MyTru Advantage

Provider Manual

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MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal. Y0150_4041_PS0072_C

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Definitions

For purposes of this manual, the following terms have the meanings stated below.

Beneficiary: An individual enrolled in a MyTruAdvantage Medicare Advantage plan.

Clean Claim: A claim submitted with all information and supporting documentation necessary for timely processing and adjudication.

Coordination of Benefits (COB): The process used to determine payment responsibility when a member has coverage under more than one health plan.

Covered Service: A medically necessary service or item included under the plan benefits, subject to applicable terms, conditions, and limitations.

Facility: Facility is defined as a licensed physical location or institution where healthcare services, testing, or treatment occur. Examples include hospitals, ambulatory surgical centers, skilled nursing facilities, home health agencies, outpatient clinics, diagnostic centers, rehabilitation facilities, end-stage renal disease facilities, laboratories, hospices, and suppliers. The definition includes anyone employed by the facility, any person or entity providing covered services under the facility's tax identification number, and any affiliate providing covered services that the facility owns or controls, even if that affiliate holds a separate tax ID.

Member: A person enrolled in a MyTruAdvantage health plan; also referred to as a beneficiary where appropriate.

MyTruAdvantage: SIHO's Medicare Advantage health plan, offering HMO and PPO plan options under contract with Medicare.

Participating Provider: A physician, other health care professional, ancillary provider, or facility that has an agreement to participate in the MyTruAdvantage network.

Primary Care Physician: Physicians who specialize in Family Practice, General Practice, General Internal Medicine, and Geriatrics.

Prior Authorization: Approval required from MyTruAdvantage before certain services, procedures, or drugs are provided for coverage under the plan.

Specialist Physician: Physicians who focus on a specific branch of medicine, organ system, or patient group after completing extra training beyond general practice.

Introduction

Welcome to the MyTruAdvantage Network. Medical providers are key to the successful delivery of healthcare for participants accessing the MyTruAdvantage Network. We encourage your active participation in the network and invite your inquiries on operational matters.

Purpose of this Manual

This Manual will acquaint you and your staff with the administration of MyTruAdvantage's health plans. The manual explains MyTruAdvantage's administrative policies and procedures.

We suggest that this manual be kept available for easy reference. This manual is frequently updated, and the most current version is available on our web site at www.MyTruAdvantage.com.

Overview of MyTruAdvantage

MyTruAdvantage was formed as a locally based health benefit program to effectively manage costs while continuing to assure quality medical care.

Health Care Delivery System

MyTruAdvantage is a provider-sponsored health plan that provides coordinated care to our MyTruAdvantage (Medicare Advantage) members. A common feature of our plans is working closely with our participating healthcare providers in performing utilization review, case management, and population health management programs.

- **MyTruAdvantage Plan (Medicare Advantage):** MyTruAdvantage offers HMO and PPO Medicare Advantage plans. Headquarters in Columbus, Indiana, powered by SIHO and owned by local health systems. MyTruAdvantage service area includes these counties in Indiana: Bartholomew, Boone, Brown, Clay, Daviess, Decatur, Dubois, Gibson, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Jennings, Johnson, Knox, Madison, Marion, Parke, Perry, Pike, Posey, Rush, Scott, Shelby, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick and Washington.

Provider directories, drug lists/formulary, and more can be found at www.MyTruAdvantage.com.

Participating Providers

Participating Providers are primary care physicians, specialist physicians, ancillary providers, and facilities who are contracted with MyTruAdvantage network.

Contact Information

A current provider directory, a drug list/formulary, and MyTruAdvantage's preventive health guidelines are available at www.MyTruAdvantage.com.

MyTruAdvantage has a web portal that allows you to:

- Verify member eligibility
- View plan benefit information
- Submit authorizations
- Check claim status

If you have questions, contact our Member Call Center at MemberServices@MyTruAdvantage.com or go to the website at www.MyTruAdvantage.com.

Give us a call at 844-425-4280 (TTY: 711). Hours of operation are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day.

- **Provider Call Center**
  For benefits, claims payment issues, multiple claims on the system, and coordination of benefits call:
  MyTruAdvantage
  (844) 425-4280 Toll Free
  (812) 348-4576 Local
  TTY: 711

- **Provider Services Department**
  For: Contracting, credentialing, provider education, quality of care issues, Federal Tax Identification Number changes, fee schedules, contract termination procedures, and provider mailings.

  Email at provider.services@siho.org or website at www.MyTruAdvantage.com
  Fax: (812) 378-8721
- **Medical Management Department**
  For: Certification for hospital admissions, appropriate outpatient services, inpatient & outpatient mental health services and referral authorizations.

  Go to website at www.MyTruAdvantage.com
  Phone: Toll Free (844) 425-4280 or Local (812) 348-4576
  Fax: (317) 860-3624
  Email: auth.submit@MyTruAdvantage.com

- **Provider Disputes**
  MyTruAdvantage participants have the right to initiate a dispute pertaining to issues of professional competency and/or conduct, quality of care, patient safety, and administrative issues. All these disputes are subject to the participating network agreement between the contracted provider and MyTruAdvantage Network, LLC.

  Providers can send all written disputes to:
  MyTruAdvantage
  Attn: Provider Dispute
  PO Box 428
  Columbus, IN 47202

Administrative Procedures

Overview

Section II of this manual details MyTruAdvantage's administrative procedures. The information provided describes claims processing, member billing, MyTruAdvantage's responsibilities and provider obligations.

Confidentiality

MyTruAdvantage employees, in accordance with HIPAA, HITECH and other applicable laws, will maintain the privacy and confidentiality of its providers and members. MyTruAdvantage acknowledges the importance of maintaining the privacy and confidentiality of provider information, peer review material, facility, and member information and documents associated with carrying out healthcare activities (verbal and/or written) and therefore, they will be kept confidential and comply with state and federal laws and regulations.

MyTruAdvantage providers must comply with all State and Federal laws concerning confidentiality of PHI (Protected Health Information) about members. Providers must have policies and procedures in place for use and disclosure of PHI that comply with applicable laws.

Non-discrimination

Providers must have policies and procedures in place to ensure that covered services are provided to members regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, and/or source of payment for care. Providers must also comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008.

Eligibility and Benefits

Member Identification

MyTruAdvantage reimburses providers only for medically necessary covered services rendered to eligible members. A member ID Card does not guarantee member eligibility.

Member ID Card

Each covered member receives an ID card with the MyTruAdvantage logo. Members are responsible for always carrying their ID card with them. To receive benefits, members are to present these cards to their health care provider when they obtain medical services.

MyTruAdvantage Member sample ID Cards

MyTruAdvantage Select (HMO)



MyTruAdvantage Red, White and Tru (PPO)

This is an MA ONLY plan, no RX benefits included.



