Provider Manual

Topics are applicable to all lines of business unless otherwise noted.

meritus

Together for better health

Contact Us

Arizona Foundation Provider Relations (PPO)
Phone: 602.252.4042 or 800.624.4277
Fax: 602.495.8684
Email: providerrelations@azfmc.com

Care1st Provider Network Operations (HMO)
Phone: 602.778.1800, option 5, 7
Fax: 602.778.1875
Email: AZPNO@care1st.com

Case Management Referral – Behavioral Health
Phone: 877.288.1012 | Fax: 888.614.0562
Email: BHCMReferrals@HealthIntegrated.com

Case Management Referral – Medical
Phone: 877.288.1012 | Fax: 855.850.2585
MedicalCMReferrals@HelathIntegrated.com

Claims Customer Service (Customer Care)
Phone: 602.957.2113 or 855.755.2700
Email: info@meritusaz.com

Claims Disputes, Appeals, and Complaints
(Complaints Appeals)
Phone: 602.957.2113 or 855.755.2700
Email: appeals@meritusaz.com
Email: complaints@meritusaz.com

Compliance Confidential Hotline
Phone: 855.400.9748 | Fax: 855.568.2800

Crisis Hotline
Phone: 877.229.8068

Customer Care
Phone: 602.957.2113 or 855.755.2700
Email: info@meritusaz.com

Delta Dental of Arizona
Phone: 602.938.3131 or 800.352.6132
Website: deltadentalaz.com

Disease Management
Phone: 855.424.5206

Hospital/SNF Admission Notification
Phone: 877.288.1012 | Fax: 855.850.2581

Member Eligibility
Phone: 602.957.2113 or 855.755.2700

Mental Health Outpatient Treatment Review Form

Phone: 877.288.1012 | Fax: 855.850.2584

Pharmacy Prior Authorizations & Questions
Phone: 855.582.2022 or 800.294.5979
Fax: 855.245.2134 or 888.836.0730

Prior Authorization & Notifications – Medical
Phone: 877.288.1012 | Fax: 855.850.2581

Quality Management
Phone: 602.957.2113 or 855.755.2700

Translation Services
Phone: 602.957.2113 or 855.755.2700

TTY/TDD
Users call 7.1.1. Have the Meritus phone number available.

Vision Services Plan
Phone: 855.332.6193 | Website: vsp.com

Write, call or email Meritus Network Development:

Meritus
Attn: Network Development
2005 W. 14th St., Suite 113
Tempe, AZ 85281

Phone: 855.755.2700 | 602.957.2113
Email: Network@meritusaz.com

Language Interpretation and TTY/TTD

Meritus provides interpretive services for its members with different languages and cultures. If you have a member who is in need of these services please contact the Customer Care Center at 602.957.2113 or toll-free at 855.755.2700. TTY/TDD users call 7.1.1.

Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the translation service. There is no cost for language interpretation services.

Tom Zumtobel
Meritus CEO

Welcome to Meritus

As a provider, you play a very important role in the delivery of care to our Members. As a new insurer you play an even more important role in helping us reach our goal of healthier and more engaged members. Working together we can develop a different member and provider/plan relationship. As a new insurer we may also have a "few glitches" along the way and we want to be sure we are listening to you, so please communicate concerns to us.

The Meritus Provider Manual is an extension of your Provider Agreement. Meritus has designed the Manual to supply participating providers and their staff with the policies and procedures Meritus uses to administer our health plan products. This Manual contains policies, procedures, and general reference information, including minimum standards of care which are required of Meritus Providers.

In accordance with the "policies and procedures" clause of your participation agreement, you will be asked to abide by all provisions contained in this Manual, as applicable. As policies and procedures change, updates will be issued to you, posted on our website and incorporated into subsequent versions of this Manual.

Change in policies and procedures must be implemented according to the time frame in your Provider Agreement. Revisions to this Manual constitute revisions to Meritus' policies and procedures. We hope you will find this Provider Manual useful but please don't hesitate to contact Meritus Customer Care at 602.957.2113 or toll-free 855.755.2700 with any questions you may have. You may also reach us by email at network@meritusaz.com.

Meritus wants to work closely with all of our providers to ensure that our Members receive medically necessary and appropriate covered services. We look forward to working with you and your staff to provide quality healthcare services to Meritus Members. We welcome any comments or suggestions on how we can improve our operations and interactions with you, our customer.

Thank you in advance for your participation with Meritus,

Tom Zumtobel
Chief Executive Officer

Table of Contents

SECTION 1

Introduction to Meritus Networks

Meritus is a member-governed, non-profit consumer operated and orientated (CO-OP) health insurance company. Organized in 2012 and headquartered in Tempe, Meritus began as a community coalition dedicated to:

- Making quality healthcare available and affordable – to all Arizonans
- Delivering efficient, evidence-based medical care
- Eliminating waste and redundancy

Provider Directory

The Meritus Provider Directory is updated on a regular basis. All providers are encouraged to review their information in the directory to ensure it is listed accurately and to notify Meritus of any corrections or changes to their information. Please reference the **Providers** page on our website at meritusaz.com to download the Provider Directory Correction Request Form which includes directions on how to submit your information. The Provider Directory is available on our website where you can perform various searches and print only the pages you need.

Meritus Networks

Provider's with questions regarding the network in which you participate are encouraged to review their information in the online directory or call Meritus at 602-957-2113/855-755-2700 or contact your Provider Network Operations Representative at 602-778-1800 or 866-560-4042 (options in order 5, 7).

Meritus PPO Network

MERITUS MUTUAL HEALTH PARTNERS

Meritus utilizes The Arizona Foundation for Medical Care (AFMC) network for our PPO plans. Please utilize the Meritus PPO provider search to find AFMC participating providers. Not all AFMC providers may be contracted through the Meritus agreement with AFMC.

PLAN NAMES
Meritus Choice Gold PPO Plus 2000
Meritus Choice Silver PPO Plus 4000
Meritus Choice Bronze PPO Plus 6000
Meritus Saver Gold PPO HSA Plus 1500
Meritus Saver Silver PPO HSA Plus 2000
Meritus Saver Bronze PPO HSA Plus 6300

In addition, Meritus contracts directly with some providers for our PPO network when services are not available through the Arizona Foundation network. These providers include Audiologists, Chiropractors, Naturopathic, Acupuncturist, Massage Therapists, Nutritionists and Dieticians. Meritus has a relationship with Multiplan/PHCS for covered services outside of the PPO members service area (state of Arizona). Meritus PPO members may utilize the PHCS network as "in" network and the Multiplan network as "out" of network.

Meritus Complete HMO Network

MERITUS HEALTH PARTNERS

Meritus built our Complete HMO network of doctors with the help from our primary care physicians. Working in partnership with these PCPs, we reached out to other physicians, specialists and hospitals to create a broad and complimentary HMO network for our members.

PLAN NAMES
Meritus Healthy Platinum Complete HMO Plus 500
Meritus Healthy Gold Complete HMO Plus 2000
Meritus Healthy Silver Complete HMO 4000
Meritus Healthy Bronze Complete HMO 6000

Meritus HMO Abrazo Network

MERITUS HEALTH PARTNERS

Meritus partners with Abrazo (Tenet Healthcare Corporation) to form this network. The network includes Arizona Heart Hospital, Arizona Heart Institute, Arrowhead, Maryvale, Paradise Valley, Phoenix Baptist and West Valley Hospitals. The Network also includes the VHS (Vanguard Health Systems) Abrazo Medical Groups. This network also contains specialists and ancillary community providers loyal to Abrazo.

PLAN NAMES
Meritus Healthy Platinum HMO Plus Abrazo 500
Meritus Healthy Gold HMO Plus Abrazo 2000
Meritus Healthy Silver HMO Abrazo 4000
Meritus Healthy Bronze HMO Abrazo 6000

Meritus HMO Banner Network

MERITUS HEALTH PARTNERS

Meritus' partner for this HMO network is Banner Health. As one of our community-based networks, this network includes all Banner hospitals and Banner employed physicians in Maricopa County, as well as MD Anderson Cancer Center, Cardon Children's Medical Center at Banner Desert Medical Center, and Banner Heart Hospital. In addition, the Meritus Community Network Phoenix includes Banner owned ancillary providers, miscellaneous additional ancillary providers and other specialists loyal to Banner.

PLAN NAMES
Meritus Healthy Platinum HMO Plus Banner 500
Meritus Healthy Gold HMO Plus Banner 2000
Meritus Healthy Silver HMO Banner 4000
Meritus Community Network Silver HMO Banner*
Meritus Healthy Bronze HMO Banner 60000

**A 2014 rollover plan formerly called Meritus Community Network Phoenix. These plans also have pediatric dental and adult limited dental.*

Meritus HMO MIHS Network

MERITUS HEALTH PARTNERS

Meritus partners with Maricopa Integrated Health System (MIHS) to form this network. The network includes Maricopa Medical Center, Arizona Burn Center, and the Comprehensive Healthcare Center. MIHS also includes 11 Family Health Centers (FHC) including the McDowell FHC. Besides the MIHS facilities, the Meritus Neighborhood Network Maricopa is primarily made up of the MIHS FHCs, District Medical Group specialists, community specialists loyal to MIHS and miscellaneous ancillary providers.

PLAN NAMES
Meritus Healthy Platinum HMO Plus MIHS 500
Meritus Healthy Gold HMO Plus MIHS 2000
Meritus Healthy Silver HMO MIHS 4000
Meritus Neighborhood Network Silver HMO MIHS*
Meritus Healthy Bronze HMO MIHS 6000

**A 2014 rollover plan formerly called Meritus Neighborhood Network Maricopa. These plans also have pediatric dental and adult limited dental.*

Meritus HMO Mohave Network

MERITUS HEALTH PARTNERS

The Meritus Mohave network is focused around the Bullhead City area and includes Western Arizona Regional Medical Center along with the Bullhead City Clinic Corporation providers. This network also includes specialists and ancillary community providers in the surrounding areas, as well as the Valley Health System hospitals located in Las Vegas. (Centennial Hills, Desert Springs, Spring Valley, Summerlin and Valley Hospital). Meritus has also formed a unique relationship with the WellHealth Network that includes providers within Mohave County, AZ and Clark County, NV.

PLAN NAMES
Meritus Healthy Bronze HMO Mohave 6000
Meritus Healthy Silver HMO Mohave 4000
Meritus Healthy Gold HMO Plus Mohave 2000
Meritus Healthy Platinum HMO Plus Mohave 500

Meritus HMO Pima Network

MERITUS HEALTH PARTNERS

As one of our community-based networks, Carondelet Health Network (CHN) includes, St. Mary's, St. Joseph's and Holy Cross hospitals, along with its affiliated clinics and physicians. Besides the Carondelet Medical Group and Carondelet Specialist Group offices, the Meritus Community Network Pima also includes area FQHCs such as El Rio, United Community, Marana Health Center and FQHC like entities such as St. Elizabeth's of Hungary. In addition. This network also contains specialists and ancillary providers who are loyal to the CHN system.

PLAN NAMES
Meritus Healthy Platinum HMO Plus Pima 500
Meritus Healthy Gold HMO Plus Pima 2000
Meritus Healthy Silver HMO Pima 4000
Meritus Community Network Silver HMO Pima*
Meritus Healthy Bronze HMO Pima 6000

**A 2014 rollover plan formerly called Meritus Community Network Pima. These plans also have pediatric dental and adult limited dental.*

+Plus = Complementary and Alternative Medicine Network

ANY PLAN WITH **PLUS** HAS THESE ADDED BENEFITS.

These benefits are designed to support overall health and well-being.

NETWORK SERVICES
Acupuncture
Naturopathy
Therapeutic Massage
Gym Membership Reimbursement

Definitions

A

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

B

Benefit Package: The set of services, such as physician visits, hospitalizations, prescription drugs that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

C

Case Management: The process of coordinating medical care provided to patients with specific diagnoses or those with high healthcare needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

Co-insurance: The percentage of the Allowable Fee payable by the Member for Covered Medical Expenses incurred for Covered Benefits. The Co-insurance amount is shown in the Member's Schedule of Benefits.

Copayment: A fixed dollar amount paid by an individual at the time of receiving a covered healthcare service from a participating provider. The required fee varies by the service provided and by the health plan.

Consumer Operated and Oriented Plans: CO-OPs are qualified non-profit, customer- governed, private health insurers that will offer qualified health plans in the exchanges.

D

Deductible: A feature of health plans in which consumers are responsible for healthcare costs up to a specified dollar amount.

Drug Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

E

Electronic Health Record/Electronic Medical Records: Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one healthcare organization or it can be shared across healthcare organizations and delivery sites.

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non- profit organizations that do not pay federal taxes.

Essential Health Benefits: A package of benefits set by the Secretary of Health and Human Services that insurers will be required to offer under the marketplaces (exchanges).

F

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and

subsidies. For 2008, the Census weighted average poverty threshold for a family of four was $22,025 and HHS poverty guideline was $21,200.

Federally Qualified Health Centers (FQHC): Safety net providers such as community health clinics and public housing centers that provide health services regardless of the ability to pay and are funded by the federal government.

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

— G —

Group Health Insurance: Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

— H —

Healthcare Cooperative (Co-op): A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels.

Health Information Technology: Systems and technologies that enable healthcare organizations and providers to gather, store, and share information electronically.

Health Insurance Marketplace (exchange): A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement.

Health insurance Portability and Accountability Act of 1996 (HIPAA): Through The Health Insurance Portability and Accountability Act of 1996, individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

Health reimbursement Account (HRA): A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA qualified health plan.

Individual Insurance Market: The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified

individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

— L —

Lifetime Benefit Maximum: A cap on the amount of money insurers will pay toward the cost of healthcare services over the lifetime of the insurance policy.

— M —

Managed Care: A health delivery system that seeks to control access to and utilization of healthcare services both to limit healthcare costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

Marketplace: The Health Insurance Exchange, sometimes referred to as the Federally Facilitated Exchange or Federally Facilitated Marketplace, as established in the state of Arizona under the authority of the Patient Protection and Affordable Care Act (PPACA). It is also referred to as the Health Insurance Exchange.

Medical Home: A healthcare setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical Loss Ratio: The percentage of premium dollars an insurance company spends on medical care or other approved expenses, as opposed to administrative costs or profits.

Modified Adjusted Gross Income (MAGI): A definition of income from the tax system that will be used under the Affordable Care Act to determine eligibility for Medicaid in all states and for tax credits available to people buying insurance in exchanges. The income calculations will take into account family size and income from all family members.

— N —

Notification: Contact to Meritus to let us know if medical services are required. This is not a prior authorization or pre-certification, just a notification that services are needed for our Members.

— O —

Out-of-Pocket Costs: Healthcare costs, such as deductibles, co- payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: A yearly cap on the amount of money individuals are required to pay out-of-pocket for healthcare costs, excluding the premium cost.

— P —

Pay for Performance: A healthcare payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Payment Bundling: A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

Pre-existing Condition Exclusions: An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Prior to January 1, 2014, insurance plans could exclude benefits for a defined period of time for the treatment of medical conditions that they determined to have existed within a specific period prior to the beginning of coverage.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Subsidies: A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Preventive Care: Healthcare that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing healthcare costs over the long term.

Primary Care Provider: A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant, etc.), who is responsible for providing primary care and coordinating other necessary healthcare services for patients.

Provider Payment Rates: The total payment a provider receives after providing medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

— Q —

Qualifying Life Event: A change in a person's life that can make them eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include: moving to a new state, certain changes in income, and changes in family size (i.e., marriage, divorce, or having a baby).

— R —

Risk Adjustment: The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

— S —

Safety Net: Healthcare providers who deliver healthcare services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

Small Business Health Options Program: SHOP is a state health insurance exchange that will be open November 2014 to small businesses up to 100 employees.

Small Group Market: Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

Socialized Medicine: A healthcare system in which the government operates and administers healthcare facilities and employs healthcare professionals.

— U —

Uncompensated Care: A measure of the costs of healthcare services that are provided but not paid for by the patient or by insurance. Healthcare providers incur some of this cost along with the federal government.

