2022

PHYSICIAN & PROVIDER

Administrative Handbook

MMM

Medicare and Much More

TABLE OF CONTENTS

WELCOME LETTER

Dear Provider:

Welcome to the MMM Provider Manual. We are so excited you have chosen to partner with MMM Medicare and Much More and believe this is just the beginning of a unique and enjoyable health plan experience for you and your team. It is our belief that together we can ensure our members receive the highest quality coordinated care possible, and we have designed this administrative resource to provide you with comprehensive information about our plan.

Please take time to familiarize yourself with our services, programs and processes as described in this manual. If you have any questions or comments, feel free to contact us at **1-888-722-7559** or via electronic mail: **providers@mmm-fl.com.**
With sincere gratitude,

Ron Schutzen

Ron Schutzen
President and CEO
MMM Medicare and Much More

Office: 1-833-334-3393
Provider Line: 1-888-722-7559
Provider Fax Line: 1-877-722-7544
www.mmm-fl.com

TIPS FOR USING THIS MANUAL

Welcome to MMM Medicare and Much More Physicians and Providers' Network. This Manual is for office staff health plan network servicing Miami-Dade, Broward and Palm Beach counties.

We understand that managing a member's health is often complex and can be administratively taxing. This Manual was developed to assist in understanding requirements and serve as a resource for answering questions you may have about our networks, products, programs, clinical guidelines and claims filing guidelines.

This Manual is not intended to be a complete statement of polices or procedures for providers. Other policies and procedures, not included in this Manual, may be posted on our website or published in special publications, including but not limited to, letters, bulletins, or newsletters.

Please be aware that you may receive notices, letters, and newsletters in both electronic and hard copy formats. Any section of this Manual may be updated at any time. MMM may notify providers of updates in a variety of ways, depending upon the nature of the update, including mailings, our provider newsletter, or posting to our website at www.mmm-fl.com.

In the event of any inconsistency between information contained in this Manual and the agreement(s) between you or your facility and MMM and its programs, which include but are not limited to MMM Medicare and Much More, MMM Elite (HMO), MMM Extra (HMO), MMM Platinum (HMO-DSNP) the terms of such agreement(s) (referred to herein as your "Agreement") shall govern. Also, please note that at various times when dealing with MMM Health Plan Programs, you may be provided information concerning a member's status, eligibility for benefits, and/or level of benefits. Receipt of said member information should never be construed as a promise or guarantee of payment, nor shall the receipt of the member information be a promise or assurance of eligibility for any such individual to receive benefits. The plan shall only issue payment in accordance with the applicable benefit plan in the individual's actual eligibility as determined by such benefit plan. Further, the presentation of an MMM identification card, neither creates nor serves as definitive verification of any member's status or eligibility to receive benefits.

To improve efficiency all providers are strongly encouraged to conduct business with us electronically through our contracted clearinghouse whenever possible. It is important to note, we reserve the right to change the location of a website, a benefit plan name, branding or the customer identification card identifier. We will communicate such changes to you.

WORK WITH MMM MEDICARE AND MUCH MORE TOOLS AND RESOURCES

Working with MMM

Doing business with us is easier and more convenient than ever when you take advantage of the wealth of information and resources available to you online. Stay up-to-date products progress and proven by simply accessing bulletins, newsletters and other valuable resources and tools available on our website at **www.mmm-fl.com.**

Provider Communication Tools

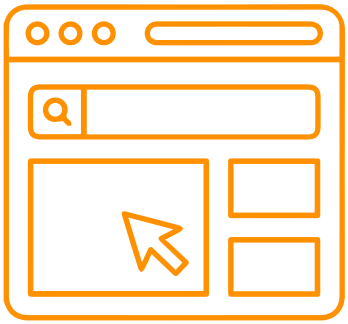
As an MMM participating provider, we have made it easy for you to access important information and communications. Providers are encouraged to conduct business with us electronically through MMM's propriety portal, InnovaMD.

InnovaMD Provider Portal

InnovaMD is a web-based portal that allows providers access from any computer with an internet connection. Participating physicians can track and report metrics, engage with their staffs and patients, and share secure information via our market-leading portal technology. Providers will have access to view the following information on InnovaMD:

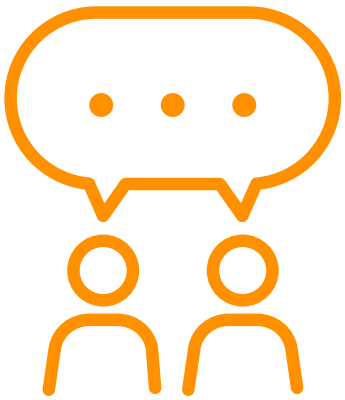
- Member Assignments (PCPs only)
- Eligibility and Member Information
- Referrals and Authorizations
- Claims Status

Participating solo practitioners may register on InnovaMD by going to https://mmm-fl.innovamd.com and clicking the "Register" button. For group account setup, please contact your provider relations representative.



Translation and Interpretive Services

MMM ensures that resources are available for staff, delegates, and provider sites to communicate with members, including those with hearing or visual impairment in the manner and method most appropriate to the needs of members. MMM offers interpretive and translation services to members, as necessary, to communicate with staff and providers of the organization, including staff and practitioners of delegates.



- Telephone translation services for medical appointments with non-English speaking members. You can call Provider Services at 1-888-722-7559 and a representative will connect you with translating services. Please note all calls are confidential and will follow HIPAA guidelines.
- For hearing-impaired members, MMM offers in-office sign language interpretation services.
- To schedule an appointment for sign language interpretation services, contact Provider Services at 1-888-722-7559.

Electronic Funds Transfer

Network Providers are encouraged to sign up for electronic funds transfer (EFT). EFT lets us send claim payments directly to your bank account. Enroll by:

Completing the EFT Authorization Agreement found on our website at https://www.mmm-fl.com/about-us/healthcare-professionals/. Email completed EFT form, voided check, bank letter and W-9 to your respective Contract Executive.

REACHING MMM MEDICARE AND MUCH MORE AND OUR PARTNERS

If you need to contact us, please use the following list to connect with the desired MMM departments and vendors, as well as other helpful resources.

Plan Contact List

Department Name	**CLEARINGHOUSE**
Phone/Fax Numbers Web	MMM selected clearinghouse: Cognizant Sales phone: 1-800-969-3666 Email: providersales@cognizant.com Support phone: 1-800-556-2231 Email: physiciansupport@cognizant.com
Send Claims to:	MMM Medicare and Much More -Electronic submission (clearinghouse Payer id: MMMFL) Mailing Address: MMM Medicare and Much More ATTN: CLAIMS DEPT. P.O. BOX 260370 Miami, FL 33126

Department Name	**ELIGIBILITY VERIFICATION**
Contact For	Eligibility
Phone/Web	Phone: 1-888-722-7559 mmm-fl.innovamd.com

Department Name	**MMM PROVIDER CONTACT CENTER**
Contact For	Inquiries related to providers
Phone	Phone: 1-888-722-7559

Department Name	**PRE-AUTHORIZATION**
Contact For	All services requiring prior authorization except for those provided by our delegated vendors (see table on next page).
Phone/Fax Numbers Web	Phone: 1-833-992-9909 Fax: 1-833-523-2627 mmm-fl.innovamd.com
Submit Pre-authorizations to:	**MMM:** Fax: 1-833-523-2627 mmm-fl.innovamd.com

Department Name	**CASE MANAGEMENT/ DISEASE MANAGEMENT**
Contact For	Complex Case Management /Disease Management related items
Phone/Fax Numbers	Phone: 1-833-991-9959 Fax: 1-833-523-2621

Plan Contact List

Department Name	**HOSPITAL CONCURRENT REVIEW**
Contact For	Hospitalization Review Process
Phone/Fax Numbers	Phone: 1-833-991-9979 Fax: 1-833-223-2623

MMM Medicare and Much More Vendor Network

Vendor Name	**MED-CARE HOME HEALTH SERVICES**
Contact For	Home Health Care, LEVEL 1 & 2 Wound Care
Phone	Miami Dade: (305) 883-2940 Broward: (954) 733-1997 Palm Beach: (561) 482-6646
Submit Pre-Authorization Requests to:	Fax: Miami Dade: (305) 883-2925 Fax: Broward: (954) 731-0110 Fax: Palm Beach: (561) 482-6714 • 1-877-715-4671
Send Claims to:	Mailing Address: MMM Medicare and Much More ATTN: CLAIMS DEPT. P.O BOX 260370 Miami, FL33126

Vendor Name	**MEDCARE HOME INFUSION DME SERVICES**
Contact For	Durable Medical Equipment, Home Infusion, Diabetic Supplies, Orthotics & Prothetics
Phone	1-800-819-0751
Submit Pre-Authorization Requests to:	(305) 571-6276
Send Claims to:	Mailing Address: MMM Medicare and Much More ATTN: CLAIMS DEPT. P.O BOX 260370 Miami, FL33126

Vendor Name	**EYE MANAGEMENT, INC.**
Contact For	Vision Services
Phone	Ophthalmology - Phone: 1-800-329-1152 Optometry - Phone: 1-833-920-0047
Submit Pre-Authorization Requests to:	Phone: 1-800-329-1152
Send Claims to:	**Eye Management, Inc.** - Electronic Submission Clearinghouse – 65062 **Mailing Address:** P.O. Box 21730 Fort Lauderdale, FL 33335

MMM Medicare and Much More Vendor Network

Vendor Name	ALIVI
Contact For	All non-emergency transportation coordination
Phone/Web	Phone: (786) 600-4793 TTY: (786) 633-4510 (hearing impaired) Web: nemt.alivi.com
Submit Pre-Authorization Requests to:	Phone: (786) 600-4793
Send Claims to:	**Electronic Submission** EPIC Ride Application

Vendor Name	LIBERTY DENTAL
Contact For	Dental Services
Phone/Fax/Web	Member Number: 1-877-550-4437 Provider Number: 1-888-352-7924 Provider Fax Number: 1-949-313-0766 Website Address: www.libertydentalplan.com
Submit Pre-Authorization Requests to:	Phone: 1-888-352-7924 Fax Number: 1-949-313-0766
Send Claims to:	Claims Fax Number: 1-888-700-1727 Claims Mailing Address: Liberty Dental Plan Attn: Claims Dept. P.O. Box 15149 Tampa, FL 33684 Claims Email Address: FloridaClaims@LibertyDentalPlan.com

Vendor Name	AUDIOLOGY DISTRIBUTION, LLC DBA HEAR USA
Contact For	Hearing/Hearing Aid
Phone	Phone: 1-855-203-1177
Submit Pre-Authorization Requests to:	Phone: 1-855-203-1177
Send Claims to:	**MMM Medicare and Much More** electronic submission (clearinghouse) Payer id: MMMFL Mailing Address: MMM of Florida, Inc. ATTN: CLAIMS DEPT P.O. BOX 260370 Miami, FL 33126

Vendor Name	AMERICAN SPECIALTY HEALTH - SILVER&FIT
Contact For	Fitness Program
Phone/Web	1-877-427-4788 TTY (711) www.silverandfit.com
Submit Pre-Authorization Requests to:	N/A
Send Claims to:	N/A

MMM Medicare and Much More Vendor Network

Vendor Name	QUEST DIAGNOSTICS
Contact For	Laboratory
Phone/Web	Phone: 1-866-697-8378 Web: www.questdiagnostics.com
Submit Pre-Authorization Requests to:	N/A
Submit Claims:	N/A

Vendor Name	NAVARRO/CVS SPECIALTY PHARMACY
Contact For	Specialty Pharmacy
Phone	Phone: (786) 220-8865
Submit Pre-Authorization Requests to:	Fax: (305) 883-0652

Vendor Name	KROGER SPECIALTY PHARMACY
Contact For	Part B Injectables
Phone/Address/Fax	Phone: 1-855-733-3126 Address: 3200 Lake Emma Rd. Suite 1000 Lake Mary, FL 32746 Fax: 1-888-315-3270
Submit Pre-Authorization Requests to:	MMM Prior Auth Fax: 1-833-523-2630 Fax Copy of prescription to Kroger Fax: 1-888-315-3270

Vendor Name	HEALTH NETWORK ONE
Contact For	Dermatology, Gastroenterology, Podiatry, PT/OT/ST, Urology
Phone/Web	1-800-329-1152 www.healthnetworkone.com
Submit Pre-Authorization Requests to:	Phone: 1-800-595-9631 Option 1 Fax: 1-866-646-1772
Send Claims to:	EDI Clearinghouse is Change Healthcare (f/k/a Emdeon) Payer ID: 65062
Paper Claims to:	HN1, P.O. Box 21608 Fort Lauderdale, FL 33316-1608

Please note that contact information is subject to change. The plan will make every attempt to maintain accurate information in this Manual. Should some of the information contained in this document be no longer valid, visit the plan website, www.mmm-fl.com, for contact details.

JOINING OUR PROVIDER NETWORKS

MMM Medicare and Much More welcomes network participation of licensed providers that meet our contracting criteria and network needs.

Providers participating in our network are reimbursed based on the terms of their Agreement for services to eligible members and have agreed to accept the MMM Health Plan rate amounts (less deductibles, coinsurance, and/or copayments) as payment-in-full for covered services rendered to eligible members.

Physicians and providers are selected to participate in our network based on an assessment and determination of the network's needs. From time to time, some of our provider networks may be closed. However, MMM may recruit providers for an otherwise closed network if there is a need in a specific service area, or for specific provider types and/or services. It is important to note that upon requesting participation, the network may be closed for your provider type in the geographic area in which you are located.

If you wish to join our network, please complete the "Request to Join our Network" form found in **www.mmm-fl.com.**

Maintaining Updated Information

It is important to maintain accurate and up-to-date provider demographics, office and billing information. Providers can notify MMM of any changes to their provider data records quickly and easily. Please note updating your provider information will not only ensure that we can reach you but will also ensure your current information is accessible to enrollees. Updates made to your provider record impact the information about your practice and/or services that displays in the MMM Provider Directories.

Beginning January 2020, the National Plan and Provider Enumeration System (NPPES) allows providers to certify their National Provider Identifier (NPI) data. NPPES provides core directory data elements (provider name, provider specialty, provider address, provider telephone number) in a machine-readable format for virtually every provider in the country.

The purpose of this initiative is to lessen the burden to both providers and plans while improving the accuracy of provider directories by treating the certified NPPES data as a valid source for provider directory data in audits of MA directory accuracy. CMS urge providers to review and, as needed, make any necessary corrections to the data, and then "attest" to the accuracy of the data. CMS recommends requesting Providers to certify their demographic data on NPPES quarterly. NPPES can be accessed online at https://nppes.cms.hhs.gov.

Timely Notification of Changes to Provider Information

Please note, providers are required to notify MMM Medicare and Much More 30-days prior to the effective date of a change to ensure the plan has ample time to confirm and process the changes, and that accurate data is displayed in the provider directory. Prior notice is essential to avoid impacts to claims processing. You may provide these updates by contacting your contracting representative or sending an email to providers@mmm-fl.com. Listed below are some of the data elements providers should always keep up to date, if applicable:

- Practitioner's First, Middle, Last Name or Facility Name
- Provider's Billing Address
- Provider's Service Location Address
- Practicing Specialty
- Phone number
- Tax ID
- Rendering and Billing NPI
- Physician Rosters
- Fax number
- E-mail
- Office Hours
- Practitioner Language(s)
- Hospital Privileges

CREDENTIALING WITH MMM MEDICARE AND MUCH MORE

The verification of credentials is an integral part of our network process. It helps ensure our members have access to quality care and it is also required to meet both state and federal guidelines. Completion and submission of the application and the required documentation does not guarantee inclusion in any of our network(s).