MyTruAdvantage Choice Plus (PPO)



MyTruAdvantage Choice Complete (PPO)



Covered Benefits
MyTruAdvantage Offers Four Different Plans: MyTruAdvantage Select (HMO), MyTruAdvantage Red, White and Tru (PPO), MyTruAdvantage Choice Plus (PPO), and MyTruAdvantage Choice Complete (PPO).

With the **MyTruAdvantage Select (HMO) plan**, beneficiaries select a primary care physician (PCP) to coordinate all their health care services. The PCPs are beneficiaries' partner in helping them stay healthy and proactively managing their health. PCPs also help arrange or coordinate beneficiary services, including consulting with other providers about their care.

With the **MyTruAdvantage Red, White and Tru (PPO), MyTruAdvantage Choice Plus (PPO) plans**, and **MyTruAdvantage Choice Complete (PPO)** beneficiaries can receive care not only from network providers but may receive covered services from out of network providers as well.

All services must be medically necessary and covered by the beneficiary's contract to be paid by MyTruAdvantage. MyTruAdvantage determines whether services are medically necessary as defined by the beneficiary's Evidence of Coverage (EOC). For both HMO and PPO plans, certain procedures, services, and drugs may need "prior authorization" or "preauthorization" from MyTruAdvantage.

To verify covered or excluded services, or services requiring prior authorization, please see the MyTruAdvantage Summary of Benefits and Prior Authorization list on www.MyTruAdvantage.com or call MyTruAdvantage Member Services at the number listed on the back of the patient's MyTruAdvantage ID card. All services are subject to applicable copayments, deductibles, and coinsurance.

Member Rights and Responsibilities
MyTruAdvantage members have the right to timely and high-quality care and to be treated with respect and dignity. Participating providers must respect the rights of all members.

Member Rights

- To be treated with dignity and respect and right to personal privacy recognized
- To have information about their diagnosis, treatment, and prognosis so they can have candid discussions with providers about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage and actively participate in decisions regarding their health and medical care
- To have timely access to their PCP, and if out of service area, receive emergency care, if necessary
- To have medical records kept confidential (except when disclosure is required by law or permitted by patient in writing) and have access to copies or request amendments to their medical records in accordance with HIPAA regulations
- To extend their rights to a guardian, next of kin or legally authorized person on their behalf
- To be advised of the probable consequences of their actions when they refuse treatment or leave a medical facility against the advice of their providers
- To receive information about the organization, its providers and services and your rights
- To exercise these rights regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or national origin, cultural or educational background, economic or health status, and/or source of payment for care

Member Responsibilities

- To be familiar with their plan and benefits and any rules that may apply
- To inform providers (to extent possible) of the information they may need to provide care and to follow treatment plans and instructions that the member and their provider have agreed upon
- To ask any questions they may have of their provider

Special Requirement for Hospitals – MyTruAdvantage (MA) Members

- **Hospital Discharge rights for MyTruAdvantage (Medicare Advantage) members:** The Centers for Medicare & Medicaid Services (CMS) requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare members, including Medicare Advantage members who are hospital inpatients. Hospitals are required to provide the IM to MyTruAdvantage members upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form.
- **Medicare Outpatient Observation Notice (MOON):** Medicare requires hospitals and critical access hospitals (CAHs) to provide the Medicare Outpatient Observation Notice (MOON) to Original Medicare members and MyTruAdvantage (Medicare Advantage) members or their authorized representatives. This includes members who do not have Part B coverage, members who are subsequently admitted as inpatient prior to the required delivery of the MOON and members for whom Medicare is the primary or secondary payer. The MOON is intended to inform members who receive observation services for more than 24 hours that they are outpatient, not inpatients, and the reasons for their status.

Billing Members

Participating providers may NOT seek payment directly from the member, except for required copayments, deductibles, coinsurance, elective services, and non-covered services. Providers are reimbursed per their provider agreement and may not balance bill members.

Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance, and copay amounts. This includes any cost share applied to these claims. Providers may not bill a dual eligible member that has this coverage for any balance left unpaid (after submission to MyTruAdvantage and subsequently Medicaid) as specified in

the Balanced Budget Act of 1997. Providers that service dual eligible members must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid guidelines. Providers who balance bill the dual eligible member are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible members as "private pay" to bill the patient directly. Providers identified as continuing to bill dual eligible members inappropriately will be reported to CMS for further investigation.

Members may not be billed for services provided that are denied due to CCI edits** or the provider's failure to file a timely claim, submit a complete clean claim, respond to requested information, or comply with policy and procedures as required by the provider's agreement with MyTruAdvantage.

Members can be billed for non-covered services but must be made aware of their financial obligation prior to the service being rendered.

**The National Correct Coding Initiative (NCCI, or more commonly, CCI) is an automated edit system to control specific Current Procedural Terminology (CPT) code pairs that can be reported on the same day. The purpose of the CCI edits is to prevent improper payment when incorrect code combinations are reported.

Claims submitted by mail should be addressed to:
MyTruAdvantage
P.O. Box 428
Columbus, IN 47202

Electronic Claims Submission

MyTruAdvantage encourages and accepts electronic claims using Payer ID # **MTAMA**. For quicker claims payment and processing, please submit claims electronically.

Not using a clearinghouse?
If your billing system has the necessary functionality, you may be able to submit claims directly to MyTruAdvantage.

- Your system must be able to generate an ASC X12N 837 (004010X098A1) file.
- Your system must be able to split claims by payer so that we only receive claims for MyTruAdvantage customers.
- Your system must be able to submit both Individual and Group NPI numbers.

Clean Claim Submission

A clean claim is a claim that has all fields required by CMS for both 1500 and UB 04 claim forms completed. A claim will not be considered clean if it is missing any of the required fields or attachments required to adjudicate the claim.

To be considered "clean," a claim must meet the following criteria:

- HIPAA compliant
- EDI compliant format
- Have all required fields completed
    - National provider identifier (NPI) numbers
        - Paper Claims: Box/field 24j displays the rendering provider (Individual NPI); box/field 33a displays the billing provider location (Group NPI)
        - Electronic Transactions: NM1 *85 segment contains the Group NPI; NM1 *82 segment contains the Individual NPI
    - Provider's name and NPI
    - Provider's federal tax identification number (TIN)
    - Vendor name and address
    - Member's full name, date of birth, and ID number
    - Date of service

    - Valid diagnosis code(s)
    - Valid procedure codes(s) and modifier code(s), if applicable
    - Valid place of service
    - Charge information and units
    - National Drug Codes, when applicable
- Not require further investigation by the plan
- MyTruAdvantage timely filing limit is one (1) year from date of service.
- Have all information necessary to adjudicate a claim including any necessary supporting documentation (primary carrier explanation of benefits (EOB), medical records, etc.)

