



2019
PROVIDER
MANUAL



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QUICK REFERENCE

Important Phone Numbers

Call to Inquire About:	Telephone Number
Provider Services (Benefit & Claim Inquiries, Eligibility Verification)	1-866-788-3640
Vision – Provider Servicing	1-800-999-5431
Dental – Provider Servicing	1-888-700-1246
Hotline to report Fraud and Abuse or Compliance Concerns	1-866-639-3611
Utilization Medical & Behavioral Health Management	1-866-689-8761
Member Services	1-888-906-3889
Pharmacy	1-866-613-0151
Care Management	1-866-391-6511
Part D Prescriber Appeals	1-866-378-8503
TTY/TDD (for all departments)	711
Fitness Program	1-888-423-4632
Transportation Services	1-844-529-1799
Over The Counter Program (OTC)	1-888-246-6001
Language Services (Offers bilingual interpreters)	1-844-203-2025

Important Addresses

Corporate Office: Eon Health 3620 Enterprise Way Miramar, FL 33025	Claims Office: Eon Health P.O. Box 21517 Eagan, MN 55121
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Reason for Mailing	Address
Claims (Medical - Behavioral Health)	Eon Health Attention: Claims P.O. Box 21517 Eagan, MN 55121

Reason for Mailing	Address
Claims Inquiries and Administrative Review	Eon Health Attention: Claims Review 3620 Enterprise Way Miramar, FL 33025
Member Appeals	Eon Health Attention: Member Appeals & Grievances 3620 Enterprise Way Miramar, FL 33025
Provider Appeals	Eon Health Attention: Provider Appeals & Grievances 3620 Enterprise Way Miramar, FL 33025
Initial Applications for Credentialing	Eon Health Attention: Provider Relations & Recruitment 3620 Enterprise Way Miramar, FL 33025
Re-credentialing Applications	Eon Health Attention: Provider Relations & Recruitment 3620 Enterprise Way Miramar, FL 33025
Practice Change Information	Eon Health Attention: Provider Relations & Recruitment 3620 Enterprise Way Miramar, FL 33025
Practice Change Information for Behavioral Health Providers:	Eon Health Attention: BH Contracting Specialist 3620 Enterprise Way Miramar, FL 33025
Routine Vision Claims	Contact Davis Vision at 1-800-999-5431
Dental Claims	Contact Liberty at 1-888-700-1246
Medicaid Claims	Follow claims processing instructions provided to you by state Medicaid

INTRODUCTION

About This Manual

Eon's Provider Relations, Provider Services, Member Services, and Member Outreach staff, among others, is committed to providing accurate, up-to-date, and comprehensive information to our member and practitioner populations through prompt and dedicated service. Understanding Eon's policies and procedures is essential. The Provider Manual is one way of providing participating practitioner offices, hospitals and ancillary providers with information regarding Eon's policies and procedures and is considered part of your contractual agreement with the health plan. Consider this manual as a general guideline for Eon's provider network. The manual is a ready reference and is updated, as needed. Please retain all updates with your manual.

This Manual and any updates are available on our website under the Providers section: www.eonhealthplan.com.

Corporate Overview

Eon Health is a Medicare Advantage Plan, which is contracted with Medicare since 2017. Eon has obtained CMS approval to operate in 68 counties across Georgia and South Carolina. Our executive and leadership team is comprised of seasoned professionals and clinicians who have a history of serving the unique needs of the Medicare population. This includes serving those who may be low income or who are faced with the challenges of living with chronic disorders.

In 2018, Eon will operate 57 counties in Georgia:



In 2018, Eon will operate in 11 counties South Carolina counties:



MISSION

To improve the health of our members by offering innovative products, cost effective solutions, and service excellence. We will accomplish this by leveraging and integrating technology with our providers and our members.

Eon Health Plan is committed to delivering quality health care services to its members and quality customer services to its providers.

OUR PLANS

Plan Types

Eon's product offerings include Special Needs Plans (SNP) serving those with Medicare Parts A and B; among other qualifying factors. These plans are:

1) Eon Deluxe-Full Dual (HMO SNP) – A Dual Eligible Special Needs Plan, (D-SNP); serving those who have BOTH Medicare Parts A and B and who receive full assistance from the state.

2) Eon's Chronic Condition Special Needs Plan (CSNP) – serve those individuals that have BOTH Medicare Part A and Part B, along with one of the following chronic conditions: Diabetes, Cardiovascular disorders or Chronic Heart Failure. These are:

a) Eon Silver (HMO SNP)

b) Eon Gold (PPO SNP)

In addition, Eon offers two Medicare Advantage Part D (MAPD) plans serving those who have both Medicare Parts A and B and live within the county service areas:

- 1) Eon Select (HMO)
- 2) Eon Choice (PPO)

Plan Co-Payments

A member's out of pocket expense or cost sharing will vary depending upon the level of assistance they may be receiving from the State, Medicare, as well as which Eon Health they have chosen to join. For more benefit information, see Eon Health Summary of Benefits. For your convenience co-pays* for frequently used services are provided below.

Dual Eligible Special Needs Plans (D-SNP)

Eon Deluxe Full Dual (HMO SNP): PCP-\$0 copay, SPC-\$0 copay, ER-\$0 copay

*Please note: All members enrolled in Eon Health Deluxe Full Dual also have Medicaid (Medical Assistance) or receive some assistance from the state. Members will be eligible for Medicaid coverage to pay for cost sharing (deductibles, copayments, and coinsurance). They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility. Please follow Medicaid coverage and claims processing guidelines. Please contact Eon Health Provider Services for member specific information.

Chronic Condition Special Needs Plans (C-SNP)

Eon Silver (HMO SNP): PCP-\$10 copay SPC-\$50 copay ER-\$80 copay

Eon Gold (PPO SNP): PCP-\$15 copay in network or 40% coinsurance for out of network providers, SPC-\$50 copay in network or 40% coinsurance for out of network providers, ER-\$80 copay in and out of network

MA-PD Plans

Eon Select (HMO): PCP-\$10 copay, SPC-\$50 copay, ER-\$80 copay

Eon Choice (PPO): PCP-\$10 copay in network or \$20 copay for out of network providers, SPC-\$45 copay in and out of network, ER-\$80 copay in and out of network

**This list does not represent every service covered or every applicable co-pay and/or coinsurance.*

***Not covered outside the U.S. except under limited circumstances.*

Compensation for Services Rendered to Enrollees: For Covered Services, PLAN shall pay prevailing Medicare Fee Schedule minus Member cost sharing (as outlined in the Member's Health Benefit Plan) adjusted by any applicable sequestration or other Medicare fee-for-service payment modification. Subject to the prohibition on collecting Part A and B cost sharing for Dual Eligibles, Provider will accept such amounts and any Member cost sharing as payment in full for Covered Services provided to Members.

BENEFITS

Medical Benefits

Eon Health members are eligible for all the benefits covered under the Original (Fee-for-service) Medicare Program. In addition, Eon Health offers additional benefits for pharmacy, dental, vision, hearing and health and wellness services (plan benefits vary by plan). For a complete list of covered benefits, please refer to the Evidence of Coverage. A complete copy of the Evidence of Coverage booklet for each health plan option is located on our website at www.eonhealthplan.com. Members obtain most of their healthcare services either directly from their primary care practitioner or upon referral (approval in advance) by an in-network specialist/ ancillary provider; except for services available on a self-referral basis, such as OB/GYN services and routine vision services. The primary care practitioner is responsible for the coordination of a member's healthcare needs and access to services provided by hospitals, specialty care practitioners, ancillary providers, and other healthcare providers as needed.

Eon offers the following benefits to members enrolled in Eon Health:

- 3) All the benefits of original Medicare and more
- 4) Prescription drug coverage
- 5) Special formulary tier focused on targeted medications to support our CSNP plan members*
- 6) Hearing, vision, and dental benefits (including dentures)*
- 7) Rewards program for members that complete preventative procedures
- 8) Fitness program to help members stay fit
- 9) Transportation*
- 10) Over the Counter (OTC)
- 11) Lower copayments and deductibles on select plans
- 12) No referrals for in-network providers

**Benefit coverage varies by product.*

Benefits to the Healthcare Provider

- No referrals in-network providers
- Quick claims payment
- Dedicated Provider Relations representative
- Innovative Care Management Model

Summary of Benefits

The covered services listed in the Summary of Benefits are covered only when all requirements listed below are met:

- Services must be provided according to the Original Medicare coverage

- Guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Medically necessary refers to services or supplies that: are proper and needed for the diagnosis or treatment of the member's medical condition; are used for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of the member or the member's doctor. Certain preventive care and screening tests are also covered.
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, and some services may need to be authorized by our Plan.
- For those temporarily out of the service area emergency and urgently needed services will be covered as provided in 42 CFR 422.113

In addition, some covered services require "prior authorization" by the Plan in order to be covered. Some of the covered services listed in the Summary of Benefits attachments are covered only if the member's doctor or other plan provider gets "prior authorization" (approval in advance) from our Plan. Covered services that may need prior authorization (approval ahead of time) are marked in the Summary of Benefits as "Authorization rules may apply".

The Summary of Benefits can be found on Eon Health's website, www.eonhealthplan.com

General Exclusions

Exclusions or limitations are described in the Evidence of Coverage (EOC) booklet. The Evidence of Coverage booklet can be found on Eon Health's website at: www.eonhealthplan.com

At any time during the year, the Medicare program can change its national coverage. Since Eon Health covers what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease benefits, depending on the Medicare program changes.

PHARMACY BENEFITS

Prescription drug benefits are available to all Eon Health members. Prescriptions must be filled by a participating pharmacy in order to be covered by Eon. When a member travels outside of the Eon service area a national network of pharmacies is available via the OptumRx network. If a member must use an out-of-network pharmacy, the member will generally have to pay the full cost of the prescription. The member may then request to be reimbursed for the cost covered by Eon.

Eon contracts with OptumRx to develop a network of chain, independent, home infusion and long-term care pharmacies in order to provide pharmaceuticals to Eon members. A list of participating pharmacies can be obtained by looking on our website on www.eonhealthplan.com or contacting Eon's Member Services Department at:

- 1-888-906-3889
- TTY: 711

Prescriptions are available to members who are eligible for pharmacy coverage when written by an Eon practitioner. Prescription coverage and cost varies by plan.

Formulary

Eon offers an extensive drug formulary. Generic prescriptions, when appropriate, are the most cost effective alternatives. Eon's formulary includes a complete list of the drugs that we cover, generic and brand name and any requirements, limits and/or restrictions for each drug, if applicable. Visit www.eonhealthplan.com for the most recent version of the formulary. Pharmacy cost information is also noted in the Evidence of Coverage booklet.

Co-payments/Co-insurance

Member cost sharing for medications varies by plan, drug type and the amount of extra help, if any, that the member may receive. Members should contact Eon Member Services to learn more about their specific coverage.

Please Note: The Plan may place limits on the amount of medication a member may receive. Members can receive up to a 31-day supply of medication for prescriptions filled at an in-network pharmacy or up to a 90-day supply of medication for prescriptions filled at an in-network 90-day retail pharmacy. A 90-day mail order benefit is available for select plans.

Some formulary medications may have additional requirements or limits on coverage. These requirements and limits may include: prior authorization, quantity limits, or step therapy. If use of a formulary medication is not medically advisable for a member, you must complete a Drug Exception Form. Please refer to the Forms and Reference Materials Section of this manual for a copy of this form. Please refer to the Referral and Authorization Section of this manual for information regarding requesting non-formulary drugs. The Drug Exception Form can also be found on Eon Health's website.

Drug Exclusions

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If one of these reference books, known as compendia, does not support the use then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Drugs Covered Under Part B

Drugs covered under Part B are typically administered and obtained at the provider's office. Some examples are certain cancer drugs, administered by a provider in his/her office; insulin when administered via pump and diabetes test strips.

Drugs Covered Under Part B or Part D

Some drugs can fall under either Part B or Part D. The determination of coverage as to whether the drug is Part B or Part D is based on several factors such as diagnosis, route of administration and method of administration. For a list of medications in this category, refer to the CMS website at www.cms.gov; choose **Medicare -> Prescription Drug Coverage-General Information -> Downloads**, and select the appropriate document. Alternatively, you may contact our Pharmacy department.

Home Infusion

Eon Health will cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. However, Medicare part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department.

Vaccines

Most vaccines and the administration fees are covered under Part D. Eon Health provides coverage of a number of vaccines, some of which are considered to be medical benefits (Part B medications) and other which are considered to be Part D drugs. If you are unsure of how a vaccine will be covered by Eon Health, refer to the Formulary which is available on our website, www.eonhealthplan.com.

Part D covers most preventative vaccines; Part B covers flu pneumococcal, hepatitis B and some other vaccines (i.e. rabies) for intermediate or high-risk individuals when directly related to the treatment of an injury or direct exposure to a disease or condition.

ENROLLMENT

The Centers for Medicare and Medicaid Services (CMS) has periods when beneficiaries can enroll or disenroll with/from Medicare. These times are known as election periods. Members can enroll into our plan by using any of these methods:

- Mailing in a paper enrollment form
- Enrolling on-line through Medicare's website
- By calling Eon Health at 1-888-822-7335 (TTY users should call 711)
- Complete an enrollment form with their sales agent, and agent submits form on their behalf.

Members of the Special Needs Plans must meet specific eligibility requirements. Eon Health confirms the beneficiary's eligibility during the enrollment process. For the C-SNPs, Eon Health obtains permission from the beneficiary to contact his/her physician in order to confirm the

beneficiary has one of the qualifying conditions. Eon Health attempts to reach the physician by telephone or fax. CMS permits Eon Health to confirm the condition with a member of the physician’s office staff. The confirmation can be given over the phone, on a recorded line. It is important that the physician’s office respond promptly to any requests for confirmation of chronic condition.