MMM Medicare and Much More currently uses Council for Affordable Quality Healthcare (CAQH) as our preferred method for credentialing. Please ensure that your credentialing information in CAQH and attestations are complete and current. This will help facilitate the credentialing verification process. MMM Medicare and Much More will access your CAQH information or contact you regarding completion of a manual application if you do not use CAQH. We highly recommend that you consider using CAQH as it will make the credentialing and re-credentialing processes much easier. Ancillary Facilities, Suppliers and Ambulatory Surgery Centers (ASC) are not required to use CAQH. They should download the applicable credentialing application directly from www.mmm-fl.com. Once completed, the application and all required documentation should be sent directly to providers@mmm-fl.com via email. Please note, if the plan receives an incomplete application, or not all the required documents, it may delay the credentialing process.

Practitioner Credentialing Requirements

Physicians should complete an application directly through the CAQH Universal Credentialing Data Source. Go to www.caqh.org/ucd_physician_faq.php for detailed information on how to create/edit your application with CAQH and to obtain a CAQH number. Please remember to allow access to MMM of Florida your CAQH application. You may be required to submit some, or all the documentation listed below. It should be emailed or faxed to your Account Representative.

- Signed attestation statement (within 180-days)
- Copy of Florida license(s)
- Education and training, if applicable
- Work history for the past five years (explain gaps of 6+ months)
- Copy of specialty board certificate, if applicable
- Hospital admitting privileges, if applicable
- Current certification of insurance (face sheet with expiration date and coverage amounts)
- Explanations for any malpractice history and disciplinary actions
- Copy of applicable certification(s), e.g., board certification, if applicable
- Explanations for any health issues
- Copy of Drug Enforcement Administration (DEA) license, if applicable
- Disclosure of ownership

Advanced Non-Physician Practitioners Credentialing Requirements

MMM Medicare and Much More currently defines Advanced Non-Physician Practitioners (ANPP) as Advanced Registered Nurse Practitioners (ARNP), Certified Nurse Midwifes (CNMs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), and Registered Nurse First Assistant (RNFAs) who practice independently or as associated members of a physician association. MMM may expand this definition in the future to include other provider types.

It is the responsibility of the physician, physician group, or facility to ensure that any employed or contracted Advanced Non-Physician Practitioner is properly licensed and supervised as may be required by law, including, but not limited to, Florida Statutes §458.347(1)(f) and §464.012. They are also responsible for ensuring that employed Advanced Non-Physician Practitioners maintain proper licenses, credentials and are registered with the State of Florida and any other applicable agency.

Ancillary Facility/Supplier Business Credentialing Requirements

In addition to a completed application you will be asked to submit the following, if applicable:

- Signed attestation statement (within 180-days)
- Copy of Florida license(s)
- Copy of Florida registration
- Current certification of insurance (face sheet with expiration date and coverage amounts) to include errors and omissions for General and Professional liability. If the insurance certificate covers multiple locations, it should either state that all locations owned by the corporate entity are covered OR have a roster of all covered locations attached.
- Explanations for malpractice history and disciplinary actions.
- Copy of accreditation documentation, if applicable (ASCs must be accredited).
- If performing MRI, CT, PET, NC (includes cone beam CT) The Joint Commission, IAC or ACR accreditation is required.
- If performing mammography services, ACR Accreditation is required.
- Copy of applicable certification(s)
- Copy of facility medical director's medical license, DEA certificate – if applicable
- Copy of Medicare certification(s), if applicable
- Copy of Medicare participation letter, if applicable
- AHCA and/or Centers for Medicare & Medicaid Services (CMS)/Medicare site survey. If not obtained, a Plans site visit is required (prior to Credential Committee).
- Disclosure of ownership

Re-Credentialing

Re-credentialing is performed every three years (36-months) or as otherwise required by law or applicable regulations and requires the submission of an updated credentialing application and documentation. Hospitals are evaluated annually for state license, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, Medicare certification, and sanction information. Failure to supply all requested documentation may result in the termination of your contract by MMM Medicare and Much More. Manual applications may be emailed to FloridaCredentialing@mmm-fl.com or E-Fax to 1-833-334-3313.

Updating Application Documentation

Providers have the right to review, correct and resubmit any of the information to support their credentialing application including but not limited to third-party sources. Corrections must be submitted by the date requested, and in all cases, not later than the completion date of the credentialing process. Delays in returning materials may result in request for termination of your contracts. Providers have the right to inquire about the status of their application. Information shared with Practitioners may include information obtained to evaluate their credentialing application, attestation or curriculum vitae (CV). Participating hospital-based physicians who practice exclusively in the hospital, skilled nursing facility and/or ambulatory service center settings are required to meet MMM's credentialing requirements established under their respective contractual agreements. This credentialing requirement is typically met by fulfilling the requirements for being on staff where they provide services as long as the facility meets our credentialing requirements. The facility is required to be credentialed by us. If this requirement is not met, and or if any services are provided by a physician outside the above settings, then the physician is required to go through our credentialing process to participate in our networks.

Confirmation of Credentialing Status

Completed applications are verified and a determination made as to the applicant's participation with MMM Medicare and Much More. Once a determination is made, MMM will send all applicants a written notice of the contracting status.

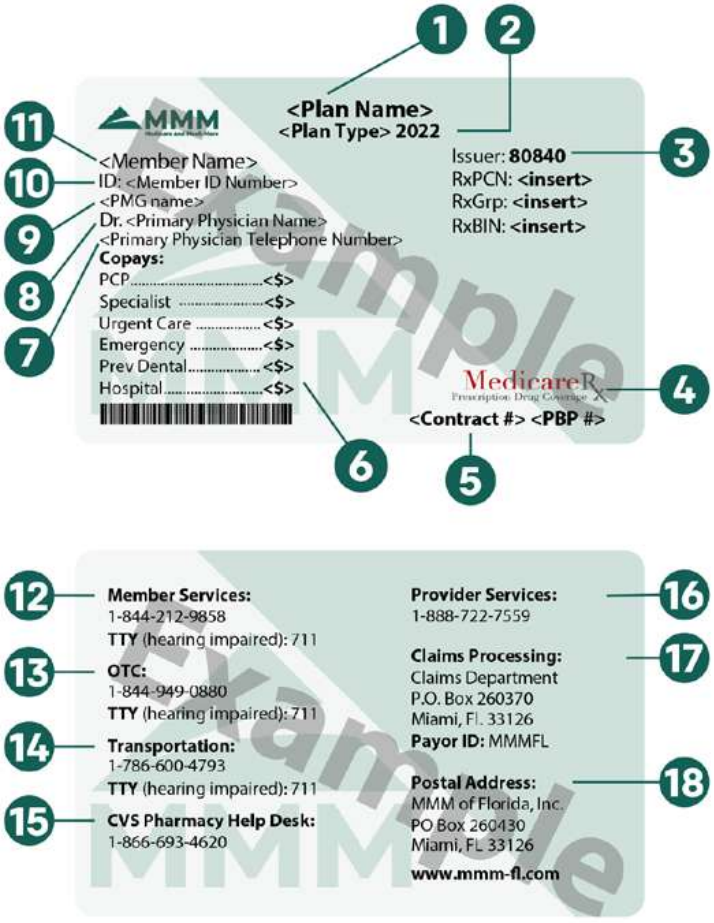
Applications may be delayed for any of the following reasons:

- Incomplete applications (All questions must be answered. Irrelevant questions must be answered as N/A).
- Missing documentation
- Expired documentation

If you have completed and submitted all required documentation and have not received any communication within 90-days, you may contact our Network Management area to obtain help with the process.

INFORMATION INCLUDED ON YOUR **MMM IDENTIFICATION CARD:**

1. Benefit Plan Name
2. Plan Type (HMO/HMO-SNP)
3. Plan Issuer Number
4. Medicare Rx Logo
5. Contract Number–Plan Number (assigned by CMS)
6. Categories and Copayment Amounts (if applicable)
7. Primary Care Provider Phone Number
8. Primary Care Provider Name
9. Primary Medical Group Name
10. Member Number
11. Member Name
12. Plan Contact Information
13. OTC Contact Information
14. Transportation Contact Information
15. CVS Pharmacy Help Desk
16. Provider Services Contact Information
17. Medical Claims Mailing Address
18. Postal Address



For more information, call our Member Services Department, Monday through Sunday, from 8:00 a.m. to 8:00 p.m. EST at 1-844-212-9858 (toll free) or 711 TTY (hearing impaired).

www.mmm-fl.com

MMM of Florida, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MMM of Florida Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-212-9858 (TTY: 711). MMM of Florida Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-212-9858 (TTY: 711).

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CLINICAL OPERATIONS

Utilization Management

MMM Medicare and Much More has an established Utilization Management (UM) Program designed to oversee all health services activities to ensure the implementation of comprehensive, systematic and continuous processes that make the UM Program effective. The UM program components include prospective, concurrent and retrospective review activities to evaluate services based on medical necessity, appropriateness of care and services. To facilitate achieving its purpose, the UM program is based upon a collaborative effort between the Plan, providers and physicians to deliver important information to members that will allow them to make informed decisions about their health care and coverage with the goal of improving health outcomes.

Clinical decision support criteria are used to help ascertain whether a requested service qualifies for coverage under the member's contract. All services must meet the definition of medical necessity as outlined in the member's benefit contract. While a service may not require authorization, it is still required to meet the definition of medical necessity and is subject to medical necessity review pre-service, post-service, post-payment or concurrently. The application of the definition of medical necessity (as defined in the member's benefit plan or Evidence of Coverage) is solely for the purpose of coverage determination or payment for services rendered by providers.

All participating providers in the MMM network are required to fully comply with all medical management programs administered by the Plan including:

- Obtaining authorizations, certifications or notifications, depending upon the benefit package requirements of the member agreement in question.
- Accurately recording and providing all clinical information which support medical necessity when requested.
- Identifying the correct contact person in a facility's medical management department to provide member's medical information to the MMM medical management onsite or telephonic nurse reviewer.
- Permitting timely access to member's medical information.
- Including the MMM medical management nurse in discharge planning discussions and meetings.
- Providing care/treatment plans, member's progress notes, and other clinical documentation as required.
- Providing quality health services to members while following utilization management guidelines.
- Provide timely post-discharge follow up appointments for members for post-discharge assessment and medication reconciliation.

Prospective/Pre-Authorization

A state licensed medical director within the Preauthorization Unit is accountable to determine medical necessity and appropriateness of services, procedures, and equipment. This affords the MMM team the opportunity to determine whether the services, procedures or equipment are a covered benefit for the member and whether the member can be directed towards in-network services when applicable and appropriate.

Preauthorization requirements apply to inpatient and outpatient services and allow for an evaluation of services prior to the care being rendered. MMM Medicare and Much More requires prior authorization for the following services:

- Inpatient Admissions
- Observations Stays
- All Surgeries including procedures considered cosmetic
- Cardiac Procedures/Surgeries, Devices and Diagnostic Testing
- Prosthetic Devices and Procedures
- Durable Medical Equipment
- Medical and Surgical Supplies
- Oncology – Radiation Therapy
- Transplant Services
- Outpatient Diagnostic Testing
- Ophthalmologic Services
- Diagnostic Imaging
- Home Health Care
- Outpatient Therapy Services
- Enteral and Parenteral Nutrition
- Dental Procedures
- Clinical Trials
- Pharmacy Services (selected medications)
- Respiratory Therapy Drugs (selected medications)
- Behavioral/Psychiatric Health Services

MMM has a vast network of behavioral health providers and Community Mental Health facilities located across the three countries in which our members reside. Behavioral health provider phone numbers and office location listings can be easily accessed via our online Provider Directory, located within our MMM home website. In addition, MMM's Health Services clinicians are available to assist members and providers in coordinating care to ensure that members' behavioral healh care needs are met.

To ensure easy access to behavioral health services, provider referrals are not required and, additionallly, most Medicare/Medicaid covered behavioral health services do not require a prior authorization from MMM for the member to receive behavioral health services.

Listed below are the behavioral health services which do require prior authorization:

- Behavioral Health hospital inpatient and/or observation admissions
- Partial hospitalization (PHP)
- Intensive outpatient services (IOP)
- Electroconvulsive therapy (ECT) inpatient and outpatient
- Neuropsychological testing and interpretation
- Targeted Case Management (TCM) and Intensive Case Management Team services (ICM)
- Psychosocial Rehabilitation services (PSR)

Please refer to MMM's provider portal at **www.mmm-fl.innovamd.com**. In InnovaMD you can check whether a service requires an authorization by either entering the CPT code or description.
Providers may submit preauthorization requests via:

- Accessing InnovaMD Provider Portal at mmm-fl.innovamd.com to complete the request online and upload the supporting clinical/medical documentation
- Faxing in the completed Preauthorization Request Form with supporting clinical/medical documentation to 1-833-523-2627
- Via telephone at 1-833-992-9909 for selected services including urgent requests (authorization may be pended, and provider may be asked to submit supporting clinical/medical documentation.)

All requests for services MUST include the following information:

- Member name
- Medicare ID
- Requesting provider name and demographic information and NPI
- Diagnosis code(s)
- Place of Service
- Services being requested and CPT code(s)
- Recommended rendering provider name and demographic information
- All relevant clinical/medical information necessary to decide for the requested service (can include plan of treatment, progress notes, etc.)

To ensure prompt determination of the service requests, providers must submit all required evidence or information associated to the requested service such as: diagnoses, labs, test results, previous related studies, and parameters, among others. To access our medical and behavioral health pre-authorization forms, please log on to our website at www.mmm-fl.com.

Concurrent Review and Discharge Planning

To ensure that all hospital admissions are medically appropriate and that the health-care services are being provided in the most appropriate setting, the health plan reviews all inpatient admissions including observation level of care, skilled nursing facility and inpatient rehabilitation admissions. Elective admissions must be reviewed before the enrollee enters the hospital.

Urgent and emergency admissions are reviewed the first business day after the admission notification occurs and at appropriate intervals thereafter until the member is discharged. This acute care review is to determine the initial and ongoing medical necessity, appropriate level of care, appropriate length of stay, and to facilitate a timely discharge. Authorization of the admission includes all services rendered during the inpatient stay.

Discharge planning begins at day one and is a collaborative effort between the facility physician and other facility staff; the Plan's concurrent review and discharge planning staff; medical director; pharmacist; case management staff; and others based on the members' needs. In addition, the PCP may be engaged during the discharge process to facilitate timely post-discharge follow-up appointments, referrals and other needed resources and services identified during the discharge process. MMM staff will provide interventions to ensure continuity of care and cost-effectiveness, promote appropriate health recovery and prevent unnecessary readmissions or emergency room visits (ER).

MMM's concurrent review decisions are made utilizing nationally recognized Evidence-Based Clinical Criteria as a guideline. Decisions take into consideration the member's medical condition and co-morbidities and are used under the direction of the Medical Director.

Frequency of onsite, fax and/or telephonic review will be based on the clinical condition of each member.

Utilization Management Determinations Criteria

When services are requested, they are reviewed against established Evidence-Based Clinical Criteria and other support systems. One or more of the following criteria are utilized:

- Medicare National Coverage Guidelines and criteria
- Local Medical Review Policy
- Florida Medicaid Guidelines
- Reasonable medical evidence or a consensus of healthcare professionals in a particular field
- Face-to-Face evaluation is used for Mobility Assistance Equipment
- MNC – Medical Necessity Certification applied to shoes for diabetic patients
- Nationally recognized evidenced-based clinical criteria

When applying criteria to members with more complex conditions, MMM Medicare and Much More will consider the following factors:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Home environment
- Characteristics of the local delivery system available

When cases do not meet these criteria, the health services staff will send case to the Plan's Medical Director for review and final determination. All new medical technology or questionable experimental procedures will require review by the Medical Director prior to approval to establish guidelines where applicable. The Provider may request a peer-to-peer call with an MMM Medical Director to discuss determination decisions prior to initiating the appeals process. Providers may request copies of decision-making criteria by submitting a request.