— W —

Wellness Plan/Program: Employment or insurance-based program to promote health and prevent chronic disease. Goals of these programs include: reducing healthcare costs, sustaining and improving employee health and productivity, and reducing absenteeism due to illness.

SECTION 2

Departmental Organization and Community Partners

Departmental Organization

Appeals and Grievances

The Appeals and Grievance department manages the processing of member appeals and provider claims disputes (collectively referred to as "Appeals"). The department also processes member grievances and prepares for and represents Meritus at both member and provider state fair hearings.

Claims

The Claims department is responsible for the adjudication of claims and coordination of benefits. This function is currently delegated to the Meritus Third Party Administrator (TPA), Care1st. Meritus Customer Care is staffed by individuals trained to answer claims questions and research and resolve claims payment related issues.

Community Outreach

The Community Outreach objective is to grow and retain the membership. This is done by providing awareness of Meritus through community outreach events.

Compliance

The Compliance department is responsible for directing and administering the health plan compliance and associated programs. The department provides education and training on compliance program resources and reporting mechanisms, including information about federal and state rules and regulations, The False Claims Act, Health Insurance and Accountability Act (HIPAA), Privacy, and Fraud, Waste and Abuse. In addition, the department conducts routine monitoring and auditing activities to verify compliance with regulatory, legal and contractual requirements and identifies best practices and areas in need of process improvements.

Customer Care

Customer Care is responsible for coordinating all membership activities including eligibility verification, responses to member inquiries, member education, translation services, assisting with changing or canceling medical appointments, and answering questions about covered services, benefits, and co-pays. The majority of concerns, complaints, and grievances from members are logged through the Customer Care Center. Customer Care is also responsible for managing the primary care assignment process for those HMO Members who opt not to choose a primary care physician and changing PCP assignments and will assist PPO Members in finding and selecting a PCP.

Finance

Finance oversees the accounting and financial activities of the organization, which includes the issuing of payments to the provider network, capital and operating budgets, internal audit, patient accounting and revenue finance.

Medical Directors

Medical Directors serve as the major interface between healthcare organizations and participating providers and other healthcare providers in the community. The role is invaluable in establishing a provider network as well as facilitating provider participation and cooperation.

Medical Management

Medical Management Services is responsible for all medical, behavioral health and pharmacy services including utilization review, prior authorization, case management, and disease management for members and providers.

Network Development

The Meritus Network Development Department coordinates and manages network operations with a partnership with our Third Party Administrator (TPA), Care1st. The Care1st Provider Network Operations Department is delegated to develop and maintain our network of PCPs, specialists, hospitals and ancillary providers. Each contracted provider is assigned a Provider Representative. The Provider Representatives serve as a provider's vital link to the Health Plan's services. The Provider staffing is maintained to enable providers to receive prompt resolution to problems or inquiries. The Provider Network Operations Department coordinates with other departments and agencies to provide valuable information on services and programs.

Contact your Provider Representative to schedule any needed staff training. Regular visits are intended to provide updates, education, review of compliance issues, as a resource to assist with improving quality of patient care and address concerns of Meritus and the provider. The Provider Representative will meet with the office manager and/or providers, when available. Visits are usually completed in less than one hour. Provider Network Operations contact information can be found in the Quick Reference Guide within this Section of the Provider Manual.

Quality Management

Quality Management is responsible for the evaluation monitoring and implementation of quality improvement activities that include general preventive health education and health promotion, as well as interventions to improve care for women, men, pregnant women, newborns and children, credentialing, investigating and tracking of clinical quality concerns and quality improvement activities such as process improvement projects and performance measures.

Meritus Partnerships

Arizona Foundation for Medical Care (Arizona Foundation) is our network for the Meritus PPO products. Arizona Foundation's responsibilities include delegated credentialing. All Meritus PPO medical claims, excluding dental and vision, must be submitted to Arizona Foundation where claims will be priced per the Provider's contract with Arizona Foundation (or in some cases Meritus) and forwarded to Care1st for final adjudication.

Care1st Health Plan Arizona, Inc. (Care1st) is the Meritus TPA and supports Meritus with many of our health plan functions. Care1st works directly with Meritus Network Operation to contract the HMO provider network and certain additional PPO providers. In addition, Care1st is responsible for provider services and credentialing the HMO provider network excluding dental and vision services. Care1st is responsible for receiving and processing HMO medical claims (excluding dental and vision) and receiving and processing "re-priced" PPO medical claims excluding dental and vision. Additional support functions of Care1st include enrollment processing, premium billing, coordination of benefits and data warehousing for all Meritus plans.

Altegra Health is a vendor that is utilized for a variety of Member outreach and education campaigns. They will serve as an extension of our staff to remind Members about programs available to them or to guide Members with their specific needs.

CVS Caremark is Meritus' pharmacy benefit manager. Our formulary is currently on our website at meritusaz.com.

Delta Dental of Arizona (DDAZ) is Meritus' dental benefit vendor and will manage dental benefits on Meritus' behalf. Meritus will utilize Delta Dental's vast PPO network for our HMO and PPO pediatric populations. DDAZ will also manage our unique adult preventive benefit. Meritus provides a preventive dental benefit (two cleanings, one set of x-rays and one exam) to adult HMO Members enrolled in the Meritus Neighborhood Network Silver HMO MIHS, Community Network Silver HMO Pima or Community Network Silver HMO Banner plan, who choose to receive dental services at a contracted FQHC. Please direct your patients to DDAZ's website at deltadentalaz.com to locate a Meritus dentist or contact Delta Dental at 602.938.3131 or 800.352.6132.

Health Integrated (HI) is our vendor for integrated case management. HI's responsibilities include delegated Utilization Review, Utilization Management (UM), Disease Management (DM), Case Management and Behavioral Health Management.

Vision Services Plan (VSP) is Meritus' pediatric vision benefit vendor and will be managing Meritus' pediatric benefit including claims payment. Please direct your patients to VSP's website at vsp.com to find a participating VSP doctor and Eye Care Center at vsp.com or by calling 855.332.6193.

SECTION 3

Provider Roles and Responsibilities

Meritus is pleased you have chosen to provide healthcare to our members and partner with our plan. Meritus has established the highest standards for the delivery of healthcare for all Members. To that end, we require the following commitments from our healthcare providers:

- Ensure members are treated without discrimination.
- Meet standards for member care.
- Meet quality and utilization management standards.
- Comply with reporting requirements.
- Meet credentialing standards.
- Notify plan with changes to providers, locations, key contacts, telephone numbers, tax identification numbers or corporate structure.
- Provide care for members via in-network facilities to ensure the most cost effective and quality care.
- Cooperate with quality improvement activities and records.
- Allow Meritus to use practice performance data.

Primary Care Physicians (PCPs) perform a critical function for Meritus. Each PCP is responsible and accountable for the coordination, supervision, delivery and documentation of medical services to any assigned Meritus (HMO) Member. A Meritus Mutual Health Partners (PPO) PCP shall carry the same definition without the need to specifically assign Members. PCPs are responsible for maintaining a complete medical record of all services delivered by all providers involved in the members care, including vision, behavioral health, rehabilitative therapy and medical specialty services, as applicable. The use of the PCP in this model provides for less fragmentation and ensures continuity of care for our members. This model helps to attain effective control over utilization of medical services while maintaining the highest level of care.

Providers shall accept members as new patients on the same basis as a provider who is accepting non-members as new patients. A provider shall

not discriminate against a Member on the basis of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of covered services, income level, or on the basis that member is enrolled in a Meritus Plan or is a beneficiary of any public or private healthcare program.

Provider may freely communicate with members about all treatment options available to them including medication treatment options, even if such treatment options may not be considered covered services. In addition, Meritus has no policies restricting dialogue between provider and member and Meritus affirms it does not direct providers to restrict information regarding treatment options. Health maintenance education is not only expected and encouraged; it is required for all providers participating in all Meritus HMO and PPO plans.

Standard of Care Programs and Procedures

Meritus develops and implements policies and procedures to ensure that our providers have information required for effective and continuous care and quality review. These policies and procedures include, but are not limited to quality improvement, utilization review, peer review, grievance procedures, credentialing and re-credentialing procedures, adverse event monitoring policies and any other policies adopted or amended by Meritus. In addition, Meritus seeks the provider's good faith effort to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follow up on unsuccessful attempts to contact a member. Members should receive counseling regarding disease management, prevention and the importance of regular health maintenance visits. The Health Plan has no policies preventing our providers from advocating on behalf of a member and encourages this dual approach to care and disease management. Members must be included in the planning and implementation of their care. Providers must recognize that it is the patient's right to choose their final course of action among clinically acceptable choices. Services must be provided in a culturally competent manner to all members, including those with limited English proficiency or limited reading skills. Providers should always consider the ethnic and religious beliefs of their members and their impact on members' participation in care. Providers must maintain compliance with Cultural Competency and Limited English Proficiency (LEP requirements).

Primary Care Provider Panel (HMO Only)

A PCP's total panel size is considered when assessing the PCP's ability to meet appointment and other standards. At a minimum, PCPs are responsible for the following activities: supervision, coordination and provision of care to each assigned member, initiation of referrals for medically necessary specialty care, maintaining continuity of care for each assigned member, maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

A PCP may limit the size of their panel by making a request to voluntarily close their panel. When a provider closes his/her panel, the provider is no longer open for member choice selection. Exceptions may be made for immediate family of members already on the PCP's panel or other reasons requested by the PCP. PCPs may also request a maximum number of members to be assigned at the time of contracting. Conversely, Meritus may elect to close or limit a provider's panel if the provider has difficulty meeting appointment standards, or if there are concerns regarding quality, utilization, or related issues. The provider's panel may be re-opened upon Meritus approval of a corrective action plan.

The Customer Care Center will ensure every HMO member is assigned to an appropriate PCP. Members may call the Customer Care Center and select a PCP on or within the first month of

enrollment. If the member has not called to select his/her PCP within the first month of enrollment, one will be auto- assigned to them. This assignment is based on the geographical location of the member's residence, needs of the member, and provider's appointment availability standards. Members are given the option of selecting another available PCP per the process noted below.

Primary Care Provider Initiated PCP Change

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Customer Care Center for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. Providers must notify the member (with a copy to the Customer Care Center) in writing that they can no longer provide services to the Member and must:

- Be sent on the provider's letterhead and include the member's name, ID, date of birth, the specific reason for the change request, and the signature of the Provider.
- Request that the member choose a new PCP.
- Indicate that the provider will continue to provide emergency care for thirty (30) day period following their written request, or, until that member is reassigned to another PCP.

Upon receipt of a change request, the Customer Care Center will contact and reassign the member considering member choice as well as geographic, linguistic, medical needs, and other member variables. The transferring provider is responsible for forwarding the member record to the new provider within 10 days of the re-assignment. The following are not acceptable grounds for a provider to seek the transfer of a member:

- Member's medical condition.
- Amount, variety, or cost of covered services required by a member.
- Demographic and cultural characteristics.

Meritus does not condone discrimination against its members for any reason and will investigate any allegations or indications of such.

Member Selection and Changing of Primary Care Providers

Members have the right to select their own PCP through the Provider Directory of participating and available providers. Each eligible member in a family may select a different PCP. Members have the right to change a PCP at any time. Most change requests received by the Customer Care Center will be effective the same date of the request. When a member changes PCPs, his or her original or copied medical records must be forwarded to the new PCP within 10 business days from receipt of the request for the transfer of medical records.

Changes in Professional and Administrative Staff

Changes in the professional staff in your office, for example Physicians, Physicians Assistants, Nurse Practitioners, or Nurse Midwives, must be reported to your Provider Representative. All professionals and all office based providers rendering care to Meritus Members must be credentialed. Lack of timely notification to Meritus may result in payment denials or delays in patient referrals.

Provider Network Changes/ Contract Notifications

All provider changes must be submitted in writing to Provider Network Operations in advance. The provider changes affected by this policy include terminations, office relocations, change in tax identification number, leaves of absence, or extended vacation. Submit all changes to:

HMO
MERITUS HEALTH PARTNERS

Direct changes to Care1st Provider Network Operations at the address/ phone/fax number below or you may e-mail your Representative directly.

2355 E. Camelback Rd.
Suite 300
Phoenix, AZ 85016

Phone: 602.778.1800 Option 5, 7
Fax: 602.778.1875
Email: AZPNO@care1st.com

PPO
MERITUS MUTUAL HEALTH PARTNERS

Direct changes to Arizona Foundation Provider Relations at the address/phone/fax number below.

326 E. Coronado Rd.
Phoenix, AZ 85004

Phone: 602.252.4042
Fax: 602.495.8684
Email: providerrelations@ azfmc.com

PCP Terminations/Member Reassignment

If the terminating PCP practices under a group vendor contract, the members may remain with the group if Meritus or the member determines that to be the appropriate course of action. If the terminating PCP practices under a solo vendor contract, the HMO members will be reassigned to another contracted PCP.

Provider Leave of Absence or Vacation

PCPs must provide adequate coverage when on leave of absence or on vacation. It is the responsibility of the provider to arrange for coverage for members 24 hours-a-day, 7 days-a-week. Meritus must be notified of any coverage dates and provider covering, in advance. Meritus must credential ALL covering providers. PCPs must submit a coverage plan to Provider Network Operations for any absences longer than four weeks. Absences over ninety (90) days may require transfer of members to another PCP. It shall be provider's sole responsibility to make suitable arrangements with the covering provider regarding the manner in which said covering provider will be reimbursed or otherwise compensated; provided, however, that provider shall ensure that the covering provider will not, under any circumstances, bill a member for covered services.

Member's Use of Emergency and Urgent Care Services

Providers are expected to educate members on the differences between urgent and emergent conditions and instruct members to contact their PCP before visiting an emergency room or calling an ambulance unless a life threatening emergency exists. Meritus members who are a patient of record in a provider's office should receive the same service in an emergency that would be extended to any other patient of record in that office.

Specialty Care Providers

If a member requires services outside the scope of the PCP practice, the PCP will refer the member to a contracted specialty care physician. PCPs are responsible and accountable for the coordination, supervision, delivery and documentation of healthcare services for members. Some services do require Prior Authorization or notification. Please refer to the Meritus Prior

Authorization matrix for additional information which can be found on the Meritus website or by contacting Provider Network Operations. The PCP is responsible for the referral of the member as well as initiating authorization for some specialties. Contracted specialists will accept referrals from PCPs and provide medically necessary services covered by Meritus within the scope of their specialty. Specialists are expected to provide appropriate visit documentation to, and care coordination with, the PCP.

Access Standards

Meritus establishes annually an Access and Availability Plan to ensure its healthcare networks are sufficient in numbers, types and geographic location of practitioners. Meritus takes into consideration the special and cultural needs of its members and implements mechanisms designed to provide adequate access to primary care and specialty care practitioners. Meritus measures the accessibility of after hour's services; urgent care services, and our Customer Care Center. Meritus collects and analyzes data to measure its performance against these standards, and identifies opportunities for improvement and decides which opportunities to pursue.

Emergency/After Hours Coverage

Providers are responsible for member coverage 24 hours a day, 7 days a week. This may be accomplished through an answering service that contacts the physician or on-call physician. The provider may also use an answering machine that directs the patient to the on-call physician. An answering machine on which the member is expected to leave a message is not acceptable. It is unacceptable to use a hospital emergency department as a means of providing twenty-four (24) hour coverage.

ACCEPTABLE EMERGENCY COVERAGE INCLUDES THE FOLLOWING:

An answering service that answers the provider's telephone after hours. The operator must be able to contact the provider or a covering provider. An answering machine that either directs the caller to the office of the covering provider, or directs the caller to call the provider at another number. Call forwarding services that automatically sends the call to another number that will reach the provider or covering provider. An answering machine that directs the caller to leave a message that will automatically page the provider to retrieve the message and respond as appropriate.