Eligibility Criteria

Enrollment Criteria	DSNP (Full Dual Plan)	CSNP	CSNP PPO	MAPD HMO	MAPD PPO
Must be entitled to Medicare Part A	YES	YES	YES	YES	YES
Must be enrolled in Medicare Part B	YES	YES	YES	YES	YES
Medicare eligibility may be due to either disability or age	YES	YES	YES	YES	YES
Must be eligible for either: FULL Medicaid/ FBDE/QMB Plus/ SLMB Plus/QMB	YES	NO	NO	NO	NO
Must have one of the following conditions: Diabetes / Chronic Heart Failure / Cardiovascular Disorder	NO	YES	YES	NO	NO

Eligibility Criteria Definitions

- **Medicaid only (“Full Dual”)** - Individual who is eligible for full Medicaid benefits. Medicaid does not pay out-of-pocket costs for Part D cost-share.
- **QMB Only**- Individual who is eligible for Medicaid payment of Medicare cost-share (i.e. Medicare Part A and/or Part B coinsurance, deductible, premium). Medicaid does not pay out-of-pocket costs for Part D cost-share.
- **QMB Plus**- Individual eligible for full Medicaid benefits and Medicaid payment of Medicare cost-share (i.e. Medicare Part A and/or Part B coinsurance, deductible, premium). Medicaid does not pay for Part D cost-share.
- **SLMB Plus**- Individual eligible for full Medicaid benefits and Medicaid payment of Medicare Part B premium only). Medicaid does not pay out of pocket for Part D cost-share.

Note: SLMB plus eligibility is only accepted for beneficiaries in the state of Georgia.

DISENROLLMENT

A **voluntary** disenrollment may occur as a result of a written request by the member.

An **involuntary** disenrollment may occur as a result of, including but not limited to, one of the following:

- If the member does not stay continuously enrolled in both Medicare Part A and Medicare Part B.

- If the member gives false or deliberately misleading information on the enrollment application having an impact on whether they qualify or not.
- If member behaves in a way that is unruly, uncooperative, disruptive or abusive and his/her behavior seriously affects your ability to arrange or provide medical services, you must notify Eon Health. Before Eon takes makes a determination to disenroll the member for this reason, Eon must obtain permission from the Center for Medicare and Medicaid Services (CMS).
- If the member allows someone else to use his/her member ID card in order to obtain medical care. Before disenrolling the member, for this reason, Eon must refer the case to the Office of the Inspector General and this may result in criminal prosecution of the member and the person(s) seeking care.

MEMBER ID CARDS

Each Eon Health member will receive an ID card. Each card is issued once, unless cards are requested or reissued due to a demographic, PCP or plan change. ID Cards are good for as long as the person is a member of Eon Health.

(Sample Member ID Cards)



Member Services:	1-888-906-3889
TTY:	711
Pharmacy Services:	1-866-714-9485
Dental Services:	1-888-700-1246
Hearing Services:	1-800-735-4534
Vision Services:	1-800-999-5431
Behavioral Health Services:	1-888-906-3889
Provider Services:	1-866-788-3640
Utilization Review/Inpatient Services:	1-866-689-8761
Paper Claims	Electronic Claims
Eon Health	Payer ID: 73780
Attention: Claims	
P.O. Box 21517	
Eagan, MN 55121	
www.EonHealthPlan.com	

Member Services:	1-888-906-3889
TTY:	711
Pharmacy Services:	1-866-714-9485
Dental Services:	1-888-700-1246
Hearing Services:	1-800-735-4534
Vision Services:	1-800-999-5431
Behavioral Health Services:	1-888-906-3889
Provider Services:	1-866-788-3640
Utilization Review/Inpatient Services:	1-866-689-8761
Paper Claims	Electronic Claims
Eon Health	Payer ID: 73780
Attention: Claims	
P.O. Box 21517	
Eagan, MN 55121	
www.EonHealthPlan.com	

Eon Deluxe – Members residing in Georgia and South Carolina will need to use their

Eon Health ID card and keep their Medicaid card to use for services covered under Medicaid (Medical Assistance) and to cover Medicare deductibles and coinsurance, as long as the provider also participates with Medicaid.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities: Georgia

We believe that patients who understand and participate in their treatment achieve better results. Please take a moment and familiarize yourself with your rights and responsibilities as a patient.

You have the right to:

- Know the risks, benefits and alternatives to proposed treatments or procedures
- Choose the physicians or other clinicians who will be providing care or treatment, as well as have information about them
- Receive information in easy to understand terms that will allow for an informed consent
- Privacy regarding medical care
- Participate in the plan of care, including your treatment plan, notifying your family or physician of admission and discharge planning
- Pain management
- Refuse care, treatment, and services in accordance with law and regulation
- Be informed about the outcomes of care, treatment, and services
- Receive information and communication in an understandable manner and preferred language including provision of interpreter and translation services
- Receive information and communication to accommodate vision, speech, hearing, or cognitive impairments.
- Formulate advanced directives and have staff and practitioners comply with those directives
- Reasonable responses to reasonable requests of service
- Leave the medical center against the advice of the physician
- Examine and receive an explanation of the bill for services regardless of the source of payment
- Select providers of goods and services after discharge
- Receive a Notice of Privacy Practices
- Request privacy protection
- Access protected health information in a reasonable time frame
- Amend protected health information
- Request an accounting of disclosures of protected health information
- Be free from any forms of restraint or seclusion as a means of convenience, discipline, coercion, or retaliation
- The least restrictive restraint or seclusion should be used only when necessary to ensure patient safety

- Care regardless of your race, color, religion, sex, national origin, age, ability to pay or disability and any other legally prohibited reasons.
- Receive care in a safe and dignified environment, free from all forms of abuse, neglect, harassment and/or exploitation
- Protection and respect of your rights if you are participating in a human research clinical trial.
- Have a support person during care provided it does not interfere with the rights of other patients or the care process.
- Consent to receive the visitors who you designate, including but not limited to a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend. You may withdraw your consent to receive any visitor at any time. To the extent this hospital places limitations or restrictions on visitation, you have the right to set any preference of order or priority for your visitors to satisfy those limitations or restrictions. This hospital does not and will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. This hospital will ensure that the visitors chosen by you will be able to enjoy full and equal visitation privileges, consistent with your preferences.

You have the responsibility to:

- Provide accurate and complete information concerning your present medical condition, past illnesses or hospitalization and any other matters concerning your health
- Tell your caregivers if you do not completely understand your plan of care
- Follow the caregivers' instructions
- Follow all medical center policies and procedures while being considerate of the rights of other patients, medical center employees and medical center properties

You also have the right to:

Lodge a concern with state and regulatory agencies, whether you have used the hospital's grievance process or not. If you have concerns regarding the quality of your care, coverage decisions, or want to appeal a premature discharge, you may contact the following regulatory agencies via phone, fax or mail:

Georgia Department of Community Health

Healthcare Facility Regulation Division Healthcare Facility Regulation Complaint Intake Unit:

404-657-5726, 404-657-5728 or 800-878-6442. Fax: 404-657-5731

2 Peachtree Street, NW, Suite 3100, Atlanta, GA 30303

Georgia Medical Care Foundation Quality Improvement Organization

800-982-0411

1455 Lincoln Parkway, Suite 800, Atlanta, Georgia 30346

Regarding problem resolution, you have the right to:

Express your concerns about patient care and safety to hospital personnel and/or management. If your concerns and questions can not be resolved at this level, contact:

The Joint Commission

1 -800-994-6610, by Fax at: 630-792-5636,

by e-mail at complaint@jointcommission.org, or by mail at: Office of Quality Monitoring

The Joint Commission One Renaissance Boulevard • Oakbrook Terrace, IL 60181

Member Rights and Responsibilities: South Carolina

1. You have a right to be informed regarding your rights.
2. You have a right to be informed regarding methods for resolving possible violations of your rights.
3. You may seek advice and assistance from the Client Advocacy Program. The telephone number is posted on your ward.
4. You may contact an attorney of your choice.
5. You may review the complete manual on patient rights located in your facility library and on your ward.
6. You are entitled to a safe and humane environment.
7. You have a right to as much freedom of movement as possible. This right may be limited only when it is necessary for the protection of yourself, others, and the community.
8. You may spend your own money, wear your own clothes, and keep personal possessions within established limits.
9. You have a right to communicate by sealed mail and telephone and receive visitors of your choice. Any restriction of these rights must be ordered by your physician and documented in your record.
10. You have a right to recognized psychiatric and medical treatment. This right includes receiving information regarding risks, side effects, and anticipated benefits of all medication and treatment. You have the right to the appropriate assessment and management of pain.
11. You have a right to participate in the formulation of your treatment plan and to know the names of the staff members responsible for your care.
12. You have a right to refuse participation in any research project and to refuse non-standard psychiatric treatment.
13. You have a right to know the cost of your treatment and to know the source of any assistance available in meeting these expenses.
14. Any work that you do at the hospital must be part of your treatment plan and designed for

your benefit. If you do accept a work assignment, you will be paid. You may refuse to work for the hospital.

15. You have a right to worship in the faith of your choice as long as you do not cause harm to yourself or infringe on the rights of others.

16. You have a right to have all information concerning your hospitalization kept confidential except when State law permits disclosure.

17. If the hospital should consider it necessary to search your belongings for any reason, you have a right to be present.

18. You have a right for planned recreational activities to be available. You also have a right to some unplanned leisure time.

19. Unless you have been declared incompetent by a court of law, you may exercise all legal and civil rights, such as disposing of property, voting, marrying, and divorcing.

20. You may report any suspected abuse or neglect of patients without fear of reprisal.

21. You may petition the court to review the appropriateness of your confinement.

22. In exercising your rights, you may not infringe on the rights of others. You also have certain basic responsibilities and you have a right to know what is expected of you.

Member Responsibilities

A. Realize that living with a group of people is different from living at home and try to get along with other people on the wards.

B. Ask questions when you do not understand what is happening to you.

C. Let a member of the staff know when you have a problem or feel sick.

D. Take part in planning for and participating in your therapy and treatment program and discharge planning, and provide information concerning your medical history.

E. Attend scheduled activities and keep appointments.

F. Help take care of and clean up your living area.

G. Show respect for the property and rights of others.

H. Take care of the hospital property and your own clothing and personal things.

I. Keep yourself clean and dressed (insofar as you are physically able.)

J. Obey the laws, which apply to all citizens.

K. Be familiar with and observe the rules and policies of your facility.

L. Accept responsibility for your actions.

M. Cooperate in the goal of achieving self-sufficiency in the management of your every-day living.

Special Notes

At times, you may feel that there are certain restrictions or limitations to some of your rights. You have a right to ask and to be told why these restrictions exist and what you can do to remove them and to avoid them in the future.

If you feel that your rights are being violated, you should talk to a treatment team member. If you are unable to get the matter resolved you may register a complaint with the Client Advocacy Program.

South Carolina Department of Mental Health

Client Advocacy Program

P.O. Box 485

Columbia, SC 29202

803-898-8569

866-300-9330 (toll free)

PROVIDER RESPONSIBILITIES

Eon Health Provider Network

Eon Health contracts directly with primary and specialty care practitioners, hospitals, and ancillary providers to provide care for our membership. Eon Health has an extensive network of pharmacies to service members across our service areas. Practitioners and other healthcare providers are chosen in such a manner that existing patterns of care, including patterns of hospital admissions, can be maintained. Participation in Eon Health in no way precludes participation in any other program with which the provider may be affiliated.

To find a provider go to www.eonhealthplan.com to access Eon's On-Line Provider Directory.

The following requirements are the basic guidelines to which you, as a provider, have agreed in your Provider Agreement with Eon Health. These requirements are organized into responsibilities for all providers, for primary care physicians, for specialist and for physician extenders. You will be updated, as necessary, with any regulatory changes that require revisions to standard responsibilities.

TITLE VI of the Civil Rights Act of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator services as necessary for these members.

Coverage Arrangements

All participating practitioners must ensure 24-hour, 7 days-a-week coverage for members.

Coverage arrangements should be made with another Eon participating practitioner or practitioners who have otherwise been approved by Eon. All encounters must be billed under the name of the rendering practitioner, not the member’s assigned primary care practitioner. Reimbursement will be paid directly to the participating covering primary care practitioner.

Covering practitioners, whether participating or not, must adhere to all of Eon’s administrative requirements. Additionally, covering practitioners must agree not to bill the member for any covered services. The covering practitioner should report all calls and services provided to the member’s primary care practitioner. Participating practitioners will be held responsible for the actions of their non-participating coverage practitioners. Participating practitioners will not use any practitioner who is excluded for the Medicare program for coverage in their absence.

Primary care practitioners agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Appointment Standards

Primary care practitioners agree to meet Eon Health’s appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately seen, or instructed to call 911 or go directly to the nearest emergency room.
Wait time for Urgent Care Appointment	Within 24 hours
Wait time for Non-Urgent Sick Visit	Within 1 week
Wait time for Routine, Wellness Appointment	Within 30 days
After Hours Care Accessibility	Access to a practitioner 24 hrs/7 days a week
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a difficult need.

* A member should be seen by a practitioner as expeditiously as the member’s condition warrants, based on the severity of symptoms. If a practitioner is unable to see the member within the appropriate timeframe, Eon Health will facilitate an appointment with a participating or non-participating practitioner, if necessary.

Missed Appointments

A member who misses an appointment without notification is considered a “no-show”. Providers should have a process in place to ensure that the “no-show” is documented within the member’s medical record. Members with chronic failure to attend appointments should be forwarded to Eon’s Care Management and/or Member Services Department for follow-up.

Office Hours

Office hours for all physicians should be posted and should be reasonable. Hours of operations must be convenient and not discriminate against Eon members relative to:

- Other, non-Medicare members
- Members who require access to care after normal business hours (5p.m – 9a.m.) for urgent medical events that require attention after hours.
- Members who are not able to take time off from work to receive their care (Medicare Working-Aged).

Provider Information Changes

The Eon Health physician agreement indicates participating providers must submit written notice ninety (90) calendar days prior to the date the provider intends to terminate. There is also sixty (60) days notice required if you plan to close your practice to new patients and thirty (30) days notice required for a practice location change. All changes must be submitted in writing to Eon Health on provider letterhead.

Patient Safety

Patient safety is the responsibility of every healthcare professional. Health care errors can occur at any point in the health care delivery system and can be costly in terms of human life, function, and health care dollars. There is also a price in terms of lost trust and dissatisfaction experienced by both patients and health care practitioners.

Providers are required to meet safety standards in accordance with the Occupational Safety and Health Administration (OSHA), Americans Disability Act (ADA), Rehabilitation Act, and other federal/state regulatory requirements. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and table, examination room and equipment are in good working order.