Organization Determinations

MMM has in place an appropriate mechanism to ensure consistent application of review criteria for authorization reviews which include:

- Medical Necessity – approved medical review criteria will be referenced and applied;
- Inter-rater reliability (IRR) – a process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria; and
- Consultation with the requesting provider when appropriate.

Expedited Organization Determinations

A member or any physician may submit an expedited request for an organization determination when they believe that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue could involve a claim for payment for services that the member has already received. However, if a case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

Expedited determinations must be completed within 72-hours. The member or the plan may extend the 72-hour time-period for making an expedited organization determination by up to (14) calendar days if a request for additional information is in the interest of the member. When the Health Plan extends the deadline, the member will be notified in writing of the reasons for the delay and informs the MMM member of the right to file an expedited grievance if they disagree with the decision to grant an extension.

MMM notifies the member of its determination as expeditiously as the enrollee's health condition requires, but not later than upon expiration of the extension. To ensure that notification is provided to the member within the 72-hours of receipt, the Plan provides an oral notification to the member of the determination (approved or adverse) and by mail within three calendar days of the oral notification. If the Health Plan grants a request for expedited reconsideration, a notice will be given in accordance with the timelines for reconsideration. It is very important to receive the authorization request with all the necessary clinical evidence to facilitate the promptness of the final determination. The notifications of final determinations are sent to providers everyday by fax and to members by mail.

Standard Organization Determinations

An organization determination will be made as expeditiously as the member's health condition requires, but not later than (14) calendar days after MMM receives the request for service. An extension may be granted for an additional (14) calendar days if the member requests an extension, or if MMM justifies a need for additional information and documents how the delay is in the interest of the member.

MMM will work with providers on standard organization determinations that require a quick decision due to appointment availability, member scheduling, or other special circumstance but that do not meet the definition of 'expedited'. MMM Medicare and Much More is committed to ensure that our members have no delays in getting the care they need.

Model of Care

MMM has established a Medicare Advantage Plan focused on individuals with special needs known as Special Needs Plans (SNPs). Services under this model were part of the Medicare Modernization Act of 2003 (MMA). MMM offers a Dual Special Needs Plan (D-SNP) for members who have both Medicare and Medicaid coverage. A central goal of the D-SNP Programs is to promote, improve and maintain members' health utilizing a coordination and continuity of care model.

As required by the "Medicare Improvements for Patients and Providers Act of 2008" (MIPPA), MMM has an evidence-based Model of Care with appropriate description of the Special Need population, multidimensional care coordination strategies, network of providers and specialists and quality measurement on performance. The Plan's Model of Care includes requirements with respect to each member enrolled in the D-SNP:

1. Conduct an initial Health Risk Assessment (HRA) and an annual reassessment that identify the medical, functional, cognitive, psychosocial, and mental health needs for each SNP member.

2. Utilize the results of the HRA and develop an Individualized Care Plan (ICP), in consultation with the member and member caregiver as appropriate and with the member's PCP and other practitioners involved in the member's care when able, that identifies goals and objectives, as well as specific services and benefits to be provided.

3. Use of a formal Interdisciplinary Care Team (ICT) for the management of care, that includes the participation of the member, the member's caregiver/family, the primary care physician, the Plan's case management team and other disciplines, as needed.

4. Support to beneficiary through care transitions by having staff available in the Care Management Program to coordinate and facilitate communication between healthcare settings, physicians involved in the member's care and the member and their caregiver.

MMM Medicare and Much More has an established Quality Improvement Program to monitor SNP health outcomes and performance of the Model of Care by collecting, analyzing, reporting data and acting on opportunities of improvement. The Plan expects every member of its provider network to actively participate in this process.

What is the Provider's Role in MMM Medicare and Much More Model of Care?

The role of the provider is vital. To meet with the MOC requirements, MMM providers shall:

- Provide face-to-face encounter (either in-person or through visual , real-time, interactive telehealth encounter) on at least an annual basis, beginning within the first 12 month of enrollment with the Plan.
- Use evidence-based clinical practice guidelines that supports improvements related to preventive services and the management of chronic conditions.
- Encourage their members to complete the HRA
- Promote members' wellbeing
- Collaborate with the Care Team in establishing care plan goals
- Be an active participant of the Interdisciplinary Care Team
- Participate in case discussions
- Identify appropriate resources for members' health care
- Engage member's in disease self-management
- Perform appropriate referrals to internal clinical programs or specialists as applicable to facilitate adequate care coordination.
- Collaborate with care transition processes
- Provide follow-ups-to member's health outcomes
- Communicate member's change in health status when feasible, among ICT members
- Complete the regulatory MOC trainings

All providers must complete the Model of Care training annually. Compliance with this training is monitored by the Plan. The Model of Care training for providers can be downloaded via the web-based provider portal www.mmmfl.innovamd.com.

Population Health Management Programs

MMM Medicare and Much More has developed an integrated approach to all its population management programs with the purpose of delivering and managing the medical and behavioral health services for members. To guarantee the improved health outcomes, we analyze and assess our population profile including specific characteristics, problems and/or needs to implement and redesign the clinical initiatives and/or programs. Based on this analysis, we update the risk stratification algorithms, review programs criteria and change or update operational processes for interventions. The established population management programs are as follows:

- Integrated Complex Case Management
- Disease Management
- Health Promotion and Education
- Care Transition/ Discharge Planning
- Social Work

We recognize the importance of the integration of all healthcare and community parties involved in the member's wellbeing and health care outcomes. Our population management programs focus on a holistic and comprehensive approach to the management of members. The staff includes discharge planners, case managers, social workers, case management assistants, health educators, disease managers, medical directors, pharmacists, data analysts and other qualified healthcare professionals. They work as a team to assist providers and members while ensuring appropriate care coordination, expand access to care and empowering

members and their designated caretakers to improve health outcomes and total quality of life. Our clinical team facilitates effective interactions between internal and external resources including community, clinical staff, members' family and clinical, behavioral and servicing providers. As a team they work hard to deliver high-quality services, expertise and targeted interventions aligned to member's needs and active decision-planning.

To refer a member to any of MMM's Population Management programs or services, providers should complete a "Referral Form" that is available in our provider portal www.mmm-fl.innovamd.com or our website at www.mmm-fl.com and send the Form via Fax to 1-833-523-2621 or call 1-833-991-9959.

Once the referral is received in our offices, someone from our team will screen for appropriateness and urgency to initiate services. If the referral is accepted, the appropriate clinical staff will begin to intervene with the member in collaboration with the Member's Primary Care Provider and with any other relevant members of the health-care team. If the referral is not accepted, the referral source will be notified and provided with the reason for not accepting the referral in writing. Members are also able to self-refer.

MMM Medicare and Much More Integrated Complex Case Management (ICCM)

The MMM Integrated Complex Case Management Program is available for the most vulnerable and for high risk members. Members who meet criteria for ICCM will be assigned a case manager. Participation is encouraged but voluntary. Members and/or providers can request to be enrolled in the program based on established criteria. Case Managers perform initial assessments to members to review clinical history, treatment, compliance, overall health outcomes, self-care skills, financial and human resource availability, supporting systems, member and caregiver involvement and opportunities and barriers to improve health care. The Case Manager develops an individualized care plan (ICP) based on identified needs or problems involving the Primary Care Provider and the member in the decision-making process. As part of the ICP, the Case Manager:

- Reviews treatment options
- Determines adequate levels of care, and
- Plans actions to ensure quality of care, cost effectiveness, and improve self-management skills

A multi-disciplinary care team is then organized to review the care plan's outcomes and barriers and to provide recommendations while maintaining direct communication with the member, primary and/or secondary care providers and other caregivers or supporting partners.

As a result of the enrollment qualifications for a D-SNP (low-income, disabled, older and eligible for both Medicare and Medicaid) members have more complex medical needs, increased psychosocial needs and are our most vulnerable members. Members are stratified as high risk when they meet the criteria defined below.

MMM Medicare and Much More's ICCM programmatic and enrollment criteria is revised yearly using the following elements:

Complex Needs	Utilization Trends	Psychosocial Risk
• D-SNP Member • Major Planned Surgeries (e.g. Organ Transplant, Bariatric) • Major Trauma (e.g. MVA, TBI) • Polypharmacy • Catastrophic Conditions (e.g. HIV, ESRD, CA, Multiple Sclerosis) • Chronic Conditions with comorbidities • Significant Change of Health Status • New Dignosis of Catastrophic • Diagnoses (e.g. Mestasttic CA) • Diabetes with serious complications (amputation, infected ulcers)	• Multiple Admissions • Readmissions • High ER Utilization	• Access to care • Cost of care • Inability to care for self • Recent falls • Significant Change in Health Status • Significant mental health or behavioral issues

These criteria and the process to access the program is informed to members and providers through Newsletters, Web Portals, Call Centers and community orientations.

MMM Medicare and Much More's Disease Management Program

The Disease Management (DM) Program is based on a multi-disciplinary, continuum-based approach to health-care delivery that proactively identifies population with chronic conditions such as:

- Hypertension (HBP)
- Diabetes (DM)

MMM's DM program is a system of coordinated healthcare interventions and communications for populations with conditions in which members' self-care efforts are significant. It supports the physician or practitioner / patient relationship and plan of care, emphasizes prevention of exacerbations and complications by using:

(a) Evidence-based practice guidelines

(b) Patient empowerment strategies, and

(c) Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health

Providers should be aware that most of the interventions within this program involve individual educational sessions by phone, face-to-face or in community settings.

MMM has adopted clinical guidelines which are systematically developed to assist providers in the decision-making process related to manage members according to the appropriate level of care and to their specific clinical circumstances. The Plan uses clinical practice guidelines for Diabetes, Heart Failure,

Hypertension, Coronary Artery Disease, Treatment of Patients with Major Depressive Disorder and Preventive services for Adults which come from recognized sources such as: The Institute for Clinical Systems Improvement and The American Diabetes Association among others.

Clinical practice and preventive reference guidelines lists are reviewed and updated annually or more frequently by the Medical Director. These guidelines are also published in the Providers Portal, mmm-fl.InnovaMD.com and on the health plan website. Guidelines are then presented to the Plan's Chief Medical Officer and to the Quality Improvement Committee for their approval prior to publication and distribution to the network.

MMM Medicare and Much More's Health Promotion and Education Program

The MMM Health Education Team (Health Educator, Case and Disease Managers, Social Workers, Case Management Coordinators and/or designee) is responsible for developing, implementing and promoting educational interventions aimed at helping members and caregivers to understand members' medical conditions and/or recent diagnoses. The latter is accomplished by providing participating members educational interventions that concentrate on how to improve their health and how to provide an opportunity for members and caregivers to engage in behaviors that will improve and promote good health while reducing complications related to their medical conditions.

The Health Education (HE) Team promotes educational campaigns which provide effective learning experiences to equip members with tools to effectively self-manage their medical conditions. The team also emphasizes actions that members can take to improve their own health and wellness, and actions to promote the common good of the community in which they live. The HE Team works to:

- Identify population educational needs via risk level stratification criteria obtained from Health Risk Assessment scoring and Comprehensive Health Assessments. Members classified as high risk receive individual educational interventions by a Care Manager (CM) as per the intervention protocol. The Health Educator or designee manages population groups comprised of members who have a risk classification of moderate or low. In addition, a population assessment is conducted annually to ensure that most common medical, psychological, social and cultural needs are identified and addressed based on the population we serve. The Health Risk Assessment and population assessment scoring tools are submitted for review and approval by the MMM Quality Improvement Committee annually.

- Use the most updated nationally or locally recognized education materials and resources focused on health maintenance, promotion of healthy lifestyles and prevention of complications associated to major chronic diseases. Educational topics may address specific disease conditions, tools to assist in monitoring conditions, and education related to the prevention of alcohol, tobacco and illicit drug use. Materials are made available to members and caregivers by mail, email, member newsletters, and are as well uploaded into the Plan's website.

- Promote healthy lifestyle choices such as fitness, nutrition and weight management. Educate member and caregiver of available expanded benefits through the Plan such as Silver and Fit Program and OTC benefits and resources to assist with smoking cessation.

- Coordinate internal and external resources to assist member and caregivers with Mental Health, Substance Use, and violence prevention services.

- Follow-up with members via phone calls, mail, email, or home visits following educational strategies implemented, in order to measure member achievement of the educational treatment goals established in the member's Individual Care Plan and to create future goals and objectives as needed.

- Maintain open communication among internal units within the Health Services Departments that would also intervene with the population identified to optimize care results and/or clinical outcomes.

- Report achievements and positive results obtained as evidence of the effectiveness of the strategies implemented within the program.

MMM Medicare and Much More's Care Transition / Discharge Planning

MMM's Transition of Care Coordinators (TOCCs) conduct transitions of care based on a bio-psychosocial model that includes members, their families/caregivers and support systems to promote a seamless transition from the hospital to an ambulatory level of care. This process is achieved through accessing appropriate resources and/or services in a timely manner. The TOCCs work collaboratively with Utilization Management, Complex Case Management, Quality program and Disease Management to design, monitor and follow-up the appropriate care plan for the served population. The TOCCs analyze clinical information about admitted members and evaluate their clinical records and/or profiles to determine the types of approach to be used and the stratification level according to pre-established criteria. The interventions of the Transition of Care Staff are addressed to guarantee continuity of care and cost-effectiveness, ensure appropriate health recovery and prevent unnecessary readmissions or emergency room visits (ER). These interventions include but are not limited to:

- Performing preauthorization and services coordination in a timely manner.
- Being a point of contact for providers and members or their caregivers.
- Maintaining communication with the Utilization Management Team to promote interactions and integration amongst the member's health-care providers.
- Performing post discharge comprehensive assessments and acute case management.
- Involving family members during assessment and care plan development to ensure appropriate care and follow-up.
- Sending educational material as needed.
- Discussing members' health outcomes with their PCPs, as needed.
- Coordinating post-discharge medical appointments.

•Referring members to other clinical programs for continuity, such as CCM and DM.
•Providing information about or coordinating benefits and/or community services which are available.
•Performing medication review and promoting post-discharge reconciliation with Primary Care Provider.
•Facilitating access to multi-disciplinary care team when feasible.

Social Work

Within its Case Management Programs, MMM provides social work services in order to promote better health outcomes through quality of life improvement. Social services provided by MMM seek to assist members to function within the social environment in which they live, embrace necessary behavioral changes to manage their condition, and improve their access to community resources. The social work services focus on integration, on improved access to services and on addressing gaps in coverage across different agencies and their services. The scope of social work is to encourage members, family or related caregivers in all health-care management and address any social issue with adverse impact on health or quality of life. The goals of the services are to:

•Capital Utilization outcomes
•Increase community services access
•Empower people on self-management and service access
•Improve home safety
•Increase medication adherence
•Remove communication and/or social barrier for better health outcomes

Our licensed case managers provide support and work collaboratively with other care managers, disease managers, pharmacists, medical directors, preauthorization and concurrent review teams, transition of care staff, customer services and other internal programs or departments to address or prevent any potential issues and/or assist with service coordination or quality of care.