UNACCEPTABLE EMERGENCY COVERAGE INCLUDES THE FOLLOWING:

An answering machine that directs the caller to go to the emergency room. An answering machine that directs the caller to a cellular phone, which bills the caller for the call. Members should not receive a telephone bill for contacting a provider. An answering machine that does not direct/educate the caller at all regarding after-hours procedures. No answering machine or service.

Appointment Availability

Meritus has made a commitment to meet appointment availability standards as set forth by community standards. All members must be offered the same appointment availability standards as other patients receiving care in their office. Should the provider segregate any Meritus members, the provider may have their provider agreement terminated. All providers are to become familiar with and adhere to the following:

PCP APPOINTMENT AVAILABILITY

- Regular and routine care appointments within 15 days of request.
- Preventative care appointments within 60 days of request.
- Urgent appointments within 48 hours of request.
- After-hours return care within 6 hours.

SPECIALTY APPOINTMENT AVAILABILITY

- Routine care appointments within 60 days of request.

BEHAVIORAL HEALTH STANDARDS

- Non-life-threatening emergency appointment within 6 hours (including a referral to the emergency room within six (6) hours if services are not readily available).
- Urgent appointments within 48 hours.
- Regular and routine office visit appointments within 10 business days.

Member Complaints

Provider shall notify Meritus within five days of any complaints it receives from members regarding provider, Meritus or any other participating providers who are providing covered services under any Meritus Plans. Meritus shall notify Provider within 5 days of any complaints it receives from members regarding provider. Provider and Meritus will work together and cooperate fully in the investigation and resolution of any such member complaint.

Access and Retention of Medical Records

All medical records, books, and papers of provider pertaining to members, including without limitation, electronic records, books and papers relating to professional and ancillary care provided to members and financial, accounting, electronic and administrative records, books and papers, shall be open for inspection and copying by Meritus, its designee and/or authorized state or federal authorities during provider's normal business hours. The provider further agrees that it shall release a member's medical records to Meritus upon provider's receipt of a member consent form or as otherwise required by law. In addition, provider shall allow Meritus to audit provider's records for payment and claims review purposes. The Health Plan will provide 30 days prior written notice of its intent to conduct such audits. Provider will provide access to records within fourteen 14 days prior to the date of the scheduled audit. Provider agrees to maintain, in an electronic format for each member receiving covered services a single standard medical record in such form and containing such information as may be required by the laws, rules and regulations of the State of Arizona. All such member medical records and information shall be treated as confidential in accordance with applicable laws. Provider agrees to maintain such medical records for the longer of ten years after the last date covered services were provided to member, or the period required by any other applicable law, rule, or regulation.

The provider understands that Meritus, through and as an extension of its parent Compass

Cooperative Mutual Health Network (CCMHN), operates under federal law as a CO-OP program and must mandate certain requirements for the Department of Health and Human Services/ Center for Medicare and Medicaid Services (CMS) to be able to access provider records.

Provider therefore agrees to:

(a) maintain and give the U.S. Department of Health and Human Services, the Comptroller General, the HHS Office of Inspector General, or their designees access to all books, contracts, records, documents, and other evidence related to Meritus' scope of work sufficient to enable the audit, evaluation, and inspection of Meritus' compliance with CO-OP program requirements; and

(b) maintain such books, contracts, records, documents, and other evidence related to CCMHN's CO-OP program throughout the last day of the Meritus performance period in the CO-OP program or from the date of completion of any audit, evaluation or inspections, whichever is later, unless: CMS determines there is a special need to retain a particular record or group of records for a longer period and has notified Meritus at least 30 calendar days before the normal disposition date; or there has been a termination, dispute, or allegation of fraud or similar fault committed by Meritus, its providers, suppliers, or contracted entities that perform functions or services on its behalf, in which case Meritus must retain records for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

Confidentiality of Medical Information

Provider shall maintain the privacy and confidentiality of all information and records regarding members, including but not limited to medical records, in accordance with all state and federal laws, including regulations promulgated under the federal and/or state Health Insurance Portability and Accountability Acts.

Any provider sending member records, upon member written request, to a new or referring provider must ensure the medical records are forwarded in such a way that unauthorized individuals are not able to access or alter PHI. HIPAA also provides the member the right to obtain a copy of their records. Any Meritus member is entitled to receive one copy of his/ her medical records from the provider office at no cost, annually. Additional HIPAA requirements and information is available through the government website: hhs.gov/ocr/privacy/hipaa/ understanding/summary.

Member Request to Amend Medical Record

Requests by a Meritus member to amend or correct information maintained in the member's medical record or other records maintained in the provider's designated record set must be made in writing and include a reason to support such a request. Routine requests for amendments or corrections to the member's contact information or other non-medical information are not required to be in writing, and may be handled by a provider's office according to the provider's administrative processes. A request for Amendment of Health Information form shall be completed by any member who wants to have information in his or her health/medical record amended. This form can be located in the forms section of our website at meritusaz.com or available by contacting Meritus Customer Care or Care1st Provider Network Operations.

Members will be directed to send the form to the provider whose entry they would like amended. Providers must act on a member's request for an amendment within 60 days after receipt of the request in writing. If provider is unable to act on the request within the 60-day period, that party may have a one-time extension of not more than thirty (30) additional days, as long as the provider has informed the member in writing of the delay,

the reasons for the delay, and a date by which they will provide a response. All documentation regarding requests to amend, and documentation regarding Meritus' response to the request, must be submitted to the Medical Records Department to retain for a period of at least six years from the date of the documentation. If provider is informed by another covered entity of its amendment to a member's PHI maintained by the covered entity, and provider has PHI or other records in its Designated Record Set affected by such amendment, provider will amend the PHI in its Designated Record Set accordingly. Provider will follow all policy and procedures regarding this request found in Meritus Policy #C146 Member Request to Amend Medical Records.

Members Transitioning Out of a Meritus Plan

If a member is under active treatment for an acute or chronic condition and transitioning out of Meritus the Primary Care Physician is responsible for providing a copy of the medical record upon request from the receiving health plan or program contractor. Medical records must include records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Meritus, unless state regulations stipulate differently. The records must be available to the new provider within 10 days of receipt of request or upon request for an urgent visit. Confidentiality must be maintained by all staff, provider and/or vendors according to medical record policy and procedure.

Members Transitioning into the Health Plan

When a case managed member is transitioned into Meritus, the new provider will receive notification from our Care Management Department. Pertinent information will be relayed via telephone or fax request. Records will be requested of current provider and forwarded to you within 10 days.

Hospital Admissions

PCPs may admit members to Meritus contracted facilities and follow his/her own patients in the hospital. If the PCP is unable to admit and or follow the patient, a contracted hospitalist may follow the member while he/she is hospitalized. PCPs are, however, expected to follow up with a member upon discharge from the hospital within 24 to 48 hours post discharge.

Referrals and Prior Authorizations

The PCP is responsible for initiating and coordinating referrals to specialists within the contracted network when necessary and obtaining prior authorization for services listed on the Prior Authorization matrix. Please refer to the Prior Authorization matrix for additional information, which can be found on Meritus website or can be obtained from Customer Care or Care1st Provider Network Operations. Meritus encourages contracted specialists to secure needed authorizations, but it is the responsibility of the PCP to ensure the authorization is requested. It is critical that the PCP maintains a strong communication link with specialists who are treating their members.

Provider as Member's Advocate

Meritus does not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's healthcare, medical needs or treatment options, including alternative treatment that may be self-administered, even if needed services are not covered by Meritus.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or non-treatment.

- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- Providers must provide information regarding treatment options in a culturally-competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options.

Non Discrimination Policy/ Culturally Competent Care

Members have the right to receive services provided in a culturally competent manner and information about member rights and responsibilities in a language of choice that includes: benefits, scope of service, covered and non-covered benefits, conditions of enrollment and other information as deemed necessary.

Services will be offered to ensure that member's rights and responsibilities to address the needs of covered persons with limited English proficiency (LEP) and illiteracy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities (including hearing impairment) will be communicated and clearly defined so the member can receive care that meets his or her needs in a way that is not judged by race, color, beliefs, sex, sexual orientation, marital status, national origin, ancestry, genetic information, values, language, special needs, mental disabilities, age, handicap or ability to pay.

Providers must provide information regarding treatment options in a culturally-competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options. Providers must be compliant with the Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability. Please refer to the table on page 33 for the regulations (source: Office of Minority Health, U.S. Department of Health and Human Services. (March 2001) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879. http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf). 80865-80879. http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf).

Language Interpretation Services

Meritus provides interpretive services for its members with different languages and cultures. If you have a member who is in need of these services please contact the Customer Care Center toll-free at 855.755.2700 or 602.957.2113. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the translation service. There is no cost for language interpretation services.

Hearing Impaired

For any provider or member requiring TTY/TDD users call 7.1.1.

Altegra Health

Altegra Health services is an extension of our staff to remind members about programs available to them, encourage selection and use of a PCP, retention/renewal or to guide members with their specific needs. The purpose of Altegra Health is to build relationships between Meritus and its members with a primary goal of retaining members and improving health outcomes. Altegra Health offers interactive and personalized education. Warm Health achieves improved results by increasing the frequency of outreach.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare

Healthcare organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Healthcare organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services

Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Healthcare organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services

Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports

Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Healthcare organizations should ensure that data on the individual patient's/consumer's race ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Healthcare organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Healthcare organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.

Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross- cultural conflicts or complaints by patients/consumers.

Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Discharge Planning and Coordination of Care

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of re-admissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member, and involving the member and family in implementing the plan.

The Concurrent Review Nurse works peripherally with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but not be limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending provider with names of contracted providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Assisting with necessary authorization of post discharge services.
- Informing hospital staff and attending provider of covered benefits as indicated.
- Referring member to Care Management as necessary.

Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs using communication and available resources to promote quality, cost-effective outcomes. Care coordination services are available to persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

PCP and Specialty Provider Coordination

Prior to the member's appointment, the PCP forwards a copy of the supporting medical records to the contracted network specialist. The Specialty Care Providers are expected to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensures the referred specialty physician is a participating provider within the Meritus network and that the PCP is aware of the additional service request. Please reference the Prior Authorization matrix on the Meritus website to determine if a referral to a specialist also requires Prior Authorization.

PCP, Hospital and Ancillary Service Provider Coordination

The designated hospitalist will communicate with the PCP during the hospital stay and upon discharge. Upon discharge from an acute care hospital the following should be provided to the PCP:

- Hospital stay summary, e.g., in-patient treatments and test results, list of specialty physician consults.
- Post-discharge plans.
- Medications.

The PCP should coordinate services with the contracted Ancillary Services Providers. Ancillary providers should provide the following to the PCP:

- Stat laboratory/diagnostic imaging results called in or faxed as soon as the test is completed.
- Routine laboratory/diagnostic imaging results processed within 48 hours with faxed results to follow.
- The ordering physician must document their review of the results along with any follow-up plans in the medical record.

Behavioral Health and Medical Provider Coordination

Participating providers are required to initiate and maintain timely communications with member's PCPs. This helps promote sharing of clinical information for comprehensive treatment and continuity of care, when appropriate, e.g. in cases of possible coexisting medical conditions, when medications are prescribed or other medical concerns are evidenced. At the time of the initial appointment or earliest practical time thereafter, providers should discuss with the member the importance of coordinated care and seek their consent to communicate with their PCP.

Behavioral Health Providers Providing Treatment to the Same Patient

Participating providers are required to initiate and maintain contact with other behavioral health providers or consultants as well as healthcare institutions when appropriate. In these situations, the behavioral health primary clinician should discuss the importance of communication with other behavioral health providers or consultants/ institutions and seek the members consent to communicate with the other providers.

Referrals Between PCP, Specialist and Hospital for Social and Community Based Services

Referrals are not limited to medical services, but will include social and community based services. It is expected that each provider involved in a member's care will identify and act on information received regarding the need for these non-medical support services. The Meritus Community Outreach and Medical Management Departments will continue to identify additional social and community resources to help support these needs. Information regarding social and community resources will be available to all providers and listed on the Meritus website with contact information and/or links to a website (if available) to the different agencies and entities. Providers are encouraged to contact the member's Meritus Case Manager or the Customer Care Center with any questions regarding the availability of social and community based services and how to encourage member participation in these available resources.

Continuity of Care Plan

In the event of a provider contract termination between Meritus and any of its participating providers or in the event of Meritus' insolvency or other inability to continue operations, Meritus will notify all affected members in writing 30 days prior to the termination or as soon as possible if provider does not give notice prior to the termination. In the event of a terminating specialist, Meritus will notify all affected members no later than 30 calendar days after receipt of notification. A Meritus affected member is a member that has had two or more visits to the PCP or specialist within a six month period, has an open referral/ authorization, or is assigned to a terminating PCP.

Meritus will make every attempt to allow for continued access to a terminating PCP or specialist through the lesser of the current period of active treatment or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition. Continued access to a practitioner through the postpartum period for members in their second or third trimester of pregnancy will be granted. Exceptions include a member who requires only routine monitoring for a chronic condition, Meritus terminated a contract due to a professional review action as defined by the Health Care Quality Improvement Act of 1986 or the practitioner is unwilling to continue to treat the member or accept contract payment methodologies for continued care.

Should Meritus' coverage of service end while a member still needs care, the member will be educated about alternatives for continuing care and how to obtain care, as appropriate. Meritus will notify members of existing available options. Those members that need transition of care services will be referred from Customer Care or Utilization Management to Nurse Case Managers or the appropriate designee.

SECTION 4

Member Rights and Responsibilities

Enrollment in Meritus carries with it certain member rights and responsibilities. While all members have access to a handbook that details those rights and responsibilities (on the following pages), you should know what our members are being told to expect from you and what you have the right to expect from those members.

Additionally, Meritus encourages its members to ask questions and to openly discuss their healthcare needs with their provider. Meritus intends to honor member rights to the fullest extent.

Member Rights

1. Members have the right to receive information about Meritus, our services, our practitioners and providers and member's rights and responsibilities in a language of choice for the member including:
   - Benefits, scope of service, covered and non-covered benefits, and condition of enrollment.
   - Provisions for after-hour and emergency healthcare services.
   - Access emergency medical care without the need to obtain prior authorization or approval from the health plan.
   - Information about available treatment options, "no treatment" options and alternative courses of care.
   - Procedures for obtaining services, including authorization requirement and any special procedures for obtaining mental health and substance abuse services or referrals for specialty services not provided by the member's primary care provider (PCP).
   - Procedures needed to obtain emergency services outside of the geographic service area.
2. Be treated with respect and recognition of their dignity and their right to privacy and confidentiality by protecting any information that can identify a member.
3. Receive care that meets his or her needs in a way that does not judge race, color, beliefs, sex, sexual orientation, marital status, national origin, ancestry, genetic information, values, language, special needs, mental disabilities, age, or handicap.
4. Receive information on how to access services in a culturally competent manner.
5. Participate with practitioners in making decisions about their healthcare and advance directives and have the right to allow a representative to facilitate care or treatment decisions, including the right to refuse treatment, when the member is unable to do so for him or herself.
6. A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage; including the right to have access to interpretive and translation service provided regardless of the language at no cost to the member.
7. Voice complaints or appeals or request for hearing about Meritus or the care we provide.
8. Make recommendations regarding Meritus members' rights and responsibilities policy.
9. Have access to interpretative and translation service provided regardless of the language at no cost to the member.
10. Obtain information to assist him or her to make informed decisions including but not limited to:
    - Accepting or refusing treatment and information about the potential risk to refusing treatment.
    - Making advance directives which designates an individual to make healthcare decisions on the Member's behalf and the ability of the member or designated individual to change his or her Advance Directives at any time.

Member Responsibilities

Meritus expects a certain level of commitment and responsibility from their members. Meritus member's responsibilities are as follows:

1. Supply information (to the extent possible) that Meritus and its practitioners and providers need in order to provide care.
2. Follow plans and instructions for care that they have agreed to with their practitioners.
3. Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
4. Know the name of his or her PCP and how to access care including PCP phone number and facility location.
5. Be considerate of the rights and property of facilities, providers, patients and staff,

including but not limited to those policies addressing smoking and visitation.