Providers will establish a plan in compliance with OSHA standards regarding blood borne pathogens. In addition, provider will make the necessary provisions to minimize sources and transmission of infection in the office.

Closing Your Practice/Panel

As an Eon participating provider, you are required to provide Eon prior written notice of no less than 60 calendar days if you are closing your practice. Providers are permitted to limit the number of new patients they accept, subject to the terms of their agreement with Eon. Please note that a panel must be closed to all new patient and not only to Eon members.

Member Confidentiality

Through contractual agreements, all practitioners and providers participating with Eon Health have agreed to abide by all policies and procedures regarding member confidentiality.

Under these policies, the practitioner or provider must meet the following:

1. Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including, but not limited to, the following:
 - Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164

- The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No.
- 111-5 (Feb 17, 2009) and related regulations
- The HIPAA Omnibus Rule, effective 3-26-2013 with a compliance date of 9-23-2013.

2. Assure that member records, including information obtained for any purpose, are considered privileged information and, therefore, are protected by obligations of confidentiality.

3. Assure that a member's individually identifiable health information as defined by HIPAA, also known as Protected Health Information (PHI), necessary for treatment, payment or healthcare operations (TPO) is released to Eon Health without seeking the consent of a member. This information includes PHI used for claims payment, continuity and coordination of care, medical record audits, treatment, health assessments, performance measures (i.e. HEDIS), quality of care issues, and care and/or disease management.

4. All staff discussions related to confidential member information should be conducted in a private area, away from treatment or waiting areas.

5. Employees should have instructions on confidentiality policy and awareness training on their legal obligations regarding confidentiality.

6. Members must be informed of your confidentiality policy and privacy practices and may sign a document to that affect.

Eon Health follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatment or operational function.

Verifying Member Eligibility

The presentation of a member's ID card neither creates nor serves to verify a member's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Providers are required to take the following steps prior to administering services:

1. Verify member's eligibility with Eon Health. Members are eligible if:
 - a. Is currently enrolled
 - b. Is eligible for the requested services
 - c. Has not exhausted his or her benefits
 - d. Did not disenroll after receiving the membership card
2. Check the authenticity of the member's ID card in order to avoid problems with identity theft or fraud. Be sure to ask the member for an additional form of identification such as a driver's license.
3. Make a copy of the member's ID card and make it part of the member's medical record.

All providers are responsible for the verification of member eligibility prior to rendering services to

ensure reimbursement. Provider can verify eligibility through the provider portal at www.eonhealthplan.com or eligibility verification line can be reached at 1-866-788-3640, from October 1 – March 31, seven days a week, from 8:00 a.m. – 8:00 p.m. EST and from April 1 – September 30, Monday through Friday, 8:00 a.m. – 8:00 p.m.

Primary care practitioners verify eligibility by consulting their panel listing in order to confirm that the member is a part of the practitioner's panel. The panel list is distributed on or about the first of every month. The primary care practitioner should check the panel list each time a member is seen in the office. If a member's name is on the panel list, the member is eligible with Eon for that month.

If a patient insists, they are a member of Eon and effective, but do not appear on the panel list, the provider should call the Eon Health Member Services Department at 1-888-906-3889.

Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a law that has come to be known as the Patient Self-Determination Act. It became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the act is to make sure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute an advance directive if they so desire. The Act also prevents discrimination in health care if the member chooses not to execute an advance directive.

As a participating provider within the Eon Health network, you are responsible for determining if the member has executed an advance directive and for providing education about advance directives when it is requested. A copy of the "Living Will" form should be maintained in the member's medical record. Eon's Medical Record Review Standards state that providers should ask members age 21 and older whether they have executed an advance directive and document the member's response in their medical records. If a member has executed an advanced directive, it will be placed in the medical record in an area that is clearly marked "Advanced Directives".

Providers will receive educational materials regarding a member's right to advance directives upon entering the Eon Health practitioner network.

To access a Living Will at no cost for the State of Georgia: TotalLegal

To access a Living Will at no cost for the State of South Carolina: USLegal

Transfer of Non-Compliant Members

Primary care practitioners agree (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Eon Health members on the basis of race, sex, age, religion, place of residence, health status or source of payment; and (b) to observe, protect and promote the rights of members as patients. Primary care practitioners shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the practitioner's panel. Eon Health's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given practitioner.

Should an incidence of inappropriate behavior occur and transfer of the member is desired, the practitioner must send a letter requesting that the member be removed from his/her panel including the member's name, Eon Health ID Number, and details of the non-compliant behavior to the Medicare Enrollment Department at:

Eon Health
Attention: Medicare Enrollment
3620 Enterprise Way
Miramar, FL 33025
Or Fax: 1-866-235-5181

The Enrollment Department notifies the requesting practitioner in writing when the transfer has been accomplished. If the member requests not to be transferred, the primary care practitioner is responsible for continuation of care for at minimum 30 days until the member is assigned to a new primary care physician.

Primary care practitioners are required to provide emergency care for any Eon Health member dismissed from their practice until the member transfer has been completed.

Fraud, Waste and Abuse

Eon Health has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. Eon Health's policy to investigate any actions by members, employees or practitioners affects the integrity of Eon Health and or the Medicare Program.

As a participating practitioner with Eon Health requires compliance with Eon Health's policies and procedures for the detection and prevention of fraud and abuse. Such compliance may include referral of information regarding suspected or confirmed fraud or abuse to Eon and submission of statistical and narrative reports regarding fraud and abuse detection activities.

If fraud or abuse is suspected, whether it is by a member, employee or practitioner, it is your responsibility to immediately notify Eon Health at 1-866-788-3640.

All practitioners and providers participating with Eon Health agree to abide Eon Health's Fraud, Waste, and Abuse and Reporting policy, which can be accessed on Eon Health's website at www.eonhealthplan.com. This policy and procedure include legal requirements determined by the state as determined by the plan's coverage area:

- 31 U.S.C. §3729 of the Federal False Claims Act
- SEC. 1128. [42 U.S.C. 1320a-7]
- 31 U.S.C. 3729 False Claims Act Sanctions
- TITLE 18--CRIMES AND CRIMINAL PROCEDURE

Providers are requested to review the Fraud, Waste and Abuse and Reporting policy on Eon Health's website periodically to determine if any changes have occurred.

It is Eon Health's policy to discharge any employee, terminate any provider or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified or

has being involved in fraudulent or abusive activities. Some common examples of fraud, waste and abuse are:

- Billing for services not rendered
- Billing for supplies not being purchased or used
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each provider is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Eon Health will assist providers in locating resources upon request. Eon Health offers the Member Handbook and other Eon Health information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please instruct members to call Member Services at 1-888-906-3889 (TTY 711).

Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting Eon Health's Provider Services Department at 1-866-788-3640. For interpreter services, please contact Eon Health's Member Services at 1-888-906-3889 to arrange and coordinate interpreter services.

Primary Care Practice Dashboard Reports

Primary care practitioners and their practice staff are challenged with handling and processing mountains of clinical mail from a myriad of sources. In response, we are making efforts to reduce the number of individual clinical mailings we send by consolidating that information into a compact, easily understandable Primary Care Practice Dashboard Report.

The Report is delivered at least quarterly (January, April, July, October) and contains data on members in your practice who are due for or missing chronic care and preventive services. Data includes member contact information, self-disclosed racial and ethnic information, preventive care (e.g., cervical cancer screening, mammography, etc.) and chronic care (e.g., diabetic testing, gaps in pharmacy fills for hypertension and asthma controllers, etc.) services for which we have no "Medical" or "Physician Office" claims or encounter submission.

Information in the Primary Care Practice Dashboard Report is compiled from claims and pharmacy data. The dashboard highlights members for whom claims and pharmacy data does not show the presence of a recommended test or treatment. This does not necessarily mean that the test or treatment has not been done; it indicates that Eon Health has not received a claim or encounter submission indicating the service was performed.

Information in the Dashboard is intended to be a practice tool that supports evidence-based care,

not as a “report card.” It does not, nor is it intended to replace your professional clinical judgment as a patient’s treating physician.

Streamlining

- Schedule patients for annual wellness visits to review all of their needs.
- Schedule follow-up appointments before patients leave the office.
- Have a reminder system. Let patients know by mail or phone of an upcoming appointment to help minimize “no shows.”
- Arrange for patients with chronic conditions to have blood work drawn a week before their next appointment. This allows the doctor to have more information at the time of the visit and reduces the amount of required follow-up communication.
- Make use of in-office testing (e.g., HbA1c, Spirometry testing, etc.), a service reimbursed by Eon.

Encounters

Primary care practitioners are required to report to Eon all services they provide for Eon members by submitting complete and accurate claims. All Eon providers are contractually required to submit encounters for all member visits and all charted diagnoses that the member may suffer from.

Accurate Submission of Encounter Data

Encounter data provides the basis for many key medical management and financial activities at Eon:

- Healthcare assessments and studies;
- Access and availability of service evaluation;
- Program identification and evaluation;
- Utilization pattern evaluation;
- Operational policy development and evaluation, and;
- Financial analysis and projection.

In order to effectively and efficiently manage member’s health services, encounter submissions must be comprehensive and accurately coded. All Eon providers are contractually required to submit encounters for all member visits. Underreporting of encounters can negatively affect all stakeholders.

For primary care practitioners, encounter data is essential as many of Eon’s quality indicators are based on this information. Eon evaluates primary care practitioner encounter data in two ways. The rate of submitted encounters, per member for individual primary care practitioner practices is measured and compared to a peer average based on specialty (i.e. Family Medicine, Internal Medicine). Additionally, Eon extracts dates of service during on-site medical record review and compares the visit dates to encounters submitted to the health plan. This rate is also compared to peer averages.

It is very important that all diagnosis codes that are applicable to the member be submitted on

every claim, especially chronic conditions. The expected rate of submission for encounters is 100%. Eon provides support and education to practices as indicated by their encounter submission rates.

CMS uses the Hierarchical Condition Categories (HCC) model to assign a risk score to each Medicare beneficiary. Accurate and complete reporting of diagnosis codes on encounters is essential to the HCC model. Physicians must establish the diagnosis in the medical record and coders must use the ICD-10-CM coding rules to record each diagnosis. Chronic illnesses should be coded on each encounter along with the presenting illness. This will help to ensure that CMS has complete data when determining the member's risk score.

There are two volumes, which consist of:

The Disease Tabular (Numeric) and is known as Volume I of ICD-10-CM. Numeric listing of codes organized by body system. This volume provides more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.

The Disease Index (Alphabetic) and is known as Volume II of ICD-10-CM. This volume is an index of all diseases and injuries categorized in ICD-10-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and sub terms that further describes or specifies the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

Provider Training

We are aware that, to provide exceptional access and quality health care to our members, it is essential that our providers and their staff have a solid understanding of the member's needs, our contract requirements and other protocols, as well as applicable contract standards and Federal and/or State regulations.

Within 30-90 calendar days of successful completion of provider credentialing and approval to participate in our network our Provider Relations Department provides introductory training to providers and their office staff. The Provider Manual is reviewed at orientation and placed on Eon Health's website, www.eonhealthplan.com. This provider training familiarizes new providers and their staff with Eon Health's policies and procedures.

Each participating primary care practice, specialty care practice and hospital is assigned a

Provider Relations Representative, who is responsible for ongoing education in their assigned

Service Area. As a follow-up to the initial orientation session, the assigned Provider Relations Representative regularly contacts each provider and their staff to ensure that they fully understand the responsibilities outlined in the Provider Agreements and Manual.

Contracts/No Gag Clause

Eon Health allows open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care for the patient. All of Eon Health's contracts with practitioners and providers include an affirmative

statement indicating that the practitioner can freely communicate with patients regarding the treatment options available to them, including medication treatment options available to them, regardless of benefit coverage limitations. There is no language in Eon Health's contracts that prohibits open clinical dialogue between practitioner and patients

Beneficiary Financial Protections

Eon Health agrees to comply with the following requirements:

- Eon Health will adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the Eon Health. To meet this requirement, Eon Health:
- Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any enrollee liable for payment of any such fees;
- Indemnify the enrollee for payment of any fees that are the legal obligation of Eon Health or the state Medicaid Program (dual eligible members). Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will accept Eon Health's payment as payment in full, or bill the appropriate State source.

Health Care Disparities

Eon understands that in order to help improve our members' quality of life, we must take into account their cultural uniqueness. For this reason, addressing disparities in health care is high on our leadership's agenda. We believe a strong patient-provider relationship is the key to reducing the gap in unequal health care access and health care outcomes due to cultural and language barriers. Eon is continuously working to close the gap in health outcomes by focusing on education and prevention.

Providers must deliver services and information regarding treatment options in a language the member understands, and in a culturally competent manner, accommodating the special needs of ethnic, cultural and the social circumstances of the patient.

QUALITY IMPROVEMENT

Purpose: Quality Improvement Program

The purpose of the Quality Improvement Program is to provide a formal process by which the quality, appropriateness, efficiency, safety and effectiveness of care and services are objectively and systematically monitored and evaluated.

This process allows the Plan to identify operational areas for improvement, effectiveness of care and services in relation to enrollee health outcomes, as well as, enrollee and provider satisfaction. The Quality Improvement Program promotes the accountability of all employees and affiliated health personnel for the quality of care and services provided to enrollees.

As a participating provider, Eon Health asks that you cooperate with QI activities to improve the

quality of care and services members receive. This may include the collection and evaluation of data, participation in various QI initiatives and programs and allowing the plan to use and share your performance data.

Goal: Quality Improvement Program

The goal of the QI Program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality services. The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Eon Health care provider network, and the effectiveness and efficiency of systems and processes that support the health care delivery system. Utilizing quality improvement concepts and appropriately recognized quality measurement tools and reports, such as qualitative, quantitative and root/cause barrier analyses, Eon Health focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of health care and health plan services, patient safety, satisfaction with care and services, and achieving positive member health outcomes.

Objectives: Quality Improvement Program

The objectives of the QI Program are consistent with Eon Health's mission, commitment to effective use of healthcare resources, to achieve program goals for continuous quality improvement. The program goals are documented in the annual QI Program Description. The QI Program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI Program objectives.

