 54P Salem OR 97309-0625	

The following information is listed on the member card:

- **Item A** lists the member by suffix number and name. Regence MedAdvantage subscribers are listed with suffix number '01'.
- **Item B** gives the member's number, which is needed for claims submission and customer service inquiries. Always include the three-digit alpha prefix (ZVX) in front of the member number on the claim. *Note:* The alpha prefix is not included in the sample card above.
- **Item C** identifies the member's group name as Regence MedAdvantage.
- **Item D** lists the member's group number, which is needed for claims submission.
- **Item E** includes 'coverage indicator' columns that tell you at a glance whether the member has medical (M), vision (V), dental (D) and/or prescription (RX) coverage.
- **Item F** shows the date the card was issued (*this is not the coverage effective date*).
- **Item G** gives instructions for non-participating providers claims submission.
- **Item H** displays important phone numbers. *Note:* The Regence MedAdvantage Provider Customer Service phone number does not appear on the card.
- **Item I** displays the addresses for submitting claims.

Payment Vouchers

Regence MedAdvantage claims are processed on our Regence MedAdvantage claims system. Your vouchers will look different than other Regence vouchers. A sample voucher follows, along with an explanation of the key information provided.

Sample Regence MedAdvantage Voucher- Page 1



Regence

P.O. Box 12625
Salem, OR 97309-0625

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association.

CLAIM VOUCHER STATEMENT

PAGE 1

(A) JANE DOCTOR, MD
1234 SW MAIN ST.
ANYTOWN, USA 99999

PROVIDER NUMBER 3000000 00
NPI Number 9999999999

DATE 06/15/05

*** Regence MedAdvantage ***

PATIENT NAME TYPE OF SERVICE	SERVICE DATE	GROSS CHARGES	FEE ADJUSTMENT	PAID BY OTHERS	PATIENT RESPONSIBILITY		REASON CODE	BENEFITS PAID
					DEDUCTIBLE	COPAY/OTHER		
(B) JOHN SMITH	MEM #: ZVX92102186		PAT ID: 000196C15		GRP #: 44040001		CLM #: 01234567890	
(C) 99214 E/M DETAILED VISIT	06/01/05	148.00	51.64	.00	.00	5.00		91.36
** CLAIM TOTALS **		148.00	51.64	.00	.00	5.00		91.36
JOHN SMITH	MEM #: ZVX92102186		PAT ID: 000196C15		GRP #: 44040001		CLM #: 01235679120	
99217 OBSERV CARE DISCHARGE	06/03/05	120.00	**** CLAIM PENDING ****	.00	.00	.00	402	.00
** CLAIM TOTALS **		120.00	.00	.00	.00	.00		.00
(D) *** VOUCHER TOTALS ***		268.00	51.64	.00	.00	5.00		91.36

FORM 4411 - Front (Rev. 11/07)

Sample Regence MedAdvantage Voucher- Page 2



Regence

P.O. Box 12625
Salem, OR 97309-0625

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

CLAIM VOUCHER STATEMENT

PAGE 2

(A) JANE DOCTOR, MD
1234 SW MAIN ST.
ANYTOWN, USA 99999

PROVIDER NUMBER 3000000 00
NPI Number 9999999999

DATE 06/15/05

*** Regence MedAdvantage ***

PATIENT NAME TYPE OF SERVICE	SERVICE DATE	GROSS CHARGES	FEE ADJUSTMENT	PAID BY OTHERS	PATIENT RESPONSIBILITY		REASON CODE	BENEFITS PAID
					DEDUCTIBLE	COPAY/OTHER		
(E) **** EXPLANATION OF CODES ****								
402	CLAIM PENDED; WAITING FOR ACCIDENT REPORT FROM SUBSCRIBER.							

FORM 4411 - Front (Rev. 11/07)

Key fields are identified below.