6. Pay his or her co-payments, deductibles and coinsurances for care received, as soon as possible.
7. Schedule appointments with his or her PCP during medical office hours when possible before using a contracted urgent care.
8. Arrive on time and advise the medical office, in advance, when he or she cannot keep a scheduled appointment.
9. Cancel non-emergent transportation services in advance of visit when the medical visit is cancelled.
10. Bring immunization record to every appointment for children 18 years old or younger.

Complaints

Members or their representative may submit a complaint to Meritus by mail, fax, email or by coming to our offices. Customer Care may request the provider's assistance to resolve the issue. Providers may be contacted to clarify the situation and/or to provide education regarding Meritus policies and procedures. The Complaints Department works to settle complaint as as quickly as possible, but no longer than 30 days from the date of receipt. If the complaint is about an urgent medical issue, Meritus will contact the member or provider within 24 hours. If the complaint is about a non-urgent medical issue, Meritus will review the complaint within 10 days following its receipt. We may contact the member or provider to get more information or to request medical records to review.

Advance Directives

Meritus members have the right to make decisions about their healthcare, including the right to accept or refuse medical care and the right to execute an advanced directive.

The Patient Self-Determination Act, passed by Congress in 1991, requires that healthcare providers educate patients on issues related to Advance Directives, which may include a living will or a healthcare power of attorney. The Act requires all Medicare and Medicaid providers to furnish timely information so patients have the opportunity to express their wishes regarding the refusal of medical care. Meritus must comply with this Act, and request your cooperation in helping us become compliant. Documentation is required in the medical record as to whether or not an adult member has completed an Advanced Directive.

Below are suggestions to assist in bringing your medical records into compliance with this standard: Add a line to your initial patient assessment record stating:

- Advance Directive discussed: ☐ Yes ☐ No
- Do you have a Living Will or Power of Attorney: ☐ Yes ☐ No

PCPs are encouraged to obtain a copy of the member's executed advanced directive from a hospital, nursing facility, home health agency, hospice or any organization responsible for providing personal care for inclusion in their medical record.

For more information on healthcare directives, the following organizations offer assistance and resources:

- **Arizona Attorney General**
  azag.gov
- **Arizona Medical Association**
  azmedassn.org
- **Arizona Hospital & Healthcare Association**
  azhha.org
- **Arizona Aging and Adult Administration**
  azdes.gov/aaa
- **American Academy of Family Physicians**
  aafp.org
- **American Association of Retired Persons**
  aarp.org
- **American Hospital Association**
  putitinwriting.org

SECTION 5

Eligibility and Enrollment

Enrollment

The Customer Care Center provides assistance to all health plan members, provides answers to members' questions, facilitates PCP changes and answers provider's eligibility inquiries. A main focus of the Customer Care Center is to assist and coordinate benefits for our members. Each new member will receive a welcome packet within 10 - 15 days of notification of enrollment. They will receive their identification card and a packet containing a welcome letter, Schedule of Benefits, Policy and information on how to access a Member Handbook, Provider Directory, and Customer Care. Language and interpretive services are available to ensure all members are aware of and understand how to access member translation services.

Eligibility

Prior to performing covered services for members, provider shall verify the identity and eligibility of the member. Meritus shall not be liable to make any payments for covered services for which provider fails to follow eligibility verification procedures. If Meritus determines that a patient is not a member, provider may collect from the patient any amounts due for services rendered. Eligibility and PCP assignment can be verified using any of the verification methods defined below.

Newborn Notification

Hospital providers are required to notify Meritus of all newborns in a timely manner to be eligible for reimbursement from Meritus. Please review the Obstetrical/Gynecological and Maternity Care Services section of the Meritus Prior Authorization and Notification Matrix for the timeline and Notification requirements.

Customer Care

To speak with a representative from our Customer Care Center call 602.957.2113 or toll-free 855.755.2700. TTY/TDD users call 7.1.1.; please have Meritus' phone number ready.

Provider Portal

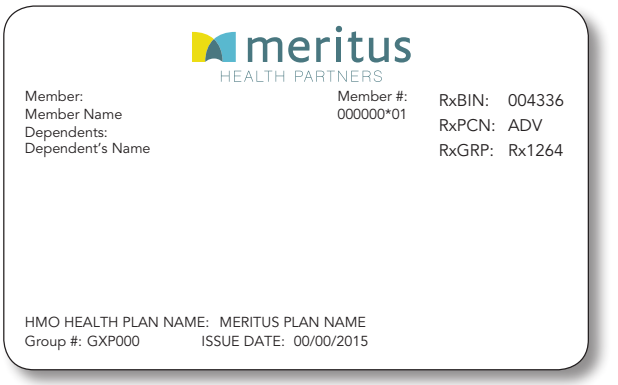
The Meritus Provider Portal is your resource for member benefits and eligibility, as well as claims and prior authorization status. Providers can also access Quality information. Each provider's office can complete one super user request form that will provide the administrative function to add delegated user accounts for each provider or staff member in your office. To obtain your log in and password, complete the Meritus Provider Super User Request Form found on the **Providers** page forms section.

Member Identification Cards

Meritus shall provide an identification card or other indicator of participating status to members, which shall identify whether the member participates in a Meritus plan. In addition, the identification card may also identify the telephone number for provider to call in order to confirm member's eligibility for covered services. The identification card does not guarantee that the member is still eligible for services. At such time as Meritus receives an inquiry from provider regarding a member's benefit plan or covered services, Meritus shall use information given by provider to make preliminary benefit decisions. Meritus shall retain the right and sole responsibility to determine whether a service is a covered service. To verify eligibility providers can contact our Customer Care Center or utilize the Provider Portal on the Meritus website, meritusaz.com

Meritus Health Partners – HMO Member ID Card

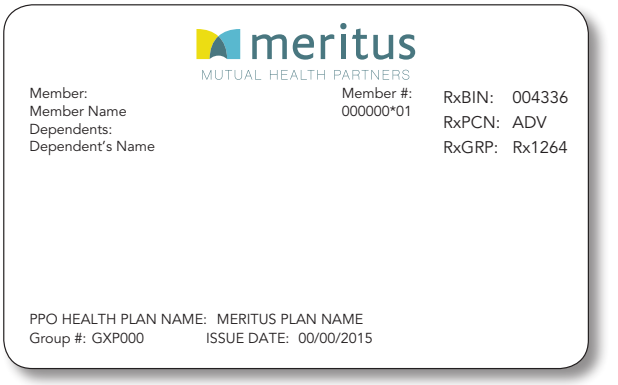
HMO members must obtain covered services within their contracted network and service area (Maricopa, Mohave, Pima or Santa Cruz Counties). There are no covered benefits outside of the member's service except in the case of an emergency. Emergency services are covered for HMO members throughout the United States. Meritus utilizes a relationship with Multiplan/PHCS to price some emergency claims for our HMO members.



Meritus Mutual Health Partners – PPO Member ID Card

PPO members must obtain covered services within their network and service area (State of Arizona). Meritus utilizes The Arizona Foundation for Medical Care (AFMC) network for our PPO plans. Please utilize the Meritus PPO provider search to find AFMC participating providers. Not all AFMC providers may be contracted through the Meritus agreement with AFMC.

Meritus has a relationship with Multiplan/PHCS for covered services outside of the PPO members service area (state of Arizona). Meritus PPO members may utilize the PHCS network as "in" network and the Multiplan network as "out" of network. Emergency services are covered for PPO members throughout the United States.



SECTION 6

Benefits and Covered Services

Covered Services

A service must be medically necessary and covered by the member's contract to be paid by the plan. The plan determines whether services are medically necessary as defined by the member's certificate of coverage. To verify covered or excluded services, call Meritus Customer Care. All services may be subject to applicable copayments, deductibles, and coinsurance.

Meritus uses the current nationally approved criteria for any medical necessity reviews required. Meritus makes coverage determinations, including medical necessity determinations, based upon its Members' certificates of coverage. However, Meritus is not a provider of medical services and it does not control the clinical judgment or treatment recommendations made by the providers in its networks or who may otherwise be selected by members. Providers make independent healthcare treatment decisions. For services that require prior authorization, please reference the Prior Authorization Matrix.

Benefits

Meritus offers both HMO and PPO products with four "metal" levels of coverage in each of our plan design packages: Platinum, Gold, Silver, and Bronze. Our packages and networks will:

- Eliminate barriers to care.
- Have predictable out-of-pocket costs.
- Have no or low co-pays for PCP visits.
- Have no or low co-pays for generic maintenance medications.
- Focus on health.
- Have no co-pays for preventive health benefits.
- Provide intensive case/care management.

The list below is a basic list of services covered by Meritus Health Partners (HMO) and Meritus Mutual Health Partners (PPO).

- Primary care doctor visits to treat an injury or illness
- Specialist doctor visits
- Preventive care, screening and immunization
- Prescription drugs
- Hospitalizations
- Emergency room services
- Urgent care services
- Maternity care services
- Lab and x-ray services
- Mental health, behavioral health and substance abuse services
- Home healthcare
- Rehabilitation services
- Habilitation services
- Skilled nursing care
- Durable medical equipment
- Hospice services
- Eye exams, glasses and dental check-ups for children
- Hearing aids
- Routine foot care for diabetics

If you have questions about covered benefits, please call Customer Care toll-free at 855.755.2700 or 602.957.2113. TTY/TDD users call 7.1.1. Or visit the Meritus website at meritusaz.com to view a full list of our benefit plans.

Non-Covered Services

NOTE: This is a list of services not covered by Meritus. This is not a complete list. Please call Customer Care with any questions regarding a member's benefits.

- Any service that is not medically necessary.
- "Medically Necessary" means that services will be covered to prevent, diagnose, correct, improve or cure conditions that endanger life, cause pain, result in illness or could cause or worsen a handicap or physical defect.
- "Medically Necessary" services must be appropriate for the specific health issue or when no other equally effective care is an option.
- Elective cosmetic surgery.
- Experimental and/or investigational drugs, procedures or equipment.
- Infertility treatment.
- Weight loss programs.
- Prescriptions not on our list of covered medications, unless approved by Meritus.

Essential Health Benefits (EHB)

Meritus offers in our individual and small group markets, both inside and outside of the Health Insurance Marketplace, a comprehensive package of items and services, known as Essential Health Benefits. Essential health benefits include items and services within at least the following 10 categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

Health Insurance Subsidies

The health insurance subsidies granted in the Health Insurance Marketplace via instant tax credits is a major benefit to making health insurance affordable and accessible to many Americans. The Affordable Care Act enhanced health insurance comprehensive benefits while providing a much higher level of consumer protections and security. This of course will add to the overall costs of health insurance premiums making the tax credit subsidies vital to affordability.

The subsidies are calculated according to income and family size. Medicaid will be available to those living under 138% of the federal poverty level. Most Americans with incomes between 138% - 400% of the federal poverty level will qualify for some level of tax credit subsidy. The subsidy scale is a progressive schedule, so that the higher the financial need for affordability tax credits, the higher the subsidy.

Americans above 400% of the federal poverty level income do not qualify for any subsidy assistance, but will still be able to shop in the competitive Health Insurance Marketplace or private plans. Meritus offers our products on and off the Health Insurance Exchange.

SECTION 7

Utilization Management

The Meritus utilization Management (UM) Program develops, implements, and monitors processes and guidelines for reviewing medical and behavioral healthcare requests for referral, triage, and a variety of inpatient, residential and outpatient services.

The UM Program supports compliance with regulatory and accreditation standards, quality review processes for assuring that medical and behavioral healthcare resources are appropriately utilized, and the efficient use of financial resources and personnel.

Utilization Management (UM) Program Overview

Utilization management must be based upon valid evidence based data in order to produce reliable reports required to analyze patterns of utilization and to work with providers to make needed improvements. The Utilization Management Department evaluates the necessity, appropriateness and efficiency of medical and behavioral healthcare services for consumers receiving or requesting services against established clinical practice guidelines and level of care criteria.

The authorization activities are clinically focused and conducted by qualified staff operating within a common definition of medical necessity that is consistently applied. The program strives for transparency, limitation of administrative costs and focusing authorization activities on services with a demonstrated need for review. Utilization management focuses primarily on utilization outliers; specifically high-intensity service use, high-cost services, and patterns of under and over utilization of services. In the event of these activities occurring through a delegated vendor, the UM committee will review at least on a semi-annual basis reporting from these vendors and assuring additional programs be put in place where appropriate. It is also the responsibility of this committee to recommend changes in Meritus plan design that aligns with appropriate utilization of medical and behavioral services.

Scope of Utilization Management (UM) Program

MEDICAL AND BEHAVIORAL HEALTH SERVICES

Meritus' UM Program provides a comprehensive, systematic, consistent and ongoing approach to the review of medical and behavioral clinical care and services utilization including referral, and inpatient and outpatient services provided by hospitals, physicians, and ancillary providers.

The Behavioral Health aspects of the program encompass mental health and substance abuse issues, including chemical dependency, managed along with a member's non-behavioral health needs for an integrated approach.

Utilization Management staff evaluates continuity and coordination of care as well as underutilization and utilization. Review activities take into account state/federal regulations and accreditation standards related to UM activities.

UM staff use nationally recognized clinical criteria to come to a determination of medical necessity. These criteria reflect evidence-based standards that have been shown to be most effective at maintaining and improving health, determining optimal levels of care and appropriate lengths of stay for inpatients. These criteria may be enhanced to include internally developed, evidence-based clinical guidelines, to determine the best clinical outcomes for the member.

UM review activities and interface directly with case managers and others to coordinate comprehensive and appropriate care management for those members with complex chronic conditions and co-morbidities, whether medical and/or behavioral. UM directly supports case management by communicating standards of care that are applicable for members in the program.

Types of Utilization Management Reviews conducted:

- Prospective Review/Pre-certification
- Concurrent Review
- Retrospective Review
- Appeals
- Experimental/Investigational

Clinical Criteria

To support UM decision making, Meritus utilizes Milliman Care Guidelines (MCG) criteria as the primary decision support. These criteria are developed by achieving multi-specialty consensus of evidence-based citations to cover the spectrum of human ailments, and involve all medical disciplines required for inpatient hospital care and transition levels of care. MCG physician panels meet regularly to review existing criteria, revise them and add new criteria based on nationally recognized guidelines and clinical protocols for standards of quality care. They solicit feedback from experienced users of the criteria as part of the updates and enhancement research.

Meritus may also develop its own clinical criteria based on the needs of its members and its experience in delivering effective and efficient care across service lines. UM Program criteria and guidelines are developed with participation from appropriate practitioners with current knowledge of the relevant criteria and guidelines under review. Internally developed clinical criteria and guidelines are based on current standards of practice within the healthcare community and are aligned with evidence-based practices.

All internal behavioral health criteria are developed by a panel of experienced clinicians with extensive expertise in the behavioral health field. This panel is composed of board certified physicians specializing in child/adolescent, adult, and geriatric psychiatry as well as substance abuse and psychology. To be eligible to participate in this panel, the physician must be board certified or have obtained diplomat status in the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP), hold an active unrestricted license, and have five or more years' experience in managing the direct care of behavioral health patients. In the case where Behavioral Health UM criteria are developed by delegated vendors, Meritus will either approve the development criteria process or use vendors that are NCQA accredited.

If a member receives healthcare services that have been pre-authorized or approved, Meritus will not review, revise, or modify criteria policies, criteria or procedures used for procedures, treatment, and services delivered to the member during the course of treatment.

Provider Access to Clinical Criteria and Guidelines

Meritus will make the clinical criteria and guidelines available to practitioners upon request per Meritus' UM policies and procedures. Practitioners can request the criteria in writing, verbally over the phone or via a faxed request.

Prior Authorization and Referral Process

Prior authorization (PA) is a process by which Meritus determines in advance whether a service that requires prior approval will be covered, based

on the initial information received. PA may be held until Meritus receives supporting clinical documentation to confirm/determine medical necessity is in compliance with criteria used by Meritus. Criteria used by Meritus to make decisions are available upon request.

