ASPIRUS®
HEALTH PLAN

Provider Manual

Your guide to providing service to Aspirus Health Plan members

April 30, 2025

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Introduction to Aspirus Health Plan

Aspirus Health Plan's mission is "*To heal people, promote health and strengthen communities*" by serving patients through the integration of all parts of a comprehensive health system.

Consistent with our mission, Aspirus Health Plan partnered with UCare to administer a Medicare Advantage plan to serve the senior population in our north and north central communities in Wisconsin.

Nondiscrimination Policy

Aspirus Health Plan complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, ethnicity, color, creed, religion, national origin, age, disability, sexual orientation, ancestry or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, ethnicity, color, creed, religion, national origin, age, disability, sexual orientation, ancestry or sex.

Provider Assistance

Provider Portal

The Provider Portal is a secure website that allows registered users of Aspirus Health Plan's Medicare Advantage provider network to access electronic transactions such as:

- Member Eligibility
- Benefits
- Claims
- Authorizations

To gain access to the Provider Portal, providers should contact the Provider Administrator within their organization. The administrator has access rights to add, update and remove users within the organization.

If there is no designated Provider Administrator established for an organization, providers may request one on the Aspirus Health Plan Provider Portal Login webpage.

Requesters will receive a response within five business days.

- If the request is approved, the administrator must activate the administrator account prior to adding users within their organization.
- Requestors will receive a notification if their request is denied.

The Provider Assistance Center is available for questions and to assist with the Provider Portal. They can be reached at 715.631.7412 or 855.931.4851 toll-free, Monday through Friday, 8 am – 5 pm.

Provider Assistance Center

When providers have questions or issues that cannot be answered by using the self-service features of the Provider Portal, they may contact Aspirus Health Plan's Provider Assistance Center (PAC). A PAC representative can be reached at 715.631.7412 or 855.931.4851 toll-free, Monday through Friday, 8 am – 5 pm.

Other Aspirus Health Plan Key Contacts

Authorizations – Medical

Utilization Management Intake Line
715.631.7443
855.931.5265 toll-free
Fax: 715.787.7316

Authorizations – Mental Health & Substance Use Disorder

Mental Health and Substance Use Disorder
715.631.7442
855.931.5264 toll-free
Fax: 715.787.7314

Fraud, Waste and Abuse

Special Investigations Unit
800.450.2339 toll-free
complianceMA@aspirushealthplan.com

Questions Regarding Provider Contracts with Aspirus Health Plan

715.843.1391
info@aspirushealthplan.com

Working with Delegated Business Services

Aspirus Health Plan works with organizations to whom we have delegated the responsibility for providing pharmacy benefit management, dental, chiropractic and hearing services through their own provider networks on Aspirus Health Plan's behalf.

Pharmacy Services

Navitus Health Solutions

Navitus Health Solutions (Navitus) is the pharmacy benefits manager for Aspirus Health Plan Medicare Advantage beneficiaries. All covered new and refill prescriptions should be processed through Navitus.

Pharmacy Network

Navitus is a full-service Pharmacy Benefits Manager. They have an extensive retail pharmacy network with more than 63,000 participating pharmacies across the country. Many of the retail pharmacies also participate in the extended day supply program.

Aspirus Health Plan members have access to all pharmacies in the network at a standard cost sharing model. An online pharmacy directory is available on the Pharmacy webpage. Costco Mail Order Pharmacy is included in the pharmacy network.

Contact Information for Costco Mail Order Pharmacy

ePrescribing	**NPI: 1073079521** **Store Name: Costco Pharmacy #1348** **260 Logistics Ave., Suite B** **Jeffersonville, IN 47130 USA**
Costco Mail Order Pharmacy (by mail)	Costco Mail Order Pharmacy 260 Logistics Ave., Suite B Jeffersonville, IN 47130-9839
Physician Fax (New prescriptions) For Physicians and Physician's Office Use Only **Some prescriptions cannot be accepted by fax (Class II controlled substances)**	Fax: 877.258.9584 toll-free
Physician Call-in (New prescriptions) **Some prescriptions cannot be accepted by phone (Class II controlled substances)**	800.607.6861 toll-free

Formulary Information, Prior Authorization and Formulary Exceptions

Formularies outlining the covered drugs and any associated limitations such as prior authorization (PA), step therapy or quantity limits are updated monthly and posted on the Pharmacy webpage. Please refer to the webpage to access the most recent formulary versions.

ePA is the preferred method to submit prior authorization requests to Navitus. Providers may access ePA through Surescripts, CoverMyMeds or through the Electronic Health Record.