Objectives are as Follows:

- Improvement of the enrollees' health status and outcomes by incorporating health promotion programs and enforcing preventive medicine;
- Identification and increase awareness of appropriate and safe delivery systems by monitoring and evaluating health care delivery and services;
- Evaluate the standards and appropriateness of clinical care and performance, and promote the most effective use of resource while maintaining coordination and continuity of health care and services;
- Evaluation of access and availability of care and services;
- Oversight and improvement of member and provider satisfaction;
- Monitor over and under-utilization of services;

Scope: Quality Improvement

The QI Program uses appropriate internal information systems, practitioners, and community resources to monitor and evaluate use of healthcare services, the continuous improvement process and to assure implementation of care intervention strategies.

The scope of the Program includes:

- Members' Rights and Responsibilities

- Network Accessibility and Availability, including those related to Special Needs
- Healthcare Disparities
- Network Credentialing/Re-credentialing
- Medical Record Standards
- Member and Provider Services
- Preventive Health
- Clinical Outcomes
- Oversight of Delegated Activities
- Member Safety
- Quality of Care
- Model of Care
- Continuous Quality Improvement

To request a copy of the Quality Improvement Program, Work Plan or Annual Evaluation please contact Eon's Provider Relations Department at 1-866-788-3620.

UTILIZATION MANAGEMENT

Utilization Management Program

The Utilization Management (UM) Program is a component of the Health Services Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care across the Medicare lines of business. The UM program facilitates optimal settings for delivery of care and educates physicians and facilities on the advantages of managing care in a medically appropriate and cost-effective manner. The UM structure is routinely evaluated such that appropriate utilization is continuously monitored and corresponding interventions initiated to improve health outcomes. The UM program maintains regulatory compliance and is annually reviewed by the Eon Health's Utilization Management Committee (UMC) and annually approved by the Quality Improvement Committee (QIC).

The UM Program and QIC work together to evaluate the care and service provided to members, identify opportunities for improvement, prioritize the improvement opportunities and interventions, and assist in the re-measurement process to determine the effectiveness of the interventions provided.

Goals and Objectives: Utilization Management Program

The UM program is designed to accomplish the following objectives:

- Demonstrate flexibility in the application of members' benefits to ensure that all medically necessary services are available to members;
- Collaborate with and provide necessary oversight to delegated entities to ensure a high quality of care for members;
- Develop, implement and maintain an ongoing process aimed at assuring proper utilization

of health care resources within the established benefit plan;

- Educate clinical and support staff on the purpose and philosophy of the UM program;
- Assure that members receive the highest quality of medically necessary care delivered in the most appropriate setting;
- Evaluate and determine benefit exception authorizations based on explicit outcome expectation, related to unique, individual needs of each member;
- Providing individualized and integrated care to each member;
- Maintain the rights and responsibilities of the member during all aspects of review;
- Review and analyze UM data and statistics to identify trends and opportunities for improvement;
- Work collaboratively and cooperatively with the Quality Improvement department;
- Review, update as necessary, approve and implement the UM program and all related processes, policies, and procedures at least annually;
- Comply with professional standards, guidelines and criteria set by governmental and other regulatory agencies;
- Improve coordination of care between Primary, Specialty and Behavioral Health disciplines;
- Optimize healthcare utilization by assisting provider with tool, resources, and information to better manage the members;
- Maintain and monitor the provider network in order to provide adequate access to covered services and to meet the needs of the member population served;
- Partner with providers including local Public Health and Social Service agencies, to achieve optimum member outcomes; and
- Monitor overutilization, underutilization and inappropriate use of services through regular care plan and service utilization reviews;

MEDICAL RECORDS

Medical record documentation should facilitate communication, coordination and continuity of care and services, as well as, promote efficiency and effectiveness of treatment. Participating providers are required to keep accurate and complete medical records of Eon Health's members for at a minimum of 10 years.

Medical Records Standards

Providers must ensure that their medical records meet Eon's medical record standards. Medical record standards incorporate criteria from applicable federal, state and regulatory requirements.

The following are expanded descriptions of the requirements:

- a. Patient Identifiers:** Patient name or unique identifier number should appear on each page of the medical record;
- b. Biographical Information:** Each medical record should contain: Patient's name, date of birth, address, home and work phone numbers, marital status, sex, name of emergency contact and phone number, appropriate consent forms and guardianship information, if relevant;
- c. Date and Signatures:** All entries on the medical record should be dated and signed/ initialed by the author. Author identification includes name of the practitioner rendering services including signature or initials followed by the title (M.D., D.O., D.C., D.P.M., P.A., A.R.N.P., R.N., L.P.N., M.A., etc.); Stamp signatures will not be accepted; ARNPs and PA's documentation must be co-signed by the physician;
- d. Language:** Documentation of primary language spoken and any translation needs must be included as part of the medical record, documentation of any other needed communication assistance;
- e. Legibility:** All entries should be legible;
- f. Past Medical History:** There should be documentation within the medical record of past medical history obtained by the member's first visit, which should include significant surgeries, procedures, past and present diagnosis;
- g. Family History:** Past family history should be documented as part of the initial visit;
- h. Allergies:** Medication allergies must be in a prominent location within the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently noted. Allergies to environmental allergens, food, pets, etc., or any other untoward reactions should also be noted;
- i. Social History:** There should be documentation of a social history including, but not limited to, the assessment of tobacco, alcohol, and drug use/abuse;
- j. Problem List:** There should be a current problem list, which includes significant past and current illnesses and medical conditions. Problem list reflects significant and /or continuing problems. A health maintenance record should be present even if there are no documented relevant problems;
- k. Immunization Documentation:** Documentation of immunizations by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine;
- l. Physical Examination:** Document pertinent physical examination, relevant to the chief complaint and the purpose of the visit and objective findings;
- m. Vital Signs:** Document vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis;
- n. Diagnosis/Assessment:** Document diagnosis and/or medical impression based on assessment or physical exam; diagnosis must be consistent with the findings and documented within the record;
- o. Previous Problems:** Unresolved problems and/or chronic problems from prior office visits

should be addressed in subsequent visits:

p. Treatment Plan/ Plan of care: A plan of diagnosis (lab testing, x-rays, etc.), therapies administered and prescribed, and management (medications dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented; Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;

q. Continuity of Care, Outcome, Follow-Up Care, Calls or Visits: Communications between the provider and the member with reference to follow-up care, test results (outcomes), etc., should be documented to indicate continuity of care; summaries of emergency services and hospital discharges with appropriate medically indicated follow-up; system in place to schedule appropriate preventive health service;

r. Medication List: Patient's current medications should be listed with start and end dates, if applicable;

s. Studies: All lab(s), studies, x-ray, EKGs, referral (s), should be included and documented within the record. The practitioner should initial study results and consultations in order to certify provider review. Abnormal test(s) results documented and discussed with the member;

t. Referral / Disposition Documentation: All specialist referrals and consultations reports are filed within the medical record. There should be documentation that the practitioner has discussed abnormal results with member, along with recommendations and instructions;

u. Hospital Care: Medical records shall contain summaries of all emergency care and hospital discharges with appropriate, medically indicated follow-up;

v. Chart Organization: The practitioner should maintain a uniform medical record system, ensure completeness of the information, accuracy, and current clinical recording and reporting with respect to services. The record should include a separate section for progress notes and the recording of results from diagnostic tests;

w. Advance Directives: Medical record has documentation of Advanced Directives and/or Living Will discussion with any patient over the age of 18; include copies of any Advance Directives executed by the member;

x. Member Non-compliance: Document missed appointments or failure to follow up on M.D. instructions in order to demonstrate non-compliance. Recommend follow up with patient via letter or phone call when appointment(s) are missed.

Medical Records Reviews

Eon Health's Quality Improvement Department reviews providers' medical records as part of Eon's re-credentialing process, "potential" quality of care issues, clinical grievance and/or appeals, claims investigations, inappropriate care / treatment and for HEDIS reporting.

The purpose of medical record reviews is to determine compliance with Eon's standards for documentation, coordination of care and outcome of services; to evaluate the quality and appropriateness of the treatment and to promote continuous improvement. These reviews are performed to evaluate compliance with requirements and do not define standards of care or replace a practitioner's judgment.

Medical record reviews will be conducted every three (3) years for re-credentialing purposes. All primary care providers and high volume specialists are subject to medical record reviews. At the conclusion of the review, the reviewer will notify the provider of any deficiencies. The provider must achieve a score of at least 80% in order to meet Eon's standards. Providers who do not meet standards have up to 30 calendar days to address the items identified and provide a written response, signed by the provider. If applicable, Eon will issue a Corrective Action Plan (CAP), or provide guidance and other tools to assist the provider in improving documentation. If a provider fails to comply with a Corrective Action Plan, the provider will be reported to the Credentialing Committee for further action.

Transfer of Medical Records

Primary care practitioners are required to transfer member medical records or copies of records within seven (7) days of request, at no charge to the member to:

- Newly designated primary care practitioners
- Newly designated Managed Care Organization
- Centers for Medicare and Medicaid Services and / or any governmental or accrediting agency.

FACILITY SITE REVIEWS

An initial site inspection is required for all provider offices participating in Eon Health with the exception of those who are accredited and/or certified.

- A site review is required as part of the initial credentialing process for new providers if that site has not been reviewed and accepted as part of our credentialing process.
- Obstetrics/Gynecology (OB-GYN) specialist sites participating in our plan and not serving as PCPs must undergo an initial site inspection.

Initial site reviews will be conducted by the Provider Relations Department. Consequently, upon re-credentialing, a member of our Quality Improvement department will call the provider's office to schedule an appointment date and time before the facility site review due date. The department will fax or mail a confirmation letter with an explanation of the audit process and required documentation.

During the facility site review, the Quality Improvement coordinator will:

1. Conduct a review of the facility and document findings according to Eon Site Audit standards;
2. Develop a corrective action plan, if applicable.

After the facility site review is completed, the QI Coordinator will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective

actions, if applicable.

2. Provide a copy of the facility site review results and the corrective action plan to the provider or office manager, or mail a final copy within 10 days of the review.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

The results of the site review and any corrective actions plans issued will be provided to the Credentialing Committee.

PROVIDER PERFORMANCE MEASURES

A. Preventable Serious Adverse Events/Hospital Acquired Conditions (HACs) and Never Events

The CMS Program established on August 2007 initiatives are to track “serious preventable events” and “hospital acquired conditions” that occur in a hospital setting.

Potential Preventable Serious Adverse Events, Hospital Acquired Conditions and Never Events are identified by several internal and external mechanisms such as, but not limited to, claims payment retrospective reviews, utilization management case review, complaint and grievance review, fraud and abuse investigations, practitioner/providers, delegates, and state and/or federal agencies.

Once a potential event has been identified, an extensive review is conducted by the Quality Improvement at Eon Health. The process includes a medical record review and possible telephonic or mail communication with the practitioner/ provider. Upon final determination of an actual event occurring, Eon Health will notify the practitioner/provider by mail that payment denial or retraction will occur. Should you have any questions, please contact Eon Health’s Provider Services Department at 1-866-788-3640.

B. Member Satisfaction Survey

The Quality Improvement department monitors providers’ compliance with Eon’s standards through periodic data collected from the CAHPS survey. The Consumer Assessment of Health Plan Survey (CAHPS) is administered to our members by CMS each year between January and April. The survey’s goal is to evaluate the experience Medicare members have had with the Eon services and our participating providers.

Quality Improvement reviews survey data to obtain a general indication of how well Eon meets member expectations and to identify areas where improvement is needed. Specific areas of focus are:

- Our members’ overall ratings of their:
 - Health Plan
 - Provider office staff performance
- Assessment of member perceptions related to:
 - Customer service

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Shared decision making
- Coordination of care
- Health promotion and education

All areas surveyed above are used to facilitate comparisons among all Medicare health plans, which are meaningful to health care consumers.

Eon Health will make the CAHPS survey results available to both members and providers. We encourage that providers review the results and share the results with office staff and incorporate appropriate changes in their offices, as applicable.

C. Provider Satisfaction Survey

A provider satisfaction survey is conducted annually by Provider Relations Department in order to obtain the providers' perspective on and satisfaction with Eon's services and program. Provider participation in the survey is highly encourage and your feedback is very important to us. Eon inform providers of the survey results and actions for improvement through provider bulletins, newsletters, website, meetings or training sessions.

D. Health Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is the set of annual performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). It is used to establish accountability with the goal of improving the quality of health care. HEDIS is one of the most widely used health care performance measures in the United States, and allows consumers to compare health plan performance to other plans and to national or regional benchmarks.

Eon will be reporting HEDIS data sets on an annual basis. HEDIS reporting includes 75 measures across the following eight domains of care:

- Effectiveness of Care
- Access / Availability of Services
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

Although many of the measures are obtained through claims/encounter data, there may be additional information that may be missing or can only be found in the member's medical record.

The QI department performs medical record abstraction to close any information gap and consequently, supplement data to improve the measurement rates.

The process of medical record data abstraction is in compliance with, and permitted by, the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, 45 CFR 164.506, and does not require consent or authorization from the member. Eon is ethically and legally bound to protect, preserve and maintain the confidentiality of any protected health information that is obtained through medical records abstraction process.

The HEDIS medical record abstraction process usually begins in March. Prior to requesting medical records, or on-site visit, your office will be contacted. Based on the number of medical records to be abstracted, the Quality staff will make the determination if an on-site visit is necessary. The QI department will send information about the visit and explain its data collection process. Chart abstractions may also involve the mailing, faxing or emailing of certain chart components for off-site review. The number of medical records to be reviewed will be based on the number of members meeting HEDIS criteria and receiving care at the provider office.

Eon requires that all providers support and cooperate with the HEDIS process. We expect that chart abstractors and reviewers to be given full access to medical records and to be allowed to copy or scan appropriate supporting documentation.

We are ready to help when providers and their office staff need training to participate in required HEDIS projects. Providers can request consultation and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for improvement of HEDIS rates

COORDINATION OF CARE

If a primary care practitioner or specialty care practitioner directs a member to an emergency room for treatment, the specialty care practitioner is required to immediately notify the hospital emergency room of the pending arrival of the patient for emergency services. The specialty care practitioner is required to notify the primary care practitioner of the emergency services within one (1) business day when the emergency room visit occurs over a weekend. Members should be directed to the closest appropriate emergency provider

Member Outreach

Member Services representatives may call members to verify or coordinate services, to facilitate referrals coming into the Utilization Management Department and to encourage member compliance with appointments. Another important component of member outreach, which is conducted by the Care Management Department, is post-discharge calls to members. These activities ensure that the member receives quality care and services and achieve positive outcomes.