Emergency services rendered in cases where a prudent person, acting reasonably, would believe that an emergency medical condition existed shall not be subject to pre-or post-service review. Emergency services approved by an agent of Meritus shall be authorized automatically. No such covered services shall be denied.

PA review functions involve both inpatient and outpatient services. Healthcare services requests may be received from health plan physicians, hospitals and ancillary providers, members, or the member's representative. Meritus accepts information from any reasonably reliable source that will assist in the certification process.

Meritus does not require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for authorization, but may request such codes, if available. Required clinical information may include the following:

- Office and hospital records.
- History of current illness including treatment to date.
- Clinical findings.
- Diagnostic results.
- Treatment plan and progress notes.
- Patient psychosocial history.
- Associated medications/treatments.
- Quantitative clinical information.
- Follow-up/discharge plans, as applicable.
- Information on consultations with the treating practitioner.
- Evaluation from other healthcare professionals.
- Photographs.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services and procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members.

All member (patient) information obtained during utilization review will be kept confidential in accordance with state and federal laws. However, patient clinical and demographic info may be shared within departments on a need to know basis so that patients, practitioners, and providers do not have to provide duplicate medical records.

Authorization Form and Submittal Information

Please direct members to contracted providers. All requested for services to a non-contracted Provider require prior authorization. Refer to the Meritus Notification and Prior Authorization Matrix for prior authorization requirements based on services category or provider specialty. Prior authorization requirements can vary by plan (HMO v PPO).

EXAMPLES:

- Plastic surgeons require authorization for both PPO and HMO plans
- Dermatologists require authorization for the HMP plans only
- Positron Emission Tomography (PET) scans require authorization for both PPO and HMO plans
- Computed Tomography requires authorization for the HMO plan only

A provider who wants to file an authorization request to refer a member when prior authorization or notification is required may do so by phone or fax using toll-free to 877.288.1012 or our fax: 855.850.2581.

The Prior Authorization matrix and Request Form are available on our website under the Provider page. Providers without internet access may contact Meritus Customer Care for a copy to be mailed or faxed to your office.

If the referral is being made to an out-of-network or non-contracted provider for a service which cannot be provided in-network, and the service is medically necessary and a covered benefit, the request will be forwarded to the UM department and/or the Provider Network Operations Department, which will attempt to put a Letter of Agreement (LOA) in place to cover the assessment and/or treatment that has been approved.

Notification of Approvals and Denials

PA is not a guarantee of payment. Reimbursement is dependent upon the accuracy of the information received with the original PA request, whether or not the service is substantiated through concurrent and/or medical review, eligibility, and whether the claim meets claims submission requirements.

- If the request is for services that are not covered in the member's benefit package and/or the referral is not considered medically necessary, the authorization will be denied and the provider and member informed of the decision by mail, fax or e-mail. Denials can be communicated by phone but must be followed up with written documentation.
- If the requested referral is consistent with the member's benefit plan, the referral is deemed medically necessary and is being made to a network provider, the request will be approved automatically and communicated to the Provider, on line or via e-mail, as well as to the member.
- If the request is for a series of services (e.g. 6 PT visits), only the number of services that are covered by the member's benefit plan and/or are medically necessary will be approved.
- If the referral meets guidelines but is being made to an out-of-network provider when there is an in-network provider who could provide the service, the referral will be rejected, and the provider and member notified of the reason. The provider will be told to call Meritus' Customer Care or to check the on-line Provider Directory for an in-network provider.
- If the referring provider has made notes as to why a particular out-of-network provider should be used (e.g. provider has a relevant sub-subspecialty), the Utilization Review Department will review the request.
- If approved, the provider and member will be notified in the same manner as any other approval.
- If rejected by the UM department, the request may be reviewed by the Medical Director prior to the denial, or upon appeal.

A PA number is issued by the PA department for approved treatment authorization requests. The PA number must be included on the claim in order for claims adjudication and payment to occur.

- UB-04 – place PA number in field 63
- CMS 1500 – place PA number in field 23

Utilization Management (UM) Denial Notices

A Utilization Denial Notice is a written notification of a UM denial decision and provides a clear explanation of the reason for the denial. It provides members and practitioners with sufficient information to decide whether to appeal the decision. Meritus complies with all laws and regulations related to Utilization Management Denial Notices, and ensures that members and practitioners receive UM Denial Notices in a timely manner, and with all of the information and instructions needed to appeal a decision to deny care or coverage. Practitioners are given the opportunity to discuss UM denials with appropriate Meritus clinical reviewers.

UM Communication Services for Members and Providers

ACCESSIBILITY OF UM STAFF AND STANDARDS OF PERFORMANCE

Meritus provides access to staff for members and practitioners/providers seeking information about the Utilization process and the authorization of care.

- Meritus UM staff identify themselves by providing their first and last name, title and name of organization to anyone who calls regarding the UM process or if the reviewer is seeking information from a provider, facility, or member. If applicable, state UM certification numbers are also provided.
- When verbally requested by members, patients, attending physicians, hospitals and other ordering providers, UM and customer service staff provide information related to Meritus' UM review processes, requirements, and operational procedures
- Requests for urgent/emergent healthcare services are reviewed and a determination is made regarding an authorization approval or denial of the services within the lesser timeframe (accreditation, client or regulatory) for the type of review. Procedures are in place for addressing lack of information and extending the period of time allowed for making a review determination.
- All UM review activities related to the collection and receipt of information and outbound communication are conducted during normal business hours. A toll free telephone line is available to all callers.
- Physicians, clinicians, members, facilities and hospitals may access the UM department on a 24/7 basis through the telephone system (877.288.1012), which routes calls directly to a UM staff member or to a voice messaging system. Staff are available at least eight (8) hours per day during normal business hours for calls regarding UM issues.
- Provider and member access to UM services are monitored through identified performance indicators and reported to the Quality and Credentialing Committee on an ongoing basis.
- Meritus uses the national 711 TRS to communicate with deaf and hearing-impaired individuals. 711 TRS uses telecommunication devices for the deaf (TDD) and teletypewriter (TTY) services to communicate with those who are deaf, have hearing impairments, or are speech-impaired.
- Meritus provides language assistance for members to discuss UM issues

ADDITIONAL PROCESS GUIDELINES AND DECISION TIMELINES

- Meritus will reimburse healthcare providers for reasonable costs of providing medical information in writing, including copying and transmitting any requested patient records or other documents.
- Review determinations are based on the medical information obtained by the UM staff from the requesting provider at the time the review is conducted. Retrospective review determinations are based solely on the medical information available to the attending physician or ordering provider at the time healthcare services were rendered.
- Review outcomes will not be reversed unless the organization receives new information that is relevant to the case that was not available at the time of the original certification.
- UM review criteria are applied based on the individual needs of the patient and characteristics of the local healthcare delivery system.
- Reviews for extension of authorized services are not routinely conducted on a daily basis. Frequency of reviews is based on case complexity and the severity of the patient's condition. Providers are instructed to communicate clinical information necessitating the extension of services prior to the expiration of the previously authorized timeframe.

- Meritus does not require submission of documentation of psychotherapy sessions or submission of a therapist's process or progress notes as a condition for certification.
- Psychiatric reviews are conducted in the same manner as medical reviews for determining medical necessity through the application of all commercially developed criteria and/or Meritus' proprietary behavioral health criteria.
- Individuals who conduct peer clinical review are clinical peers who, unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a peer clinical review.

Peer Review of Special Request Authorizations

Meritus' UM department processes requests for authorization of services. The UM Director or Medical Director guides the request through the physician review process. They forward special requests to a diverse panel of specialized, experienced physician reviewers, including providers credentialed by Meritus as part of its delivery network and external to Meritus.

Physician reviewers provide medical necessity determinations for prior authorization requests, concurrent review, and retrospective reviews for all levels of behavioral and medical healthcare, as well as related services and procedures, appeals and grievances. The Medical Director may also engage outside reviewers for consultation services and disability reviews.

Behavioral Health Triage and Referral

Meritus' Behavioral Health Triage and Referral policy outlines how member calls will be evaluated and managed to ensure that members receive appropriate and timely Behavioral Healthcare for both non-urgent and urgent behavioral healthcare needs including emergent referral and intervention when such care is indicated. The policy also applies to the following mental health and substance abuse or crisis situations:

- Chemical dependency
- Overdose or suspected overdose
- Domestic violence elder or dependent abuse/neglect/exploitation
- Homicidal ideation
- Incapacitated caller
- Neglect
- Sexual abuse
- Suicidal ideation
- Suspected child abuse/neglect/exploitation
- Threats
- Violent crimes

The Behavioral Health Clinician determines the service site and level of care the member needs by selecting the appropriate setting of care:

- Outpatient referral
  - Urgent – seen within twenty four (24) hours
  - Routine – seen within ten (10) business days
- Inpatient referral
  - Life threatening – seen immediately
  - Emergency – seen within six (6) hours
- Meritus Case Management department
- Partial Hospitalization Program (PHP)
- Other (911 response team)

For behavioral health emergencies, call 911. The Behavioral Health Crisis Assistance can make referrals and help enroll members to receive behavioral health services. Meritus' Crisis Hotline is available 24 hours a day, 7 days per week for members at 1.877.229.8068.

Meritus allows the first three outpatient mental health or outpatient substance abuse rehabilitation services to occur without the need for prior authorization (HMO) or notification (PPO). Should

more than three outpatient treatments be required, please complete the Meritus Mental Health Outpatient Treatment Review Form found on the **Provider Resources and Education** page of the Meritus website (meritusaz.com), or call Meritus Customer Care at 855.755.2700 or 602.957.2113 to request a copy of the form.

NOTE: This form differs from the standard Prior Authorization & Notification Form.

Utilization Management Appeals Process

Meritus has a process to ensure that the Utilization Management Department provides for a thorough, appropriate and timely resolution for member appeals. While all members must be notified in writing of the appeal process, their appeal rights, and the timelines for submitting appeals, providers may submit an appeal on a member's behalf.

Appeal Process

There are two types of appeals: expedited appeals for urgent requests for covered services, and standard appeals. Each type of appeal has 3 levels. You can reach our appeals team at:

Meritus
Attn: Appeals Department
2005 W. 14th Street, Suite 113
Tempe, AZ 85281

Phone: 602.957.2113 | Fax: 855.568.2800

Email: appeals@meritusaz.com

Member and Practioner Notice of Appeal Rights

Each Meritus UM Denial Notice will include an explanation of Meritus' appeal process for all denied requests including Behavioral Health Denials. The explanation will include:

- The time frame in which the member must file an appeal.
- Opportunity for the member to submit written comments, documents or other information relating to the appeal.
- The time frame in which Meritus has to make a decision on the appeal, including the different time frames for expedited appeals of urgent PA or urgent concurrent denials.
- Notification that an expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

Expedited Appeals for Urgently Needed Services Not Yet Rendered

LEVEL 1: EXPEDITED MEDICAL REVIEW

A provider must provide written certification, including supporting documentation, that the time period for the standard appeal process is likely to cause a significant negative change in the member's medical condition. Meritus has one business day to make a decision and notify the provider and the member with a notice of the decision, including the criteria and clinical reasons used and any references to supporting documentation.

LEVEL 2: EXPEDITED APPEAL

If the provider chooses to appeal our Level 1 denial, the provider must immediately send a written appeal that includes any additional material justification or documentation to support the requested service. Meritus has three business days to provide notice of our decision.

LEVEL 3: EXPEDITED EXTERNAL INDEPENDENT REVIEW

The member may initiate an expedited external independent review if the Level 2 appeal is denied by mailing a written request to Meritus within five business days. Meritus must then, within one business day, forward the request and supporting documentation to the Department of Insurance, who then has two business days to assign the appeal to an independent review organization. Cases involving medical necessity will be decided within three days (72 hours). Cases involving coverage issues will be decided with two business days.

Standard Appeal for Non-Urgently Needed Services Not Yet Rendered

LEVEL 1: INFORMAL APPEAL

Meritus has 30 days after the receipt date to decide whether Meritus should change our decision and authorize a requested service. Within that same thirty (30) days, Meritus must send the provider and the member our written decision. The written decision will explain the reasons for our decision and tell the provider the documents on which we based our decision. The provider will have 60 days to appeal to Level 2.

LEVEL 2: FORMAL APPEAL

After the provider receives our Level 1 denial, the provider must send Meritus a written request within 60 days to tell us you are appealing to Level 2. Meritus has five business days after we receive your request for a formal appeal to send an acknowledgement. For a denied service that the member has not yet received, Meritus has 30 days after the receipt date to decide whether we should change our decision and authorize the requested service. For denied claims, Meritus has 60 days to decide whether we should change our decision. Meritus will send the provider and the member our decision in writing. The written decision will explain the reasons for the decision and tell you the documents on which we based the decision. The provider will have four months to appeal to Level 3.

LEVEL 3: EXTERNAL, INDEPENDENT REVIEW

The provider may appeal to Level 3 only after the provider has appealed through Levels 1 and 2. The Provider has four months after receipt of our Level 2 decision to send us a written request for External Independent Review. There are two types of reviews: 1) Medical Necessity Cases and 2) Contact Coverage Cases. For Medical Necessity Cases, within five days of receiving your information, the Department of Insurance must send all the submitted information to an external independent review organization (the "IRO"). Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director. Within five business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Meritus, the provider, and the member. For contract coverage cases, within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, the member, and the treating provider.

- A statement about the member's right to have a representative of their choosing, including an attorney, act on their behalf at all levels of appeal.
- Information about the availability of an applicable office of health insurance consumer assistance or ombudsman and the contact number.

Affirmative Statement About Incentives

Meritus makes Utilization Management (UM) decisions based on appropriateness of care and service and existence of coverage. We do not use incentives to encourage barriers to care and service.

Meritus does not compensate practitioners or individuals for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization.

Meritus ensures independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion and any other similar matters.

In addition, Meritus provides access to staff for members and providers seeking information about the UM process and the authorization of care. The Meritus UM Department staff identify themselves by providing their first and last name, title and name of organization to anyone who calls regarding the UM process or if the reviewer is seeking information from a provider, facility, or member.

Privacy

All employees, vendors and business associates of Meritus, including all contracted practitioners, will maintain the confidentiality of the member's personally identifiable health information

(medical record, claims and administrative data) per organizational policy. They must assure Meritus that such information and records are not, either inadvertently or purposefully, improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any breaches of privacy or confidentiality must be reported to Meritus according to contractual terms with external individuals or entities. Information released to other healthcare practitioners and Providers is limited to only that information necessary for continuation of care and services. Any breach may subject the practitioner to sanctions, which may include termination of the contract with Meritus.

Provider Feedback/Comments

If you have any feedback related to Meritus' UM Program, quality assurance and improvement activities, or clinical or service studies please contact: Director of Quality or Chief Medical Officer at Meritus. Comments and suggestions are reviewed and assessed for quality improvement opportunities.

Health Risk Assessment (HRA)

Health Risk Assessments provide the opportunity to identify at-risk and high-risk individuals, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are also an educational tool that can engage members in making healthy behavior changes. Meritus administers a health risk assessment (HRA) to individuals as a means of measuring and improving health.

Meritus' Health Appraisals (HA) includes the following information in easy-to-understand language:

1. An explanation of how the information obtained from the HA will be used.
2. A list of organizations and individuals who might receive the information and why.
3. A statement that the participant may consent or decline to have information used and disclosed.
4. An explanation of how the organization assesses member understanding of the language used to meet factors 1–3 above.

The Health Risk Assessment (HRA) will be performed initially with each new member within three months of the Member's enrollment and will review and update the HRA annually. The HRA will include the following information:

- Questions on member demographics.
- Questions on personal health history, including chronic illness and current treatment.
- Questions on self-perceived health status.
- Questions to identify effective behavioral change strategies, using a standardized theory.
- Questions to identify members with special needs in the areas of hearing impairment, vision impairment and language preference.