Prior authorization and formulary exception request forms are found on the Pharmacy webpage. These forms can be faxed to Navitus at the number on the form or called into Navitus directly by the physician's office. If you wish to prescribe a medication that requires prior authorization or a formulary exception, you may reach out to Navitus at the following numbers:

- Medicare Phone Line for Prior Authorizations: 833.837.4300 toll-free
- Medicare Fax for Prior Authorizations: 855.668.8552 toll-free

Physician Administered Drugs

Some medical injectable drugs given in the doctor's office require authorization. Visit the Pharmacy page and open the Medical Injectable Drug Prior Authorization Resources drawer to view the Medical Injectable Drug Authorization List, Medical Drug Policies and Authorization Request Forms.

Participating providers can submit prior authorization, authorization adjustment and pre-determination requests to Care Continuum in one of the following ways:

- Online (ePA) via the OnePA portal at www.evicore.com. Providers can submit requests, check the status of submitted requests and submit an authorization renewal on the OnePA portal. The website also provides 24/7 access, potential for real-time approvals and email notifications once a decision is reached.
- Fax to Care Continuum at 866.540.8935
    - Access the Authorization Request Form in the Medical Injectable Drug Prior Authorization Resources drawer on the Pharmacy webpage.
- Call Care Continuum at 866.540.8289

Non-participating and MultiPlan providers can submit prior authorization, authorization adjustment and pre-determination requests to Aspirus Health Plan one of the following ways:

- Fax to Aspirus Health Plan Clinical Pharmacy Intake at 715.841.4322
    - Access the Authorization Request Form in the Medical Injectable Drug Prior Authorization Resources drawer on the Pharmacy webpage.

- Mail to:
  Aspirus Health Plan
  Attn: Pharmacy
  P.O. Box 52
  Minneapolis, MN 55440-0052

An adjustment to an existing prior authorization can be requested if:

- The authorization is active.
- An end date extension is needed due to scheduling issues or health reasons (e.g., chemo delayed due to blood count) that may prevent the administration of the previously approved drug.
- There has been a change in dosing and additional quantity is needed.

Include the reason for the extension, requested end date, current dosing and any other pertinent clinical information.

Adjustments will not be approved, and a new or renewal authorization request will be required when:

- An additional drug is being requested.
- An authorization is expiring or has expired and will need renewal.

Below are decision timeframes for medical injectable drug requests when a complete request is received:

- Standard request: 72 hours
- Expedited request: 24 hours

Post-service or retrospective authorization requests should be completed using a Provider Claim Reconsideration Form, located on the Claims & Billing webpage, under Forms and Links.

Appeals and grievance are managed by Aspirus Health Plan and should follow the member appeal process outlined in the Member Appeals & Grievances section of this manual.

Medication Therapy Management Program

The Medication Therapy Management (MTM) Program is a service for Aspirus Health Plan members with multiple health conditions who take multiple medicines. CMS requires that plan sponsors incorporate an approved Medication Therapy Management Program (MTMP) within their benefit structure. Eligible members will meet telephonically with a pharmacist for a Comprehensive Medication Review (CMR). During a CMR, a pharmacist will review all prescriptions and over-the counter medications with the member to make sure they are safe, effective and convenient to use. MTM pharmacists will work collaboratively with providers to address any medication-related concerns. The service incurs no cost to members.

For more information about MTM, including eligibility information, please review the Medication Therapy Management Program Information on the Aspirus Health Plan website.

Pharmacy Claims

If you require assistance processing Pharmacy claims, please call Navitus Pharmacy help desk at 833.837.4300 toll-free.

Vaccines Covered by Medicare Part D

Aspirus Health Plan will deny claims for providers administering Medicare Part D vaccinations in their clinics. Providers will need to bill both the vaccine and its administration through the member's Part D benefit.

The preferred method is to have a Part D vaccination provided at a pharmacy provider.

- Member buys a Part D vaccine at a pharmacy and has it administered at the pharmacy. The member is only responsible for the coinsurance or copayment.

If the Part D vaccination is provided at the clinic, we request that the provider do the following:

- Provider submits the claim electronically using the electronic claims adjudication portal called TransactRx. By submitting the claims electronically, the patient is charged the same copay that they would be charged at a retail pharmacy at the time of service, and the provider is reimbursed for their cost in a timely manner. There is no need to submit a claim form to Aspirus Health Plan.
- Using TransactRx is a voluntary process for providers administering Part D vaccines to Aspirus Health Plan members. To use the TransactRx claims submission portal, providers need to enroll with POC Technologies at: http://www.transactrx.com/physician-vaccine-billing. Enrollment information and instructions are available online. Providers who need to track vaccine claims trends and reimbursement for claims will be able to do so with TransactRx, as POC Technologies saves past data.