Health Risk Assessment

Eon Health will conduct a comprehensive Health Risk Assessment (HRA) to all members within 90

days of members' enrollment and re-assessed no later than 365 days from the completed initial Health Risk Assessment. The assessment will identify the members' medical, physical, cognitive, psychological, functional and social service needs. The HRA is comprised of the following sections:

- Member Demographic Information – inclusive of primary language, marital status
- Caregiver Assessment
- Advanced Directives
- Nutritional Status – dietary needs/preferences, BMI, Height, Weight
- Current Medications
- Clinical History – hospitalizations, ER visits
- Physical Health
- ADL's and IADL's
- Preventive Screenings
- Mental & Behavioral Health
- Supplies & Services
- Social Services & Status
- Social Resources
- Environmental Assessment

The HRA will be performed by a license professional in accordance to State, federal and accreditation standards and will be made available to all participating providers.

Concurrent Review

Concurrent review is a targeted review that is performed during a hospital and skilled nursing facility stay. The review is performed to confirm the appropriateness of the setting in meeting the medical needs of the member and to initiate the member's discharge planning process. In general, the concurrent review process examines the length of stay and medical necessity and appropriateness of the admission and/or continued hospital stay.

The Nurse Care Managers performs the concurrent review activities. The reviews are conducted either onsite and/or telephonic. On occasions, a provider or facility will be notified of cases that do not meet coverage criteria for continuation of services. The provider or facility is responsible for providing clinical documentation to support coverage decisions.

Upon receiving the supporting documentation, Eon Health may consider such factors as the number or length of services, the location of services, and/or the member's severity of illness and intensity of service to determine whether the services meet the definition of medical necessity for coverage purposes only. If coverage criteria is NOT met, the Care Manager will provide notification to the provider, facility and in some situations, the member.

Discharge Planning

The discharge planning process is a collaborative effort between Eon Health's Concurrent Reviewers, the hospital/facility care manager, the member, and the admitting provider. The main

goal of discharge planning is to ensure the coordination and quality of medical services through the post-discharge phase of care.

Providers and facilities are required to provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. The extension must be requested prior to the expiration of the approved days.
- The member's discharge plan, which indicates that transfer to an alternative level of care, is appropriate.
- The member is in need of a complex plan of treatment, which includes home health services, home infusion therapy, total parental nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

The Nurse Care Managers can conduct onsite and/or telephonic reviews to support the discharge planning efforts in order to coordinate health services prior to the discharge.

Eon may assist, but is not required to, help identify health care community resources following an inpatient stay.

Members who are discharged from the hospital receive a written notice called "Important Message from Medicare". When discharge from a facility such as a Skilled Nursing Facility (SNF) or when home health services are to be discontinued, members receive a notice called "Notice of Medicare Non-Coverage". These notices provide information and instructions to members regarding their right to appeal the decision. All members receive these documents, not only those who may disagree with a non-coverage determination.

HEALTH SERVICES

Service Authorization Requests (Pre-Certifications)

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who may benefit from case management or disease management.

Authorization is the responsibility of the ordering or admitting provider and can be obtained by completing a [Prior Authorization Request Form](#) and sending it to Eon Health's Utilization Management Department. The Utilization Management Department assesses the medical necessity and appropriateness of services using nationally recognized criteria, such as MCG[®] Guidelines, the Centers for Medicare and Medicaid Services' (CMS) definition of medical necessity and CMS National and Local Coverage Determinations when authorizing the delivery of healthcare services to members. MCG[®] Guidelines are used in conjunction with the member's benefit plan and the provider's recommendation to approve, append and/or deny services.

Providers must submit the appropriate clinical supporting documentation for review with the authorization request or the authorization will NOT be processed. Documentation should include:

- Medical records that describes the planned treatment, including the medical rationale for the services being requested, lab reports, radiology reports, etc.
- All pertinent medical information supporting the requested treatment and/or procedure.

NOTE: Non-Participating providers must complete a Prior Authorization Request Form; sign the attestation for a one time out of network agreement and submit a W9.

Expedited Reviews:

The Utilization Management Department will process an expedited review for a member with a life-threatening condition, or for a member who is currently hospitalized and needs specialized services not covered under the hospitalization, or to authorize a treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

For expedited requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request and written notification to the member and provider will be provided.

Standard Reviews:

For standard pre-certification requests, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires. Notification will be sent to the requesting provider and member in writing on all standard authorization determinations no later than 14 calendar days from the receipt of the request.

A 14-day extension may be granted if the member requests it or if we have a need for additional information and the extension of time benefits the member (for example, if additional medical records are needed in order to change a potential denial decision).

The Utilization Management Department is committed to assuring prompt, efficient delivery of healthcare services. The Utilization Management Department can be contacted between the hours of 8 AM and 5 PM, Monday through Friday at 1-866 689-8761. When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. Urgent requests or questions are directed to call 1-866 689-8761.

Inpatient Hospital Services Authorizations

(Inpatient Pre-Certifications)

Inpatient Hospital Services Authorizations request for inpatient hospital services and/or admissions must include appropriate supporting medical documentation, such as treatment plans, test results, medical history, needed to determine medical necessity to issue the authorization. The supporting medical information will help the Utilization Management Department facilitate the authorization process.

A. Direct Hospital Admissions – the primary care provider or specialist can refer a member directly to a participating hospital of an inpatient admission. The hospital, primary care provider or specialist can obtain authorization numbers. All direct hospital admissions are subject to review and approval by the Medical Director.

B. Non-Urgent or Elective Hospital Admission – the primary care provider or specialist may request the admission. Authorization requests must be submitted to Eon Health’s Utilization Management Department at a minimum of 72 hours prior to the admission.

Inpatient hospital admissions are all reviewed for medical necessity and must be approved by the Medical Director.

Medicare Outpatient Observation Notice (MOON)

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 18669(a) (l) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and critical access hospital (CAHs) to provide written notification and oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospital or CAHS.

- The MOON is a form that must be delivered before the member receives 24 hours of observation as an outpatient.
- If the member is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of Medicare observation services is measured as the clock time observation services are initiated in accordance with a physician’s order.
- The MOON notice is required to be delivered to psychiatric hospital.

Further information about the MOON can be found in CMS site: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html>

Instructions on how to complete the MOON can be found at: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf>

Penalties for Not Obtaining Approval for Requested Services

Depending on the member’s benefit plan, payment may be delayed, reduced or in some circumstances, withheld, if approval is not obtained when required. If there are extenuating circumstances that delayed the authorization process, the provider should advise the Utilization Management Department when requesting an authorization.

Out of Network Authorization Requests

(Out of Network Pre-Certifications)

Occasionally, a member may need to see a healthcare professional outside of Eon Health’s provider network. When the need for out-of-plan services arises, the primary care practitioner

must contact Eon Health's Utilization Management Department to obtain an authorization. The Utilization Management Department will review the request and arranges for the member to receive the necessary medical services with a specialty care practitioner in collaboration with the recommendations of the primary care practitioner. Best effort will be made to locate a healthcare professional within an accessible distance to the member.

Second Opinions

A member may request second opinions from a qualified health care professional. When requesting a second opinion consultation, Eon Health recommends that the practitioner refer the member to an in-network qualified health care professional that is not in practice with the practitioner who rendered the first opinion. If an in-network, qualified health care professional is not available, contact Eon Utilization Management Department to assist in arranging and obtaining an authorization for the second opinion of an out-of-network provider at no additional cost to the member.

Emergency Care and Services (ER)

Federal and state regulations prevent us from requiring members to contact a primary care practitioner, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. Per CMS guidelines: "An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Members are instructed to call 911 and/or go to the nearest emergency room for treatment if they believe that they are having a medical emergency. Medical emergencies include and are not limited to: severe chest pain, shortness of breath, uncontrolled bleeding, broken bones, sprains, burns, poisoning, convulsions and extended fever.

All Eon Health members or responsible party is informed that they should contact their primary care practitioner prior to seeking treatment for non-life or limb threatening conditions in an emergency room. However, Eon Health realizes that there are situations when a member is under the care of a specialty care practitioner for a specific condition. In these cases, the member may contact the specialist for instructions. Eon request that a member contact their primary care physician within 48 hours of the ER visit to schedule follow-up care.

Physicians, specialist and covering physician must provide advice, consultation, and access to care appropriate for each member's medical condition.

- All life-threatening conditions must be referred to the nearest emergency room.
- All providers must notify Eon Health of known emergency room visits and emergency room admissions.

- Providers directing members to an emergency room for treatment are required to notify the emergency room of the pending member arrival.
- Specialty care providers referring members to the ER are required to notify the primary care provider of member's emergency service visit. If the emergency room visit occurs during a weekend, the specialist must provide notification within one (1) business day of referral.

Emergency services are NOT REQUIRED to have prior authorization and CANNOT be denied retrospectively for eligible members.

Service Denials

Eon may deny a pre-certification request for several reasons:

- Member is not eligible;
- Service is not a covered benefit;
- Member has exhausted his or her benefits;
- Services is not deemed medically necessary (based on utilization guidelines).

Eon Health will notify you in writing of any adverse decision (partial or complete) within standard referral time frames. The notice will state the reasons for the decision and also inform of the right to file an appeal. If the notice is not received within 14 calendar days of your request for services, you may assume the decision is a denial, and an appeal may be filed.

Self-Referrals

All Eon Health members are encouraged to coordinate care with their primary care practitioner prior to receiving specialty services except for the services that can be accessed by self-referral. Members may refer themselves for the following PREVENTIVE types of care.

The following Preventive Care Guidelines have been adopted by Eon Health and are the recommendations by the U.S. Preventive Services Task Force.

HEALTH SERVICES

Adults 25-64 Years	
Screenings	Frequency
General Physical Exam	Annual *
Height / Weight	Periodically *
BMI	Routinely
Blood Pressure	Routinely
Total blood cholesterol (TC and HDL-C)	Routinely for men and women 20 years and older
Colorectal Cancer Screening	
Fecal Occult Blood Test (FOBT)	
Annually beginning at age 50	

Colorectal Cancer Screening	
Colonoscopy	
Every 10 years beginning at age 50	
Colorectal Cancer Screening	
Sigmoidoscopy	
Every 5 years beginning at age 50	
HIV Screening	Routinely, for all adults at risk of HIV infection
Syphilis screening	Periodically, for all persons at increased risk
Hepatitis B and C	Routinely for all adults at increased risk
Lung Cancer Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
Tuberculosis Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
Vision Screening	Annually or more often for Diabetic members
Glucose Test	Annually for those members at increased risk
Hearing Assessment	Annually
Oral Exams/Cleaning	Bi-annually
Female Screenings	Frequency
Clinical Breast Exam (Ages 20 to 40 yrs.)	Every 3 years
Clinical Breast Exam (Age 40 >)	Annually
Mammogram	1-2 years for women age 40 and older
Papanicolaou (Pap)	Every 1 to 3 years for sexually active female beginning at age 18. Annual Pap if Cancer or if cervix remaining and post hysterectomy
Chlamydia Screening	Routinely – For all sexually active females
Gonorrhea Screening	Routinely – For all sexually active females including those that are pregnant
Male Screenings	Frequency
Testicular Screening	Annually for <ul style="list-style-type: none"> • Men 40 yrs. of age and older of African-American descent • Men 40 yrs. of age and older with an affected first-degree relative • Men 50 yrs. of age or older
Immunizations	Frequency
Rubella serology or vaccination history	Recommended once for all females of childbearing age
Tetanus-diphtheria (Td)	Boosters every 10 yrs. or as recommended

Influenza	Annual, at risk
Hepatitis B	Ask physician
Other Preventions	
Aspirin Therapy	Men 40 years and older Postmenopausal women Young people with risk factors for CHD
Multivitamins with folic acid	Females planning/ capable of pregnancy
Asymptomatic bacteriuria	Routine, urine culture at 12-16 weeks of gestation for all pregnant women
Depression Screening	Routinely
Chemoprevention of Breast Cancer	Females at high risk for breast CA and at low risk for adverse effects of chemoprevention. Inform patients of the potential benefits and harms of chemoprevention
Symptoms of Endometrial Cancer	Presence of unexpected bleeding or spotting
Physician Discussion Topics/Health Risk Factors	
Diet and Exercise	Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
	Regular physical activity
	Adequate Calcium intake
Substance Use	Avoid underage drinking / illicit drug use
	Avoid tobacco use
	Discuss harmful effects of smoking / alcohol / drug use on fetal and child health
Sexual Behavior	Sexually Transmitted Disease (STD) Screening
	Prevention of unintended pregnancy / abstinence
	Avoiding high-risk behavior
	Unintended pregnancy
Injury Prevention	Bicycle / motorcycle / ATV / Helmet -safety
	Lap and shoulder seat belts
	Smoke detectors
	Firearm safety
	CPR training for parents/caregivers
	Occupational Hazards
Domestic Violence/Abuse	Routinely
Dental Health	Regular dental visits
	Floss, brush and flouride
Adults 65 Years and Older	
Screenings	Frequency
General Physical Exam	Annual *
Height / Weight	Periodically *
BMI	Routinely