If a claim does not meet all the criteria listed above, the statutory period for processing will not apply. In some cases, if the information is incomplete or incorrect, we will be required to return the claim with a cover letter that will include what is necessary to process the claim.

Resubmitting Claims

Prior to resubmitting a claim, check the claim's status through the MyTruAdvantage website or call the MyTruAdvantage Call Center. The provider should only resubmit the claim if one of the following is not received within 30 days:

- Payment
- Remittance advice
- Letter requesting additional information
- Any other form of notification from MyTruAdvantage regarding the status of a submitted claim

Submitting a Corrected Claim

- HCFA 1500- Indicate "Corrected Claim Submission" on the claim or provide a cover letter to indicate the claim is a revision of a previous submission.
- UB 04—Indicate the appropriate bill type on the claim.

Payment Listing—Remittance Advice

The MyTruAdvantage Remittance Advice form explains the payment or denial on each claim that was submitted by the provider and processed by MyTruAdvantage.

Fraud, Waste & Abuse

MyTruAdvantage is dedicated to the detection, prevention, and correction of potential healthcare Fraud, Waste, and Abuse ("FWA"). Our FWA Program was developed in accordance with the following Federal and State statutes, regulations, and guidelines:

- Applicable State laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

The FWA Program has been developed to comply with all standards set forth by the regulations and laws of the United States Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS). The FWA Program and the FWA Program Description are reviewed periodically by MyTruAdvantage's Compliance Committee with revisions made as needed.

Definitions:

- Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are not medically necessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other facts.

Examples of Fraud, Waste, and Abuse
Please report fraud, waste, and abuse if you see it. There are many examples of fraud, waste, and abuse. Some examples are below.

- A provider charges MyTruAdvantage for services it did not provide.
- A provider offers a MyTruAdvantage member money or kickbacks to use their services.
- A MyTruAdvantage member lends an ID card to someone else.
- A MyTruAdvantage member sells drugs they were prescribed or forges a prescription.
- A provider performs medically unnecessary services to receive payment from MyTruAdvantage.

FWA Hotline
MyTruAdvantage accommodates anonymous, confidential, and private reporting of good faith concerns of suspected FWA. MyTruAdvantage maintains confidential reporting mechanisms that individuals can use to report suspected FWA. MyTruAdvantage's FWA Hotline is available 24/7.

To report an issue by telephone, call toll-free at 844-255-7120.

Coordination of Benefits (COB)

Coordination of benefits is a provision in an insurance plan that guarantees each responsible insurer (when a patient is covered under more than one plan) pays only its own portion of claims and prevents double recovery of claims.

Coordination of benefits also designates the order in which multiple carriers pay benefits. The following is a list of definitions used when coordinating benefits. Note that self-funded employer sponsored plans may have specific rules for their member benefit plan. The listed definitions are standard industry guidelines.

MyTruAdvantage (Medicare Advantage)

- **Retiree with**
  - Retiree insurance (insurance from former employment) – Medicare Advantage pays first
- 65 or older who have
  - Group health plan coverage based on their or their spouse's current employment, and the employer has ***20 or more employees*** – The group health plan pays first
  - Group health plan coverage based on their or their spouse's current employment, and the employer has ***less than 20 employees*** – Medicare Advantage pays first
- Under 65 and disabled who have
  - Group health plan coverage based on their or their family member's current

employment, and the employer has ***100 or more employees*** – The group health plan pays first
    - Group health plan coverage based on their or their family member's current employment, and the employer has ***less than 100 employees*** – Medicare Advantage pays first
- **End-Stage Renal Disease (ESRD)**
    - If a patient has Medicare because of End-Stage Renal Disease (ESRD – permanent kidney failure requiring dialysis or a kidney transplant) – The group health plan will pay first for the first 30 months after you become eligible to join Medicare. Medicare will pay first after this 30-month period.

Appeals

A provider or facility may initiate an inquiry into issues related to the pricing or reimbursement of covered services as priced and outlined in the contract.

For any issues related to adverse benefit determinations per the member's summary plan description and any other applicable rules/laws, contracted providers may submit an appeal to the address listed below.

For MyTruAdvantage (Medicare Advantage), non-contracted providers are permitted to file a standard appeal for a denied claim only if the non-contracted provider completes a waiver of liability statement, which provides that the non- contracted provider will not bill the member regardless of the outcome of the appeal. These non-contracted providers who have completed the waiver of liability form are not required to complete the Appointment of Representative form since they are not representing the member.

A written appeal of a contractual issue on behalf of the provider or facility may be submitted to the Appeal's Coordinator at the address identified in the "Provider Disputes" information located on page 5. A response to such an appeal will be issued to the provider within the timeframe allotted within the members' plan.

Both contracted and non-contracted providers or facilities shall submit all documentation that supports the details described in their appeal request. Appropriate medical and non-medical staff will consider initial appeals. If the decision rendered by the reviewing party is unsatisfactory to the provider or facility acting on behalf of the member, in certain situations, the provider or facility may request in writing a second level, or External Review, appeal. For MyTruAdvantage (Medicare Advantage) members, the case file will automatically be sent to a second level reviewing party by MyTruAdvantage.

Providers can submit all appeals to:
MyTruAdvantage
Attn: Appeals
P.O. Box 428
Columbus, IN 47202

Complaints

MyTruAdvantage recognizes that providers may encounter situations in which our operation does not meet their expectations. When this happens, the provider is encouraged to contact MyTruAdvantage. MyTruAdvantage will promptly consider all complaints by its providers.

Complaints are classified by MyTruAdvantage into three categories:

- Administrative complaints: such as claim payment issues, balance billing, benefit applications, etc.
- Medical complaints: such as denial of a referral, denial of certification.
- Quality of Care complaints: such as appropriateness of care, continuity of care or refusal of care.

The Medical Management Department addresses medical complaints. The Quality Improvement Department evaluates and resolves quality of care complaints. Administrative complaints are routed to the appropriate department. Complaints are resolved in a timely manner at the department level.

If the resolution of a complaint is unsatisfactory to the provider, he/she may file a written appeal. The written appeal should state the reason(s) for the provider's dissatisfaction with the original decision. Any additional information the provider wishes to have considered should be submitted with the written appeal.

Credentialing and Recredentialing of Providers

Credentialing
MyTruAdvantage credentials contracted providers to verify their professional qualifications. MyTruAdvantage uses CAQH (Council for Affordable Quality Healthcare) for all credentialing activities. New providers joining the MyTruAdvantage Network should complete the CAQH application online to begin the credentialing process. The CAQH DataSource is free and offers a fast and easy way for providers to securely submit their credential information to health plans and networks.