Item A

- Physician's, other health care professional's or facility's name
- Regence provider identification number
- National Provider Identifier (NPI) number (not shown in the sample above)
- Regence MedAdvantage product name
- Voucher page number
- Date of check that accompanies this voucher

Item B

- Patient's name
- Member number
- Patient's account number (if one was submitted on the claim)
- Member's Regence MedAdvantage group number
- Claim number

Item C

- CPT, CDT, or HCPCS codes billed
- Written description of the service
- First and last dates of service
- Total charge for the service
- Fee adjustment or the amount not covered by the member's plan. The member may not be held responsible for this amount
- Amount paid by another carrier
- Amount of patient responsibility. This amount includes copayment, coinsurance, deductible or any non-covered services
- The reason code explaining how this particular claim was processed. Refer to the last page of the voucher for descriptions
- Amount paid by Regence MedAdvantage

Item D

- Claim voucher totals

Item E

- Description of reason codes entered in the reason code column in Item C

Emergency Care Guidelines

Emergency Care

To comply with the Balanced Budget Act of 1997 (BBA), Regence defines *Emergency Services* for members enrolled in our Regence MedAdvantage plans as follows:

Emergency services means covered inpatient and outpatient services that are:

1. Furnished by a physician or other health care professional qualified to provide emergency services, and
2. Needed to evaluate or stabilize an emergency medical condition.

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

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

Urgent Care

Regence defines *Urgently Needed Services* for Regence MedAdvantage plan members as follows:

Covered services provided when an enrollee is temporarily absent from the Plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the Plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury or condition and
2. It was unreasonable, given the circumstances, to obtain the services through the Plan

Provider Responsibility

Availability

All Regence MedAdvantage physicians and other health care professionals must provide or arrange for medical care 24 hours a day, seven days a week for all our members. The provider or the designated covering physician or other health care professional must be available to provide care personally or direct members to the most appropriate treatment setting. In addition, if triage is conducted by a health care professional that is not a physician, the minimum credentials of this health care professional must be one of the following:

- Certified nurse midwife
- Licensed practical nurse
- Nurse practitioner
- Physician assistant
- Registered nurse

After-Hours Answering Systems

In order for members to access their physician after regular office hours, all primary care physicians (internal medicine, family practice and general practice) must have a telephone answering system or service available. If your office utilizes a telephone answering system after regular office hours, the answering message must include the name and telephone number of the on-call physician or other health care professional with complete instructions as to how to contact him or her.

Accessibility

We are committed to providing our members the necessary information to:

- Be able to use their health plan benefits
- Have reasonable access to health services and
- Be assured the number of physicians, other health care professionals and facilities will be appropriate to satisfy their health care needs.

We request that all physicians and other health care professionals review this information carefully. If your office currently is not meeting these standards, please take the steps necessary to comply with them to ensure that our members, your patients, have access to quality care. This information and these standards take into account the immediacy of patient needs and common waiting times for comparable services in the community. You should have a system in place in order to evaluate the urgent and emergent needs of members and to determine the appropriate site for care in a timely fashion.

To ensure that Regence MedAdvantage members have equal access to medically necessary health care services, the following are to be considered as minimum access standards:

Type of Care/ Need of Member	Acceptable Time Frame
Emergent care (assess, treat or refer)	Immediately
Urgent, non-emergent care	Within 24 hours
Non-urgent, but in need of attention (symptomatic or chronic care)	Within one week (seven days)
Routine (non-symptomatic) and preventive care	Within 30 days or the community standard
After-hours care	Available 24 hours a day, seven days a week

Cultural Competency

Legislative requirements emphasize the importance of demonstrating cultural competency in the provision of health services. The Balanced Budget Act of 1997 also added cultural competency requirements for plans contracting for Medicare. CMS interpreted these requirements to mean services should be provided in a culturally competent manner to all enrollees who meet one or more of the following criteria:

- Limited English proficiency or reading skills
- Diverse cultural or ethnic background

- Physical or mental disabilities
- Homeless individuals

It is our policy to seek physicians and other health care professionals who speak languages in addition to English and who have an awareness of the social and cultural composition of the community.

Additionally, we require that Regence MedAdvantage members have access to information in their primary language, and that primary care physician offices have provisions for non-English speaking patients.

Access for Special Needs Members

If your Regence MedAdvantage patients have a serious, complex medical condition and require additional assistance navigating the health care system, you may contact Medical Services at 1 (800) 824-8563, option 3, to request case management. Case management staff will work with your office and the patient to provide assistance with this process, and refer you to the appropriate case manager.