HRA provided by the organization assess at least the following personal health characteristics and behaviors:

- Weight
- Breast cancer screening
- Height
- Colorectal cancer screening
- Smoking
- Cervical cancer screening
- Physical activity
- Influenza vaccination
- Healthy eating
- Risky drinking
- Stress
- Depressive symptoms
- Productivity or absenteeism

Participants receive their HA results, which include the following information in language that is easy to understand:

- An overall summary of an individual's risk or wellness profile;
- A clinical summary report describing individual risk factors;
- Information on how to reduce risk by changing specific health behaviors;
- Reference information that can help the participant understand the HA results; and
- A comparison to the individual's previous results, if applicable.

Distribution of Results and Monitoring

Members will receive an analysis of their personal information and may also receive summaries of the analysis of all or a fraction of Meritus' membership, for comparison purposes. Results of the analyses will be forwarded to Meritus' Health Education or other department(s), as well as any employers, who are responsible for implementing programs and activities for engaging members in improving their health status. Meritus shall provide monitoring of all health appraisal-related activities of delegated entities. The Quality Director shall report on the results of Health Appraisals and the results of follow up activities to the Quality Committee on a quarterly basis. Meritus makes HAs available in language that is easy to understand and in consideration of the needs of a diverse population. The results will be available online, in print or by telephone.

SECTION 8

Quality Management

Meritus' Quality Management (QM) Program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, safety, efficiency, equity, timeliness and effectiveness of the care and service provided to our customers.

The program also seeks to meet customer expectations of high quality, affordable healthcare, and to ensure that adequate health maintenance, appropriate treatment of illness and timeliness of clinical and administrative services meet these expectations.

This is accomplished through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles. The program proactively seeks customer feedback for satisfaction and includes education in its improvement efforts.

The purpose of the program is accomplished by:

- Identifying the scope of covered benefits and service provided by the plan;
- Development of clinical practice guidelines and service standards by which performance will be measured;
- Monitoring and evaluating quality improvement activities provided to members and practitioners of the plan;
- Conducting satisfaction surveys for feedback on opportunities to improve healthcare and customer service;
- Assuring a network of qualified practitioners/providers through a process of credentialing and re-credentialing;
- Providing oversight of delegated services;
- Resolving identified quality issues; and
- Complying with all regulatory requirements; achieving and maintaining accreditation and necessary certifications.

Disease Management (DM)

Disease Management is a multi-disciplinary, continuum-based approach to healthcare delivery that focuses on the identification of populations with, or at risk for, established medical conditions. Meritus' disease management programs are integrated into the case management scope to ensure effective population heath management. The DM program supports the relationship between practitioners and their patients. Its goal is to reinforce the established plan of care and self-management plan and emphasize the prevention of exacerbations and progression of disease.

To refer a patient for Disease Management, please contact Meritus Customer Care toll-free at 855.755.2700 or 602.957.2113. You can also complete the Case Management & Disease Management Referral Form located on the **Provider Form** page of our website.

Case Management (CM)

The Case Management program intervenes to support members in times of acute care need by coordinating care across the healthcare spectrum to keep members moving forward to optimal health. Meritus looks at its entire population, identifying members, their needs, and their eligibility for Case or Disease Management.

Case Managers work with members, their families, providers and community support services, as appropriate, to assist in assessment, development and implementation of individualized plans of care to meet the identified needs of the member.

Meritus' Complex Case Management program supports members with physical or developmental disabilities, serious mental illness, multiple chronic conditions or severe injuries. Complex Case Management provides telephonic case management to assist in the education and healthcare coordination of members with complex needs and their families. These members may have complex medical/psycho-social needs or may be identified as requiring individual case management services for their chronic condition(s). The primary goal of case management is to ensure that care needs are met and that interventions occur as early as possible to avoid or minimize deterioration in health status, pain, and suffering. This proactive approach uses health risk assessment tools, clinical practice guidelines, community resources, and other tools to manage care.

Meritus' Case Management program has implemented the following programs available for members who are diagnosed with any of the following chronic conditions.

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Heart Disease

The goals of Case Management are to:

- Promote self-management of chronic conditions;
- Improve adherence to treatment plans with an emphasis on medication therapy;
- Reduce or delay disease progression and complications;
- Reduce hospitalizations and emergency room visits; and
- Improve quality of life.

At least annually, Meritus assesses satisfaction with its case management and complex case management program by surveying members and by analyzing member complaints. Additionally, Meritus reviews improvements in health status using clinical indicators and performance measures. At least three measures of outcomes or processes that have significant bearing on this population are selected for analysis. Additionally, participation rates are collected and analyzed for Meritus' Disease Management and Complex Case Management programs.

To refer a patient for Case Management, please contact Meritus Customer Care toll-free at 855.755.2700 or 602.957.2113. You may also visit our website at meritusaz.com. Click on **Provider Forms** tab to download and print a Case Management & Disease Management Referral Form.

Credentialing

As a quality measure, Meritus requires providers to complete the credentialing process prior to rendering care to our members. The initial credentialing process includes extensive review and verification of education, training, previous work history, licensure, professional liability coverage, malpractice history, as well as all other information relevant to the qualifications and ability of any provider to render quality medical care to members in accordance with our policies and procedures. The credentialing process is based on the standards of the National Committee for Quality Assurance (NCQA). Procedures are also in compliance with all applicable State and Federal legal requirements.

All HMO Providers are credentialed through a delegated credentialing agreement with Care1st. Most PPO Providers, with the exception of Naturopathic doctors, Acupuncturists, Massage Therapists, Chiropractors and limited PPO Providers under direct contract with Meritus are credentialed by Arizona Foundation. Ultimately, Meritus is responsible for the oversight of all credentialing activities and approval of its Provider network. No matter the delegated credentialing relationship, Meritus follows or requires NCQA guidelines be followed for credentialing.

Credentialing Peer Review

Peer review is conducted according to the regulatory, accreditation, and Meritus established standards and/or laws and regulations. The Medical Director manages the peer review process. Cases requiring peer review are identified through member, practitioner, or provider grievances and other sources.

All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in

Notification of Practitioners Rights During Credentialing Process

RIGHT TO REVIEW INFORMATION

- Meritus provides practitioners with the opportunity to review information that has been obtained to evaluate their credentialing application, attestation, or CV.
- This includes information obtained from outside sources, including malpractice insurance carriers and state licensing boards.
- This does not include references, recommendations or other peer-review protected information.

RIGHT TO CORRECT ERRONEOUS INFORMATION

- Meritus notifies practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Meritus also notifies practitioners of the specific timeframes and methods of submission.
- Meritus notifies practitioners of a discrepancy (including discrepancies involving actions on a license, malpractice claims history and board certification) in writing via certified mail.
- Meritus allows practitioners to submit corrected information within 15 days of being notified of a discrepancy. Practitioners must submit corrections in writing via certified mail to:

  Meritus Credentialing
  c/o Care1st
  2355 East Camelback Road, Suite 300
  Phoenix, Arizona 85016

- Meritus documents the notification to the provider (including the date and method of notification) as well as the receipt of the corrections.
- Meritus is not required to reveal the source of information if the information is not obtained to meet Meritus' credentialing verification requirements or if the law prohibits disclosure.

RIGHT TO BE INFORMED OF APPLICATION STATUS

Meritus provides practitioners with the opportunity to be informed of the status of their application upon request. Meritus will respond to each request within 15 days of receipt and will provide practitioners with the following information about their application:

- Substantial variations in:
- Actions on a license
- Malpractice claims history
- Board Certification
- Date Received
- Date scheduled for review
- Final determination

active practice. At least one (1) consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.

If the Peer Review Committee makes a recommendation to the Board of Directors to deny, limit, suspend or terminate privileges based on a medical disciplinary cause or reason, the affected provider shall be entitled to a formal hearing pursuant to the Fair Hearing Procedure.

NOTIFICATION OF AUTHORITIES AND PRACTITIONER APPEAL RIGHTS

A provider is entitled to an appeal and/or hearing if the Peer Review Committee makes a recommendation to suspend, terminate or non-renew a physician's credentialing. It is the policy of Meritus to use objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards. Meritus will notify the appropriate authorities when it takes a professional review action against a practitioner for quality reasons. Meritus will provide the affected practitioners with timely notification of the review action and their appeal rights and will provide practitioners with a fair and impartial hearing, upon request. Meritus will provide practitioners with timely notification of the appeal decision and the reasons for the decision.

REPORTING TO AUTHORITIES

Meritus maintains a record of each notification, including the date of the notification, the agency that was notified, the practitioner involved, and the reason for the suspension or termination. The following quality-related reasons are grounds for suspension/termination and are reportable:

- If the physician appears to be mentally or physically unable to safely engage in the practice of medicine;
- Guilty of unprofessional conduct;
- If privileges are denied, revoked, suspended or limited because of actions their actions; and
- If while a physician is under investigation, the physician resigns.

PRACTITIONER APPEAL PROCESS

The Meritus practitioner appeal process provides an opportunity for the affected practitioner to appeal Meritus' decision to suspend or terminate the practitioner's contract. Meritus will provide the affected practitioner with written notification that a professional review action has been brought against the practitioner and the reasons for the action. The written notification will include the following information:

- A summary of the practitioner's appeal rights and the Meritus appeal process;
- The practitioner's right to request a hearing within 30 calendar of receiving the notification;
- The practitioner's right to be represented by an attorney or another person of the practitioner's choice.

If the practitioner requests a hearing, Meritus appoints a hearing officer or a panel of individuals to review the appeal. Once the hearing has taken place and the decision on the appeal has been made, Meritus provides the practitioner with written notification of the appeal decision. The notification contains the specific reasons for the decision and is provided to the practitioner within ten (10) working days of the decision.

ASSESSMENT OF ORGANIZATIONAL PROVIDERS

Before Meritus contracts with an organizational provider, it conducts a thorough assessment of the organization's ability to provide high quality medically necessary covered services to Meritus members. It is the policy of Meritus to ensure that the organizational providers with which Meritus contracts meet or exceed the standards of state and federal licensing and regulatory agencies and accrediting bodies.

Meritus will conduct onsite evaluations of any provider that has not been accredited and will conduct a follow-up evaluation of each contracted

provider at least once every three years. To accomplish these goals, Meritus takes the following steps for each provider:

1. Verifies that the provider has met all state and federal licensing and regulatory requirements.
2. Verifies whether a recognized accrediting body has approved the provider.
3. Conducts a site visit if a recognized accreditation body has not accredited the provider.
4. Maintains electronic or hard copies of licenses, accreditation reports, or letters from the regulatory and accrediting bodies regarding the status of the provider.
    - Meritus only accepts a copy of the license, accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider. Meritus will not accept an attestation of such from provider organizations regarding licensing and accreditation.
    - Meritus may verify accreditation by searching the list of accredited organizations on the accrediting body's website.
5. Maintains a tracking mechanism for documenting that it has completed each of the steps above.

TYPES OF ORGANIZATIONAL PROVIDERS WHICH REQUIRE AN ASSESSMENT

Meritus ensures that the following types of providers receive an initial assessment before being contracted:

1. Hospitals.
2. Free-standing surgical centers.
3. Home health agencies.
4. Skilled nursing facilities.
5. Inpatient Behavioral Healthcare facilities.
6. Residential Behavioral Healthcare facilities.
7. Ambulatory Behavioral Healthcare facilities.

PRACTITIONERS CREDENTIALING REQUIREMENTS

It is the policy of Meritus to maintain a well-defined credentialing and re-credentialing process for evaluating and selecting licensed independent practitioners to provide care to its members and to comply with the credentialing requirements established by the National Committee on Quality Assurance (NCQA).

Meritus will credential/re-credential all licensed practitioners or groups of practitioners who provide care to the organization's members, except as noted below. Practitioners who are certified or registered by the state to practice independently (i.e. without direction or supervision) and provide care to the organization's members are within the scope of the credentialing standards. Meritus will credential all practitioners with whom it has independent relationships (i.e. those who Meritus selects and directs its members to see, including all Primary Care Practitioners).

CREDENTIALING REQUIREMENT BY TYPE OF PRACTITIONER

The following types of providers must be credentialed by Meritus:

Medical Practitioners:

1. Medical doctors, including hospital-based physicians unless physician does not provide care outside of the hospital setting (e.g. at free-standing imaging or pain management centers) and does not have a direct relationship with Meritus to provide other services
2. Dentists, including oral surgeons, providing care under medical benefits
3. Chiropractors
4. Osteopaths
5. Podiatrists.
6. Naturopathic Physicians
7. Massage Therapists
8. Acupuncturists

Behavioral Health Practitioners:

1. Psychiatrists and other physicians.
2. Addiction medicine specialists.
3. Doctoral or master's-level psychologists who are state certified or licensed.
4. Master's-level clinical social workers who are state certified or licensed.
5. Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed.
6. Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently.

Non-physician practitioners who have an independent relationship with Meritus and provide care under Merits' medical benefits, including:

1. Nurse practitioners and nurse midwives who are licensed, certified or registered by the state to practice independently.
2. Physician assistants.
3. Physical, speech/language and occupational therapists.

The following types of providers do not have to be credentialed by Meritus:

1. Physicians who practice exclusively in inpatient settings and provide care for Meritus members only as a result of members being directed to the hospital or another inpatient setting.
2. Pathologists
3. Radiologists
4. Anesthesiologists
5. Neonatologists
6. Emergency room physicians
7. Hospitalists.
8. Telemedicine consultants
9. Locum tenens

Practitioners who practice exclusively within free-standing facilities who provide care for Meritus members only as a result of members being directed to the facility. Such facilities include by are not limited to:

1. Mammography and imaging centers.
2. Urgent care centers.
3. Surgicenters.
4. Ambulatory behavioral healthcare facilities.
5. Psychiatric and addiction disorder clinics.

Pharmacists who work for a pharmacy benefits management (PBM) organization to which Meritus delegates utilization management (UM) functions:

1. Covering practitioners (e.g., locum tenens).
2. Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).

The credentialing staff reviews the submission for completion and reviews the expiration dates on licenses, etc. to ensure that these will remain current during the credentialing process. If one or more document expires during the process, the department will call the provider thirty (30) days before the expiration to obtain an updated copy. During the data gathering process, staff will keep all files out of sight to unauthorized viewers and will keep them in locked drawers at the end of the business day to maintain confidentiality. Other than authorized staff, data in the files shall be shared only with the applicant, who has a right to view the file at any time during the credentialing process.

PHYSICIAN SITE AND MEDICAL RECORD REVIEW

Meritus has established standards and thresholds for office site criteria and medical/treatment record- keeping practices for all practice sites within its network. This is to ensure the quality, safety and accessibility of office sites where care is delivered to our members. As part of the initial credentialing process, Meritus or credentialing delegate may request a site visit or medical record review. In addition, if Meritus receives a

sufficient number of complaints from members an additional site visit or medical record review will be conducted within 60 calendar days.

This review is to document any deficiencies, and institute actions which may include a Corrective Action Plan, to correct the deficiency. Continued evaluation of the effectiveness of the corrective actions will be monitored at least every six months, until deficient offices have met the thresholds. Meritus may initiate efforts to terminate the provider at its discretion in the event the provider is unable to correct any complaints to Meritus' satisfaction.

FILE AUDITS

The objectives of the file audits are to: 1) evaluate the completeness and appropriateness of information necessary to provide safe clinical care to members; 2) reflect that continuity and coordination of care is documented; 3) monitor adherence to evidence-based guidelines, 4) monitor compliance with state/ federal regulatory requirements, 5) monitor compliance with guidelines required by accrediting bodies, and 6) improve performance, as appropriate, in documentation of the care and service delivered to Meritus Members.

PROVISIONAL CREDENTIALING

Meritus may grant provisional credentialing status for up to 60 days to a practitioner applying to Meritus for the first time if doing so would be beneficial to its members. Such status may only be granted a single time to any provider. The process for presenting provisional credentialing files to the Credentialing Committee or Chief Medical Officer is the same process as the regular credentialing process.

MERITUS CREDENTIALING DELEGATION

Meritus has partnered with two Contracted Network Entities (CNE's). Our PPO Provider Network is managed by the Arizona Foundation for Medical Care (Arizona Foundation). Arizona Foundation is delegated to perform all credentialing to our PPO Network Providers. Our HMO Provider Network is delegated to Care1st who is responsible for managing the HMO network, plus other applicable providers such as naturopathic doctors and chiropractors, and the ongoing maintenance of the network includes credentialing delegation. Care1st utilizes AzAHP credentialing alliance partners, Optum Insight's Aperture Credentialing.