If you are adding a physician to your practice, contact our Provider Call Center at (844) 425-4280 toll-free or by email at provider.services@siho.org.

Once the application has been received, our staff completes the Primary Source Verification process to verify education, licensing, and board certification where applicable. Incorrect or incomplete applications must be corrected within 15 days. Applications are reviewed and approved by MyTruAdvantage's Quality Improvement Committee before the provider is deemed in-network.
Completed applications are credentialed within 90-180 days of receipt and notified of final approval/disapproval within 10 days of determination. MyTruAdvantage ensures the confidentiality of credentialing information.

Recredentialing
MyTruAdvantage may recredential any participating provider within the scope of the network as often as every three years or otherwise required. Approximately 3-6 months before the recredentialing date, the application is obtained from CAQH, and we will contact the office if additional information is required. Recredentialing is similar to the initial credentialing process as the standard CAQH application will be reviewed. Providers will be notified of any discrepancies between recredentialing applications and MyTruAdvantage's review of the information allowing them a chance to submit additional materials to resolve any issues. All recredentialing application are reviewed and approved by MyTruAdvantage's Quality Improvement Committee. Providers who fail to submit required credentialing documents in a timely manner may be terminated from the network and no longer eligible to see members.

MyTruAdvantage monitors participating providers and reserves the right to terminate or suspend a provider from the network. Monitoring can include, but is not limited to, reviewing Medicare or Medicaid sanctions, limitations on licensures, member complaints and information regarding adverse events or quality issues.

Appeals process
An appeals process is available to providers in the event he/she should be denied participation, suspended, or terminated from our network due to a credentialing review or quality issues. At the time of notice of an adverse credentialing/recredentialing decision, the provider will be notified of appeal rights and procedures, including but not limited to:

- Provider may request a hearing; the notice will state the deadline for submitting the request
- Allow 30 calendar days after the notification for provider to request a hearing
- Allow provider to be represented by an attorney or another person of his/her choice
- Allow a hearing officer or a panel of individuals to review the appeal
- Written notification of the appeal decision that contains specific reasons for the decision

Except for the following reasons, termination from the network will not occur until the appeals process is exhausted by the provider or the provider chooses not to appeal in the required time period. In addition to the

termination provisions contained in the provider's contract, providers are terminated immediately from MyTruAdvantage's network for any of the following confirmed reasons:

- Loss or surrender of license
- Loss of sufficient liability coverage
- Exclusion or suspension from Medicare or Medicaid program

MyTruAdvantage is responsible for reporting provider quality deficiencies that affect network participation to the appropriate state and/or federal organizations. Reportable deficiencies may be related to professional competence or conduct as well as quality of care.

If you have questions about credentialing, please contact our Provider Relations Department:

- Email at provider.services@siho.org
- Provider Portal at www.MyTruAdvantage.com
- Provider Call Center at 844-425-4280

Primary Care Physicians

Overview

MyTruAdvantage Primary Care Physicians are defined as physicians who specialize in Family Practice, General Internal Medicine, General Practice, and Geriatrics. MyTruAdvantage plans require members to select a Primary Care Physician.

The Primary Care Physician provides, coordinates, or is aware of all aspects of the member's health care and history. Primary care physicians shall not discriminate or differentiate in the treatment of members based on race, color, gender, age, religion, national origin, health status, or source of payment.

Responsibilities

The responsibilities of the primary physician include:

- Providing primary care services to members
- Maintaining centralized medical records for applicable members
- Coordinating all aspects of members' health care
- Providing 24-hour coverage with appropriate call coverage arrangements to ensure that health care services are available to members in the primary care physician's absence
- Meeting MyTruAdvantage's credentialing/re-credentialing requirements
- Following MyTruAdvantage's Utilization Management/Quality Improvement guidelines and adhering to its policies and procedures
- Notifying MyTruAdvantage of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting MyTruAdvantage's products, procedures, and other delivery system requirements
- Maintain procedures to inform members of follow-up care or provide training in self-care as necessary
- Contributing to MyTruAdvantage's improvement and accomplishment of its goals and mission by voice, written word, and committee involvement in a cooperative, collaborative manner

Panel Status

Unless otherwise notified, MyTruAdvantage will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact MyTruAdvantage to have the panel status updated.

Appointment Standards

Providers should make their best efforts to accommodate members and provide service as quickly as possible. At a minimum, providers should adhere to the following standards:

Waiting time for routine and preventive care:	within 30 business days
Waiting time for semi-urgent care visits:	within 7 business days
Waiting time for urgent care visits:	Same day
Average time to see a physician from appointment time:	within 30 minutes or less

On-Call Requirement/Covering Physicians

Primary care services must be available to MyTruAdvantage members 24 hours a day, 7 days a week. When the primary care physician is unavailable, it is his or her responsibility to arrange coverage for MyTruAdvantage members. The covering physician should report calls and services to the member's primary physician.

Covering physicians, whether participating or not, must adhere to all administrative requirements and agree not to bill the member for services other than the copay, deductible, coinsurance or to the extent as defined in the member's benefit plan. It is the physician's responsibility to explain MyTruAdvantage's applicable billing, referral and certification requirements to the covering physician.

When a covering physician sends a claim to MyTruAdvantage, covered services will be reimbursed at the rate contracted with the primary care physician at the time the services were rendered.

Specialist Physicians

Overview

MyTruAdvantage Specialist Physicians are defined as physicians who focus on a specific branch of medicine, organ system, or patient group after completing extra training beyond general practice. This section discusses the responsibilities of the MyTruAdvantage Specialist Physician.

Responsibilities

Contact with the primary care physician should be maintained throughout the Specialist Physician's treatment of the member. In some MyTruAdvantage products, such communication is required.

Specialists are responsible for the following:

- Meeting MyTruAdvantage's credentialing/re-credentialing requirements
- Following MyTruAdvantage's Utilization Management/Quality Improvement guidelines and adhering to its policies and procedures
- Notifying MyTruAdvantage of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting MyTruAdvantage's products, procedures, and other delivery system requirements
- Maintain procedures to inform members of follow-up care or provide training in self-care as necessary
- Contributing to MyTruAdvantage's improvement and accomplishment of its goals and mission by written word and committee involvement in a cooperative, collaborative manner

Panel Status

Unless otherwise notified, MyTruAdvantage will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact MyTruAdvantage to have the panel status updated.

Facilities

Overview
Facility is defined as a licensed physical location or institution where healthcare services, testing, or treatment occur. Examples include hospitals, ambulatory surgical centers, skilled nursing facilities, home health agencies, outpatient clinics, diagnostic centers, rehabilitation facilities, end-stage renal disease facilities, laboratories, hospices, and suppliers. The definition includes anyone employed by the facility, any person or entity providing covered services under the facility's tax identification number, and any affiliate providing covered services that the facility owns or controls, even if that affiliate holds a separate tax ID.