Members with Physical Disabilities

Participating physicians and other health care professionals must guarantee that medical services are accessible to people with physical disabilities. Participating physicians and other health care professionals must ensure the following provisions for access:

- Clearly-identified handicapped parking spaces
- Wheelchair accessible offices

Help in identifying handicapped parking spaces can be obtained from the following sources:

- Signs: Your state's Disabilities Commission can assist you with obtaining signs designating handicapped (including van-accessible parking). Signs can also be obtained through other commercial vendors.
- Striping and stenciling: Parking space painting and stenciling can be arranged through a variety of commercial vendors. See your telephone directory listing under "Pavement Marking" for the name of a contractor near you.

Service dogs must be permitted to accompany disabled patients to all areas of your facility where patients are normally allowed. An individual with a service dog may not be segregated from other patients.

If your office is unable to serve a particular disabled population or individual, please contact Regence MedAdvantage Provider Customer Service at 1 (877) 508-7362, so that other arrangements or referrals can be provided.

Members with Visual Impairments

The following information may assist you in providing services to visually impaired patients:

- Assign someone in your office to assist visually impaired patients. If your office is located in a newer building, you should already have Braille signs on restrooms and elevators to meet American Disability Act requirements. However, Braille signs can also be added to older buildings to assist visually impaired patients. Contact your state's Commission for the Blind for a vendor.
- Evidence of Coverage booklets for Regence MedAdvantage members are available on audio-tape, compact disc or in large print upon request. If your patient requires this option, please contact Regence MedAdvantage Provider Customer Service.
- Guide dogs must be permitted to accompany visually impaired patients to all areas of your facility where patients are allowed.

Non-English Speaking and Hearing Impaired Members

Situations may arise in which a member experiences difficulty accessing medical care due to a language barrier. If you have a member for whom language is a barrier to receiving appropriate care, please contact Regence MedAdvantage Provider Customer Service at 1 (877) 508-7362. Through an arrangement with AT&T, we can provide access to a translation service available by telephone.

Our members who are hearing impaired have access to the TTY line in Customer Service for any questions they may have. Members may access the TTY line by calling 711.

Interpreter Services for Regence MedAdvantage Members

To ensure accurate interpretation and translation, we strongly encourage use of an interpreter service or a staff person who is trained in translating medical terminology. Asking family members or friends to act as an interpreter is not recommended. Friends or family members may not be familiar with medical terms and translation errors may occur; in addition, information may be overlooked or withheld.

We will make on-site interpreters available for non-English speaking or hearing impaired Regence MedAdvantage members. Authorization must be obtained *in advance for each visit*. Please allow 48 hours advance notice for non-emergent appointments and 24 hours for cancellations. To schedule an interpreter, call Regence MedAdvantage Provider Customer Service at 1 (877) 508-7362. Please have the following information available when calling:

- Member's name and member number

- Appointment date and time
- Provider name, address and telephone number
- Specific language or signing interpretation needed and the home telephone number of member, if known.

We will arrange and schedule the interpreter. Charges will be submitted directly to Regence. Please give as much advance notice as possible when scheduling interpreters as some language interpreters are difficult to schedule on short notice.

Notice of Medicare Non-Coverage (NOMNC) Form

CMS requires the Notice of Medicare Non-Coverage (NOMNC) form to be issued by home health and skilled nursing facilities (SNF) for every discharge. Regence MedAdvantage members have the right to a fast track review by a Quality Improvement Organization (QIO) if they appeal the discontinuation of their home health coverage or SNF coverage. The NOMNC form informs the patient the date coverage of services from the facility ends, and describes the member appeal process.

The following information highlights the form process that Regence MedAdvantage participating home health and skilled nursing facilities must follow.

Who must sign:

Patients (or their authorized representative) whose coverage for services from your facility will end.

What you must do:

- Provide a Regence NOMNC form to Regence MedAdvantage patients and obtain their signature on the form.
- Fax a copy of the signed and dated form to Regence at 1 (800) 453-4341 and keep a copy in the patient's medical record as required by CMS.
- In the case of an emergency, the information on the Regence NOMNC form can be conveyed over the telephone to the authorized representative. In this circumstance, facilities must document on the NOMNC form that the notice and telephone number for the QIO was provided via telephone.