DENTAL SERVICES

MMM Medicare and Much More offers dental services through Liberty Dental Plan. Some of the services require preauthorization. Providers may access the preauthorization list in the MMM Provider Portal (mmm-fl.innovamd.com). For more information about the process, providers can contact MMM Provider Center at 1-888-722-7559 or The Liberty Dental Plan toll-free number dedicated to MMM members/recipients at 1-877-550-4437. Hearing or speech impaired members may call 1-877-855-8039. Providers will use the Liberty Dental Plan National Provider line, 1-888-352-7924.

MMM Medicare and Much More is not responsible for:

1. Dental treatment not approved by the ADA.
2. Dental care which commenced before the member was covered by MMM.
3. Dental care that is solely for cosmetic purposes.
4. Dental care and charges incurred for patient behavior upon agreement.
5. Claims with more than 90-days from the date of services.

Dental services claims provided by a contracted provider should be sent electronically, via fax or by mail. Claims are submitted by the treating dentist on behalf of the member and are processed within 30-days upon receipt, granted all proper documentation is submitted.

- LIBERTY's Payer ID for electronic submissions is CX083
- LIBERTY's Claims fax number is 1-888-700-1727
- LIBERTY's Mailing Address for Claims is: Liberty Dental Plan
  P.O. Box 15149
  Tampa, FL 33684

MEDICAL POLICIES AND COVERAGE GUIDELINES

We process claims based on the member's eligibility, benefits, and the medical necessity of the service provided. Evidence-based Medical Policies (Evidence-based Clinical Guidelines) are used to help determine coverage under the medical necessity provisions of member contracts and Certificates of Coverage. In developing Medical Policies, we look to current best available external clinical evidence, specialty societies, physician consultants and the Food and Drug Administration (FDA).

Note: CMS establishes its own medical guidelines mandated by law for Medicare beneficiaries. Although the criteria for reviewing services may be similar, the Medicare medical guidelines and our Medical Policies are not interchangeable.

Authorization Guidelines

An authorization is defined as an approval of medical services by an insurance company and is usually required prior to services being rendered.

Failure to obtain a preauthorization for procedures and services that require one may result in the provider not being reimbursed for the non-authorized procedure or visit.

Note: Members should be referred to a participating provider to maximize benefits and to avoid higher out-of-pocket expenses.

Referral Guidelines

A referral is defined as the process of directing or redirecting (a medical case or a patient) to an appropriate specialist or agency. For MMM Medicare and Much More members, referrals for specialists must be obtained from the member's Primary Care Physician (PCP) to a participating specialist and/or ancillary location (i.e. Rehab, and Free-Standing Facilities) by entering a referral in the Plan's provider portal, www.mmm-fl.innovamd.com.

Pharmacy Utilization Management Guidelines

Select prescription drugs, including injectable medications, may require that specific clinical criteria are met before the drugs will be covered under MMM Medicare and Much More pharmacy and/or medical benefit programs.

Reference the Pharmacy Drug List in our Provider Portal mmm-fl.InnovaMD.com or on the Plan's website www.mmm-fl.com for a list of drugs requiring prior approval.

A Pharmacy Drug List (drug formulary) is a list of prescription drugs, both generic and brand name, covered by a plan. The drug formulary and utilization management edits are reviewed and approved by CMS. The formulary is developed by a Pharmacy and Therapeutics Committee composed of pharmacists and physicians from various medical specialties. The committee reviews new and existing medications and selects drugs to be included in the health plan's formulary based on safety and effectiveness. The committee then selects the most cost-effective drugs in each therapeutic class. When a generic becomes available for a brand drug already included in formulary, a process exists for the inclusion of the generic drug in formulary. The continuing inclusion of the brand drug is then reviewed by the committee. The list of drugs selected represents the prescription therapies that are necessary as part of a quality pharmacologic treatment program. The plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary. All prescriptions should be filled at plan network pharmacies and following other plan rules.

In general, the Pharmacy Drug List is updated yearly, although it is subject to maintenance changes throughout the year. Some changes are additions of new drugs, and others occur if the FDA deems a drug to be unsafe or due to CMS removals.

Specialty Pharmacy and Diabetic Testing Supplies

Certain medications, such as injectable, oral, inhaled, and infused therapies used to treat complex medical conditions are typically more difficult to maintain, administer, and monitor when compared to traditional drugs. Specialty medications may require frequent dosage adjustments, special storage and handling, and may not be readily available at local pharmacies or routinely stocked by physicians' offices, mostly due to the high cost and complex handling required. Use of the Specialty Pharmacy to provide specialty medications results in significant cost savings, which lowers the amount members have to pay for these medications.

Part D

CVS Specialty® is a Part D Specialty pharmacy that is a provider for the MMM Medicare and Much More network. Using the CVS Specialty® pharmacy will help our patients adhere to their plan of care while helping to make sure the administrative process is as efficient as possible for your practice. Condition-specific clinicians help ensure your patients start and stay on your prescribed regimen. From therapy education to adherence support, they are always ready to help.

You can send a specialty prescription to many of the CVS Pharmacy® locations or directly to CVS Specialty. Your patients can choose to pick up their medication at a CVS Pharmacy or get delivery by mail to their residence. If you wish to use the services provided by CVS Specialty®, you can E-Prescribe (E-Rx), phone or fax prescription to any CVS Pharmacy or CVS Specialty. If faxing, please include a copy of the patient's medical and prescription ID cards. If the medication requires preauthorization, please also include a completed Coverage Determination form with your submission. Phone: (786) 220-8865 Fax: (305) 883-0652 for E-Prescribe: E-Rx# 5708283 Pharmacy NPI 1508133885.

Part B

MMM Medicare and Much More contracts with preferred Specialty Pharmacies who will deliver medication directly to your office location. Buy and Bill options will be at the discretion of health plan (where applicable). All medication fulfillment will be through our selected Specialty Pharmacy vendor. Requests for medications that are to be administered in an office setting or in outpatient facility must be sent directly to MMM's Utilization Management unit via the Provider portal or by fax. When faxing in your request, please ensure to include our Preauthorization Form (found on our website) along with pertinent clinical progress notes. The medication request will be reviewed by a qualified clinician and a decision will be rendered timely based on CMS guidelines. Please remember to reserve expedited requests for "true emergent situations". Please send requests timely (Monday through Thursday) to avoid delays and to allow MMM to review your request. Our Fax number is 1-833-523-2630, Phone: 1-888-722-7559, Select Option #6 to speak to one of our Provider Relations Associates.

Diabetic Testing Supplies

MMM Medicare and Much More has a preferred Diabetic Testing Supply product line. We prefer the product line from Trividia Health. Products include: TRUE METRIX AIR (meter and strips), TRUEdraw (lancing device), TRUEplus (lancets, pen needles and syringes). For a complete listing of products, you can visit the manufacturers website: www.trividiahealth.com.

CLAIMS PROCESSING AND PAYMENT GUIDELINES

MMM Medicare and Much More (MMM) will process 95% of clean claims within thirty 30-days of receipt. A "clean" claim has no defect or impropriety, including lack of required substantiating documentation from providers and suppliers, or circumstances requiring special treatment that prevents timely payment from being made on the claim. A claim is clean even though it may be referred to a medical specialist for examination within MMM. If additional documentation involves a source outside MMM, the claim is considered "unclean". MMM makes an initial determination within sixty 60-days from receipt on all claims considered "unclean" from both contracted and non-contracted providers.

Types of Claim Submissions

Electronic Claims

Participating Providers are required to submit claims with appropriate documentation. Provider must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse and use current HIPAA ANSI X1 25010 837 format. This is the only acceptable format for submitting claims and encounter data. The Payer ID number is: MMMFL.

Paper Claims

We encourage providers to file claims electronically, however, submission of paper claims are accepted. Claims submissions via email or fax are not acceptable. Instructions for completing the CMS-1500 and UB-04 claim forms can be obtained from the following websites:

CMS	www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List
National Uniform Billing Committee	www.nubc.org
National Uniform Claim Committee	www.nucc.org

Please send via mail to:

MMM Medicare and Much More
ATTN: CLAIMS DEPT
P.O. Box 260370
Miami, FL. 33126

Claims That Correspond to a Delegated Entity

Providers submitting new claims or requesting a reconsideration, correction or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment must submit their request to the delegated entity responsible for payment.

Timely Filing Limits

Providers must file claims within the time set forth in their MMM Medicare and Much More participating provider Agreement(s) unless applicable law requires a greater time period for filing of claims. If applicable to a particular benefit agreement, current Florida law and other legal requirements provide that claims must be filed within 180 days after the date of service and receipt by the provider of the name and address of a patient's health insurer.

Provider should submit claims indicating their usual fees for services rendered. MMM will make appropriate adjustments based on the contractual agreement. MMM complies with applicable legislation regarding timeliness of filing and processing claims.

Claims and Encounter Data Submissions

You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the member. If you have questions about submitting claims to us, please call us at the phone number listed on the member's health-care ID card.

Providers must bill for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

Required Elements

The following information must be included on every claim:

- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges for service provided
- Place and type of service code
- Days or units as applicable
- Provider tax identification
- National Provider Identifier (NPI)
- Rendering Provider as applicable

Records Review for Claims Payment

Under certain circumstances, MMM Medicare and Much More will suspend claims for medical review in order to determine if the services rendered are covered. Clinical information/medical records for these select procedures/services may be requested to support claims adjudication. Failure to submit the clinical information/medical records may result in processing and payment delays.

Clinical documentation/medical records that may be requested include, but are not limited to the following:

- History and physical
- Operative reports
- Physician/nurse notes
- Consultation reports
- Lab reports
- Radiology reports
- Anesthesia notes and time
- Physician orders
- Plan of treatment
- Medication name, physician order, dosage, units and NDC number

When additional documentation is required to process a claim and it is not received, MMM Medicare and Much More will provide a denial reason in the Explanation of Payment (EOP). The denial reason will state that the claim needs documentation.

Claims Adjustments

Adjustments are defined as claims that have been previously paid (partially or completely) in which a provider identifies a payment error. The time limit to submit an adjustment is 90-days from the last date of payment on the Explanation of Payment (EOP).

Steps to submit an adjustment:

1. Fill out Adjustment Request Form located in provider portal www.mmm-fl.com/about-us/healthcare-professionals
2. Provider will submit copy of the claim or the EOP identifying claims with a payment error. If submitting multiple claims, include the claim number of each claim on a separate sheet and attach EOPs.
3. Copy of any additional documentation is accepted, such as, but not limited to:
    a. Clinical information
    b. Progress notes
    c. CMS policy. Any other documentation the provider deems necessary

4. Provider needs to submit the claims identified with an adjustment with an Adjustment Form that requires the following information:
    a. Identify if the provider submitting adjustment is a physician or a facility
    b. Identify if provider is participant or non-participant of the network
    c. Provider name
    d. Provider NPI (Rendering and Billing)
    e. Contact name
    f. Provider or contact telephone number
    g. Member name
    h. Member ID number
    i. Claim number
    j. Cross-reference number
    k. Date of service
    l. Date of payment (remittance date)
    m. Reason for adjustment. Please select from the following:
        1) Copy does not apply
        2) Insufficient payment
        3) Difference in units
        4) Incorrect diagnosis
        5) Incorrect provider
        6) Incorrect place of service
    n. Other (please give details)
    p. Representative signature
    q. Date (date document was prepared)
5. Claims submitted for adjustment are received and stamped with the receipt date in the Claims Department.
6. Adjustment is analyzed and processed according to payment policy and procedures within the established time frame of 30-days from receipt date.

Please send to: MMM Medicare and Much More
ATTN: Claims Disputes Deparment
P.O. Box 260370
Miami, FL. 33126

Electronic Corrected Claim

Providers with EDI or batch processing can electronically submit corrected claims to us via Electronic file 837. If you file these claims with the appropriate bill or frequency type codes listed below, then they can be included in your normal electronic submission process. Contact your vendor if you need assistance identifying the loop and segment for the type codes.

For institutional claims, use the three-digit Bill Type (XX7 or XX8) ending in the appropriate number. For professional claims, use the appropriate number (7 or 8) for the Frequency Type.

7 – Replacement of Prior Claim - If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

8 – Void/Cancel of Prior Claim - If you have submitted a claim to MMM Medicare and Much More in error, resubmit the entire claim. If the claim was paid, resubmit the claim to MMM using the Claims Overpayment Refund Form located on mmm-fl.innovamd.com.

Claim Status

If you would like to follow up on the status of your claim, you may contact the Provider Contact Center Department at 1-888-722-7559 (Toll-Free) Monday through Friday from 8:00 a.m. to 5:00 p.m.

Pharmacy Claims (Part B)

Submit claims for payment directly to MMM Medicare and Much More following the guidelines below.

Drug Units

The drug units must always be included on the claim submission. The drug units should be based on the HCPCS code, not the NDC, unless a specific J code is not assigned to the drug.

Unclassified drug codes (J3490, J3590, J9999, J1599, etc.) must always be billed with the drug name, NDC and NDC units. The NDC should be provided in field 24G on a CMS-1500 and in loop 2410 segment LIN on an electronic 837 Professional claim submission.

Diagnosis

Include the primary diagnosis code on the claim, which is the reason for the drug use.

Coordination of Benefits with Medicare Group Plans

Coordination of Benefits (COB) is administered according to the member's benefit plan and in accordance with law. Coordination of Benefits (COB) is used to process health-care payments when a member has coverage with more than one insurer. When it is identified that a member has coverage with more than one insurer:

- Providers should first submit a claim to identified payers who have primary responsibility for payment.
- When filing a claim, you must include a copy of the other insurance's EOB.
- MMM Medicare and Much More will pay deductibles, copayments, coinsurances, and other member responsibility amounts not paid by the Primary Carrier as long as the total payment does not exceed the amount MMM would pay as the Primary Carrier.

- MMM Medicare and Much More may request a refund for COB claims paid in error for up to thirty (30) months from the original payment date.
- MMM Medicare and Much More will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

COB allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

The COB Process

- Ensures claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer, whether Medicare or other insurance, pays first.
- Shares Medicare eligibility data with other payers and transmits Medicare-paid claims to supplemental insurers for secondary payment. Note: An agreement must be in place between the Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the BCRC to automatically cross over claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.
- Ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payments.

Your Responsibilities

Gather accurate plan coverage data to determine whether Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness. Bill the primary payer before billing Medicare, as required by the Social Security Act. Institutional providers: Submit any MSP /COB information on your claim using proper payment information, value codes, condition and occurrence codes, etc. (If submitting an electronic claim, provide the necessary fields, loops, and segments for Medicare to process an MSP claim.) Professional providers: Submit an Explanation of Benefits (EOB), or remittance advice, from the primary payer with your Medicare claim, with all appropriate MSP information. (If submitting an electronic claim, provide the necessary fields, loops, and segments for Medicare to process an MSP claim.)

Subrogation

We have the right to recover benefits paid for a member's health-care services when a third-party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan.

Claim Payments and Statements

Remittance Advice

The remittance advice provides you with claim payment and rejects information. When you file a claim, you can view your remit online using your clearinghouse if a payment is due, you will receive payment by check or Electronic Funds Transfer (EFT).

Claims are processed daily and combined into a weekly payment. Remittance advice is also generated on a weekly basis. Providers receiving payments via EFT may view the electronic remittance in their clearinghouse portal. Providers that elect to be paid by Paper check will receive payments and hard copy of the remittance advice at the provider's payment to location for the claim.

If you file electronically, you can receive the 835 ERA upon request. Refer to the Health Care Payment/Advice section for additional information on how to start receiving the 835.