Responsibilities
Facility will provide services in accordance with the terms of the contractual Agreement.

Work Stoppage
In the event of a work stoppage at Facility, Network agrees to work with the Participating Providers to defer elective admissions, and Facility agrees to cooperate with Network in using its best efforts to provide continuity of care to Covered Persons who have been admitted until normalization of operations at Facility.

Disaster or epidemic
In the event of any major disaster or epidemic, Facility agrees to render COVERED SERVICES insofar as practical according to its best judgment, within the limitations of those facilities and personnel which are available.

Medical Management

Overview
The purpose of the Medical Management Program (MMP) is to ensure that members receive the clinically necessary and appropriate care (including frequency of service and duration) in the right setting; the care is cost effective; and the care results in improved functional, clinical and financial outcome, all while following the client specific summary plan document, and local, state and federal guidelines.

Managed Care responsibilities include, but are not limited to, precertification, referral, determination of medical necessity, steerage to in-network services, evaluation of protocol compliance and Case Management.

Prior Authorization Guidelines
Prior Authorization ensures that a high quality, cost-effective and medically necessary method of treatment has been selected for a member's illness.

MyTruAdvantage Prior Authorization guidelines can be found at https://MyTruAdvantage.com/Prior-Authorization-Coverage-determination

Important Note:
The following services will always require Prior Authorization:

- Inpatient hospital admissions – medical and surgical
- Observation Admission > 2 midnights
- Long Term Acute Care Hospital (LTACH) admissions
- Inpatient Sub-Acute and Acute Rehab Facility admissions
- Skilled Nursing Facility admissions
- Mental Health and Substance Abuse admission
    - Inpatient/Detox (IP)
    - Residential (RES)

    - Intensive Outpatient Programs (IOP)
    - Partial Hospitalization Programs (PHP)
- Non-emergent Ambulance services
- Home Health Care (if extending beyond consecutive 60-day period)
- Select Oncology services – Chemotherapy and Radiation
- Durable Medical Equipment / Prosthetics / Orthotics- Purchases greater than $2,000 and Rentals exceeding $150/month. (Please note: MyTruAdvantage may allow purchase of some rented medical equipment after a certain number of payments. Please contact Member Services for details.)
- Part B Medications (includes select specialty medications) - Please refer to medication list at https://www.mytruadvantage.com/information-2027 for full listing.
- Physical, Occupational, and Speech Therapy - (exceeding 20 visits each)
- Advanced Diagnostic Imaging
    - PET Scan - (only required if not billed with a cancer diagnosis)
- Select Genetic and Molecular Testing Services
- Treatments related to gender reassignment
- Transplant Services - Organ, Cell & Gene Therapy Services; Ventricular Assist Devices
- Select Outpatient Procedures and Services (includes services performed at Ambulatory Surgery Centers and Outpatient Hospital Settings):
    - Joint replacements
    - Orthopedic trauma surgery/open reduction internal fixation fracture repairs
    - Arthroscopic procedures
    - Spinal surgery
    - Podiatry surgery
    - All neurological implants and implanted nerve stimulator devices
    - Bariatric surgery procedures not performed as inpatient
    - Procedures that could be considered cosmetic
- Infertility – care and treatment
- Treatment with Human Growth Hormone

Some services may be covered with a Letter of Medical Necessity:

- Treatment of impotence or sexual dysfunction
- Sclerotherapy

MyTruAdvantage Prior Authorization requirements are listed at www.MyTruAdvantage.com.

To obtain Prior Authorization, the Covered Person or the Physician must provide MyTruAdvantage's Medical Management Department with the appropriate medical information prior to obtaining the proposed services. Please go to www.MyTruAdvantage.com and visit the “provider” tab for authorization forms. You may also choose to submit a prior authorization directly online utilizing the provider portal.

Generally, if a MyTruAdvantage Network Physician is seen, he/she will obtain the necessary Prior Authorization from MyTruAdvantage.

The required information may be sent to:
MyTruAdvantage
P.O. Box 428
Columbus, IN 47202

Fax: (317) 860-3624 (MyTruAdvantage) For services requiring prior authorization: Information must be received by MyTruAdvantage as soon as possible, prior to services being received. In the case of an emergency admission the Covered Person, or someone acting on his/her behalf, must provide the appropriate information to MyTruAdvantage within forty-eight (48) hours of the event, or if the forty-eight (48) window falls on a weekend or holiday, the following business day.

If prior authorization is not obtained, a penalty may be applied even if the service would otherwise be covered. Providers are ultimately responsible for obtaining prior authorization for services, though a member submission of authorization request is permissible. If the admission, service, or equipment requiring prior authorization is not approved, the member or the physician may request another review of the case. Upon presentation of *new* evidence of extraordinary circumstances or justifying medical cause, MyTruAdvantage may certify service which is justified upon second review.

Failure to recertify *continued* services (concurrent review) will cause claims to be denied and no payment will be made. If this occurs, providers may submit medical documentation supporting the need for the continued services to MyTruAdvantage. If appropriate, claims may be reopened and processed according to the member's benefit plan.

Prior authorization does not guarantee either payment of benefits or the amount of benefits.

Written Orders

Durable Medical Equipment, Speech, Occupational, and Physical Therapy, Home Care, and all medications require submission of a written order with the supporting clinical documents for review for precertification.

MyTruAdvantage's definition of Durable Medical Equipment is equipment that can withstand repeated use, is generally not useful to a person in the absence of sickness or injury and is appropriate for use in the home. Durable Medical Equipment must serve a medical need and not be considered items of convenience.

Out of Network Authorizations

Members who wish to use non-network providers may be subject to higher cost-share including deductibles and out-of-pocket expenses. MyTruAdvantage offer both HMO and PPO plans and certain network designs are established based on the type. MyTruAdvantage Medical Management reviews requests from members and providers for services provided out of network that are asked to be paid at the in-network benefit level. This is subject to scrutiny of medical necessity and ability for care to be provided in the primary network. If services are available in-network, MyTruAdvantage may deny coverage at a higher benefit level.

Case Management

The Plan provides specialized case management for catastrophic and long-term care cases to help ensure that members receive care in the most appropriate and cost-effective setting. Case Management is a collaborative effort among the member, the members' physician and family, and MyTruAdvantage. As part of this process, MyTruAdvantage may customize benefits by approving otherwise non-covered services or coordinating an earlier discharge from an inpatient setting when the member can safely receive care in an alternative setting. Based on specific screening criteria, MyTruAdvantage Nurse Case Managers may contact members after discharge. Provider participation is essential to these efforts, as Nurse Case Managers may rely on your medical records to update the member's care plan and may contact your office to coordinate care plan goals. You may also receive letters outlining a mutual patient's MyTruAdvantage Case Management care plan. Please contact the Case Manager with any questions.