Provider Exclusion List

In accordance with applicable laws, rules and regulations and the FWA Guidance, Provider represents that he/she is not on the Department of Health and Human Services Office of Inspector General (OIG) and General Service Administrative (GSA) exclusion lists and agrees to review the OIG and GSA exclusion lists upon initially hiring, appointing or contracting with any physician extenders, including, but not limited to, nurse practitioners, physician assistants and other ancillary personnel who provide Covered Services to members on behalf of provider. Provider agrees at least once a year thereafter to confirm that such physician extenders are not included on such exclusion lists.

Pharmacy Management

The QM department recognizes the important role that pharmacy coverage and services are in patient care and seeks to work collaboratively with Meritus' delegated pharmacy services provider. Meritus delegates pharmacy services. This includes utilization management, medication safety and quality management. A designated pharmacy services expert is involved in the program implementation and oversight and approves Meritus' Quality and Utilization Management programs.

CVS Health is our Prescription Benefit Manager (PBM) and they manage all prescription drug transactions and pharmacy networks for Meritus. For a list of the pharmacies included in the Meritus network please visit the Meritus website at meritusaz.com.

Drug Formulary/Generic Substitutions

Where applicable by Meritus Plans, provider shall use the drug formulary designated by Meritus when prescribing medications for members. Please review the Meritus Formulary for medications that may require a prior authorization, quantity limits or medications that require step therapy. If for medical reasons, provider believes a non-formulary drug should be dispensed, provider agrees to obtain prior authorization or prior approval. The Drug Formulary may be modified from time to time by Meritus. Provider acknowledges the authority of Meritus contracting pharmacies to substitute generics for brand name drugs, as allowed by Arizona law, unless otherwise indicated. The Meritus Drug Formulary can be found on the Meritus website under the **Provider Resources and Education** page at meritusaz.com or you may contact Customer Care for a copy. The formulary is updated quarterly, usually in the months of March, June, September and December. Information on any changes made will be posted in the provider portal on our website. Provider signatures on prescriptions must be legible in order for the prescription to be dispensed. If you have questions or require further clarification please call Customer Care.

Non Formulary Prior Authorization Requests

Request for non-formulary pharmacy authorization are to be submitted to CVS Caremark by calling CVS/Caremark at 855.582.2022 or 800.294.5979 for questions or to verbally submit the PA request or by completing the Non-Formulary Prior Authorization Form located on the **Provider Forms** page on meritusaz.com and then fax to 888.836.0730 or 855.245.2134. Once approved, the Pharmacy Department will fax back the approval to your practice.

Meritus has a mechanism for reviewing and making exceptions on the pharmacy benefit regarding the formulary or medication management program based on medical necessity as requested by the prescribing practitioner. Practitioners will be asked to share pertinent information in order to make a decision on whether medical necessity requires the exception. The PBM or their designate will delegate the decision of medical necessity to a licensed healthcare provider to consider the exception request. This mechanism will meet agreed upon time frames for both decision making and member and provider notification. It will also set forth an appeals process in the case of a denial. Reasons for denial and the appeals process will be communicated to the member and the provider when it does not approve the exception request. This request for exceptions may be communicated through either telephone, secure email or via U.S. mail.

Confidentiality and Conflict of Interest

All information related to the QM process is considered confidential. All QM data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated and secured area within the QM Department. All aspects of quality review are deemed confidential. All persons attending the Quality Operational Oversight Committee (QOOC) or its related committee meetings will sign a Confidentiality Statement. All Meritus personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in the review process of QM issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

Furthermore, information provided to physicians within the network may be proprietary and/or confidential. When this occurs it is expected that physicians will hold this information in confidence and treat the handling of such information with care.

Release of Member Information

To ensure the confidential release of member information, the following apply:

- Providers should submit all necessary documentation when submitting a request for a referral.
- Providers may release a member's medical information to other healthcare providers

and Meritus as long as it is necessary for treatment of the member's condition, or administration of the program.

- Member's records are to be transferred to a new PCP within 10 business days when one is selected.
- Release of medical information to out-of-network providers generally requires authorization from the member or guardian.
- Medical records must be released in accordance with Federal or State laws, court orders, or subpoenas.

Medical Record Guidelines

PCPs must maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures, and/or for whom a provider receives medical/behavioral health records from other providers who have seen the enrolled member. The record must be kept up-to-date, be well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record that incorporates at least the following components:

1. Member identification information on each page of the medical record. (i.e., name or identification number);
2. Identifying demographics including the member's name, address, telephone number, identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative;
3. Initial history for the member that includes family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history;
4. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
5. Immunization records (required for children; recommended for adult members if available);
6. Dental history if available, and current dental needs and/or services;
7. Current problem list;
8. Current medications;
9. Documentation, initialed by the member's PCP to signify review of:
    - Diagnostic information including:
    - Lab tests and screenings
    - Radiology reports
    - Physical examination notes, and/or other pertinent data
    - Reports from referrals, consultations and specialists
    - Emergency/urgent care reports
    - Hospital discharge summaries, and
    - Behavioral health referrals and services provided, if applicable;
10. Documentation as to whether or not an adult member has completed advance directives;
11. Documentation related to requests for release of information and subsequent release;
12. Documentation that reflects diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's healthcare;
13. Obstetric providers must also complete a risk assessment tool for obstetric patients, i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool (MICA) or American College of Obstetrics and Gynecology (ACOG). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines;
14. Documentation that each member of reproductive age is notified verbally or in writing of the availability of family planning.

Practice Guidelines and Evidence-Based Practices

Meritus has adopted Practice Guidelines (PG's) and Evidence-Based Practices (EBP's) for acute, chronic and preventative services in regard to both medical and behavioral services. Meritus PG's are from recognized sources which develop evidence-based clinical practice guidelines and include professional medical associations, voluntary health organizations, ARHQ and NIH Centers and Institutes. Meritus PG's and EBP's will be reviewed at least every 2 years by the QOOC along with recommendations to continue, modify, or discontinue the use of the current practices. As guidelines are updated or revised, they will also be disseminated to practitioners by mail, email and/or via the Meritus website. Copies of PG/EBP are available by contacting Customer Care.

Meritus has elected to focus on asthma, diabetes and cardiovascular disease as the chronic conditions. For the treatment of Asthma, we offer the guidelines developed by the New York State Consensus Asthma Guideline Expert Panel. For the treatment of Diabetes, we chose guidelines developed and promoted by the American Diabetes Association. For the treatment of cardiovascular disease, we selected guidelines from the American Heart Association national guidelines for cardiac care.

The behavioral health conditions Meritus will focus on are depression and ADHD. The depression guidelines used are from Health Integrated's Clinical Practice Guideline for Depression. Our ADHD guidelines were taken from Psychiatry Online.

For preventive health, Meritus decided on the preventive care guidelines for adults offered by the Agency for Healthcare Research and Quality, and for children, guidelines promoted by the American Academy of Pediatrics. Perinatal guidelines, also from the American Academy of Pediatrics, complete our list of preventative guidelines.

These guidelines can be found in the provider portal of the Meritus website.

HEDIS/QRS Matrix

Meritus is committed to measuring and improving the quality of healthcare and service our members receive. Our commitment to quality began before we enrolled our first member through earning NCQA Health Plan accreditation. NCQA Health Plan accreditation is an external objective review of the systems and processes we have for measuring and improving the quality of care and service you receive.

We regularly measure our performance and seek ways to improve. In 2015, we will be using data from 2014 to assess a variety of different aspects of the care our members receive, including preventive care and care for chronic conditions such as diabetes, heart disease and behavioral health problems. In addition, we will be asking for members input on their experience as a Meritus member. The full range of measures can be found in the table below. The data will be compiled and analyzed and next fall we will tell you more about how we did, what our improvement opportunities are, and how you can help. In the meantime, if you have any improvement suggestions, we would love to hear about them. You can share your improvement suggestions by contacting the Meritus quality department at 855.755.2700 or email quality@meritusaz.com.

Measures

- Access to Care
- Access to Information
- Annual Dental Visit
- Annual Monitoring for Patients on Persistent Medications
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Care Coordination
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Controlling High Blood Pressure
- Cultural Competence
- Flu Shots for Adults
- Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Plan Administration
- Prenatal and Postpartum Care
- Proportion of Days Covered
- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist
- Relative Resource Use for People with Diabetes (Inpatient Facility)
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

SECTION 9

Billing, Claims and Encounters

Billing, Claims, and Encounters

Provider shall be responsible for collecting all applicable co-insurance, co-payments, and deductibles for covered services and payments for non-covered services directly from members, as applicable.

Claims Customer Service

Meritus Customer Care Team is available to assist you Monday-Friday, 8 am – 5 pm by calling 602.957.2113 or toll-free 855.755.2700.

NOTE: Claim status requests by phone are limited to five (5). Please utilize the Provider Portal for unlimited access to claim status.

Medical Claim Submissions

ELECTRONIC DATA INTERCHANGE (EDI) SUBMISSIONS

Meritus encourages you to submit your medical claims electronically. Advantages include:

- decreased submission costs;
- faster processing and reimbursement; and
- timely following for documentation.

NOTE: EDI is for primary claims only, any claims that require secondary payments must continue to be sent on paper with a copy of the primary EOB attached.

Meritus works with Emdeon for acceptance of EDI claims. Claims may be submitted electronically directly to Emdeon or from your clearinghouse to Emdeon. If you experience problems with your EDI submission, first contact your software vendor to validate the claim submissions and upon verification of successful submission, contact Emdeon directly at 877-334.8608 with any further questions. Our Emdeon Payer ID numbers are:

- Meritus Health Partners (HMO Claims) - 45150
- Meritus Mutual Health Partners (PPO Claims) - 86062

PAPER SUBMISSIONS

Direct Meritus Health Partner (HMO) medical paper claims submissions to:

Meritus Health Partners
PO Box 83150
Phoenix, AZ 85071

Direct Meritus Mutual Health Partner (PPO) medical paper claim submissions to:

Meritus Mutual Health Partners
c/o Arizona Foundation
PO Box 2909
Phoenix, AZ 85062-2909

Meritus Mutual Health Partners (PPO) Medical Claims are re-priced by our partner Arizona Foundation for Medical Care and forwarded to Care1st for processing.

DENTAL CLAIMS

Delta Dental of Arizona (DDAZ) is Meritus' dental benefit vendor. Please direct claims submissions to DDAZ. For information on DDAZ dental claims submission process, please contact DDAZ by calling 602.938.3131 or toll free 800.352.6132 or visit their website at deltadentalaz.com

VISION CLAIMS

Vision Services Plan (VSP) is Meritus' pediatric vision benefit vendor. Please direct claims submissions to VSP. For information on VSP claims submission process, please contact VSP by calling 855.332.6193 or visit their website at vsp.com

Electronic Funds Transfer (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

The EFT Authorization Form is available on our website at meritusaz.com under the Provider drop down menu under the Forms section. If you do not have internet access, contact Customer Care or Care1st Provider Network Operations for a copy.

Required ID Numbers

FEDERAL TAX ID

The Provider must also report the Federal Tax Identification Number (TIN) under which they will be paid. The Federal TIN (Employer Identification Number, EIN) must also be billed on the CMS 1500 form in Field 25 and on the UB-04 in Field 5.

NATIONAL PROVIDER IDENTIFICATION (NPI)

Meritus requires that all providers submit the rendering/servicing provider's NPI on every claim. In addition, when applicable, the prescribing, referring, attending and operating provider NPI(s) must also be present on claim submissions. Please work with your billing team to ensure that NPI(s) are being submitted appropriately with each claim submission.

- To apply for your Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or call 800.465.3203 to request a paper application.
- If you have not yet notified Meritus of your NPI(s), please fax a copy of your NPI(s) confirmation to:

HMO

Meritus Health Partners
c/o Care1st
2355 East Camelback Rd.
Suite 300
Phoenix, AZ 85016

Phone: 602.778.1800 Option 5, 7
Fax: 602.778.1875

PPO

Meritus Mutual Health Partners
c/o Arizona Foundation
326 E. Coronado Rd.
Phoenix, AZ 85004

Phone: 602.252.4042
Fax: 602.495.8684

Claim Forms

Meritus follows CMS and NUCC guidelines related to the implementation of the new CMS1500 Claim Form. According to those guidelines, claims received April 1, 2014 or after must be submitted on the revised red and white CMS1500 Claim Form (version 02/12). Claims submitted on the old claim form will be denied. The claim forms were revised to incorporate the required NPI fields:

- Practitioners – CMS 1500
- Facilities – UB-04

Services can be billed on the CMS 1500 claim form for professional services or the UB-04 for inpatient and outpatient facility services, dialysis, and nursing home and hospice services. All Providers must submit claim forms as documentation of services rendered, even if the Provider has a capitated agreement with Meritus for the service.

Timely Filing Guidelines

When Meritus is primary, the initial claim submission must be received within six months from the date of service. Secondary claim submission must include a copy of the primary payer's remittance advice and be received within 60 days of the date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

Acceptable proof of timely filing documentation must establish that Meritus or its agent has received a claim or claim related correspondence. Acceptable examples of proof of timely filing include:

- Signed courier routing form documenting the specific documents contained;
- Certified mail receipt that can be specifically tied to a claim or related correspondence;
- Successful fax transmittal confirmation sheet documenting the specific documents faxed; and
- Acceptable confirmation report from Emdeon (our sole electronic clearinghouse). Unacceptable examples of proof of timely filing include:
- Provider billing history;
- Any form or receipt that cannot be specifically tied to a claim or related correspondence; and
- Acceptance confirmation report from any electronic clearinghouse other than Emdeon.

Duplicate Claims

To avoid duplicate claims, we recommend validating claims status after 14 days following submission and allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments. Resubmission of claims prior to 60 days causes slower payment turnaround times. Verify claim status prior to resubmitting a claim. Minimizing duplicate submissions reduces your administrative costs.

Refunds

Providers will refund promptly to Meritus any payment incorrectly collected from Meritus for services for which another carrier or entity has or should have primary responsibility. In the event of any overpayment, erroneous payment, duplicate payments or other payment of an amount in excess of which the provider is entitled, Meritus may, in addition to any other remedy, recover the same by offsetting the amount overpaid against current and future reimbursements due to the provider.

When resubmitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable). If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Refunds are mailed to:

Meritus
c/o Care1st
2355 East Camelback Rd., Suite 300
Phoenix, AZ 85016

Scanning Tips

All paper claims are input into our system using process called data lifting.

1. Printing claims on a laser printer will create the best possible character quality;
2. If a dot matrix printer must be used, please change the ribbon regularly;
3. Courier 12 pitch non proportional font is best for clean scanning;
4. Use black ink for all claim submissions;
5. Always attempt to ensure that clean character formation occurs when printing paper claims (i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number);
6. Ensure that the claim form is lined up properly within the printer prior to printing;
7. If a stamp is required, refrain from red ink as this may be removed during the scanning process;
8. Make every effort to not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. (characters on the claim from outside of the lined boxes have a tendency to "throw off" the registration of the characters within a box);
9. Use an original claim form as opposed to a copied claim form as much as possible; and
10. Use a standard claim form as opposed to a form of your own creation (individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly).

Other Insurance/Coordination of Benefits

Provider shall identify and first bill other third-party carriers or insurers. If a member has third-party coverage, including, but not limited to Medicare Part A or Part B, Provider shall include a completed copy of the third-party carrier's explanation of benefits (EOB) or remittance advice when submitting a claim. A claim, plus a completed copy of the third-party carrier's EOB or remittance advice for any balance due, must be initially received by Meritus within 60 days from the date of the third-party carrier's EOB or remittance advice or 180 days from the date of service, whichever is greater. The allowed amount of the claim shall be based upon the lesser of the Meritus' fee schedule, less the paid amount by the third-party carrier(s) or the remaining balance of the claim, which shall be paid by Meritus as a coordination of benefits.