Blood Pressure	Routinely
Total blood cholesterol (TC and HDL-C)	Routinely for men and women 20 years and older
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT)	Annually beginning at age 50
Colorectal Cancer Screening Colonoscopy	Every 10 years beginning at age 50
Colorectal Cancer Screening Sigmoidoscopy	Every 5 years beginning at age 50
Cologuard Test	Annually beginning at age 50
Hepatitis B	Screening for Hepatitis B in persons at high risk for infection
Hepatitis C Screening	Screening for Hepatitis C infection in persons at high risk for infection. USPSTF recommends one-time screening to adults born between 1945 and 1965.
Lung Cancer Screening	Annual screening with low dose computed tomography in adults' ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
HIV Screening	Routinely, for all adults at risk of HIV infection
Syphilis screening	Periodically, for all persons at increased risk
Diabetes Monitoring / Management	Glucose monitoring and self-management training, periodically
Bone Mass	At risk, periodically
Vision Screening	Annually (more often for Diabetics)
Glucose Test	Annually for at risk
Hearing Assessment	Annually
Oral Exams/Cleaning	Bi-Annually
Female Screenings	Frequency
Mammogram	1-2 years for women age 40 and older
Papanicolaou (Pap)	Not recommended, if recent screening have yielded normal Pap results, total hysterectomy or 3 or more normal cytology results within 10 years
Gonorrhea	Routinely, for all sexually active women, including those that are pregnant
Osteoporosis Screening	Routinely
Male Screenings	Frequency
Prostate Test	Annual PSA for males after age 50
Testicular Exam	Annually
AAA (Abdominal Aortic Aneurysm Screening)	One time screening by ultrasonography in men aged 65 to 75 who have ever smoked
Immunizations	Frequency
Tetanus-diphtheria (Td)	Boosters every 10 years or as recommended
Influenza	Annually

Pneumococcal	Once by age 65
Hepatitis B	Ask physician
Other Preventions	
Aspirin Therapy	Men 40 yrs. and older.
	Postmenopausal women
	Young people at risk factors for CHD
Diabetic Preventive Screening Retinal eye Exam	Annually
Diabetic Preventive Screening Foot Exam	Annual – 4 times a year; comprehensive and educational
Diabetic Hgb A1C Screening	Annually ; every 6 months for insulin dependent patients
Depression Screening	Routinely
Osteoporosis Screening	Routinely, recommended for women age 65 and older; screening to begin at age 60 if woman is at increased risk for fractures
Chronic Illness Care	Periodically
Physician Discussion Topics/Health Risk Factors	
Diet and Exercise	Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
	Regular physical activity
	Adequate Calcium intake
Substance Use	Avoid underage drinking / illicit drug use
	Avoid tobacco use
	Discuss harmful effects of smoking / alcohol / drug use on fetal and child health
Sexual Behavior	Sexually Transmitted Disease (STD) Screening
	Prevention of unintended pregnancy / abstinence
	Avoiding high-risk behavior
	Unintended pregnancy
Injury Prevention	Bicycle / motorcycle / ATV / Helmet -safety
	Lap and shoulder seat belts
	Smoke detectors
	Firearm safety
	CPR training for parents/caregivers
	Occupational Hazards
Domestic Violence / Abuse	Routinely
Dental Health	Regular dental visits
	Floss, brush and fluoride

- Frequency of the preventive screenings should be discussed with the physician

MEDICARE DIABETES PREVENTION PROGRAM (MDPP)

The MDPP is an expansion of CMS's Diabetes Prevention Program under the authority of Section 11154(b) of the Social Security Act.

The MDPP aims to prevent the onset of type 2 diabetes among eligible Medicare members with an indication of pre-diabetes. The goal of the intervention is lowering the progression to type two (2) diabetes, measured using a proxy of at least 5% average weight loss. The program includes 16 core group-based, classroom-style sessions over a period of 6 months, which provide training in dietary changes, physical activity and weight control. After the core sessions, monthly follow up meetings are available to members in order to maintain healthy behavior.

The Program begins April 1, 2018, and there's no cost for eligible members. Eligible members may participate in the core sessions as a one-time benefit. If the members do not meet the program goals, they are not eligible to take part in the follow-up meetings and can't start over, even if they change insurance carriers.

Providers wanting to offer the MDPP services must be reviewed and certified by the Centers of Medicare & Medicaid Services (CMS). This network of providers is still being developed and some areas may not have a Certified provider.

For more information, visit CMS's Medicare Diabetes Prevention Program (MDPP) Expanded Model page. Looking for a MDPP Supplier? Access the MDPP Supplier Map or view a list of Current MDPP Suppliers. Have additional Questions about the program? Access the CMS Frequently Asked Questions page.

NEW TECHNOLOGY

Any new technology identified during the Utilization Management review process, and requiring authorization for implementation of the new technology will be forwarded to the Medical Director for authorization. If there is a question about the appropriate governmental agency approval of the technology, the Medical Director will investigate the status of the technology with the agency, consult appropriate specialists related to the new technology, and/or utilize a nationally recognized contracted services for information related to the new technology. The technology will also be investigated through CMS National and Local Coverage Determinations. If the technology has not been reviewed by appropriate governmental regulatory bodies, the Medical Director will discuss the need for the specifically requested technology with the primary care practitioner and may consult with a participating specialist from the Eon Health expert panel regarding the use of the new technology. The new technology review will be presented to the Eon Health QI Committee. If it is determined that no other approved technology is available and/or the Medical Director and consultants feel that the possibility for a positive outcome would be achieved with the use of the new technology, approval may be given. Eon will consider those specific medical items, services, treatment procedures or technologies not specifically identified as non-covered or non-reimbursable by Medicare as defined within National Coverage Determinations.

POLICIES AND PROCEDURES

Eon Health has developed policies and procedures to provide guidelines for identifying and resolving issues with practitioners who fail to comply with the terms and conditions of the

applicable Practitioner Agreement and Eon Health policies and procedures.

Policy Changes

In order for Eon Health to be in compliance with Federal and State Laws, Regulations and Regulatory Bulletins governing the Medicare and Medicaid Program in the course of providing services, Providers and their staff will be bound by all applicable federal and state Medicare and Medicaid laws and regulations. Providers will comply with all applicable instructions, bulletins and fee schedules promulgated under such laws and all applicable program requirements of regulatory agencies regarding the Medicare and Medicaid programs.

Additionally, providers need to be aware that no regulatory order or requirement of the Centers for Medicaid and Medicare, Departments of Insurance or any other state or federal agencies shall be subject to arbitration with Eon Health.

Practitioner Education and Sanctioning

Eon Health practitioners will be monitored for compliance with administrative procedures, trends of inappropriate resource utilization, potential quality of care concerns and compliance with medical record review standards. Practitioner education is provided through Quality Improvement Nurses, Provider Relations Representatives and Eon Health Medical Directors. Network practitioners who do not improve through the provider education process will be referred to the Eon Health Quality Improvement/Utilization Management Committee for evaluation and recommendations.

CMS GUIDANCE ON MEDICARE MARKETING ACTIVITIES

Below is the CMS guidance on provider marketing activities as detailed in the Medicare Marketing Guidelines Provider-Based Activities.

Although providers may not be fully aware of all plan benefits and costs and may face conflicting incentives when acting as a Plan/Part D Sponsor representative, Plans/Part D Sponsors may not prohibit contracted providers from engaging in discussions with beneficiaries should a beneficiary seek advice. To ensure that providers do not appear to be a Plan/Part D Sponsor agent, Plans/Part D Sponsors must ensure through their agreements with providers, that contracted providers are advised of the need to remain neutral when assisting with enrollment decisions. Plans/Part D Sponsors should ensure that a provider assists a beneficiary in an objective assessment of his/her needs and potential options to meet those needs. Plans/Part D Sponsors should ensure that any assistance provided to a beneficiary by a contractual, co-branded, or otherwise affiliated provider, results in a plan selection that is always in the best interest of the beneficiary.

Plans/Part D Sponsors may not allow contracted providers to:

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Plans/Part D Sponsors

- Offer anything of value to induce enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Plans/Part D Sponsors may allow contracted providers to:

- o Provide the names of Plans/Part D Sponsors with which they contract and/or participate
- o Provide information and assistance in applying for the LIS
- o Make available and/or distribute plan marketing materials in common areas
- o Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at <http://www.medicare.gov/> or 1-800-MEDICARE
- o Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from <http://www.medicare.gov/>), or other documents that were written by or previously approved by CMS

CLAIMS AND BILLING

Claims General Information

Procedures for Eon are as follows:

- Payment for CPT and HCPCS codes are covered to the extent that they are HIPAA compliant. Eon Health utilizes CMS place of service codes to process claims, and they are the only place of service codes that are accepted.
- Hospitals should bill on an original UB-04 Form, and other providers, including ancillary providers should bill using an original CMS-1500 (08-05) Form.
- Eon Health does accept bills through electronic data interchange (EDI) and encourages facilities and providers to submit claims via this format.
- Paper and EDI claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form. Paper claims will be handled just like rejected EDI claims and will not be loaded in Eon Health's claims system. Providers will be held to Eon Health's timely filing policies in regards to submission of the initial and corrected claims.
- Correct/current member information, including Eon Health Member ID Number, must be entered on all claims. The format is 8 or 12 digits for the Eon member number. Eon Health member number or HIC number in alpha and numeric format will be accepted on Electronic claims. Eon Health prefers that the Eon Health ID number be submitted to assure that the claim is processed under the correct individual.

- Please allow four to six weeks for a remittance advice. It is the practitioner's responsibility to research the status of a claim.
- Eon Health encourages providers to submit initial bills within 180 days from the date of service, however any initial claim not submitted within 180 days must be submitted within 365 days from the date of service. Initial bills submitted after 365 days will be denied as untimely.
- Corrected claims or requests for review are considered if information is received within the 180-day follow-up period from the date on the remittance advice.
- Eon Health is secondary to any commercial plan. Claims must be submitted within Eon Health's timely filing guidelines.
- Inpatient hospital claims must be submitted with an MS-DRG Code.
- Providers of obstetric services are reimbursed on a global basis for deliveries. Individual visits are not reimbursed and should not be billed.

Timely Filing

Providers are encouraged to submit a complete original, initial CMS-1500 (08-05) or UB-04 Form within 180 calendar days after the date of service. If you bill on paper Eon will only accept paper claims on a CMS-1500 (08-05), or a UB-04 Form. No other billing forms will be accepted.

Providers must bill within 180 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Eon is secondary. An original bill along with a copy of the EOB is required to process the claim. Requests for reviews/corrections of processed claims must be submitted within 180 calendar days from the date of the corresponding remittance advice. All claims submitted after the 180-day period following receipt of the EOB or after the 180-day follow-up period from the date on the remittance will be denied.

Any claim that has been submitted to Eon but does not appear on a remittance advice within 60 days following submission should be researched by calling Eon's Provider Services Department to inquire whether the claim was received and/or processed.

Electronic Claims Submission

Eon can accept claims electronically through Emdeon. Eon encourages practitioners to take advantage of our electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy
- Time and Cost Savings

For submission of professional or institutional electronic claims for Eon Health, the Eon Health Payer ID is 73780.

Requirements for Submitting Claims to Eon through Emdeon

To submit claims to Eon Health please note the Eon Health Payer ID Number is 73780. Eon has a

health plan specific edit through Emdeon and for electronic claims that differ from the standard electronic submission format criteria. The edit requires:

An Eon Health assigned 10-digit member identification number, the member number field allows 6, 8, or 12 digits to be entered. For providers who do not know the member's Eon Health identification number it is acceptable to submit the member's HIC Number on electronic claims.

In addition to edits that may be received from Emdeon, Eon has a second level of edits that apply to procedure codes and diagnosis codes. Claims can be successfully transmitted to Emdeon, however, if the codes are not currently valid they will be rejected by EON. Providers must be diligent in reviewing all acceptance/rejection reports to identify claims that may not have successfully been accepted by Emdeon and Eon Health Plan. Edits applied when claims are received by Eon will appear on an EDI Report within the initial acceptance report or Claims Acknowledgment Report. A claim can be rejected if it does not include required NPI(s) and current procedure and diagnosis codes. To ensure that claims have been accepted via EDI, providers should receive and review the following reports on a daily basis:

- Emdeon -- Provider Daily Statistics (RO22)
- Emdeon -- Daily Acceptance Report by Provider (RO26)
- Emdeon -- Unprocessed Claim Report (RO59)

If you are not submitting claims electronically, please contact your EDI vendor for information on how you can submit claims electronically. You may also call Emdeon directly at 1-877-469-3263

Eon will accept electronic claims for services that would be submitted on a standard CMS-1500 (08-05) or a UB-04 Form. However, the following cannot be submitted as attachments along with electronic claims at this time:

- Claims with EOBs
- Services billed by report

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required in order to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Only version 5010 transactions will be accepted for dates of service on or after 1/1/2017. Effective January 1, 2017, the billing provider address submitted on claims must be a physical address. Claims submitted via Emdeon or will be rejected if a P.O. Box number is submitted as the billing address. In order to prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Electronic Remittance Advice/Electronic Funds Transfer

Providers may receive electronic claims remittance advice (ERA). Eon uses Emdeon to transfer the 835 Version 4010A Healthcare Claim Remittance Advice to claim submitters.

The Companion Documents, which are located in the Forms and Reference Materials Section of this Manual, provide information about the 835 Claim Remittance Advice Transaction that is specific to Eon and Eon's trading partners. Companion Documents are intended to supplement the HIPAA Implementation Guides. Rules for format, content, and field values can be found in

the Implementation Guides available on the Washington Publishing Company's website at: www.wpcedi.com

Due to the evolving nature of HIPAA regulations, these documents are subject to change. Substantial effort has been taken to minimize conflicts and errors.

There is a distinct data variation between the current Eon Claims Remittance Advice and the 835 Transaction. The difference occurs in the code sets that tell claim submitters the results of each claim's adjudication. Few Eon and HIPAA Adjustment Reason Codes have solid, unambiguous matches at the same level of detail. A crosswalk has been created in attempt to ease the code set transition and can be located on Eon's website at www.eonhealthplan.com and going to "Providers" and then "[Electronic Billing Companion Document](#)" in the "Forms and Reference Materials" section. These documents can also be found in the Forms and Reference Materials Section of this Manual.

Providers may receive claims payments via electronic funds transfer (EFT). Providers must first be set-up to receive ERA and complete the EFT Authorization Agreement Form located in the Forms and Reference Materials Section of this Manual.

Claims Review Process

Eon will review any claim that a provider feels was denied or paid incorrectly. The request may be conveyed in writing (per instructions below), or verbally through Eon's Provider Services Department if the inquiry relates to an administrative issue. Please forward hard copy information via mail to the Claims Review Department along with all of the appropriate documentation, i.e. the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All follow-up review requests must be received within 180 calendar days of the initial remittance advice.

Eon cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form located in the Forms and Reference Materials Section of this manual.