Overpayment Recovery

An overpayment is reimbursement in excess of the monetary obligation that we have with respect to a claim. MMM Medicare and Much More pursues timely recovery of all identified overpayments in accordance with applicable law.

Provider Identified Overpayments

If you identify a claim for which you were overpaid, you must send the overpayment within (30) calendar days from the date of your identification of the overpayment. If overpaid funds are not returned in a timely manner, the plan may request repayment. If we do not receive repayment within 45-days of our written request, the plan may take action to recover overpayment, to the extent permitted by applicable law, including but not limited to, by offsetting against future claim payments.

Providers can handle repayments in the following manner:

- Complete the Claim Overpayment Refund Form.
- You do not need to return the original check. You may use a personal/company check. Please also refer to the remittance advice/explanation of payment if the repayment is only for one or two patient claims that were incorrectly paid. Please enclose copies of the remittance advice/explanation of payment pages, highlighting the claims that were erroneously paid.

Return address for overpayment refund: MMM Medicare and Much More
ATTN: Claim Refund of Payments
PO BOX 71305
San Juan, PR 00936-8405

APPEALS & GRIEVANCES

An appeal refers to the review of adverse organization determinations for the health-care services a member is entitled to receive, or any amounts that the member must pay for a service. These procedures include reconsiderations by the MA organization, an independent review entity, and hearings before Administrative Law Judges (of the Social Security Administration) or review by the board of judicial review. If a DSNP, the member may request a Medicaid Hearing Appeal with the Medicaid state agency.

A member has the right to appeal any adverse benefit determination made by MMM Medicare and Much More (MMM) for: • Payment for emergency services, post-stabilization care, urgently needed services, or temporarily out-of-area renal dialysis; • Failure to approve, furnish, arrange for, or provide payment for, in whole or in part, services the member believes should be covered; or • Discontinuation of services that the member believes are medically necessary/appropriate and should be continued.

Members are able to challenge national and local coverage determinations. A member can only seek review if he or she needs (a) service(s) that is(are) applicable to a national or local coverage determination as documented by the treating provider.

MMM Medicare and Much More has a standard appeals process and an expedited appeals process. Details are summarized on the following pages.

Member Appeal & Grievances General Rule

General rules regarding MMM Medicare and Much More grievance and appeal process include the following: A grievance or appeal must be filed with the Plan within 60-days of the date of the occurrence that initiated the grievance or appeal. In order for grievances or appeals, concerning adverse benefit coverage determinations based upon medical necessity/appropriateness, to be reviewed by the Plan Appeals and Grievances medical director, the member must submit the grievance or appeal within (60) calendar days from the receipt of MMM Medicare and Much More coverage determination.

A member must cooperate fully with the Plan in its effort to promptly review and resolve a complaint, grievance or appeal. In the event the member does not fully cooperate with MMM, the member will be deemed to have waived his or her right to have the complaint, grievance or appeal processed within the time frames set forth above.

MMM Medicare and Much More shall offer to meet with the member if the member believes that such a meeting will help the Plan resolve the grievance or appeal to the member's satisfaction. The meeting will be held in the Plan's local office within the service area or at such other mutually agreeable location within the

service area that is convenient to the member. The member may elect to meet with Plan representatives in person, by telephone, conference call, or by videoconferencing (if facilities are available). Appropriate arrangements will be made to allow telephone conferencing or videoconferencing to be held at the administrative offices of MMM within the service area. The Plan will make arrangements with no additional charge to the member. The member must notify the Plan that he/she wishes to meet with MMM representatives concerning the grievance or appeal. The member has the right to submit oral or written documents, records, or other information relating to their grievance or appeal.

MMM Medicare and Much More will provide to the member any of the forms necessary with each written decision letter or upon request of the member. The member may obtain such forms by calling the customer service number shown on the ID card.

If the grievance or appeal involves an adverse benefit coverage determination for payment of a service that does not meet the Plan's medical necessity/appropriateness criteria, or the service is excluded from payment because it meets the definition of experimental or investigational, the member may request copies of the scientific or clinical criteria utilized in making the adverse benefit coverage determination.

For reconsiderations involving adverse benefit coverage determinations MMM Medicare and Much More will appoint (a) physician(s) not involved in the initial review process to review the appeal. The appointed physician(s) will not be the individual who made the initial adverse determination nor be (a) subordinate(s) of such individual. MMM Medicare and Much More will resolve a member's grievance/appeal within (30) calendar days of receipt of the grievance or pre-service appeal, within (60) calendar days of receipt of the appeal for a post-service claim and within 72-hours for an appeal involving urgent care.

Who May File an Appeal, Grievance, or Complaint?

A member may file an appeal, grievance or complaint or may appoint an individual as a representative to act on his or her behalf by submitting to MMM Medicare and Much More their name, original Medicare number, and a statement or appointment of representative (AOR) form, which appoints an individual to act as their representative.

Note: A member may appoint a physician or provider to act as their representative. The statement must be signed and dated by the member and the appointed representative unless the representative is an attorney. The signed statement must be included with their appeal.

A member has the right to make a complaint if they have concerns or problems related to coverage or care. Appeals and grievances are the two different types of complaints a member can make, depending on the situation. If a member makes a complaint, we must treat the member fairly and not discriminate against him or her because of the complaint. A member also has the right to get an informational summary about past appeals and grievances that other members have filed against MMM Medicare and Much More in its capacity as a Medicare Advantage (MA) organization.

Members have appeal rights in the event of an adverse pre-service benefit determination:
A member, or provider on behalf of a member, has the right to a pre-service benefit determination. In the event of an adverse determination, the member, the member representative, the member's treating physician acting on behalf of the member, or staff working under the direction of the provider, or any other provider or entity (other than MMM) determined to have an appealable interest in the proceeding, may submit an appeal on a member's behalf.

Member Grievance and Appeals Process

MMM Medicare and Much More has established a process for reviewing member complaints; grievance or appeals. The purpose of this process is to facilitate review of, among other things, a member's dissatisfaction with the Plan, its administrative practices, benefit coverage and payment determinations, or with the administrative practices and/or the quality of care of any of the independent contracting health-care providers in the MMM Medicare and Much More provider network. The MMM Grievance and Appeal Process also permits a member, or his/her physician, to expedite the Plan's review of certain types of complaints or grievance or appeals. Members must follow the process set forth below in the event of a complaint, grievance or appeal. All references to "member" also include a member's authorized representative.

A member, or a provider acting on behalf of the member, may submit a grievance or appeal. To submit or pursue a grievance or appeal on behalf of a member, a health-care provider must previously have been directly involved in the treatment or diagnosis of the member. The attending physician, if authorized to do so by the member, may act on behalf of the member to request a standard review of an adverse benefit determination made by the Plan within 60-days of the initial adverse determination notice.

In order to begin the formal review process, the member must submit a Grievance/Appeal request by contacting Customer Service Department or sending a written request to the plan. If the member submits the request in writing the letter should:

- Contain the member's full name, plan identification number, and a contact phone number
- Explain the facts and circumstances related to the grievance/appeal, including the date it occurred.
- Include as much back-up documentation as possible such as copies of any relevant documentation.

The member or a provider acting on behalf of a member may call MMM Medicare and Much More at the number listed on the ID card or at 1-844-212-9858. Hearing and speech impaired members may contact MMM by dialing 711 TTY.

If you want to write to us rather than file a verbal grievance, you may address your correspondence to the following address:

MMM Medicare and Much More
Appeals and Grievances
P.O. Box 260430
Miami, FL 33126

Member Grievance

Grievance refers to any member complaint or dispute other than one involving an organization determination as described under the appeal section. Examples are waiting times and provider behavior, adequacy of facilities, formulary and/or its administration, the quality of service received and other similar member concerns.

Member may present a grievance by calling the customer service number listed on the ID card or in writing. Upon request, member services representatives will assist the member in preparing the grievance. Hearing and speech impaired members may contact MMM Medicare and Much More by dialing 711 TTY.

MMM Medicare and Much More will review the grievance in accordance with the standard grievance process and advise the member of its decision verbally or in writing if the grievance was presented in writing or is a quality of care grievance. Review by the Plan will take no longer than (30) calendar days from receipt of the member's grievance. The Plan may extend this time frame up to (14) calendar days if the member requests the extension or the Plan believes that requesting additional information might be helpful to the member clinical criteria utilized in making the adverse benefit coverage determination.

For reconsiderations involving adverse benefit coverage determinations MMM Medicare and Much More will appoint (a) physician(s) not involved in the initial review process to review the appeal. The appointed physician(s) will not be the individual who made the initial adverse determination nor be (a) subordinate(s) of such individual. MMM Medicare and Much More will resolve a member's grievance/appeal within (30) calendar days of receipt of the grievance or pre-service appeal, within (60) calendar days of receipt of the appeal for a post-service claim and within 72-hours for an appeal involving urgent care.

Expedited Grievances

Member grievances are handled as expeditiously as the situation warrants; however, there are three situations where the member has the right to file an expedited grievance.

1. When there is a decision not to grant the member's request to expedite an initial determination or appeal
2. For Part D only: The member has not yet obtained the drug
3. For Part C only: The plan extends a time frame related to an organization determination or appeal When an expedited grievance is filed, the plan must respond to the member within 24-hours in the following situations:
    - To advise the member that their request for an expedited organization determination does not meet criteria and inform them that standard time frames have been applied to their case.
    - To advise the member that their request for an expedited appeal does not meet criteria and the standard time frame/reconsideration process is applicable.
    - To grant an extension of up to 14-days for an expedited or standard organization determination or appeal and the member disagrees with the plan's decision to grant an extension.

Reconsideration Is the First Step in the Appeal Process

Reconsideration consists of a review by MMM Medicare and Much More of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit, or the Plan or CMS obtains.

There are two types of reconsideration - standard and expedited. A standard reconsideration can be requested by the member or their designated representative; an assignee of the member (a physician or other provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service); a legal representative of a deceased member's estate; any other provider or entity (other than MMM) determined to have an interest in the appeal proceeding; or any other provider or entity (other than MMM) whose rights with respect to the organization determination may be affected by the reconsideration as determined by the entity that conducts the reconsideration. Contracted providers are required to submit a signed authorization of representation in order to be a party to reconsideration, except in expedited requests. An expedite reconsideration can be requested by the member or their designated representative; any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the member.

Standard Reconsideration Requests

There are two categories of standard reconsideration - services or payment. A request for reconsideration must be filed in writing within (60) calendar days of the organization determination notification date. The 60-day time frame may be extended if the requester submits the request in writing and shows a good cause for not filing the request on time.

1. For Pre-Service or benefits: Original Adverse Organization Determination Overturned: If the MMM Medicare and Much More reconsideration determination is completely favorable to the member, then MMM must issue the determination and effectuate it (authorize or provide service under dispute) as expeditiously as the member's health condition requires, but not later than (30) calendar days (or not later than expiration of an extension of up to 14-days) from the date request is received; except in the case of Part B drugs where the standard timeframe is 7-days and timeframe cannot be extended. MMM may extend the 30-day time frame for Part C Pre-services or benefits by up to (14) calendar days if requested by the member or if MMM justifies a need for additional information and how the delay is in the interest of the member.

Original Adverse Organization Determination Upheld: If the plan's reconsideration determination confirms, in whole or part, the adverse determination under appeal, MMM Medicare and Much More must submit a written explanation and the case file to the independent entity contracted by CMS as expeditiously as the member's health condition requires, but no later than (30) calendar days (or not later than expiration of an extension of up to 14-days) for Part C services or benefits or not later than 7-days for Part B drugs from the

date the request is received. MMM may extend the 30-day time frame by up to (14) calendar days if requested by the member or if MMM justifies a need for additional information and how the delay is in the interest of the member when applicable.

2. For Payment: Original adverse organization determination overturned: If the MMM Medicare and Much More reconsideration determination is completely favorable to the member, MMM must issue the determination and pay for the service under dispute not later than (60) calendar days from the date the request was received.

Original Adverse Organization Determination Upheld: MMM Medicare and Much More reconsideration confirms, in whole or part, the adverse determination under appeal, MMM must submit a written explanation and the case file to the independent entity contracted by CMS not later than (60) calendar days from the date the request was received.

Providers can submit a service appeal on behalf of the member if the provider is the member's PCP or a treating physician. A written representative authorization must be submitted with the standard appeal in order to be reviewed. Contracted providers do not have appeal rights. If the provider needs to make a claim regarding of how a claim was processed, paid or denied, these requests should be treated as a claim adjustment with the Claims Department.

Expedited Review of Urgent Complaints - Grievances or Appeals

If MMM Medicare and Much More, based on information received, makes an adverse benefit coverage determination that a service, which has not yet been provided to the member is not a covered benefit for payment purposes or is specifically limited or excluded from benefit coverage under the terms of the member's handbook, the member, or a provider acting on behalf of the member, may submit a verbal or written request for expedited review.

A member, or a provider acting on behalf of the member, may request expedited review if a delay in making a benefit coverage determination by applying the standard timeframes of the grievance and appeal process would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, or in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the complaint.

Medicare Expedited 72-Hour Determination and Appeal Procedures

A member may request and receive expedited decisions affecting his or her medical treatment in time-sensitive situations. A time-sensitive situation occurs when waiting for a decision within a standard time frame could seriously jeopardize the member's life, health, or ability to regain maximum function. If MMM Medicare and Much More decides, based on medical criteria, that the member's situation is time-sensitive or if any provider makes a request for the member by writing or calling in support of the member's request for an expedited review, we will issue a decision as expeditiously as the member's condition requires, but not later than 72-hours after receiving the request for items and services; or 24-hours after receiving the request for Part B drugs.

MMM Medicare and Much More may extend this time frame by up to (14) calendar days if a member or provider requests the extension or if we need additional information and the extension of time benefits the member. For example, MMM Medicare and Much More may need additional medical records from non-contracting providers that could change a denial decision. A decision will be made as expeditiously as the member's health requires, but not later than the end of any extension period.

An expedited reconsideration may not be a request for payment. If the Plan denies a request for an expedited reconsideration, the request becomes a standard reconsideration subject to the (30) calendar-day time frame. MMM Medicare and Much More promptly notifies the member verbally within 72-hours by telephone or in person. MMM sends a letter within (3) calendar days of the oral notification explaining that the request will be processed using the 30-day standard reconsideration time frame. The letter informs the member of the right to file an expedited grievance if the member disagrees with a decision not to expedite. Instructions about the grievance process and time frames are also included.

If a request is made or supported by a provider, MMM Medicare and Much More must provide an expedited reconsideration if the provider indicates that applying the standard reconsideration time frames would seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

The provider should specifically request an expedited review. If the Plan upholds its initial determination it must forward the member's case file to the independent review entity as expeditiously as the member's health requires, but not later than within 24-hours of affirmation of its adverse organization determination. If you appeal, we will review our initial decision. If payment for any of your claims is still denied, we will forward your appeal to the Centers for Medicare & Medicaid Services Independent Review Entity (IRE) for a new and impartial review. If the IRE upholds our decision, you will be provided with further appeal rights as appropriate.

Appeals for Non-Par Providers

Providers not participating with MMM Medicare and Much More have the right to appeal. You may file your appeal in writing within (60) calendar days after the date of the remittance advice. To obtain the Non-Participating Medicare Advantage Appeal form, go to the Web Portal. The time can be extended if you can provide evidence for what prevented you from meeting the deadline. For us to review your appeal, we will need your completed signed Waiver of Liability Statement. To obtain a Waiver of Liability form, go to the Web portal. Upon review of this Appeal form and the Waiver of Liability (WOL) form, we will give you a decision on your appeal within (60) calendar days. Physicians and suppliers who have executed a waiver of liability are not required to complete the CMS-1696, Appointment of Representative, form. In this case, the physician or supplier is not representing the beneficiary, and this does not need a written appointment of representation. If the MMM Medicare and Much More plan does not receive the form/documentation by the conclusion of the appeal time frame, the plan would dismiss the appeal.