When to issue the NOMNC form:

- The form must be signed and a copy faxed to Regence no later than two home health visits before a patient's coverage of services from your facility is due to terminate. For SNF patients, the form must be signed and faxed no later than two days before a patient's coverage of services from your facility is due to terminate.
- If services are expected to be less than two home health visits or SNF days, deliver the notice upon admission.

- If the patient chooses to appeal, he or she must contact the QIO to request a review no later than noon on the day before services are to end. The QIO appeal decision will generally be completed within 48 hours of the patient's request for a review.
- With respect to weekends, although QIOs are open, Regence is closed. If possible, providers should try to deliver the Regence NOMNC form early enough in the week to minimize the possibility of extended liability for weekend services.

Where to find Regence NOMNC Forms:

Forms are available on our *Provider Web Site* at www.or.regence.com/provider, in the Provider Library section, under Forms. Be sure to select the correct version of the form for home health or skilled nursing facilities.

Releasing a Member from Medical Care

Reasons for Release

Participating physicians and other health care professionals may release a patient who is enrolled in Regence MedAdvantage from his/her medical care when in his/her professional judgment, it is in the best interest of the patient to do so.

The reasons a member may be released from medical care include, but are not limited, to the following:

- Missed appointments, two or more. (The physician or other health care professional should document that he/she has attempted to ascertain the reasons for the missed appointments and has assisted the member in receiving services.)
- Disruptive, unruly or abusive behavior to the point that it seriously impairs the physician or other health care professional's ability to furnish services either to the member or other members.
- Threat or commission of an act of physical violence directed at a physician or other health care professional, their office staff, or other patients on their property.
- Fraudulent or illegal acts, including permitting the use of his/her member card by others, altering prescriptions, theft or other criminal acts committed on the other health care professional's office premises.
- Missed copayments, coinsurance or deductible.

While we recognize that a physician or other health care professional may release a patient from care based on his/her professional judgment, we discourage releasing Regence MedAdvantage members solely because:

- The member has a physical or mental disability.

- There has been an adverse change in the member's health.
- The member's utilization of services (either excessive or lack of) or mental illness, unless such mental illness has a direct impact on the physician or other health care professional's ability to deliver services.
- The member has requested a hearing.
- The member has been diagnosed with end-stage renal disease or placed in a hospice.
- The member has exercised his/her option to make decisions regarding his or her treatment.

Procedures for Releasing a Member from Medical Care

In cases of threats or acts of physical violence and fraudulent or illegal acts, the physician or other health care professional may immediately release a member from their medical care and simultaneously give his or her provider relations representative notice that he or she has done so. In follow-up, the physician or other health care professional must provide written documentation upon request to his or her provider relations representative documenting the circumstances leading to the request.

For all other circumstances, the following steps must be adhered to when releasing a member from medical care:

1. Consistent with professional and ethical standards, the physician or other health care professional must notify the member within a reasonable time up to 30 days in advance of the provider's intent to release the member from his or her care. Physicians or other health care professionals should simultaneously provide verbal notice to his/her provider relations representative at Regence. The written notice to the member can be either by certified mail or first class US mail to the member's last known address (when it is the policy of the practice to confirm current addresses at each visit). The words "address services requested" must appear in the upper left-hand corner, under the return address on the front of the envelope.
2. During the period after notification has been given and before termination becomes effective, the physician or other health care professional will remain responsible for providing acute, urgent or emergent medical care to the member.
3. The physician or other health care professional agrees to make medical records available to another physician or other health care professional on request from the member.
4. Regence will assist if necessary in locating another physician or other health care professional on the network who will accept the member as the provider's patient. If needed, we shall obtain a release of information in order to share the information necessary for a new physician or other health care professional to evaluate if he or she can treat the member.
5. The physician or other health care professional should make every effort to work with the member to resolve the presenting problem or problems. The physician or other health care professional must document in the medical record all efforts made to resolve the situation.