The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

Eon Health
Claims Review Department
3620 Enterprise Way
Miramar, FL 33025

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Eon Health Plan. For inquiries requiring documentation or received in the mail, Claims Review Representatives evaluate whether the documentation attached to the claim is sufficient to allow it to be reconsidered. Claims that

qualify for adjustments will be reprocessed, and claim information will appear on subsequent remittance advices. Claims that do not qualify for reconsideration will be forwarded to the Appeals Department for review. All review requests must be received within 180 days of the initial remittance advice.

Please refer to the Appeals and Grievances Section of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to:

Eon Health
Attention: Claims Review
3620 Enterprise Way
Miramar, FL 33025

Coordination of Benefits

Some Eon Health members have other insurance coverage. Eon follows Medicare coordination of benefits rules. Eon does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third party liability is identified in Eon's records for the member at the time the claims are submitted.

Please note the following criteria applies and designates when Eon is not the primary plan for Medicare covered members:

- Enrollee is 65+ years, and covered by an Employer Group Health Plan (EGHP) because of either current employment or current employment of a spouse of any age and the employer employs 20 or more employees.
- Enrollee is disabled and covered by an Employer Group Health Plan because of either current employment or a family member's current employment, and the employer that sponsors or contributes to the Large EGHP plan employs 100 or more employees.
- For an enrollee entitled to Medicare solely on the basis of end-stage renal disease and Employer Group Health Plan coverage (including a retirement plan), the first 30 months of eligibility or entitlement to Medicare.
- Workers' compensation settlement proceeds are available.
- No-fault or liability settlement proceeds are available.

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits, the practitioner should submit a claim to Eon Health Plan. The practitioner must:

1. Follow all Eon authorization and billing procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.

3. Submit a copy of the primary carrier's EOB with the claim to Eon within 180 days of the date of the primary carrier's EOB.
4. The amount billed to Eon must match the amount billed to the primary carrier. Eon will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Members seeking care, regardless of primary insurer, are required to contact their primary care practitioner and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

BILLING

Billing Procedures

A "clean claim" as used in this section 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 requirement for equivalent claims under Medicare.

In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with Eon's Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS-1500 (08-05) Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through a EON-contracted clearinghouse:

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-10 surgical diagnosis code(s) (as applicable);
6. Name of practitioners/providers and applicable/required NPI numbers;
7. Provider tax identification number;
8. Valid CMS place of service code(s);
9. Billed charge amount for each covered service;
10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD-10-CM diagnosis code;
12. MS-DRG code for inpatient hospital claims.

Eon processes medical expenses upon receipt of a correctly completed CMS-1500 (08-05) Form

and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS-1500 (08-05) Form can be found in the Forms and Reference Material Section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

Eon requires all providers to submit claims according to the updated National Provider Identification (NPI) submission procedures. These changes went into effect January 1, 2013 as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010. The Final Rule, published in the April 27, 2012 Federal Register, is applicable to all claims submitted to Eon Health. Below please find a few highlights of the ACA requirements and Eon policies and procedures to support these requirements.

- NPIs for billing providers are required to be reported on paper claims in addition to electronic claims
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper claims and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in Eon's claims system. Providers will be held to Eon's timely filing policies in regards to submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

- **CMS-1500** The following fields are to be reported as indicated:

Field 17b – NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health)

Field 24J (b) – NPI of Rendering Provider (if applicable) Field 32a – NPI of Service Facility (if applicable)

Field 33a – NPI of Billing Provider (required)

- **UB-04** The following fields are to be reported as indicated:

Field 56 – NPI of Billing Provider (required)

Field 76 – NPI of Attending Physician (required) Field 77 – NPI of Operating Physician

(if applicable) Field 78 & 79 – NPI of Other Physician (if applicable)

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires but does not include the fourth or fifth digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient

and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained in the claim is true, accurate and complete.

Eon's claim office address is:

Eon Health
Attn: Claims Department
P.O. Box 21517
Eagan, MN 55121

Any questions concerning billing procedures or claim payments can be directed to Eon's Provider Services Department at **1-866-788-3640**.

Surgical Procedure Services

Eon determines reimbursement of surgical procedures upon the clinical intensity of each procedure and reimburses at 100% for the most clinically intensive surgery, and 50% for the subsequent procedures. Reimbursement for more than 5 procedures requires medical record documentation. Pre- and post- operative visits will only be reimbursed to the extent that they qualify for payment according to the follow-up criteria.

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Hospital Services

Hospital claims are submitted to Eon on a UB-04. To assure that claims are processed for the correct member, the member's 8-digit Eon identification number must be used on all claims. To aid in the recording of payment, patient account numbers recorded on the claim form by the practitioner are indicated in the Patient ID field on the Eon remittance advice. Please review field numbers below carefully as many of them differ from the former UB-92 format.

UB-04 Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field	Description	Requirements
1	Provider Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required
2	Pay to Name, Address, City, State, Zip	Required If Different from Billing Provider in Field 1
3a	Patient Control Number	Required
3b	Medical Record Number	Not Required
4	Type of Bill	Required – If 4 Digits Submitted, the Lead 0 will be Ignored
5	Federal Tax Number	Required
6	Statement Covers Period	Required
7	Unlabeled Field	Not Used
8a	Patient Name	Required
9	Patient Address	Required
10	Birthdate	Required
11	Patient Sex	Required
12	Admission Date	Required for Inpatient and Home Health
13	Admission Hour	Not Required
14	Type of Admission/Visit	Required, If Inpatient
15	Source of Admission	Required
16	Discharge Hour	Not Required
17	Patient Status	Required
18-28	Condition Codes	May be Required in Specific Circumstances (Consult CMS Criteria)
29	Accident State	Not Used
30	Unlabeled Field	Not Used
31-34	Occurrence Codes and Dates	May be Required in Specific Circumstances (Consult CMS Criteria)
35-36	Occurrence Span Codes and Dates	Required, If Inpatient
37	Unlabeled Field	Not Used
38	Responsible Party Name and Address	Not Required

Field	Description	Requirements
39-41	Value Codes and Amounts	Required, If Inpatient
42	Revenue Codes	Required
43	Revenue Descriptions	Required
44	HCPCS/Rates/HIPPS Codes	Required, If Outpatient
45	Service Dates	Required, If Outpatient
46	Service Units	Required
47	Total Charges	Required
48	Non-covered Charges	Required, If Applicable
49	Unlabeled Field	Not Used
50	Payer Identification	Required
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Required
53	Assignment of Benefits	Not Used
54	Prior Payments	Required, If Applicable
55	Estimated Amount Due from Patient	Not Required
56	National Provider ID	Required – NPI Number
57	Other Provider ID	Eon Health® Practitioner Identification Number should be entered on paper claims only- legacy number reported as secondary identifier to NPI on electronic claims
58	Insured's Name	Required, If Applicable
59	Patient Relationship to Insured	Required, If Applicable
60	Certificate-Social Security Number-Health Insurance Claim-Identification Number	Eon Member Identification Number Required
61	Insurance Group Name	Required, If Applicable
62	Insurance Group Number	Required, If Applicable
63	Treatment Authorization Code	Required, If Applicable
64	Document Control Number	Not Required
65	Employer Name	Required, If Applicable
66	Diagnosis and Procedure Code Qualifier	Required
67	Principal Diagnosis Code	Required (Coding for Present on Admission data required)
67A-67Q	Other Diagnosis Codes	Required (Coding for Present on Admission data required)
68	Unlabeled Field	Not Used
69	Admitting Diagnosis Code	Required
70A-70C	Patient Reason for Visit	Not Required

71	Prospective Payment System (PPS) Code	Required for DRG Code – If 4 Digits Submitted, the Lead 0 will be Ignored
72	External Cause of Injury Codes	Not Used
73	Unlabeled Field	Not Used
74	Principal Procedure Code and Date	Required, If Applicable
74A-74E	Other Procedure Codes and Date	Required, If Applicable
75	Unlabeled Field	Not Used
76	Attending Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
77	Operating Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
78-79	Other Provider Name and Identifiers (Including NPI)	May be Required in Specific Circumstances (Consult CMS Criteria) If Not Required, Do Not Send
80	Remarks	May be Required in Specific Circumstances (Consult CMS Criteria)
81	Code – Code Field	Optional (Consult CMS Criteria)

CMS-1500 (08-05) Data Elements for Submission of Paper Claim Forms

EDI requirements must be followed for Electronic claims submissions

Field #	Description	Requirements
1	Insurance Type	Required
1a	Insured Identification Number	Eon Health® Member Identification Number
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient Relationship to Insured	Required
7	Insured's Address	Required
8	Patient Status	Required
9	Other Insured's Name	Required, If Applicable
9a	Other Insured's Policy or Group Number	Required, If Applicable
9b	Other Insured's Date of Birth, Sex	Required, If Applicable

Field	Description	Requirements
9c	Employer's Name or School Name	Required, If Applicable
9d	Insurance Plan Name or Program Name	Required, If Applicable
10	Is Patient Condition Related to: a. Employment b. Auto accident c. Other accident	Required, If Applicable
10d	Reserved for Local Use	Not Required
11	Insured's Policy Group or FECA Number	Required
11a	Insured's Date of Birth, Sex	Required, If Applicable
11b	Employer's Name or School Name	Required, If Applicable
11c	Insurance Plan Name or Program Name	Required, If Applicable
11d	Is There Another Health Benefit Plan?	Required, If Applicable
12	Patient or Authorized Person's Signature	Required
13	Insured's or Authorized Person's Signature	Required
14	Date of Current: Illness OR Injury OR Pregnancy	Required, If Applicable
15	If Patient has had Same or Similar Illness, Give First Date	Not Required
16	Dates Patient Unable to Work in Current Occupation	Required, If Applicable
17	Name of Referring Practitioner or Other Source	Required, If Applicable
17a, b	Identification Number of Referring Practitioner	
18	Hospitalization Dates Related to Current Services	Required, If Applicable
19	Reserved for Local Use	May be Required in Specific Circumstances (Consult CMS Criteria)
20	Outside Lab	Not Required
21	Diagnosis or Nature of Illness or Injury	Required
22	Medical Resubmission Code	Not Required
23	Prior Authorization Number	Not Required
24a	Date(s) of Service	Required
24b	Place of Service	Required
24c	Type of Service	Not Required
24d	Procedures, Services, or Supplies CPT/HCPCS/Modifier	Required
24e	Diagnosis Code Pointer	Required
24f	Charges	Required
24g	Days or Units	Required

24h	EPSDT Family Plan	Not Required
24i	ID Qualifier	Required, if applicable
24j	Rendering Provider ID	Not Required
25	Federal Tax Identification Number	Required
26	Patient Account Number	Not Required
27	Accept Assignment	Not Required
28	Total Charge	Required
29	Amount Paid	Not Required
30	Balance Due	Not Required
31	Signature of Practitioner or Supplier including degrees or credentials	Eon Individual Practitioner Name and Date Required
32	Service Facility Location Information	Facility Name and Address where Services were Rendered Required
33	Billing Provider Info and Phone #	Eon Vendor (Payee) Name, Address, and Phone Number Required. NPI and Eon Legacy Number should be Entered.

APPEALS AND GRIEVANCES

Introduction

Eon Health members have the right to communicate dissatisfaction with the quality of care that they receive, the timeliness of services, or decisions made by Eon or its providers. CMS separates these into two categories: grievances and appeals.

A “grievance” is any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Eon Health or one of our plan providers provides health care services, regardless of whether any remedial action can be taken.

A complaint is any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the member believes he or she is entitled.

A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care. Examples of grievances include:

- Any matter pertaining to the contractual relationship between the member and the Plan;
- Availability, coverage, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to our utilization review programs;
- Complaints regarding claims payment, handling, or reimbursement for health care services;
- Complaints regarding member issues, member behavior, adequacy of facilities, providers, or other similar issues.

- If the member disagrees with our decision to process your appeal request for a service or to continue a service under the standard 30 calendar day time frame rather than the expedited 72-hour time frame.

If you have a question about what type of complaint process to use, please call Eon Member Services Department at 1-888-906-3889.

Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complaint, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

How to File a Grievance

Generally, grievances should be filed directly with Eon Health Plan, but for matters related to quality of care, members also have the opportunity to file such complaints with a Quality Improvement Organization (QIO). The QIO in Georgia and South Carolina is KEPRO.

Members are encouraged to contact Eon Health Member Services first in order to be provided with immediate assistance. Our staff will try to resolve any complaint over the telephone. If a written response is required or requested, one will be provided. Eon employs a formal, multi-disciplinary process to review member grievances.

Members may file a grievance by:

- Calling our Member Services Department at 1-888-906-3889 (TTY: 711)
- Mail - **Eon Health
Attention: Appeals & Grievances Dept.
3620 Enterprise way
Miramar FL 33025**
- Fax: 1-866-235-5181
- To mail or fax a grievance, an Eon Grievance Form may be used which can be found at <https://www.eonhealthplan.com/appeals-n-grievances>.

Who May File a Grievance

A member or the member's authorized representative may file a grievance.

Providers may file a grievance on behalf of the member, if they have been designated as the member's authorized representative and can supply the member's written consent to this designation.

When to File a Grievance

Grievances must be filed within 60 calendar days of the date of the incident.

Timeframes for Resolution

Grievances must be resolved as expeditiously as the member's case requires, based on the member's health status, but no later than 30 calendar days after the date the Plan receives the oral or written grievance. We may extend this time frame by up to 14 calendar days if you request the extension or if we need additional information and the extension of time benefits you (for example, if we need additional medical records that could change a denial decision). We must make a decision no later than the end of any extension period. If we extend the time frame, we will notify you.

Expedited Grievances

A member or the member's authorized representative may file expedited grievances in the following circumstances:

- When we have extended the timeframe to make an Organization Determination.
- When we have extended the timeframe to resolve a standard request for Reconsideration.
- When we have refused to grant a Member's request for an expedited Organization Determination.
- When Eon has refused to grant a Member's request for an expedited Reconsideration (Appeal).

Expedited grievances must be resolved within twenty-four (24) hours of receiving the request. All affected parties will be notified of the decision by telephone within twenty-four (24) hours of filing the Expedited Grievance, and a letter explaining the decision will follow within three (3) days.