Medicaid Fair Hearing Request

A DSNP enrollee can request a fair hearing orally or in writing when the plan appeals process is completed in the following circumstances:

- After receiving notice that the health plan is upholding the adverse benefit determination (the plan appeal is denied)
- If the health plan fails to meet the notice and timing requirements for resolving a plan appeal.
- Enrollees may represent themselves in a fair hearing, they may be represented by a non-attorney authorized representative, or, by an attorney authorized to practice law in Florida retained by the enrollee.
- Any person making a hearing request on behalf of a recipient or seeking to represent a recipient in a fair hearing, must file with the State of Florida Agency of Health Care Administration Office of Fair Hearings a written authorization signed by the recipient or by a person with legal authority to act on behalf of the recipient, designating the person as the recipient's authorized representative.
- The enrollee must complete the Plan appeal process before asking for a Medicaid fair hearing. The plan appeal is complete when:
- The enrollee receives an adverse determination from the plan or
- The plan fails to adhere to notice and timing requirements applicable to plan appeals. An enrollee who has completed the Plan's appeal process may file for a Medicaid Fair Hearing within (120) calendar days of receipt of the Plan's notice of plan appeal resolution.
- Not later than 10-days before the date of the Hearing, the enrollee should send to the hearing officer at the Office of Fair Hearings all documents that he/she plans to review at the hearing.
- The Office shall provide each party with a written notice of fair hearing at least 14-days in advance of the fair hearing date.
- Each party must comply with all prehearing instructions issued by the Office or a Hearing Officer.
- A Hearing Officer is authorized to deny or dismiss a request for a fair hearing for reasons consistent with this rule, including lack of jurisdiction, failure to complete the plan appeal process, untimely request, failure to appear, and enrollee withdrawal. The Hearing Officer will provide each party with written notice when a fair hearing request is denied or dismissed.
- The fair hearing officer will make a final decision on the enrollee's fair hearing in about 90-days.
- The enrollee has the right to appeal the decision of the Hearing, but Medicaid and the health plans cannot.
- The enrollee has 30-days from the date on the Final Order to send in an appeal. This appeal of a Final Order goes through the District Court of Appeals. The hearing officer's final order may be appealed by the enrollee to the Florida District Courts of Appeal.

QIO Review of a Member's Hospital Discharge Appeal

When a member is admitted to an acute care hospital to receive care, the member will receive a notice entitled Important Message (IM) which is delivered to all Medicare inpatients by the hospital prior to admission or near admission, but not later than (2) calendar days following the date of admission. If the member is being discharged more than (2) calendar days after receiving the IM at admission, hospitals must deliver the follow-up copy as far in advance of discharge as possible, but no more than (2) calendar days before the anticipated/planned date of discharge.

When a member believes that they are being asked to leave the hospital too soon and chooses to exercise the right to an immediate review, he/she must submit a request to the QIO not later than midnight of the day of discharge and it may be in writing or by telephone. When the QIO notifies the Plan that a member has requested an immediate review, the Plan must, directly or by delegation, respond to the member as soon as possible, but not later than noon of the day after the QIO's notification. A member may also appeal the decision when being discharged (transferred) to a lower level of care within the same acute care facility.

The hospital and/or MA Organization must submit medical records and other pertinent information to the QIO as soon as possible, but not later than by close of business of the day the MA Organization notifies the hospital of the request for this information.

As part of the review, the QIO must solicit the views of the member, the hospital and the Plan and may contact the attending physician. The attending physician should be cooperative and candidly express their opinion as it pertains to the member's continued hospital stay. The QIO must notify the member, the hospital and the MA Organization of its determination within one calendar day after it receives all necessary information from the hospital and/or the MA Organization by telephone, followed by a written notice.

If the member wishes to appeal the discharge decision but does not do so within the time frames noted above, he or she may request an expedited reconsideration by the MA Organization.

Note: ''Member'' as used in this section includes a member's representative.

QIO Review of Members' SNF, Home Health Care, and Comprehensive Outpatient Rehabilitation Facility Discharge Appeal

Members of MA plans who are receiving authorized, covered services from SNFs, home health agencies, or comprehensive rehabilitation facilities are afforded the opportunity to appeal the termination of coverage by requesting an expedited reconsideration by the QIO or through MMM Medicare and Much More's expedited appeal process if they are dissatisfied with the decision to terminate coverage, and have missed the QIO filing deadline. Members will receive written notices regarding the termination of coverage and the appeal process. The written notice is called the Notice of Medicare Non-Coverage (NOMNC). Termination of coverage can result from either of the following activities:

- Attending physician discharges the member from the services being received; or
- The plan, in conducting concurrent care reviews, determines that the member no longer meets criteria to continue coverage for the services being rendered.

If a member disagrees with the termination of services and appeals to the QIO, the QIO will notify the Plan and the Facility or Provider of the appeal. All parties must respond to the QIO by the end of the business day when the appeal is received or by noon the following day if notification is received at the end of the day. The Plan must respond using the Detailed Explanation of Non-Coverage (DENC), CMS model form.

For dual SNP members receiving services only under the Medicaid benefit, the AHCA process, including the opportunity for Fair Hearing, is followed.

QIO Review of Quality of Service Complaints

A member may contact the QIO at the address below if they have complaints about the quality of care they received from contracting providers including physicians, hospitals, skilled nursing facilities and home health agencies. Each complaint is investigated and reviewed by appropriate qualified clinical personnel.

KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Phone: (844) 455-8708 or Fax: (844) 834-7129

COMPLIANCE & QUALITY PROGRAMS

Quality Programs

Physician and Provider contracts require participation in our Quality Programs and initiatives. As part of our Quality Improvement Program, we may utilize information such as claims and encounter data and/or medical record data to monitor the health care and services delivered to our members, to identify deficiencies and inform our improvement interventions.

MMM Medicare and Much More (MMM) QI Programs include; but are not limited to, the following:

- Clinical Practice Guideline Adherence Monitoring
- Medical Records Requirements & Audits
- Condition-Specific Interventions and Programs
- Credentialing/Re-credentialing
- UM Affirmative Statement
- Incident Reporting
- Member and Provider Satisfaction
- Preventive Health Monitoring and Improvement
- Quality Performance Indicators
- Utilization and Over-Utilization Assessment

Clinical Practice Guideline Adherence Monitoring

Clinical practice guidelines are used to assist practitioners and members in their decisions about appropriate care for specific clinical circumstances. MMM uses national, state, or specialty recognized guidelines. Local physicians participating in our committees can make recommendations on the use of these guidelines.

Some of the clinical practice guidelines adopted by the Plan include:

- US Preventive Services Task Force (USPSTF) – Preventive Care & Screening
- The American Diabetes Association - Adult Diabetes
- American Heart Association – Congestive Heart Failure
- Centers for Disease Control & Prevention - Asthma
- The Journal of the American Medical Association – Hypertension
- American Psychiatric Association – Substance Abuse

We select several key indicators from these clinical practice guidelines to monitor the outcomes of care. This requires periodic review of the participating physician's office records.

Clinical practice guidelines are periodically reviewed and evaluated for updates and changes. Adopted Clinical Practice Guidelines are available on our website mmm-fl.innovamd.com and on the health plan website mmm-fl.com.

Medical Records Use and Disclosure Guidelines

MMM Medicare and Much More will follow the usual and customary protocols within the provider community to utilize member records maintained by providers. These records will include member's diagnoses, medical conditions, medications, progress notes and services/treatments provided to the member. Records must be maintained for at least 10 years.

Confidentiality and accuracy of a member's record must be maintained at all times. MMM requires that all providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of member data. The privacy of any information that identifies a member must be safeguarded. Information from or copies of a member's record may only be released to authorized individuals.

Providers must take steps to prevent unauthorized individuals from gaining access to or altering a member's record. Original records may only be released in accordance with state laws, court orders or subpoenas, and timely access by members to the information that pertains to them must be ensured. Additionally, MMM and providers must abide by all federal and state laws regarding confidentiality and disclosure of all member records and information.

Additionally, the member records must include substantive documentation that prominently demonstrates whether they have executed an advance directive. MMM Medicare and Much More, AHCA, and any federal or state agency, and their designees, must have access to member records.

Special protection applies to psychotherapy notes, these are defined by the Privacy Rule as notes recorded by a mental health professional documenting or analyzing the contents of a conversation during private, group, family or joint counseling sessions, these must be and kept separate from the patient's medical and billing records.

Release of Member Records

If the member is present and has the capacity to make health care decisions, providers may only communicate with a patient's family members, friends, or other persons if the member consents 45 CFR § 64.510(b). The provider may request the member's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object.

If the member is not present or is incapacitated, the provider may share the patient's information with others involved in their care or payment for care, if they have written of consent from the member or, if the provider determines, based on professional judgment, that doing so is in the best interests of the patient. In all cases, disclosures must be limited to only the protected health information directly relevant to the individual's involvement in the patient's care or payment for care.

In all cases, psychotherapy notes are private and may not be disclosed without the member's consent, including disclosure to a health-care provider other than the originator even in cases where the disclosure is for treatment purposes. Exceptions for disclosures required for law enforcement, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).

Medical Record Keeping & Documentation Standards

All physician and practitioners must maintain a clinical records system that supports the capacity to properly process, store, retrieve and distribute such records. This applies to electronic and paper records and accounts for, at least:

- Maintenance
- Storage
- Confidentiality
- Release

The office staff is aware of the Medical Record Retention policy as established by CMS.

"CMS requires that providers submitting cost reports retain all patient records for at least five years after the closure of the cost report. And if you're a Medicare managed care program provider, CMS requires that medical records are retained for 10 years."

The Medicare program does not require a specific media format—records can be in the original form or in a legally reproduced form—which may be electronic or digital. Whichever format is used, it's important to use a system that protects and ensures the security and integrity of all records. Records should be accurately written, promptly completed, properly filed and readily accessible.

Confidentiality of Member Information

All health care professionals who have access to medical records have a legal and ethical obligation to protect the confidentiality of member information. In order to fulfill these obligations, the following guidelines have been developed:

- By Federal Statute, all individuals and institutions with access to PHI must comply with the HIPAA Privacy Final Rule.
- All health-care professionals and employed staff who have access to member records or confidential member information should be made aware of their legal, ethical and moral obligation regarding member confidentiality and may be required to sign a document to that effect.
- Member records should be accessed only by authorized staff; should not be left in public view and should be stored in an organized and consistent manner.
- Members have the right to access their medical records according to MMM Medicare and Much More rules and in accordance with applicable law.
- Any and all discussions relating to confidential member information by staff should be confidential and conducted in an area separate from member treatment or waiting areas.

- Safeguards to maintain the confidentiality of faxed medical information should be in place.
- Primary and specialty physicians and their staff are to receive periodic training regarding protection of confidentiality of patient records and the release of records.
- In the event member records are to be sent to another provider, a copy of the signed authorization for the release of information should be enclosed with the records to be sent. The records should be marked "Confidential".

A copy of the policy on confidentiality of medical records may be posted in the provider's office.

Required Content & Documentation Standards

An individual medical record is maintained for every patient. For each member encounter, entries into the medical record should be timely and accurate. Significant medical advice or direction given to the member, either on-line, via telephone, after hours, or during other such activities should have a signed entry in the medical record.

1. Each page within the record contains both the patient's name and last names, date of birth (DOB) or Member ID number.
2. The record includes personal and biographical data. The following information must be included: Name, gender, date of birth, member insurance ID number
3. All entries dated and authenticated by either the initials or signature of a physician followed by credential (M.D.)
4. The record must be legible to all reviewing parties.
5. The record includes medication list and any medication allergies or adverse reactions (patient-stated intolerances to medications) must be noted in the record. If there are no known allergies or no known drug allergies, the "NKA" must be prominently displayed.
6. For patients seen at least three times, the record must document the following, if applicable:
    a. Use of Tobacco
    b. Use of Alcohol
    c. Substance Abuse
7. There must be a physician's signature or initial on all ancillary reports. Ancillary reports include, but are not limited to consultant summaries, laboratory and radiology or imaging study results. Appropriate lab and radiology studies are ordered, documented and consistent with physical findings.
8. A complete immunization history or notation that immunizations are "up to date" must be included on all records of patients who have been seen three or more times.
9. An initial (and annually thereafter) history and family history profile must be completed and documented for patients with two or more visits.
10. A comprehensive physical examination must be completed and documented annually for patients with two or more visits.
11. History of present illness is documented on each visit; the physician obtains information from the patient/caregiver of patient's complaint or reason for the visit and it is recorded in the chart. The physician conducts an assessment and enters a diagnosis.

12. Diagnostic work-up and plan of treatment is recorded.
13. If prescriptions were given to the patient, are documentation of instructions, e.g., dosage and frequency documented in the chart? If medication was administered to the patient, was the drug dosage, and site recorded?
14. Medication reconciliation for members after a hospital discharge must be included.
15. Unresolved problems from previous office visits shall be noted and addressed in subsequent visits.
16. When consultations are required, the reason for the referral is noted in the patient record.
17. Abnormal consultations, labs, X-ray reports filed in the chart have explicit notation on record of follow-up plans.
18. There is evidence of patient education/counseling regarding self-care, specific illness, or preventive medical care located in the patient record.
19. When applicable, there is a discharge note written on the record of a patient who undergoes an office procedure.
20. There is evidence of a discussion regarding treatment preferences or an "Advance Directive" noted in a prominent place in the patient's record.
21. Evidence in the record of functional status assessment for patients 65 y/o >. Documentation in the medical record must include evidence of functional status assessment and the date on which it was performed. Notations for functional status assessment may include the following:
    a. Functional independence
    b. Loss of independent performance
    c. Activities of Daily Living (ADL)
    d. Social activities
    e. Instrumental Activities of Daily Living (IADL)
    f. The level of assistance needed to accomplish daily activities
22. Evidence in the record of Pain Screening for patients 65 y/o >. Documentation in the medical record must include evidence of pain screening or a pain management plan and the date on which it was performed. Evidence of pain screening may include the following:
    a. Notation of the presence or absence of pain
    b. Results of a screening using a standardized pain screening tool.
    c. Evidence of a pain management plan may include the following.
        i. Notation of no pain intervention and the rationale.
        ii. Notation of plan for treatment of pain, which may include use of pain
23. Evidence in the record of height, weight, Body Mass Index (BMI) at least once a year. The chart has notation of height, weight, Body Mass Index (BMI) at least once a year.
24. Evidence in the record B/P at least for each visit
25. Evidence in the record of the signed HIPAA document
26. Screening preventive test results. Evidence in the record of the following preventive measures, diagnostic results of:
    a. LDL
    b. Mammography
    c. Colonoscopy
    d. Sigmoidoscopy
    e. Urinalysis

f. Occult blood
g. Glaucoma screening
h. PSA screening in older men
i. The chart has diagnostic results of all the above at least annually except as specified.