Member Rights and Responsibilities

We are committed to providing our Regence MedAdvantage members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

Providing the best possible health care coverage requires more than comprehensive benefit packages, prompt claims processing and efficient customer service. It also includes notifying our members of their rights and responsibilities and conscientiously protecting these rights. Therefore, we have developed a written policy based on regulatory requirements for entities such as CMS and Federal and State Patient Protection Acts.

Each individual within the Plan is responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to respect these rights.

Rights of Members Enrolled in Regence MedAdvantage

Although we establish guidelines that affect how benefits are paid, no one can deny beneficiaries the right to make their own decisions. Members of Regence MedAdvantage have the right to:

Timely and Quality Care

- Access to a network of qualified physicians
- Timely access to all covered services
- Access to emergency services
- Access to urgently needed services when traveling outside the service area or in the service area
- Continuity of care, and to know in advance the time and location of an appointment, as well as the provider who will render care
- Receive care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- Participate with physicians and other health care professionals in decision-making regarding their care and treatment planning
- Participate in a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

Treatment with Dignity and Respect

- Be treated with respect, dignity and compassion
- Exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or

- Expect these rights be observed by the Plan, contracted physicians, and other health care professionals
- Confidential treatment of all communications and records pertaining to their care
- Timely access to medical records, except as authorized by state law
- Extension of the member's rights to any person who may have legal responsibility to make decisions on the member's behalf
- Understand the reason for tests, treatments, or procedures, knowing the identify of the person who provides them, and the associated risks
- Refuse treatment or leave a medical facility, even against the advice of physicians, provided the member accepts the responsibility and consequences of the decision
- Refuse to sign a consent form if they feel they do not understand its purpose, or to cross out any part of the form they do not want applied to their care, or to change their mind about any treatment for which they have previously given consent
- Be involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment
- Complete an advance directive (living will) or other directive to their physician(s) and other health care professional(s)

Health Plan and Other Important Information

- Receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements
- Expect a clear explanation regarding benefits and exclusions of their policy
- Know the name and qualifications of the physicians, nurses or other health care professionals providing care
- Receive information about illness, the course of treatment and prospects for recovery in terms they can understand
- Receive information about their medications – what they are, how to take them and possible side effects
- Receive information regarding how medical treatment decisions are made by the health plan or contracted medical groups, including payment structure
- Be advised if a provider proposes to engage in experimentation affecting their care or treatment, and the right to refuse or participate in such research projects.
- Be informed of continuing care requirements following discharge from inpatient or outpatient facilities
- Receive as much information as needed about a proposed treatment or procedure to give or refuse informed consent about a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks

- Examine and receive an explanation of any bills for non-covered services, regardless of payment source
- Receive general coverage and plan comparison information
- Understand utilization control procedures
- Receive statistical data on grievances and appeals
- Receive information on the financial condition of their health plan
- Summary of physician and other health care professionals compensation agreements

Timely Problem Resolution

- Receive timely responses to reasonable requests made for covered services
- Present questions, concerns, or complaints to Customer Service without discrimination and expect problems to be fairly examined and appropriately addressed
- Be informed of their right to voice a complaint about their health plan or the care provided including the right to appeal, and the process involved
- Make recommendations regarding the health plan members' rights and responsibilities policies

Responsibilities for Members Enrolled in Regence MedAdvantage

In addition to their rights, members of Regence MedAdvantage have the responsibility to:

- Identify themselves as a member of Regence MedAdvantage and present their member card when requesting health care services
- Provide, to the extent possible, information that their health care organization and its physicians and other health care professionals need in order provide care
- Be on time for appointments
- Notify their physician or other health care professional as soon as there is a need to cancel an appointment
- Call their physician or other health care professional if they are going to be late for an appointment
- Pay their physician or other health care professional applicable fees for a missed appointment
- Provide complete health information to their physician and other health care professional to assist in an accurate diagnosis and appropriate treatment
- Do their part to improve their health condition by following the plans and instructions that are recommended by those providing care
- Act in a manner that supports the care provided to other patients and the general functioning of the office or facility