Quality Improvement Organization Review (QIO)

Complaints concerning the quality of care received under Medicare may be investigated and acted upon by Eon Health under the internal grievance process or by an independent organization called the Quality Improvement Organization (QIO) or by both. For example, if member believes that his or her pharmacist provided the incorrect dosage of a prescription or was prescribed a medication in error, the enrollee may file a complaint with the QIO in addition to or instead of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, Eon must cooperate with the QIO in resolving the complaint.

How to File a Quality of Care Complaint with the QIO

QIOs are assigned regionally by CMS. For members who reside in the below states, quality of care complaints filed with the QIO must be made in writing to the following addresses:

For Georgia and South Carolina:

KEPRO QIO

5201 W. Kennedy Blvd, Suite 900

Tampa, FL 33609

Local: 813-280-8256

Toll Free: 1-844-455-8708

Fax: 1-844-834-7129

TTY: 1-855-843-4776

Appeals

A reconsideration consists of a review of an adverse organization determination or termination of services decision, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by Eon Health, the QIO, or the independent review entity.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than Eon Health) determined to have an appealable interest in the proceeding.

A non-contract provider, on his or her behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the member regardless of the outcome of the appeal.

A contracted provider, on his or her behalf, is permitted to file a standard appeal for a denied claim only if the contracted provider is appointed as an authorized representative by the member.

Who May Request a Reconsideration?

Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or physician.

For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form as long as proof of previous encounters with the member is provided.

You may contact Eon Health for additional information as to when standard pre-service reconsiderations can be filed without a completed representative form.

How to Request a Standard Reconsideration

Standard reconsideration requests must be submitted to Eon Health in writing by:

- Mail -
Eon Health
Attention: Appeals & Grievances Dept.
3620 Enterprise way
Miramar FL 33025
- Fax: 1-866-235-5181

An Eon Appeal Form may be used which can be found at

<https://www.eonhealthplan.com/appeals-n-grievances>

How to Request an Expedited Reconsideration

An enrollee or any physician (regardless of whether the physician is affiliated with Eon Health) may request that Eon Health expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, including cases in which Eon Health makes a less than fully favorable decision to the enrollee. Due to the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

To request an expedited reconsideration, a member or a physician must submit a verbal or written request directly to Eon Health. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.

Reconsideration Filing Timeframes

Parties have 60 calendar days from the date of the notice of the organization determination or claim denial to file the request for reconsideration.

If a request for reconsideration is filed beyond the 60 calendar day timeframe and good cause for late filing is not provided, Eon Health will forward the request to the independent review entity for dismissal.

Good Cause for Late Filing Exception

If a request for reconsideration is filed beyond the 60 calendar day timeframe and good cause for late filing is provided Eon Health will extend the time frame for filing the request for reconsideration. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;
- The enrollee was seriously ill, which prevented a timely appeal;
- There was death or serious illness in the enrollee's immediate family;
- An accident cause important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

The party requesting the good-cause extension may file the request with Eon Health in writing, including the reason why the request was not filed timely. If Eon Health denies an enrollee's request for good cause extension, the enrollee may file a grievance with Eon Health.

Reconsideration Decision Timeframes

Eon Health will issue a decision to the member or the member's representative within the following timeframes from the date the Plan receives the request:

- Standard Pre-Service Request: 30 calendar days
 - Timeframe will be extended by up to 14 calendar days if the enrollee requests an extension or if Eon Health justifies a need for additional information. In the event Eon Health extends the timeframe it will notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with Eon Health's decision to grant itself an extension.
- Retrospective Request: 60 calendar days
- Expedited Request: 72 hours

Regarding Hospital Discharge

There is a special type of appeal that applies only to hospital discharges. If a member feels that the Eon coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). Quality Improvement Organizations are assigned regionally by the Centers for Medicare and Medicaid Services (CMS).

The QIO for the state of Georgia and South Carolina is KePro. The QIOs are groups of health professionals that are paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his or her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. "The Important Message from Medicare" document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

In order to request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than noon the day of discharge. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all of the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, we will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his or her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask Eon for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member's favor, we will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) Services

There is another special type of appeal that applies only when coverage will end for SNF, HHA or CORF services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

If Eon Health and/or the care provider decides to end coverage for SNF, HHA or CORF a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two (2) calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider's records.

Quality Improvement Organization (QIO) Review

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. The member or his or her authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency. If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received. If the notice is received more than two (2) days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, the QIO will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that Eon provides to the QIO. It is very important that the provider immediately faxes all of the member's medical records to the QIO for their review. Eon will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to make a decision. If the QIO decides in favor of the member, will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original

Medicare nor Eon will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his or her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If Eon staff decides upon expedited appeal review that services are medically necessary to continue, we will continue to cover the care for as long as medically necessary. If the decision is not in the member's favor, we will not cover any of the care that was provided beyond the termination date, and the member may be financially responsible.

IRE Review

Eon will notify the member and provider in writing when an appeal has been forwarded to the

IRE for review. The member may request a copy of the file that is provided to the IRE for review. The IRE will review the request and make a decision about whether Eon must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to sixty (60) calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to thirty (30) calendar days to issue a decision.

For expedited appeals regarding medical care, the IRE has up to seventy-two (72) hours to make a decision. These timeframes can be extended by up to fourteen (14) calendar days if more information is needed and the extension is in the member's best interest.

The IRE will issue its decision in writing to the member (or authorized representative) and the plan. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative Law Judge Review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. The ALJ will hear the case, weigh all of the evidence and make a decision as soon as possible.

The ALJ will notify all parties of the decision. The party against which the decision is made has the opportunity to request a review by the Medicare Appeals Council/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The party against whom the ALJ decision is made has the right to request the review by the Medicare Appeals Council (MAC). This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal Court

The party against whom the Medicare Appeals Council decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Acting as an Authorized Representative

Eon will accept requests made by the member and/or his or her authorized representative or the prescribing physician or other prescriber or a non-participating provider involved in the member's care. A member may have any individual (relative, friend, advocate, attorney, congressional staff member, member of advocacy group, or suppliers, etc.) act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

In order to act as a representative, the member and representative must complete the Appointment of Representative Form, which can be found online at <https://www.eonhealthplan.com/appeals-n-grievances>

A representative must sign the appointment within thirty (30) calendar days of the member's signature. The appointment remains valid for a period of one year from either the date signed by the party making the appointment or the date the appointment is accepted by the representative, whichever is later. The appointment is valid for any subsequent levels of appeal on the claim or service in question unless the member specifically withdraws the representative's authority.

If the requestor is the member's legal guardian or otherwise authorized under State law, no appointment is necessary. Eon will require submission of appropriate documentation, such as a durable power of attorney.

A physician who is providing treatment to a member (upon providing notice to the member) may request an appeal on the member's behalf without having been appointed as the member's representative.

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Further, the provider appointed must acknowledge in a signed, dated statement that the member will not be held financially responsible for payment for the services under review. Providers who do not have a contract with Eon must sign a "Waiver of Liability" statement, which can be found in the Forms and Reference Material Section of this manual, that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal.

It is important to note that the appeals process will not commence until Eon receives a properly executed AOR or for non-participating providers, a properly executed Waiver of Liability statement.

INTRODUCTION TO CREDENTIALING

Who is Credentialed?

Practitioners: Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS), Doctor of Optometry (OD), Master's level and Doctorate of Psychology (Ph.D), Doctorate of Philosophy (Ph.D) and Clinical Social Workers. (This listing is subject to change.)

Extenders: Physician Assistant (PA), a Certified Nurse Midwife (CNM), a Certified Registered Nurse Practitioner (CRNP), Master level Clinical Nurse Specialist (CNS) and a Certified Nurse Practitioner (CNP). (This listing is subject to change.)

Facility and Ancillary Service Providers: Hospitals, Nursing Homes, Skilled Nursing Facilities, Home Health, Rehabilitation Facilities, Ambulatory Surgical Centers, Portable X-ray Suppliers, End Stage Renal Disease Facilities, Clinical Laboratories, Outpatient Physical Therapy and Speech Therapy providers, and Facilities

providing mental health and substance abuse services. (This listing is subject to change.)

Purpose of Credentialing

Credentialing is the process of performing a background investigation, as well as validation of a practitioner and provider's credentials and qualifications. The credentialing and re-credentialing processes also encompass a complete review of, to include but not limited to, malpractice histories, quality of care concerns and licensure status. Eon prides itself on the integrity and quality of the composition of the practitioner and provider networks.

Credentialing Standards

Eon has established credentialing and recredentialing policies and procedures that meet CMS, DOH, DPW, and NCQA standards.

All information must be current and up-to-date to begin the credentialing process. Therefore, it is important to provide Eon with either your CAQH ID on the CAQH Provider Data Form or submit all applications and attachments in a timely manner with the most current information available.

In addition, extenders are required to submit a copy of their collaborative/written agreement with a Eon participating supervising practitioner. This agreement would include the extender's responsibilities and must be signed and dated by both the extender and the Eon participating supervising practitioner. Any time there is a change in the extender's supervising physician, the extender will be required to submit to Eon Helath Plan, a current copy of his/her new collaborative/written agreement as indicated in his/her approval letter. Where applicable, the submittal of the collaborative/written agreement to Eon must include a copy of the letter of approval from the State and if applicable per the collaborative/written agreement, a DEA is required.

Eon's standards, include but are not limited to, the following:

- A current, unrestricted license.
- Fully completed and signed application, which includes a National Provider Identifier (NPI) number
- Curriculum Vitae and/or Work History to include month and year
- Copy of current, unencumbered DEA certificate, if applicable
- Current hospital admitting privileges for PCPs
- Acceptable malpractice history as subject to decision by Eon Medical Directors and Legal Counsel
- Unexpired professional liability coverage as mandated by state law, of no less than \$500,000 per occurrence, \$1,500,000 per aggregate and coverage provided by the Medical Care Availability and Reduction of Error Fund (Mcare) or Federal Tort Coverage
- Active participation in the Medicare and/or Medical Assistance Programs; free of sanctions
- Foreign graduates must submit an ECFMG certificate
- Other items as deemed appropriate

The credentialing/re-credentialing process involves primary sourced verification of practitioner credentials.

Eon's Credentialing Department will notify practitioners, in writing, within forty- five (45) calendar days of receiving any information obtained during the credentialing or re-credentialing process that varies substantially from the information provided by the practitioner. Practitioners have the right to correct erroneous information submitted by another party or to correct his or her own information submitted incorrectly. Applicants have ten (10) calendar days from the date of Eon's notification to submit written corrections and supporting documentation to Eon's Credentialing Department. A credentialing decision will not be rendered until the ten (10) calendar days have expired.

Practitioners, upon request, have the right to be informed of the status of their credentialing or re-

credentialing application, or a copy of the credentialing criteria. Practitioners also have the right to review any information submitted in support of their credentialing applications except for National Practitioner Data Bank (NPDB) and/or Healthcare Integrity Practitioner Data Bank (HIPDB) reports, letters of recommendation, and information that is peer review protected. A practitioner must submit a written request to review their credentialing information. All appropriate credentialing information will be sent by Certified Mail, overnight mail or carrier to the practitioner within ten (10) business days from the date that the Credentialing Department received the request.

All practitioners must be re-credentialed at least every three (3) years in order to continue participation within Eon Health. This helps to ensure Eon's continued compliance with Center for Medicare and Medicaid Services (CMS) and), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

Eon is committed to protecting the confidentiality of all practitioner information obtained by the Credentialing Department as outlined in Eon Health Confidentiality of Practitioner/Provider Credentialing Information Policy and Procedure.

Ongoing and Performance Monitoring

Eon's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt Out Listing (CMS), and applicable state disciplinary report. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB)/Healthcare Integrity Practitioner Data Bank (HIPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Eon participating practitioner is found on the OIG, Medicare Opt Out List, or applicable state disciplinary action report, the practitioner's file is immediately pulled for further investigation. Depending on severity level of the sanction, the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Eon Credentialing Department reviews complaint reports, which reveals member complaints, filed against practitioners. The Credentialing Department will review and investigate all complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented. Depending upon the severity level of the complaint(s), the practitioner may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Eon's re-credentialing process includes a comprehensive review of a practitioner's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Practitioner Absences

Eon continues to follow NCQA guidelines for practitioners called to active military service, on maternity leave or an approved sabbatical. However, it is the practitioner's or his/her office's responsibility to notify Eon in writing that the practitioner is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the practitioner who will be covering during his or her leave. The Eon Credentialing Department will not terminate the practitioner called to active duty, on maternity leave or on an approved sabbatical, if appropriate coverage is in place. Practitioner/practitioner's office should notify Eon of practitioners return, as soon as possible, but not exceeding ten (10) business days from the practitioners return to the office. The Eon Credentialing Department will determine,

based upon the length of time, if the practitioner will have to complete a recredentialing application. If the practitioner requires re-credentialing, it must be completed within sixty (60) calendar days of the practitioner resuming practice.

Denial and Termination

In accordance with Eon's business practices, the inclusion of a practitioner in the Eon Practitioner/Provider Network is within the sole discretion of Eon Health Plan.

Eon conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Eon understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation.

If a practitioner does not meet Eon's baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a practitioner fails to submit information and/or documentation within requested time frames, processing of the practitioner application may be discontinued or terminated. All requests for re-credentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation.

Denial and termination decisions that are made based on quality concerns can be appealed and are handled according to Eon's Due Process Policy and Procedure. If necessary, the information is reported to the National Practitioner Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Eon Health will notify providers in writing of any decisions to deny, suspend or terminate their privileges to participate in the network

Practitioners who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Eon within thirty (30) calendar days of the date of the certified notification.

Delegated Credentialing

Delegation is the formal process by which Eon has given other entities the authority to perform credentialing functions on the behalf of Eon Health. Eon may delegate certain activities to a credentialing verification organization (CVO), Independent Practitioner Association

(IPA), hospital, medical group, or other organizations that employ and/or contract with practitioners. Organizations must demonstrate that there is a credentialing program in place and the ability to maintain a program that continuously meets Eon's program requirements. The delegated entity has authority to conduct specific activities on behalf of Eon Health. Eon has ultimate accountability for the quality of work performed and retains the right to approve, suspend, or terminate the practitioners and site. Any further sub delegation shall occur only with the approval of Eon and shall be monitored and reported back to Eon Health.



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