27. Preventive screening at least once a year and maintain in control values:
    a. Diabetic Member:
    b. Eye Exam
    c. Foot Care
    d. Glycosylated hemoglobin
    e. Micro albumin or macro albumin results
28. The chart has diagnostic results of all the above at least annually.
    a. CHF Member
        i. Echocardiogram results
    b. MI Member
        i. Evidence of Beta-blocker
    c. COPD Member
        i. Simple Spirometry results annually
        ii. Chest X-ray results
    d. Asthma member
        i. Evidence of Inhaled Steroids use

Condition-Specific Interventions and Programs

Condition-specific interventions and programs focus on improvement of specific clinical conditions and promote continuous quality improvement for our members. Providers are encouraged to collaborate with us to close gaps in clinical care. This can be accomplished by referring members with chronic conditions into our Clinical Operations Programs, where they will receive condition-specific coaching and education.

UM Affirmative Statement for Utilization Management Programs

Our policy on financial incentives for Utilization Management (UM) programs applies to practitioners, providers, and employees involved in, or those who supervise those involved in making coverage and benefit UM decisions. Our policy on financial incentives is as follows:

- Utilization Management decision-making is based on the factors set forth in our definition of medical necessity for coverage and payment purposes in accordance with Medical Policy Guidelines, then in effect, and the existence of coverage and benefits under a particular contract, policy or certificate of coverage. We are solely responsible for determining whether expenses incurred, or to be incurred, or whether medical care is, or would be, covered or paid under a contract or policy. In fulfilling this responsibility, we shall not participate in or override the medical decisions of any physician or provider.
- Our payment policies are not designed to reward practitioners or other individuals conducting UM for issuing denials of coverage or benefits.
- Financial incentives for UM decision makers are not designed to encourage decisions that result in underutilization. Rather, the intent is to minimize payment for unnecessary or inappropriate health-care services, reduce waste in the application of medical resources, and minimize inefficiencies, which may lead to the artificial inflation of health-care costs.

Incident Reporting

MMM Medicare and Much More complies with incident reporting as defined in the Florida Administrative Code (F.A.C. 59A12.012(4) and requires provider assistance in obtaining the information to be reported.

The state defines the type of incidents that must be reported as, ''an event over which health-care personnel could exercise control,'' and:

- Is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and
- Is not consistent with or expected to be a consequence of such medical intervention; or
- Occurs as a result of medical intervention to which the patient has not given his informed consent; or
- Occurs as the result of any other action or lack thereof on the part of the facility or personnel of the facility; or
- Results in a surgical procedure being performed on the wrong patient; or
- Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries and procedures to remove foreign objects remaining from surgical procedures; and
- Causes injury to the patient.

Report such incidents to the Provider Contact Center and request an incident report be submitted to the Risk Manager.

Adverse and Critical Incident Reports

Adverse Incidents are unexpected occurrences in connection with services that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to an individual receiving service through MMM Medicare and Much More Health plan or any third party that becomes known to the plan's staff. Adverse and Critical incidents must be reported by both providers and vendors.

A Critical Incident as defined by the Agency for Health Care Administration (AHCA): ''Critical events that negatively impact the health, safety, or welfare of members. Critical incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.'' This may result in, but is not limited to, the following:

- Death
- Abuse/neglect/exploitation
- Major medication incident
- Altercation requiring medical intervention
- Involvement with law enforcement
- Member elopement/missing
- Member major injury
- Member major illness

According to the Adverse Incident Reporting Guide distributed by AHCA, the term ''adverse incident'' means an event over which health-care personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and results in one of the following injuries:

- Death
- Brain or spinal damage
- The performance of a surgical procedure on the wrong patient.
- The performance of a wrong surgical procedure.
- The performance of a wrong-site surgical procedure.
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition.
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process.
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

If either an Adverse or Critical incident is identified, the providers may report the incident as follows:

1. Download and complete the MMM Medicare and Much More Adverse Incident Report form from our website at mmm-fl.innovamd.com and fax to: 1-833-523-2631.
2. Contact MMM Medicare and Much More to report the incident. Be prepared to provide the same level of detailed information that is requested on the form. Such as:
    a. Identification Information
    b. Member Demographic Information
    c. Details of where, when and nature of the incident
    d. Name and contact information of any persons present at the time of the incident
    e. A succinct and accurate description of the occurrence
    f. Physician Information if known, and whether he/she has been notified
    g. Your name, role, and full contact information of the person and whether you've contacted the Agency.

Please note: The critical incident reports fax is unattended on weekends and holidays. Providers must follow-up by emailing the critical incident email for incidents that occur on weekends and holidays.

Adverse/critical incident reports must be completed in their entirety and faxed to 1-833-523-2631. For any incidents that occur on the weekends (after 5 p.m. Friday), and on holidays, providers must also report the incident immediately via the Provider Call Center's fax number at 1-833-523-2631.

Member and Provider Satisfaction Assessment

- Satisfaction surveys are a critical component of quality improvement.
- Surveys are conducted in order to obtain the member's perspective of the quality of care and service received.
- Feedback is provided to primary care physicians.
- Providers are surveyed to gain an understanding of their level of satisfaction with the quality of services provided by various departments within MMM Medicare and Much More.
- Results and improvement goals are shared with members and providers via newsletters and the website.

Preventive Health Monitoring and Improvement

The Preventive Health Monitoring and Improvement program promotes the appropriate use of preventive health services for members in order to positively impact personal health behaviors and medical outcomes. Program monitoring in the form of focused studies may require periodic review of the participating physician's office records.

MMM Medicare and Much More has adopted the USPSTF Preventive Services Guidelines, which are available on our website under Medical Information.

Quality Performance Indicators

Performance measures have been selected for the purpose of assessing certain ''process of care'' and/or ''outcome of care'' dimensions for each important aspect of care and service.

- Measures serve as indicators to both consumers and the public in evaluating how well the MMM Medicare and Much More health-care delivery system is meeting customer needs in these areas.
- Measures can also be used by health-care providers to evaluate and improve care and service to members.
- The performance measures were developed through review of work conducted by leaders in the field of health-care quality improvement.
- Currently, the Plan reports data from HEDIS as well as results from conducted member surveys such as CAHPS and HOS.

Underutilization and Overutilization Assessment

CMS requires Medicare Advantage plans to facilitate delivery of appropriate care and monitor the impact of its UM programs to detect and correct potential under/over utilization of services. MA health plans using physician incentive plans that place a physician or physician group at substantial financial risk (as defined at 42 CFR § 422.208(d) should review utilization data to identify patterns of possible underutilization of services that may be related to the incentive plan.

Underutilization of services may exist when medical services vary substantially, when physicians are compared to a peer group, or services are not provided according to the level specified in practice parameters, industry standards, or other benchmarks.

Audit Programs

All participating providers are required to comply with our audit programs and to cooperate and assist us in conducting audits of claims submitted. Audits are intended to determine if claims payments were accurate. If a provider fails to follow the procedures for disputing or contesting an audit finding, then we may proceed with collection of such amounts as allowed by law, including but not limited to, offsetting against other amounts due to provider.

This information is intended to serve only as a general reference resource regarding our provider audit and recovery process and is not intended to address all reimbursement situations or all processes that may be utilized.

The Healthcare Provider Audit department is responsible for identification and recovery of overpayments through audit activities for all providers. The scope of audit focuses primarily on the identification of claims overpayments and subsequent recoveries.

All claim audits are conducted on a claim-by-claim basis. Some audits review many issues concerning the claims, but others are targeted reviews related to specific issues. A typical audit may include not only a review of the claim itself but also a review of the medical records or other supporting documents to substantiate the claim submitted. Audits may be conducted by us, our customers or governmental, accreditation or regulatory agencies. Providers are required to participate in audits conducted by all such parties, including any contracted vendors utilized to conduct the audits.

Depending on specific claim reimbursement terms, audit reviews may consider, but are not limited to:

- Compliance with contractual conditions and terms
- Appropriateness of coding (e.g., national coding standards; CPT, HCPCS, ICD10-CM, others as applicable)
- Unbundling of services/procedural codes (e.g., Hospital Charge Reimbursement Definitions, Correct Coding Initiative and code editing hardware)
- Billing accuracy
- Duplicate payments
- Member benefits, exclusions and coverage periods
- Claims processing guidelines
- Criteria supporting medical appropriateness of care and/or compliance with MMM Medicare and Much More Medical Policies (Medical Coverage Guidelines)
- Accuracy of the authorization and prior approval processes, where indicated or required
- Our payment methodologies

We may request medical records or supporting documentation in connection with an audit. If we request medical records, you will provide copies of those free of charge unless otherwise required by law or contract.

All audits will be conducted in accordance with any applicable state or federal laws or requirements along with any provisions set forth in a provider's participation agreement with us.

In House Audits

Certain audits do not require us to be onsite at the provider's location. Such audits are less costly and administratively burdensome for both us and the provider. Providers are required to provide us with any medical records or supporting documentation required to conduct such desk audits. Desk audits include, but are not limited to the following:

Check Run Audits:

Based on the weekly check runs, individual claim payments may be audited based on specific payment parameters for each type of service (e.g., all outpatient claims over a specific dollar amount).

Claims Payment Review:

Verifies payment accuracy in accordance with the provider's contract, applicable processing/coding guidelines and the member's benefits/limitations.

Targeted Audits:

Systemic auditing using certain payment codes, specific contract terms, specific contract load issues, or procedures that have been identified as a concern for all or specific contracted providers.

Special Request Reviews:

Review of a specific provider as requested by an account or group such as our Medical Operations, Marketing, Special Investigations or other areas within the Plan for a specific purpose.

Provider Audit Process

Notification/Confirmation Responsibilities:

- Prior to a provider audit, the plan will send the provider written notice of the upcoming audit 10 working days prior to the audit start date. Audit notifications can be sent to the provider by email, mail, or fax.
- The notification will at minimum indicate the following:
  - Type of audit
  - When applicable, a list of claims to reviewed containing claim number, member name, patient account number and date of service
- A request for medical documents or components to support billing
- The plan may request a formal entrance conference with applicable provider designee and our audit staff when conducting an Onsite Audit. The formal entrance conference will be held on day one of the onsite visit. Note: Certain targeted audits are conducted without prior notification to the provider. In these instances, the provider will have the opportunity to respond to the findings.

Provider Audit Responsibilities

MMM Medicare and Much More requires the provider acknowledge receipt of audit notification in writing. Said acknowledgement should include at minimum:

- Contact name and telephone number for individual(s) responsible for coordinating the audit and the provider designee responsible for finalizing and approving audit findings.

- For onsite audits, confirmation of the date, time and location for the entrance conference and, if applicable, medical record review.
- If requested, provide facilities for the entrance and exit conference and ensure attendance by staff authorized to approve audit findings.

During the Audit, the Provider Agrees to

- Provide all charts, invoices, itemized bills, financial records and other data requested to support the documentation of claims payment accuracy.
- Provide copies of requested documentation, to be given to auditor or mailed to appropriate address as directed by the auditor.

Audit Findings

- The provider designee will review/communicate the preliminary audit findings with provider personnel authorized to finalize audit findings.
- Provide formal acceptance of each finding in anticipation of the exit process.
- When applicable, refund member copayments and correct the audited accounts to ensure no further adjustment activity occurs.

MMM Medicare and Much More Audit Responsibilities

- Perform audit
- Discuss preliminary findings with the provider. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.
- Mail a copy of the preliminary audit findings to provider designee. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.

Audit Escalation Process

Issues and concerns related to findings resulting from an audit should follow a normal course of resolution, which is resolved through:

- Prior to issuing final audit findings, the MMM Medicare and Much More assigned auditor will review any issues and refer the matter to the responsible MMM Auditing Manager.
- After the issuance of the final audit findings, if provider followed the required process to dispute or contest the plan's findings, as outlined above, the matter will be referred to the appropriate resource:
  - Contractor/Negotiator
  - Medical Director
  - Legal Affairs Division
- If after following the appropriate processes to contest audit finding the matter remains unresolved, then either party may proceed to a formal dispute resolution in accordance with provider's participating provider agreement.

Exit Process

Plan Responsibilities in Exit Process:

An exit conference will be conducted with provider designee including an overview of audit findings. Exit conferences may be conducted via telephone if in person conference is not required.

- Discussion of overpayment recovery process: Upon completion of the audit, repayment will be requested from the provider, to be mailed to the MMM Overpayment Recovery lockbox with audit summary attached (refer to Overpayment Recovery) or recoupment may be initiated by offsetting refunds due to us.
- In cases where the provider requests the use of the offset payment methodology, no checks should be sent to us. Using the offset process will significantly reduce the potential for duplicate recovery processing.

A final exit letter documenting agreed upon audit results, terms of collections for overpayment, and names of the designees present at the exit.

Vendor Audits

We may use contracted vendors to supplement audit activities when considered necessary to reduce risk and exposure to the company. Contracted vendors must follow all audit procedures when conducting audits for us. Vendor activities are centrally coordinated by the Healthcare Provider Audit department to ensure statewide consistency. In these audits, the provider will need to send the check to the address contained in the audit letter, not directly to MMM Medicare and Much More. The directions indicated in the audit letter need to be followed to ensure appropriate adjustments and credits are made to the audited claim.

Primary Care Physician Medicare Record Review

MMM Medicare and Much More monitors providers with medical record-keeping through the QI Department on an on-going basis. The purpose of this review is to ensure compliance with medical record-content policies, with clinical practice and preventive health guidelines, and specific CMS Star metrics. This review will be conducted on a periodic basis through various types of reviews that may include routine medical record review, HEDIS review, quality of care review, review of complaints and grievances, and/or investigations of an incident report. The provider will be provided results and feedback of these reviews as indicated and interventions may be initiated depending on the review findings.

Medicare Advantage Onsite Compliance Audits

To comply with CMS guidelines, selected claims from Medicare Advantage providers are audited on an annual basis. The provider is responsible for ensuring the "original" records are authenticated by one of three forms handwritten signature, signature stamp, or electronic signature. Transcribed records must have one of the above forms of authentication.

A formal entrance conference will provide the scope and purpose of the audit, arrangements for photocopying and/or scanning of medical documentation, as well as to establish the exit conference criteria.

In cases where discrepancies are noted from the audit, adjustments will be made to the diagnoses based on the medical record documentation.

We will provide information and education to provider staff and possible follow-up audits may be scheduled to ensure encounter data submission accuracy.

Specialized Audits

Specialized audits may be performed on but not limited to the following:

- Claims payment based on charges
- Catastrophic/Trauma claim audits/claims payment based on charges
- Itemized bills for inpatient claims, meeting specific provider contractual limitations/conditions and Hospital Charge Profile/Charge Reimbursement definitions in conjunction with our billing guidelines.

Encounter/Claim Data Audits

Medicare Advantage providers will be randomly selected for provider audits to verify compliance with encounter/claim data submission. Providers will be notified (15) working days prior to the onsite audit. The focus of the audits will be:

- To determine based on the audit findings that the encounter/claim data audited is complete, truthful, and accurate.
- To compare reported encounter/claim data to a sample of medical records to verify the accuracy and timeliness of the reported information. The audit unit will provide the provider with written information concerning compliance and/or audit findings.

Provider Non-Compliance/Penalties

If it is determined through provider audits, or any other means, that a provider is non-compliant with encounter/claim data submission, the following steps will be taken:

- The provider will be notified in writing and we will place the provider on corrective action for 30-days. During this time, we will work with the provider to obtain compliance.
- Provider compliance will be re-assessed after 30-days. If it is determined that a provider is complying with encounter/claim data submission, the provider will be removed from corrective action. However, if the provider is still non-compliant after 30-days, we may initiate termination of the Agreement.

Fraud, Waste, and Abuse

At MMM Medicare and Much More we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. Accordingly, we want to share with our providers' information on fraud, waste and abuse.

Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions or inadequate oversight. Waste is not typically the result of criminal actions.