- Review information regarding covered services and policies and procedures as stated in their *Evidence of Coverage* or *Member Handbook*
- Follow Plan requirements to have services properly authorized before receiving medical attention
- Participate, to the degree possible, in understanding their health problems including behavioral health, and developing mutually agreed upon treatment goals
- Contact Customer Service by phone or in writing if they feel they are not receiving adequate care
- Check their *Evidence of Coverage* or *Member Handbook* and follow proper procedures for illness or accidents needing medical attention after business hours
- Read and understand all material concerning their health benefits
- Accept the financial responsibility for any copayment or coinsurance associated with covered services while under the care of a physician or other health care professional or while a patient at a facility
- Accept the financial responsibility for any premiums associated with membership in Regence MedAdvantage
- Ask questions of their physician, other health care professional or Regence
- Call Customer Service if a question arises or there is a payment issue
- Let us know if they have any concerns, or if they feel their rights are being compromised so we may act on their behalf

Advance Directive

The goal of the Federal Patient self-determination Act (Section 4751 of OBRA 1991) and Natural Death Act (Chapter 70.122 RCW) is to provide the member with the knowledge and tools necessary to create an advance care document if he or she so desires and to ensure that it becomes part of the medical record.

"In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care". *Washington State Chapter 70.122 RCW, Natural Death Act, 1966*

There are two advance directive forms:

- The "Power of Attorney for Healthy Care"
- The "Living Will- Directives to Physicians"

If members have signed either of these forms, copies should be included in his or her medical record. For all Regence MedAdvantage members, Regence requests that

documentation include discussions of a member's right to predetermine future health-care and specific treatment preferences if expressed. Providers and staff members who make entries on member charts regarding this subject should identify themselves by signing or initialing each entry.

To ensure our Regence MedAdvantage members' wishes are met concerning the provision of health care if the member becomes incapacitated and is unable to make those wishes known, Regence requests that physicians, other health care professionals and facilities comply with the following:

- The office or facility should either have copies of advance directives available for their patients to complete, or advise the patient how to obtain one from the hospital or their attorney.
- If the office has received a signed advance directive, a copy of the document must be prominently displayed in the patient's chart so that it is easy to see.
- The physician or other health care professional must document in a prominent location within the patient's medical record whether or not the patient has executed an advance directive.

Regence Medicare Advantage Appeal Procedures

Regence MedAdvantage members have a legal right to file an appeal if they do not agree with the Plan's decision regarding medical claims, or if he or she thinks:

- The Plan has not paid a claim;
- The Plan has not paid a claim in full;
- The Plan did not approve benefits for services that the member believes should be covered.

Standard Appeal Process

A member must request an appeal of an adverse determination in writing within 60 days of the date of the Plan's determination. Appeal requests may be accepted beyond this 60-day guideline if the member can provide documentation for "good cause" as to why the appeal request is late. It is the Plan's responsibility to decide whether or not to accept an appeal request beyond the 60-day guideline, and if so, to fully document the reason.

An appeal request must be made in writing and signed by the member or their appointed representative for pre-service and post-service denials, or by a treating physician or prescribing physician or other provider, for pre-service denials.

If the appeal request is made by anyone other than the member or their provider, the Plan must have the enrollee's written permission for that person to act on their behalf. The Plan must have a signed Appointment of Authorized Representative form or a copy

of the Power of Attorney in order to proceed with an appeal from someone other than the enrollee.

A non-participating provider may become a party to an appeal only if the provider has executed a waiver of liability form. This form ensures that the enrollee will not be held financially responsible for any charges should the provider lose the appeal.

How to File an Appeal

If a member wishes to file an appeal, he or she may call Regence MedAdvantage Customer Service and request an appeal form. The member may also print an appeal form from the Regence Web site, complete it, and send it to the following address:

Medicare Advantage / Medicare Part D
ATTN: Appeals and Grievances, M/S S6D
P.O. Box 12625
Salem, OR 97309-0625

The member may also fax the written request to 1 (888) 309-8784, or deliver the request in person.

Support for an Appeal

The member has the opportunity to provide additional information in support of an appeal in person or in writing. In the case of the expedited appeal, the member or his or her authorized representative may submit evidence in person, via telephone, or in writing via fax at the address and telephone number referenced above under "How to File an Appeal."

Expedited Appeal Process

Members who believe that waiting for a reconsideration of a pre-service denial under the standard 30-day appeal process could jeopardize their life, health or ability to regain or maintain maximum function may request an expedited appeal.