Claims Resubmission Policy

Provider may resubmit claims that have been denied or adjudicated by Meritus. Claim resubmissions must be received by Meritus within 12 months of the date of service or 60 days from the date the claim was denied or previously adjudicated by Meritus, whichever is later. Meritus will re-adjudicate claims resubmitted by provider only if an initial claim has been properly filed within the described submission deadlines. Claim resubmissions shall be designated as such and shall consist of, at a minimum, the following: Original claim number, copy of the claim, a copy of Meritus payment (if any), supporting documentation and a written explanation as to the reasons for resubmission.

NOTE: Resubmissions following an adjustment where a recoupment was initiated for any reason, including but not limited to; claim disputes, encounter pends/denials or policy changes must be received by the plan within 12 months from the date of service or eligibility posting date, 60 days from the date of the recoupment, or 60 days from the primary carrier EOB (whichever is greater). The 60 day timely filing requirement is based on the date the recoupment was issued and the date the resubmission was received.

Explanation of Remittance Advice

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claims payment to the provider. The report identifies key payment information. If you have any questions regarding a RA, please contact Meritus Customer Care.

The following are the report columns and descriptions included in the Remittance Advice:

Company	Number, name, address, and telephone number of the company defined in the general ledger on the Company Name and Address Maintenance screen and assigned to the LOB on the Enter/Update Line-of-Business Codes screen.
Vendor/Subscriber	Name and address of either the vendor or subscriber, depending on who is being paid for the claim. The vendor is defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. The subscriber information is defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Vendor No.	The code identifying the claim vendor defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. If the vendor has multiple addresses, "An" displays to the right of the vendor number, where n represents the vendor's address number used.
Check No.	The check number pulled from the MASTER. CLAIM file.
Payment	The amount being paid by the check. The payment amount is pulled from the Master Claim file.
Document Number	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Date Approved	The approval date of the general claim. The claim is approved on the Enter/Update General Claims screen and the date is stored in the Master Claim file.
Member	The member's number and name defined either on the Enroll Subscribers screen or the Enroll Additional members screen.
Procedure	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Qty	The number of times the procedure was performed between the from and through dates. This information is entered on the Procedure Information screen.
Req. Amt	The requested amount for the procedure entered on the Procedure Information screen.
Elig. Amt	The eligible amount for the procedure. The eligible amount is the lesser of the requested amount or the maximum allowable amount, both of which are entered on the Procedure Information screen.
COB. Amt	The coordination of benefits amount entered on the Procedure Information screen.
W. Hold	The amount withheld by the healthcare organization from the payment amount. The amount withheld is based on the agreement made with the vendor, provider, or LOB and is entered on the Procedure Information screen.

Discount	The amount withheld by the healthcare organization for discounts. This is also based on the agreements made with the vendor, provider, or LOB. The discount is defined on the Regional Vendor Information screen and entered on the Procedure Information screen.
Copay	The amount the member paid for copayment defined on the co-pay/co-insurance maintenance screen and entered on the Procedure Information screen.

Claim Payment Detail

Provider/Member	The provider code, or the member number and name of the person who should receive the corresponding payment amount. Provider codes are defined on the Enter/Update Provider Codes screen and entered on the Enter/Update General Claims screen. Member numbers are defined either on the Enroll Subscribers screen or the Enroll Additional Members screen and entered on the Enter/Update General Claims screen.
Payment	The payment amount due to the provider or member. This amount is entered on the Enter/Update General Claims screen.

Other A/P Transactions

Invoice No.	Invoice number (defined on the Enter Invoices screen) or memo number (defined on the Debit and Credit Memo Entry screen).
Type	The batch source of the invoice or memo. The type is defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Date Approved	The invoice or memo approval date defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Description	The invoice or memo description defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen. If the invoice was for a capitation payment, the comment will be "Capitation Payment."
Amount	The invoice or memo total amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Payment	The invoice or memo payment amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Less Discount	The total discount amount of the invoices and memos.
Total Transactions	The total payment amount of A/P invoices and memos that affect the amount of the check for the vendor or family.

Notification to Provider when Premium Payment Lapse by Member

In the event a member has lapsed more than one (1) month, but less than three (3) months, on their premium payment, Meritus will notify providers of care known to have provided services to a Member whose premium payments have lapsed. The notice is to inform the Provider of the lapse in premium payments and of the possibility that Meritus may deny payment of claims incurred during the second and third months of the grace period if the member exhausts the grace period without paying their premiums in full.

Meritus will notify all potentially affected providers as soon as is practicable when an enrollee enters the grace period, since the risk and burden are greatest on the provider. Meritus will include the following information in the provider notification:

- Purpose of the notice;
- A notice-unique identification number;
- Names of all members affected under the policy and possibly under the care of this provider;
- An explanation of the three month grace period, including applicable dates;
- Whether the member is in the second or third month of the grace period;
- Consequences of grace period exhaustion for the member and provider;
- Options for the provider;
- The Meritus Customer Care telephone number.

Provider Claim Disputes

Meritus encourages providers to contact Meritus Customer Care for assistance with questions or issues regarding claim payment, partial payment, or non-payment. Customer Care may be able to assist you with your concern such that filing a claims dispute may not be necessary.

A claim payment, payment reduction or claim denial may be disputed by filing a claim dispute. In order to file a claim dispute, the initial claim submissions must be received within your allowed contracted timeframe from the date of service.

A Claim Dispute is:

1. A formal legal challenge of a health plan's disposition of a claim.
2. The final means afforded to a provider to resolve a claim determination.
3. A time sensitive process that is without exception.

A Claim Dispute is not:

1. An alternate claim submission or resubmission process.
2. A billing and or write off requirement.
3. A means for a contracted provider to seek an exception of claims rules.

All claim disputes (i.e. complete or partial denial of a claim) can be submitted in writing within the greater of 12 months from the date of service or 60 days from the date the claim was denied or previously adjudicated by Meritus. A provider should never wait longer than the required timeframes to file a dispute however, providers are encouraged to exhaust all other available means of resolving an issue before filing a dispute.

Meritus has two types of claims disputes: Informal and Formal.

To file an informal claims dispute, please contact Meritus Appeals Department by phone at 602.957.2113. Please have all information necessary to discuss the claim available during the call. If a provider is dissatisfied with the outcome of the informal appeal decision, the provider has the greater of 60 days from the date of the informal decision or one year from the date of remittance to file a formal claims dispute. Formal appeals must be submitted in writing to Meritus.

All disputes should include:

1. A completed claim dispute form or a letter detailing the factual and legal basis for the dispute. You must include the following information: member name and ID number, provider

name and address, date of service, claim number at issue, and the reason you are disputing Meritus' disposition of your claim. Disputes that fail to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without review. Meritus will not attempt to solicit supporting documentation.

2. If submitting by form, please use the Health Care Appeal Request Form and use one (1) form for each disputed claim. The Health Care Appeal Request Form is available on our website in the **Provider Forms** section which can be found on the **Providers** drop down menu or by contacting Meritus Customer Care. You are not required to use this form – you may send a letter that includes all of the information listed in item 1 above instead.
3. A copy of the original claim and remittance advice.
4. Supporting documentation for reconsideration. For provider disputes with a clinical component (such as denied inpatient days, or services denied for no prior authorization), additional documentation should include a narrative describing the situation, an operative report and medical records as applicable.
5. Mail the completed form(s) and documentation to:

   Meritus
   Appeals Department
   2005 W. 14th Street, Suite 113
   Tempe, AZ 85281
   Email: appeals@meritusaz.com

Provider has two levels for review of claim disputes - informal and formal. If the provider is still dissatisfied with the results of the formal dispute process, the provider is welcome to seek permission from the applicable member to take the claim to the Arizona Department of Insurance or the provider may seek resolution of the dispute by following the dispute resolution process outlined in the provider's contract.

Reminders

LAB & RADIOLOGY

Meritus members must be referred to in-network laboratory and radiology facilities for services to be covered under the Meritus Network. Please refer to the Provider Search tab on the Meritus Website (meritusaz.com) for a listing of covered ancillary providers. When lab services are obtained in office, please ensure lab testing is being sent to an in-network lab.

- When a complete laboratory service is performed (both professional and technical component), the service should be billed on a single service line with no modifier.
- When both the technical and professional component are performed by the same provider of service, the service code(s) should be billed on a single service line without a modifier, and not billed on two separate lines with the TC and 26 modifiers.

BILLING REQUIREMENTS

- Ambulatory Surgery Centers are required to bill modifier SG on surgical procedures to identify the facility billing. Modifier SG is not used for billing the professional services.
- Anesthesia Claims – The specific anesthesia start and end time must be submitted on the CMS-1500 form. The total number of minutes is required in the unit field (25G).
- New CMS 1500 Claim Form – Meritus follows CMS and NUCC guidelines related to the implementation of the new CMS1500 Claim Form. According to those guidelines, claims received April 1, 2014 or after must be submitted on the revised CMS1500 Claim Form (version 02/12). Claims submitted on the old claim form will be denied.
- Consultation Code Billing – Meritus follows CMS guidelines for consultation codes billing. Consultation codes (ranges 99241-99245 and 99251-99255) are not recognized for coverage and providers should code the appropriate patient evaluation and management visit with E/M codes that represent where the visit occurred and they identify the complexity of the visit preformed.

SECTION 10

Fraud, Waste and Abuse

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste is defined as an overutilization of services or other practices that result in unnecessary costs; the misuse of resources.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary costs to the health program.

Fraud and Abuse Prevention

Meritus strictly enforces fraud and abuse prevention policies by ensuring all staff members and business partners receive prevention, detection, investigation and reporting training at least annually. Educational materials are available on the Meritus intranet and website.

To eliminate fraud and abuse successfully, everyone must work together to prevent, identify, and report inappropriate and potentially fraudulent practices. This can be accomplished in part by:

- Monitoring claims submitted for compliance with billing and coding guidelines.
- Adherence by providers and facilities to Treatment Record Standards.
- Quality management and provider audits.
- Education of all staff members who have any contact with PHI.
- Referring cases of suspected fraud and abuse.

TRAINING AND DOCUMENTATION

As a contracted provider, you are required to train your staff and document training on the following components of the False Claims Act:

- Administrative remedies for false claims statements.
- Any State laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower protections under such laws.

Provider Responsibilities

Meritus providers are responsible for understanding:

- Coding Standards - Select appropriate CPT code for service rendered.
- Meritus Provider Standards - Understand roles and responsibilities as participating providers and know licensure responsibilities and restrictions.
- Documentation standards - Meritus adheres to national standards for documentation.

EXAMPLES OF POTENTIAL FRAUD, WASTE OR ABUSE

- Falsifying claims/encounters
- Alteration of claim
- Super imposed material
- White outs
- Erasures
- Altered changes
- Different colored inks used
- Incorrect coding
- Double billing
- Up coding
- Billing for services not rendered
- Misrepresentation of services/supplies
- Substitution of services
- Misspelled medical terminology
- No provider information on claim
- Diagnosis does not correspond to treatment rendered
- Member eligibility fraud
- Ineligible member using eligible member's ID card to obtain services
- Misrepresentation of medical condition
- Failure to report third party billing
- Eligibility determination issues

Laws that Regulate Fraud Waste and Abuse

- False Claims Act (FCA)
- Stark Law
- Anti-Kickback Statute
- HIPAA

FALSE CLAIMS ACT

Under the False Claims Act (FCA), 31 U.S.C. §3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. This act also contains the Whistleblower Employee Protection Act, which prohibits an employer from discharging, demoting, suspending, threatening, harassing or discriminating against any employee who reports actual or potential fraud, waste or abuse. As a contracted provider, you are required to train your staff and document training on the following components of the False Claims Act:

- Administrative remedies for false claims statement
- Any State laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws

Detailed information on the False Claims Act can be found on the CMS website.

STARK LAW

Self-Referral (Stark Law) Statutes, 42 U.S.C§1395, pertains to physician referrals under Medicare and Medicaid. Referrals for the provision of healthcare services, if the referring physician or an immediate family member has a financial relationship with the entity that receives the referral, is prohibited.

ANTI-KICKBACK STATUTE

Under the Anti-Kickback Statute, 41 U.S.C§1320, it is a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration for any item or service that is reimbursable by any Federal healthcare program. Penalties many include exclusion from Federal healthcare programs, criminal penalties, jail and civil penalties for each violation. Examples of kick-backs: money, discounts, gratuities, gifts, credits, and commissions.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Title II, §201-250, provides clear definition for Fraud & Abuse control programs and establishes criminal and civil penalties and sanctions for noncompliance. This act protects the privacy of the patient.

Sanctions and Penalties for Fraud and Abuse Violations

Meritus has and applies appropriate sanctions against providers and vendors who fail to comply with the policies and procedures of Meritus and/or the requirements of the federal laws and statutes. In addition, federal and state government agencies prosecute these providers and vendors accordingly. Convictions of fraud, waste and abuse can carry civil and criminal penalties including civil monetary penalties and felony or misdemeanor convictions.

The Centers for Medicare and Medicaid Services (CMS) and Fraud, Waste and Abuse

Through the Fraud Prevention Initiative, the Centers for Medicare & Medicaid Services (CMS) is working to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable healthcare services. In 2010, CMS formed the Center for Program Integrity (CPI). This involved pulling together existing anti-fraud components from other areas of the agency, as well as forming new ones.

CMS FRAUD REPORTING TOOLS

Email: HHSTips@oig.hhs.gov

Fax: Information is faxed to 800.223.8164 (No more than 10 pages)

Phone Number: Fraud can be reported by calling 800.447.8477

Mail: Office of Inspector General Department of Health & Human Services
ATTN: HOTLINE
P.O. Box 23489
Washington, DC 20026

How to Report Fraud, Waste and Abuse

Anyone can report suspected or observed fraud, waste and abuse to Meritus, the State of Arizona or the Federal government. When you file a complaint with Meritus, you do not have to identify yourself, and all calls are considered confidential. However, it may not be possible to conduct a complete investigation if no contact information is given. If you provide your contact information, you will be given a reference number for future contact, including updates on the status of the investigation, if any are available.

When you file a complaint about suspected fraud, waste and abuse, with Meritus you do not have to identify yourself, however it may not be possible to conduct a complete investigation if no contact information is given. We will make every effort to maintain your privacy and confidentiality, but there may be circumstances that require us to disclose your name and contact information during an investigation. In accordance with Federal law, we are prevented from retaliation or intimidation against any person that reports potential fraud, waste and abuse violations, even if the concern does not amount to a confirmed violation. We will notify you within 30 days of the outcome of any investigations, unless you submitted your report or form anonymously (without your name and contact information). If you filed a verbal complaint, we will notify you by telephone. If you filed a written complaint using our Fraud, Waste and Abuse Reporting Form, we will notify you by mail

If you suspect a Meritus provider or member of fraud, waste or abuse, please contact us at any of the following:

Meritus
Compliance Department
2005 W. 14th Street, Suite 113
Tempe, AZ 85281

Phone Number: 602.957.2113 or Toll-free: 855.755.2700. TTY/TDD users call 7.1.1. Have Meritus' phone number available

Compliance Hotline: 855-400-9748 (anonymous and confidential)

Email: compliancedepartment@meritusaz.com

You may also mail or email us a completed Compliance Issue Reporting Form (located on the **Member** page of our website or call our Customer Care Center for a copy).

If you wish to report fraud, waste, or abuse directly to the government, you may contact the Arizona Department of Insurance at: azinsurance.gov/fraud.html or the Office of the Inspector General at https://forms.oig.hhs.gov/hotlineoperations/

ADDRESS
2005 West 14th Street
Suite 113
Tempe, Arizona 85281

WEBSITE
meritusaz.com

EMAIL
network@meritusaz.com

PHONE
602-957-2113

TOLL FREE
855-755-2700

TTY
7.1.1

HOURS OF OPERATION
8 am to 5 pm (M-F)

meritus

Together for better health

MKG20.02.15