FWA Program

In continuing its efforts to further promote its Compliance Program, MMM Medicare and Much More has developed the Fraud, Waste and Abuse (FWA) Program. The FWA Program addresses a set of guidelines for the development and implementation of a comprehensive compliance program to reduce fraud, waste and abuse, enhancing health-care provider operations, improving quality health-care services, and reducing overall costs. The FWA Program will assist the Company in fulfilling its legal duty to provide quality care, refrain from submitting false and inaccurate claims or cost information to the Centers for Medicare & Medicaid Services (CMS), Office the Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA).

MMM Medicare and Much More will comply with all the federal and the state regulations related to fraud, waste and abuse, which include but do not limit the following:

- The Title XVII of the Social Security Act
- Medicare regulations governing Parts C and D found at 42 C.F.R. § 422 and 423 respectively
- Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119)
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191)
- False Claims Act (31 U.S.C. 3729-3733)
- Federal Criminal False Claims Statutes (18 U.S.C. 287, 1001)
- Anti-Kickback Statute (42 U.S.C 1320a-7a (a)(5))
- Civil monetary penalties of the Social Security Act (42 U.S.C. 139w-27 (g))
- Physician Self-Referral (''Stark'') Statute (42 U.S.C. 1395nn)
- Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act

- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government 42 U.S.C. 1395w-27 (g)(1)(G).
- Fraud Enforcement and Recovery Act of 2009
- All sub-regulatory guidance produced by CMS and HHS such as manuals, trainings materials, HPMS memos, and guides.

In addition, the FWA Program applies to all business contractual arrangements with providers, i.e. physicians, vendors, subcontractors, hospitals, brokers, FDRs, agents, and any other person subject to federal, state laws and regulatory oversight in relations to FWA.

FWA Audits and Investigations

The Compliance Department conducts, coordinates, and reports audit and investigation activities for the purpose of preventing and detecting fraud, waste, or abuse in the delivery of health care.

In general, FWA situations often relate to the following:

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Up-coding

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member Fraud, Waste and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

The detection and prevention of FWA is the responsibility of everyone. MMM Medicare and Much More has written policies and procedures that address the prevention, detection, and investigation of suspicious noncompliance activity. MMM also conducts compliance training and regularly publishes articles related to FWA on the provider portal. In addition, the Company has established a Compliance Hotline 1 (844) 992-4848, the EthicsPoint web-based reporting system at mmm-fl.ethicspoint.com, and the email siu@mmm-fl.com for employees, subcontractors, customers, and the general public as an important mechanism to anonymously report fraud, waste, abuse and misconduct. The hotline is an effective tool of communication that helps prevent and detect Fraud, Waste and Abuse and protect funds by identifying ways to reduce costs and streamline operations within MMM Medicare and Much More.

If you have questions about Compliance efforts, please contact your Provider Relations Representative.

PARTICIPATING PROVIDERS

Below are "highlights" of responsibilities generally associated with our provider agreements; this listing is not all-inclusive.

- Provide covered services to members with MMM Medicare and Much More coverage.
- Do not discriminate against any member based on race, color, religion, gender, national origin, age, and health status, participation in any governmental program, source of payment, marital status, sexual orientation or physical or mental handicap.
- Always provide timely covered services to members.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Agreement (which includes the most current manual).
- Accept payment, plus the member's applicable deductible, coinsurance and/or copayment, as payment-in-full for covered services.
- Provider does not balance-bill the member for any differences between the charge and the contractual allowance. The member is only responsible for any applicable deductible, coinsurance, and/or copayment and non-covered service amounts or services exceeding any benefit limitations.
- Adhere to guidelines for usage of all electronic self-service tools.
- Fully comply with our Quality Improvement, Utilization Management program, Case Management, Disease Management, Focused Illness/Wellness, and Audit Programs.
- Adhere to MMM business ethics, integrity and compliance principles and standards of conduct as outlined in the Plan's code of conduct.
- Promptly notify us of claims processing payment errors.
- Maintain all records required by law regarding services rendered for the applicable period.
- Make such records and other information available to us, any referring Physician and appropriate government entities.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA-AS and HITECH requirements.
- Immediately notify us of adverse actions against license or accreditation status.
- Comply with all applicable federal, state, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of your Agreement.
- Notify us of the intent to terminate your Agreement as a participating provider within the timeframe specified in your Agreement.
- Network providers will not file additional claims for Medicaid deductibles or co-payment reimbursement and will not balance-bill MMM Medicare and Much More enrolled dual eligible beneficiaries.

Provider Responsibilities When Agreement Is Terminated

- Continue to provide services to members who are receiving inpatient services until they are appropriately discharged, and/or the specific episode of care is completed.
- Accept payment at rates in effect under the Agreement immediately prior to termination.

Provider General Responsibilities

This section is an overview of responsibilities for which all participating MMM Medicare and Much More providers are accountable. Please refer to the Provider Participation Agreement (the Agreement) or contact a Provider Relations representative for clarification of any of the following.

Participating MMM Medicare and Much More providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to the plan members as required by state and federal laws.
- Provide covered services in a manner consistent with professionally recognized standards of health care 42 C.F.R. § 422.504(a)(3)(iii).
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct member care within the scope or practice established by the rules and regulations of the approved AHCA, and the plan guidelines.
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- Clearly identify physician extender titles (examples: MD, DO, ARNP, PA) to members and to other health-care professionals.
- Always honor any member request to be seen by a physician rather than a physician extender.
- Administer, within the scope of practice, treatment for any member in need of health-care services.
- Respond promptly to the plan or member's request(s) of information malpractice insurance upon request. If the provider lacks malpractice insurance, provider must post such information in a prominent location in their office.
- Maintain the confidentiality of member information and records. Allow the plan to use provider performance data for quality improvement activities.
- Respond promptly to the plan's request(s) for medical records in order to comply with regulatory requirements.
- Maintain accurate medical records and adhere to all the plan's policies governing content and confidentiality of medical records as outlined in Quality Improvement and Compliance.

- Ensure that:
- All employed physicians and other health-care practitioners and providers comply with the term and conditions of the Agreement between provider and the plan.
- To the extent physician maintains written agreements with employed physicians and other health-care practitioners and providers, such agreements contain similar provisions to the Agreement.
- Physician maintains written agreements with all contracted physicians or other health practitioners and providers, whose agreements contain similar provisions to the Agreement.
- Maintain an environmentally-safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene. Maintain programs, including training staff on infection prevention and safety. In the plan's efforts to ensure an optimal environment of care and safety, compliance with these requirements will be monitored through provider site visits, analysis of member experience data (complaints, satisfaction surveys) and reporting of adverse incidents.
  - Infection Prevention Program
    - Reporting of untoward events in accordance with local requirements
    - Staff education for infection prevention
  - Safety Program
    - Management of potential threats and hazards
      - Medication error avoidance
      - Fall prevention
      - Reporting of adverse events to the plan
      - Emergencies, evacuation, and disaster readiness
- Compliance with all Federal, State and local regulations for safety & fire prevention
- For further information on these requirements, contact your provider contracting representative
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the plan, the member or the requesting party at no charge, unless otherwise agreed.
- Preserve member dignity and observe the rights of mto know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Do not discriminate in any manner between members and non-plan members.
- Ensure that the hours of operation offered to the plan members are no less than those offered to commercial members or comparable Medicare Fee-For-Service recipients if provider serves only Medicare Advantage recipients.
- Do not deny, limit or condition the furnishing of treatment to any plan member on the basis of any factor that is related to health status, including, but not limited to, the following:
      - Medical condition, including mental as well as physical illness
      - Claims experience
      - Receipt of health care

        - Medical history
        - Genetic information
            - Evidence of insurability
            - Including conditions arising out of acts of domestic violence, or disability
- Freely communicate with and advise members regarding the diagnosis of their condition and advocate on member's behalf for their health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are covered services.
- Identify members that need services related to health education and wellness, domestic violence, smoking cessation, substance abuse or other behavioral health issues. If indicated, providers must refer members to MMM Medicare and Much More-sponsored or community-based programs.
- Must document the Referral to MMM-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the service.

Appointment Standards

Network Providers are to responsible to comply with the following appointment availability standards for regular and routine care appointments, urgent care appointments and after-hours care:

PCPs must provide reasonable access for Members enrolled with MMM Medicare and Much More, including, but not limited to the following:

- Standard visits: (i.e. comprehensive exam, preventive care appointment) within four weeks of request .
- Routine appointments: within (10) business days or two weeks of request, whichever is sooner; non-urgent, symptomatic appointments within four calendar days of request.
- Urgent appointments: within 24-hours of request; and response by Physicians to an emergent call within 30- minutes of receipt of the call during office hours.
- All PCPs shall also assure that MMM Members enrolled have reasonable access to a Physician by providing:
    - Evening or early morning office hours three or more times per week;
    - Weekend office hours two or more times per month; and
    - Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed 30-minutes;
    - A 24-hour answering service and assure that each PCP provides a 24-hour answering arrange ment, including a 24-hour on-call arrangement for all members

Specialists shall ensure that all MMM Members enrolled have reasonable access to a physician by providing:

- Standard (regular/routine) appointments within 30-days.
- Urgent appointments with 72-hours and respond to emergency calls within 30-minutes of an emergency call or leave a message with "call 911 or go to ER."

Mental Health/Substance Abuse providers ensure Members have reasonable access to a physician by providing:

- Standard/Routine appointments within 10-days
- Urgent / Expedited appointments within 48-hours
- Emergency appointments within 6-hours or less (Emergency that doesn't represent risk to patient's life).
- Life-threatening emergency care available 24-hours/7 days per week.

After Hours Accessibility and Continuity of Care - MMM Medicare and Much More also ensures that when medically necessary, services are available and accessible to Members twenty-four (24) hours per day, seven (7) days per week, and three hundred sixty-five (365) days per year and in a manner that assures continuity of care. This may be through the help of a support center or by referring to facilities that offer services after hours. This includes requiring that all primary care physicians (PCPs) have appropriate back-up for absences.

- Provider (primary or specialty care) must provide the plan with at least a 30-day notice when voluntarily terminating from the network and comply with continuance of care policies of the Plan.
- Back-up provisions - On-Call and covering providers. In the event that a provider uses the services of other physicians for coverage purposes, covering arrangements shall be made with other physicians except in unusual and unanticipated circumstances such as emergent and urgent care. In all cases, the provider shall arrange with the covering physician that they will accept payment from the health plan according to the Health Plan's Medicare Fee Schedule as payment in full, except for any applicable member cost-sharing amounts. Provider shall ensure that the covering physician shall execute a Covering Physician Agreement (included in this Provider Manual) and that the covering physician will not, under any circumstances, bill members for covered services, except for any applicable member cost-sharing, and except as otherwise provided in the applicable Member Agreement.

It is the policy of MMM Medicare and Much More, as defined in its Risk Management Program, that a member may be refused care or dismissed from care by the provider if:

a. As a patient they pose a risk to themselves or others through their actions and behaviors;
b. there is evidence of continued failure to follow their physicians plan of care;
c. they cause disruption or threaten personnel, other patients, visitors or property.

Behaviors, non-compliance with care, disruptions or threats may include, but are not limited to:

a. raised voice or yelling and threatening physical actions like pushing, shoving or hitting.
b. verbal threats to staff or others present on the premises.
c. patient leaving against medical advice (AMA) in more than one occasion and documented on the chart /EMR.
d. chronic "no shows" to scheduled appointments/treatment despite appropriate and timely reminders by the office staff and documented in the chart/EMR.

If any of the above applies, The provider must provide the member/patient a written notice of the dismissal. The notice must include:

- A 30-day timeframe within which the physician will provide care for urgent/emergent needs only per the Florida Board of Medicine.
- A list of resources for the member to find another provider. The list must include the MMM Medicare and Much More Customer Service phone number 1-888-722-7559 among others such as the County Medical Society phone number to assist finding another Primary Care Provider in the area.
- The letter must be submitted by certified mail and the member/POA must be verbally notified in person or by phone.
- Information and receipt of the certified mail must be documented on the members chart.
- MMM Medicare and Much More Network/Contracting Dept must be notified within 1 business days from the dismissal and evidence of the above must be submitted to MMM.

MMM
Medicare and Much More

MEMBER RIGHTS, RESPONSIBILITIES & PROTECTIONS

Both MMM Medicare and Much More and you, as healthcare provider, must honor your patients' rights as members of a Medicare Advantage plan:

- To be treated with respect, consideration, and dignity.
- To be sure that the privacy of their personal health information is protected.
- To know how their health information has been shared and to request a restriction of their health information, as permitted by law.
- To receive information in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- To get timely access to their covered services and drugs.
- To receive information about the plan, its network of providers, their insurance coverage and their covered services.
- To select and change providers.
- To receive complete information about their health evaluation, diagnosis, treatment, and prognosis, and participate in decisions about their health care.
- To make complaints and to ask us to reconsider decisions we have made.
- To report discrimination if they believe they are being treated unfairly or their rights are not being respected.
- To give instructions about what is to be done if they are not able to make medical decisions for themselves·through establishment of an advance directive or living will.
- To be given the right to make decisions about their care.

They also have some responsibilities as members of a Medicare Advantage plan:

- Getting familiarized with their covered services and the rules they must follow to get these covered services.
- Letting us know if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- Informing their doctor and other healthcare providers that they are enrolled in our plan.
- Helping their doctors and other providers help them by giving information about their health, all medications including over-the-counter, dietary supplements and allergies or sensitivities, asking questions, and following through on their care.
- Being considerate and respectful.
- As Medicare Advantage plan members, they are responsible for the payment of any applicable premiums, copays, coinsurance, or fees particular to their coverage plan.
- Letting us know if they move.
- If they suspect or experience fraud, waste, abuse, or any misconduct, they must report It to us.
- Calling Member Services for help If they have questions or concerns.
- Letting us know if they have a living will or medical power of attorney.

2022 Training Attestation
Fraud, Waste and Abuse {FWA), Cultural Competency, General Compliance Training, Risk Management Training and Dual Special-Needs Plan

I certify I am an authorized representative of my organization with direct or indirect responsibility over all employees, Board of Directors, officials, contracted personnel, providers/physicians, hospitals, contractors, subcontractors, and vendors subscribed in my organization, who have direct or indirect contact with Medicare businesses. I certify that I have received from MMM of Florida, Inc. the CMS standardized General Compliance and FWA training modules, and Risk Management Training, the presentation Integrating Compliance and within MMM of Florida and and Dual Special-Needs Plan within MMM of Florida and Cultural Competency training module.

I certify that these documents will be used without modification and will be distributed to all employees and subcontractors at the time of hiring/contracting, and annually thereafter. I certify that I will maintain records for at least 10 years after training completion and will disclose them to MMM of Florida, Inc. upon request. Please complete the following information. If you do not complete this section, your attestation will be deemed incomplete and you will be out of compliance with the requirements.

Group Practice / Staff Model

Facility/Group: Billing NPI:

1. Practitioner Name _____ Rendering NPI: _____
2. Practitioner Name _____ Rendering NPI: _____
3. Practitioner Name _____ Rendering NPI: _____
4. Practitioner Name _____ Rendering NPI: _____
5. Practitioner Name _____ Rendering NPI: _____
6. Practitioner Name _____ Rendering NPI: _____
7. Practitioner Name _____ Rendering NPI: _____
8. Practitioner Name _____ Rendering NPI: _____
9. Practitioner Name _____ Rendering NPI: _____

_____ _____

Signature of Authorized Representative Date

Please email this form to: Providers@mmm-fl.com
You may also mail it to: MMM of Florida, Inc.
Compliance Department
5775 Blue Lagoon Drive - Ste 450, Miami, FL 33126

Medicare and Much More