Disease Management

Members with chronic illnesses such as heart disease or diabetes account for a very high proportion of healthcare dollars and services. Disease management programs allow the plan to provide a member focused resources into management and education designed to improve health and reduce costly and tragic complications associated with chronic illnesses.

If a member has an illness that falls into one of MyTruAdvantage's Disease Management Programs, the member may receive specialized educational materials regarding this illness from time to time. A member may be contacted by mail, telephone, or electronic means to participate in meetings or programs designed to improve their health. MyTruAdvantage may use one or more of its Business Associates to perform these functions. To the extent permitted by law, a listing of names, addresses and phone numbers may be shared with MyTruAdvantage's Business Associates. These lists will be maintained with the strictest level of

confidentiality as required by law and will not be used or sold with the intent of solicitations or for any purpose outside the scope of Disease Management.

Additionally, MyTruAdvantage will collaborate with the provider network to maximize their initiatives toward disease management as much as possible. Recognizing that unmanaged risk in the member population drives poor outcomes and cost, Disease Management is a cooperative effort focused on risk reduction.

Denials and Appeals

- In the event a medical service is not approved, the process requires that the member be notified in a timely manner of the reason for the denial
- A member whose referral or certification request is not approved has the right to appeal such adverse determination in accordance with MyTruAdvantage's appeal procedure.
- Review criteria are available onsite and when permitted by license, will be distributed on request. Criteria are reviewed regularly to ensure that the most recent versions are being utilized and are approved.

MyTruAdvantage's criteria or guidelines include but are not limited to:

- To the extent possible, MyTruAdvantage utilizes Medicare National (NCD) and/or Local Coverage Determination (LCD) when completing medical necessity review. Access to these NCD and LCD coverage criteria can be accessed by following the link below:

  CMS Medicare Coverage Center

  In the event that criteria is not available within LCDs or NCDs, MyTruAdvantage may use existing industry standard resources to determine medical necessity, those may include:

- InterQual– we use these guidelines to help make decisions on allocation of services based on members' medical conditions. They are nationally recognized and evidence based.
- NCCN – National Comprehensive Cancer Network – these are nationally recognized recommendations for the care of cancer. These are treatment plans for services of cancer by site along with supportive cancer treatment care and principles of adjuvant care such as monitoring, imaging, etc. Many oncology practices utilize NCCN to guide their prescribing.
- FDA – We focus on ensuring services and therapies are certified by the FDA if they are new to the market or not common to certain diagnoses – FDA approval and "non-experimental" is often a requirement per SPD on most groups
- CDC and US Preventative Services Task Force – These entities guide preventative health benefits and/or coverage for similar services
- MyTruAdvantage Clinical Guidelines – Established by the MyTruAdvantage Medical Management staff, validated by the Quality Management Committee; for services with little to no formalized criteria from the entities above, or for services with MyTruAdvantage-specific limitations
- Medical Director Review (Internal and External Review completed by applicable service specialty)

Review criteria are available onsite and when permitted by license, will be distributed on request. Criteria are reviewed regularly to ensure that the most recent versions are being utilized and are approved.

MDPP (Medicare Diabetes Prevention Program) for members diagnosed with pre-diabetes

- The MDPP expanded model aims to prevent type 2 diabetes among Medicare beneficiaries with prediabetes. Type 2 diabetes affects more than 1 in 4 Americans age 65 or older, and its prevalence is expected to increase if current trends continue.
- The Medicare Diabetes Prevention Program, or MDPP, delivers a lifestyle change program that was proven effective in the NIDDK-sponsored Diabetes Prevention Program (DPP) and refined for real-world implementation in a number of translation studies.

- The MDPP is part of a CDC-recognized lifestyle change program designed to delay or prevent the onset of type 2 diabetes called the National Diabetes Prevention Program (National DPP) External link. The CDC-led National DPP is a partnership of public and private organizations working to prevent or delay type 2 diabetes. The National DPP provides a framework for type 2 diabetes prevention efforts in the United States, and its scientifically proven and effective lifestyle change program is a critical component.
- The MDPP allows eligible Medicare beneficiaries to access the core, year-long program, which consists of weekly 1-hour sessions with a trained lifestyle coach for the first 6 months and then monthly for the next 6 months. What Medicare is also providing to participants who meet weight loss and attendance goals is a second year of the program, which is really considered ongoing maintenance.
- Health care professionals need to know that they should screen, test, and refer their patients. Medicare beneficiaries are an important population for this program. We know from the DPP that there was a 58 percent reduction in the incidence of type 2 diabetes for the overall study population, but a 71 percent reduction for those who are over 60 years of age, so it's a very effective intervention. This is also brand new. This is the first time in history that CMS (The Centers for Medicare & Medicaid Services) is paying for the delivery of this lifestyle intervention, which can be delivered by both health care professionals and trained lay people within health care systems and community-based organizations. This is historic and transformational.

Health care professionals can take these steps to help Medicare beneficiaries with prediabetes access MDPP services.

- Screen and test your patients for prediabetes. More than half of U.S. adults age 65 and older have prediabetes, but only about 1 in 10 know they have it. Screening and testing can raise awareness about prediabetes and the risk of developing type 2 diabetes.
- Refer eligible Medicare beneficiaries with prediabetes to the MDPP. While CMS doesn't require a referral for MDPP services, your referral can help raise awareness about the program and its benefits.
- Encourage your organization or other organizations in your community to provide MDPP services. To provide MDPP services, organizations must first receive recognition through the CDC Diabetes Prevention Recognition Program External link and then apply to become Medicare suppliers. Increasing the number of MDPP service providers will give us all more access to this very, very effective program.

MyTruAdvantage covers this benefit with no coinsurance or copay to members.

National Registry of MDPPs - https://dprp.cdc.gov/registry

Prediabetes Risk Test - https://www.cdc.gov/prediabetes/risktest/index.html

Sources: https://www.niddk.nih.gov/health-information/professionals/diabetes-discoveries-practice/medicare-diabetes-prevention-program

Quality Improvement Program

Overview

The MyTruAdvantage Quality Improvement Program (QIP) strives to improve the quality of health care and administrative services offered to members, physicians, and employers. It does so through the establishment of a formal process and an infrastructure for continuously monitoring, evaluating, and improving the health care and administrative services provided under all managed medical products. MyTruAdvantage places great emphasis on the QI process because it is the organization's desire to assure that the quality of clinical and administrative services provided to MyTruAdvantage members is continuously improving.