The expedited appeal process is for pre-service denials only. Claim denial issues are not eligible for the expedited appeal process.

A member, member's authorized representative or physician may request an expedited appeal verbally or in writing. Issues that may be expedited include, but are not limited to, any request for an expedited appeal from a physician or an appeal of a pre-service denial for:

- An experimental and/or investigational treatment (depending on the patient's condition)
- A terminally ill patient

- A refusal by the provider to proceed with a scheduled service because the Plan has failed to give an authorization

Upon receipt of an expedited appeal request, a response must be made to the appealing party within 72 hours, or as expeditiously as the member's health requires. This can be extended by up to 14 calendar days, if the extension is in the member's best interest.

Second Level Appeals – MAXIMUS Federal Services

If the Plan's initial decision is adverse, the appeal is prepared for review by MAXIMUS Federal Services (a CMS contractor). MAXIMUS will make a determination and notify the Plan and the member in writing. MAXIMUS must adhere to the same timeliness guidelines as the Plan in making their determination:

- For expedited cases, a decision must be rendered within 72 hours, with a 14 calendar day extension if it is in member's interest, or sooner if warranted by the member's medical condition.
- For standard pre-service cases, a decision must be rendered within 30 calendar days, with a 14 calendar day extension if it is in the member's interest, or sooner if warranted by the member's health condition.
- For standard claim cases, a decision must be rendered within 60 calendar days.

If the Plan is overturned by MAXIMUS, the Plan must effectuate, authorize or provide the service within 72 hours for expedited cases. For standard pre-service cases, the Plan must effectuate, authorize the service, within 72 hours, or provide the service within 14 days. For standard post-service cases, the Plan must pay the claim within 30 days of notification from MAXIMUS.

Additional Appeal Rights for Members

Additional appeal rights exist for members beyond the MAXIMUS Federal Services process:

- If MAXIMUS Federal Services decision is not in the member's favor and the dollar value of the medical care is at least \$130, the member may ask an administrative law judge (ALJ) to consider the case.
- If the member or the Plan is unsatisfied with the decision made by the ALJ, a review request may be made to the Medicare Appeals Council.
- If the member or the Plan is unsatisfied with the decision made by the Medicare Appeals Council, the case may be taken to a Federal Court in which case the dollar value of the medical care must be at least \$1,260.

Fast Track Appeals

Regence MedAdvantage members have the right to an expedited review by a Quality Improvement Organization (QIO) if they disagree with the Plan's decision to discontinue coverage of skilled nursing facility (SNF), home health agency (HHA), or certified outpatient rehabilitation facility (CORF) services. QIOs are contracted with CMS to direct and review fast track appeals.

Upon notification from the QIO that a member is requesting a fast track appeal, the Plan's appeal coordinator requests a copy of the *Notice of Medicare Non-Coverage* (NOMNC) notice from the provider. If the notice is valid, the appeal coordinator will provide the QIO with pertinent medical records and a *Detailed Explanation of Non-Coverage* (DENC). If the notice is invalid, the appeal coordinator will rescind the NOMNC and require the provider to issue a valid NOMNC.

If the QIO concurs with the Plan's decision to discontinue coverage, the member is responsible for any and all charges after the date given on the NOMNC. If the QIO overturns the Plan's decision to discontinue coverage, the member's services are covered until the Plan issues another NOMNC.

If the member or member's authorized representative disagrees with a QIO's decision to concur with the Plan, reconsideration may be requested from the QIO within 60 days of the date of the decision. The QIO will have 14 days to have another physician review the case and render a decision.

If the QIO's reconsideration again concurs with the Plan's decision, the member or member's authorized representative may request an ALJ hearing within 60 days of the date of the reconsideration decision by the QIO. If the ALJ upholds the Plan denial, the member or member's authorized representative may request a review by the Departmental Appeals Board (DAB). If the DAB concurs with the Plan's decision, the final level of appeal is to the Federal District Court.

Regence Medicare Advantage Grievance Procedures

Regence MedAdvantage members have a legal right to file a grievance if they are dissatisfied with any action of the Plan, Plan staff, and/or a contracted physician or other health care professional. A member may file a grievance verbally or in writing about problems he or she observes or experiences, including:

- Physician or medical facility issues;
- Involuntary disenrollment situations;
- If the member disagrees with the decision to process his or her appeal request under the standard 30 day time frame rather than the expedited 72 hour time frame.

If the request is made by anyone other than the enrollee, the Plan must have the member's written permission for that person to act on their behalf. The Plan must have a signed *Appointment of Authorized Representative* form or a copy of the Power of Attorney in order to proceed.

Standard Grievance Process

All grievances are investigated and responded to within 30 days from the date the grievance is received. The Plan may take an extension of up to 14 days if it notifies member.

A Grievance that is defined as a quality of care issue or has the potential to be a quality of care issue will be routed to the appropriate Plan staff for review. The quality of care grievance response includes information about how the member may file a separate complaint with the QIO.

Regence MedAdvantage will fully cooperate with the QIO on resolving the complaint.

Expedited Grievance Process

The Plan will identify grievances that must be processed in an expedited timeframe. Expedited grievances will be resolved and the member will be notified within 24 hours of receipt of the verbal or written grievance.

How to File a Grievance

If a member would like to file a grievance, he or she may call Regence MedAdvantage Customer Service at 1 (800) 541-8981. Regence MedAdvantage staff will attempt to resolve the dispute on an informal basis. If informal attempts do not resolve the problem, and the member wishes to file their complaint verbally, the complaint information will be taken over the phone, repeated back to the member and documented. The member must file the grievance within 60 days of the event or incident that precipitated the grievance. The member may also print a grievance form from the Regence Web site, complete it, and send it to the following address:

Medicare Advantage / Medicare Part D
ATTN: Appeals and Grievances, M/S S6D
P.O. Box 12625
Salem, OR 97309-0625

The member may also fax the grievance to 1 (888) 309-8784, or deliver it in person.

The request should be filed with Regence MedAdvantage as soon as possible after any action taken by the Plan, the Plan's contracted physician or other health care professional, or a Plan's representative has left the member dissatisfied.

Medicare Risk Adjustment

Medicare risk adjustment is part of the Regence Medicare Program Management. Risk adjustment is based on the Medicare Hierarchical Condition Category (HCC) algorithm, utilizing the diagnosis codes submitted from physician and hospital inpatient and outpatient claims. The diagnosis codes are assigned to categories defined by CMS. These categories are used to calculate a risk score for each Medicare Advantage beneficiary that reflects his or her overall health status. Payments from CMS to health plans are based entirely on the risk scores; therefore, it's important that the data submitted includes as much detail as possible. Regence conducts regular reviews of medical records to validate the risk scores reported to CMS.

Documentation and coding tips

The following tips can help ensure accurate medical coding and billing compliance, as well as the detail needed to accurately assess the risk scores of Regence MedAdvantage members.

- Include a legible identifier (name and credentials of provider) for services rendered/ordered:
 - The method used must be hand-written or an electronic signature to authenticate an order or other medical record documentation. **Rubber stamp signatures are not acceptable.**
 - Initials are acceptable only if the full name and credentials of the provider appear elsewhere in the record (e.g., in the letterhead on which the documentation is recorded or on a signature log, which can be produced upon request.)
- Record the patient's name and date of service on each page of documentation.
- Evaluate the status of each active diagnosis (including chronic conditions) on the patient's problem list, and update the progress notes accordingly. The problem list alone is not reportable documentation.
- Report chronic conditions at least once each calendar year, preferably at the patient's annual physical. These conditions may not have been routinely submitted on claim forms as a secondary diagnosis (e.g., history of myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, complications of diabetes).
- Include information in the patient's progress note to reflect all over-the-counter or prescription medications that are being actively managed or assessed on that date of service for each acute and/or chronic condition (e.g., "DM well controlled - taking Metformin", "Atrial fib stable – on Coumadin as directed").
- Include an accurate ICD-9-CM diagnosis code selection, including the fourth and fifth digits, when required.
- Include the maximum number of codes allowed per submission.
- Look for documentation and include coding from physician reporting of chronic conditions. These conditions may not have been previously or routinely

submitted on claim forms as a secondary diagnosis (e.g., history of myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, complications of diabetes).