Utilization Management Committee

MyTruAdvantage utilizes nationally recognized criteria from the following entities: CMS NCD/LCDs, InterQual, and National Comprehensive Cancer Network (NCCN). These criteria updates are maintained and reviewed by an internal committee annually. If internal MyTruAdvantage criteria are developed by our Medical Director team to address services with little to no formalized criteria, those are also reviewed annually. Current review criteria are available onsite and when permitted by license, will be distributed on request. Criteria are reviewed regularly to ensure that the most recent versions are being utilized and are approved.

Quality Improvement Committee (QIC)

The committee is comprised of MyTruAdvantage Medical Directors, Network Physicians, and MyTruAdvantage leadership. Functions of the QIC include but are not limited to:

- Oversight of MyTruAdvantage quality management activities, with recommendations for improvement, as appropriate.
- Systematic, ongoing monitoring and evaluation processes to identify opportunities for improvement.
- Establishment of medical policy.
- Maintenance of disease management protocols.
- Oversight and approval of credentialing and recredentialing activities.

Medical Record Guidelines

MyTruAdvantage's medical record guidelines were developed and approved through the Quality Improvement Committee. The goal of these guidelines is to improve the quality of documentation in medical records. MyTruAdvantage requires that individual medical records be maintained for each member according to accepted professional guidelines, which include that records are current, dated and have the provider's signature.

All information in the medical record and information received from physicians, practitioners and health facilities must be kept confidential.

Each office must have established policies to assure that the medical records are complete, promptly filed and safely retained in accordance with acceptable professional practices and state statutes. MyTruAdvantage expects that patient confidentiality will be practiced by every provider.

General Guidelines

Medical record documentation must include the following:

- Patient's name and ID #
- Patient's biographical data
- Allergies or absence of allergies noted
- Significant illnesses and medical conditions are indicated on a problem list.
- Past medical history is identified and includes serious accidents, operations, and illnesses.
- The history and physical examination documents appropriate subjective and objective information for the presenting complaints.
- Documentation of informed consent for applicable procedures or treatment where appropriate.

All entries should be:

- In ink or EHR
- Legible
- Signed
- Dated

Each visit must be documented in the medical record to support the diagnosis and to justify the treatment.

Documentation for a visit should include the following:

- Date of visit
- Chief complaint or purpose of the visit

- Pertinent vital signs
- Objective findings
- Diagnosis or clinical impression
- Studies ordered, such as laboratory or x-ray procedures
- Therapies administered
- Disposition, recommendations, and instructions to members
- Referrals to specialists or therapy practitioners.
- Signatures or initials of practitioners, practitioners' names, and professional designation (such as MD, DC, DO, DPM, RN)
- Advanced directives or documentation of discussions regarding advanced directives, when appropriate.

Follow-up

Notes should indicate follow-up care, telephone calls or visits. A specific time for the follow-up should be noted in weeks, months or as needed.

Follow-up documentation should indicate:

- Adverse clinical findings
- Unresolved problems from previous office visit
- If a consultation had been requested, there is a note from the consultant
- Results of studies ordered should be filed in the chart and initialed by the primary care physician to signify review
- Discharge summaries include condition at time of discharge and post-operative instructions given to the patient
- Emergency care

Health Education and Preventive Services

Health education, preventive services, recommendations, and wellness counseling should be clearly noted and incorporated in the progress notes or in a specially designated section.

These services should be documented as applicable:

- Colorectal Cancer screening
- Physical/Mental Health screenings
- Immunizations
- Blood Pressure Screenings
- Breast Cancer screening
- Medication compliance

Medical Records Review

The objectives of the medical records review are:

- To evaluate the structural integrity of the medical record
- To evaluate ambulatory medical record documentation for the presence of information that conforms to good medical practice which includes continuity and coordination of care and is necessary to provide quality care
- To evaluate compliance with preventive health care guidelines as designated by MyTruAdvantage

Never Events, Serious Reportable Events, and Hospital Acquired Conditions

MyTruAdvantage reviews inpatient claims to identify eight (1) specified hospital-acquired conditions, as defined by the National Quality Forum. MyTruAdvantage does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Patients likewise are not responsible for payment.

In addition, the health plan and its members do not pay any charges related to three never events (2) or for a set of eight (3) serious reportable events, also defined by the National Quality Forum.

If a never event or a serious reportable event occurs, MyTruAdvantage requires hospitals in its network to notify the health plan, along with at least one of three designated patient safety organizations: The Joint Commission; the state reporting program for medical errors; or a patient safety organization such as a state-specific patient safety center.

MyTruAdvantage's Quality Improvement Department reviews all identified never events and serious reportable events and follows up with individual facilities. Facility representatives must identify root causes of never events and serious reportable events, and they must identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.

I. The eight specified hospital acquired conditions, as defined by the National Quality Forum, are as follows: (1) unintended retention of a foreign object in a patient after surgery or other procedure; (2) hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products; (3) failure to identify and treat hyperbilirubinemia in neonates; (4) a burn incurred from any source while being cared for in a healthcare facility; (5) intravascular air embolism that occurs while being cared for in a healthcare facility; (6) medication error; (7) a fall while being cared for in a healthcare facility; and (8) deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures: total knee replacement and hip replacement.

II. The National Quality Forum defines a "never event" as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a healthcare facility." For purposes of this policy, MyTruAdvantage defines the following events as never events: (1) surgery or invasive procedure performed on the wrong person; (2) surgery or invasive procedure performed on the wrong side or body part; (3) performance of the wrong surgical or invasive procedure.

III. MyTruAdvantage will not pay facilities for a set of eight serious reportable events, as defined by the National Quality Forum: (1) unintended retention of a foreign object in a patient after surgery or other procedure; (2) patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products; (3) patient death or serious disability associated with an electric shock while being cared for in a healthcare facility; (4) intraoperative or immediately post-operative death in an ASA Class I patient; (5) patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a healthcare facility; (6) death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates; (7) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances; and (8) patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.

Preventive Health Benefit Guidelines

Overview

This section details MyTruAdvantage's preventive health benefit guidelines. The information provided describes policy benefits and elements of periodic health evaluation visits.

Preventive Health Benefit

The Preventive Health Benefit, in general, is intended to cover exams, immunizations, and diagnostic testing for non-high risk, asymptomatic patients. Therefore, it represents suggested testing for patients who present with no additional complaints and are not high risk. The tests, immunizations, and exams indicated on the

benefit grid are covered at 100% when administered within the appropriate time frame for those members who have MyTruAdvantage's Preventive Health Benefit.

Coding for Preventive Health Benefits

When additional, medically appropriate, tests are indicated for patients who present for a preventive health exam but have other complaints and/or family history that would indicate the need for additional testing, the physician should submit an appropriate ICD-10 Diagnosis Code in addition to the preventive health V-Code. If additional testing is done without medical documentation, the patient may be responsible for the charges.
Please have your office staff let patients know when they may be responsible for such charges.

Sources

Organizations whose standards are used in developing and updating the preventive health benefit include the CMS Preventive Health Guidelines, Advisory Committee on Immunization Practices, the Centers for Disease Control and Prevention (CDC), the US Preventive Services Task Force recommendations, HRSA (Health Resources and Services Administration), and State law amendments as applicable, SIHO approved preventive benefits that be in addition to federal/state mandates.

Pharmacy Services

Overview

This section provides a summary of the MyTruAdvantage Pharmacy Procedures and is designed to assist you and the member's Pharmacy in filing claims for services rendered to MyTruAdvantage members who utilize MedImpact Healthcare Services, Inc., (MedImpact) as their Pharmacy Benefit Manager (PBM). MedImpact administers Part D benefits for MyTruAdvantage plans.

**Note – not all plans have access to pharmacy benefits. If you are enrolled in the MyTruAdvantage Red, White and Tru, this is a Medicare Advantage only plan and does not offer Part D. Under MyTruAdvantage Red, White and Tru, you may still be eligible for Part B drug coverage.*

MyTruAdvantage Pharmacy Services

MedImpact is known as one of the leading PBMs in America. MedImpact was founded more than three decades ago by a pharmacist and independent drug store owner who saw firsthand how families struggled with the high cost of prescriptions, and how it impacted their lives, financial security, and health. Today, MedImpact is one of the leading PBM's in America.

Pharmacies can conduct the following transactions online

- Member Eligibility verification
- Drug pricing information
- Deductible/co-pay/co-insurance calculations
- Coordination of Benefit determinations
- Drug interaction analysis
- Automatic claim filing with MyTruAdvantage

Covered Prescriptions

- Drugs which by Federal Law require a prescription and have received FDA approval for the intended use
- Insulin and insulin syringes
- Compounded medications that include at least one Federal Legend Drug or State Restricted Drug in a therapeutic amount
- Drugs covered under member benefits

MyTruAdvantage provides no coverage for drugs that are not on its formulary. However, a MyTruAdvantage member can ask for an exception for covering a prescription that is not on the formulary. If we agree to cover a drug not on the formulary, the member will need to pay the cost-sharing amount that applies to drugs in Tier 4. The member cannot ask for an exception to the required cost-sharing amount for the drug.

Days Supply/Refills

MyTruAdvantage (Medicare Advantage Prescription Drug Plans)
MyTruAdvantage plans have 30, 60, or 90/100-day options to supply or refill. 100-day options apply to Tiers 1,2 and 6.

Pharmacy Prior Authorization

Certain prescriptions may require prior authorization by MedImpact.

Some of the most common drugs requiring a prior authorization are:
Biotech or specialty medications such as Synagis, Enbrel, Ozempic, and Mounjaro.

It is important to submit the prior authorization at the time the prescription is written so that a member's prescription is not denied when being filled at the pharmacy. All prior authorization requests are processed within 72 hours. If you believe that waiting 72 hours for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision MedImpact will automatically give a decision within 24 hours, for an expedited (fast) decision. An expedited (fast) coverage determination cannot be requested if the prescription has already been received by the member.

Request for Medicare Prescription Drug Coverage Determination can be found on our website at:
Request for Medicare Prescription Drug Coverage Determination

Forms should be returned to:

Address: 10181 Scripps Gateway Court, San Diego, CA 92131
Fax: 858-790-7100
Phone: 1-800-788-2949

Listed below are the MedImpact phone numbers for prior authorization:
MedImpact
877-403-6035
www.medimpact.com

MyTruAdvantage/MedImpact Drug List, also referred to as our Formulary

The MyTruAdvantage prescription drug benefit program's goal is to provide quality pharmaceutical care at lower costs. As a means of controlling costs, MyTruAdvantage encourages its physicians to prescribe drugs on the MedImpact drug list/formulary. Prescribing drugs on the drug list/formulary usually results in lower member costs and helps keep overall drug costs down. Allowing substitution of generic products is encouraged when appropriate. Questions about the drug list/formulary should be directed to MedImpact customer service. The MedImpact drug list/formulary for MyTruAdvantage's Medicare Advantage Prescription Drug members is included in these materials and available on the MyTruAdvantage website www.MyTruAdvantage.com.

Step Therapy Programs

MyTruAdvantage uses pharmacy step therapy programs, which require members to try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the members medical condition, MyTruAdvantage may not cover Drug B unless the member first tries Drug A. If Drug A does not work, we will then cover Drug B

Quantity Limit

Quantity limits are implemented to promote safety in medication use and prevent overuse or abuse of certain drugs. MyTruAdvantage may restrict the amount of prescription drugs that we will cover over a specified period of time for certain drugs. Drugs that have quantity limits are clearly marked within the drug list/formulary. For questions regarding coverage call MedImpact 877-403-6035 or visit their website at www.medimpact.com.

Miscellaneous

Pharmacy Directory

To find a list of pharmacies in MyTruAdvantage's network visit our website at https://openenrollment.medimpact.com/#/web/sih/chooseplan.

Mail Order

MyTruAdvantage offers members the ability to purchase medications through our mail order pharmacy. The program includes Birdi as our preferred mail order pharmacy for home delivery. Birdi makes it easy to manage medications. In addition, Birdi offers after hours service, sends refill reminders to make sure members have the right amount of medication on hand and accepts manufacturer coupons to save on copay amounts.

For more information contact:

Mail Order Pharmacy	Toll-Free Phone Number	TTY Number
MedImpact Direct Mail ® Program patientcare@birdirx.com	(855) 873-8739 (Birdi)	711
MedImpact	(877) 403-6035	711

*Note: Specialty Tier-5 prescription drugs are not included in the mail order program, those prescriptions will need to be filled at your local retail pharmacy.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option on the prescription drug law that works with the members current drug coverage to help manage your Part D out-of-pocket costs across the calendar year (January – December).

Anyone with a Medicare drug plan or Medicare health plan with drug coverage can use this payment option. Participation is voluntary.

If you select this payment option, each month the member will continue to pay their plan premium (if they have one) and they will receive a monthly bill from MyTruAdvantage to pay for prescription drugs (instead of paying at the pharmacy). There is no cost to participate in the Medicare Prescription Payment Plan.

For more information visit the MyTruAdvantage website www.MyTruAdvantage.com/medicare-prescription-payment-plan.com.

Electronic Forms

MyTruAdvantage.com has electronic forms available for your convenience. The forms and more are found in the provider section of the MyTruAdvantage website at www.MyTruAdvantage.com.