If claims are submitted to Aspirus Health Plan, they will be denied as Patient Responsibility (PR) with the CARC and RARC described below:

- **CARC** - 280 - Claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
- **RARC** - N751 - Adjusted because the patient is covered under a Medicare Part D plan.

Dental Services

DentaQuest

Aspirus Health Plan has arranged with DentaQuest to serve the dental needs of Aspirus Health Plan members.

Wisconsin dental providers that have questions can call DentaQuest at 855.453.5287.

Members in Medicare Advantage Plans are considered in-network with DentaQuest Providers.

Dental Claims

Dental providers should submit claims to DentaQuest. For more information or questions about dental claims submissions, please email DentaQuest at denclaims@DentaQuest.com.

Chiropractic Services

Fulcrum Health

Aspirus Health Plan has arranged with Fulcrum Health, Inc. (Fulcrum) to serve as administrator of its chiropractic benefits and manager of the chiropractic network for Aspirus Health Plan members.

Fulcrum Health maintains contractual relationships with chiropractic providers.

Fulcrum Health offers an online provider directory at www.fulcrumhealthinc.org. This online provider directory is also available through the Aspirus Health Plan website.

Contact the Provider Services Department at Fulcrum Health at www.fulcrumhealthinc.org/contact-us/ or by calling 877.886.4941 toll-free.

Chiropractic Claims

If you have questions about Chiropractic claims submissions, please call the Provider Services Department at Fulcrum at 877.866.4941 toll-free.

Hearing Aid and Hearing Aid Assessment Services

TruHearing

Aspirus Health Plan has arranged with TruHearing to administer the hearing aid and hearing aid assessment benefits for Aspirus Health Plan members.

Current procedure codes covered under this benefit are:

- V5010-Assessment for Hearing Aid
- V5050-Hearing Aid, Monaural, In the Ear
- V5060-Hearing Aid, Monaural, Behind the Ear
- V5130-Hearing Aid, Binaural, In the Ear
- V5140-Hearing Aid, Binaural, Behind the Ear
- V5210-Hearing Aid, BICROS, In the Ear
- V5220-Hearing Aid, BICROS, Behind the Ear
- V5254-Hearing Aid, Monaural, Completely in Canal
- V5255-Hearing Aid, Monaural, In the Canal

- V5256-Hearing Aid, Monaural, In the Ear
- V5257-Hearing Aid, Monaural, Behind the Ear
- V5260-Hearing Aid, Binaural, In the Ear
- V5261-Hearing Aid, Binaural, Behind the Ear

TruHearing contracts with providers for these services, and the benefit is only available to members when the TruHearing network is utilized. TruHearing providers follow TruHearing claims submission and reimbursement processes.

Providers with questions about TruHearing can contact them at https://www.truhearing.com/ or 855.286.0550 toll-free.

Members can contact TruHearing at 844.782.6486 toll-free.

Provider Responsibilities

Appointment Availability Standards

To ensure members receive timely manner care, Aspirus Health Plan established appointment availability standards for primary care, mental health and substance use disorder and high impact or high-volume specialty providers. Aspirus Health Plan monitors providers to ensure adherence to these standards. If providers are identified as being outside of the guidelines, we will follow up to understand and address any systemic issues.

Primary Care

Emergency: immediately or instruct the member to call 911
Urgent care: within 24 hours
Routine/follow-up care: within one week
Preventive: within 30 days

Mental Health and Substance Use Disorder Services

Emergency: immediately or call 911
Non-life-threatening emergency (medication refill, immediate crisis, claims to commit crime, suicidal ideation): within six hours
Urgent care: within 48 hours
Initial visit for routine care: within 10 days
Follow-up care: within seven days

High Impact/High Volume Specialty Care

(Cardiovascular, general surgery, OBGYN, ophthalmology, oncology, orthopedic surgery, neurology)

- Established patient follow-up care: within 30 days
- New patient: within 45 days

Change of Ownership

Provider agrees to notify Aspirus Health Plan within 60 days prior to the effective date of a change in its ownership status due the following:

- The removal, addition or substitution of a partner, owner or managing employee.
- The transfer of title to property to another party in the case of sole proprietorship.
- The merger of the corporation into another corporation.
- The consolidation of two or more corporations into a new corporation.

Provider notification should be in the form of a letter or email communication and should be sent to Aspirus Health Plan's provider data validation mailbox at: providerdatavalidationMA@aspirushealthplan.com

Communication with Enrollees

Providers have the right and are encouraged to discuss with each enrollee pertinent details regarding the diagnosis of such enrollee's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

Per the Provider Participation Agreement, providers may not discuss Aspirus Health Plan's reimbursement method with an enrollee. Such discussions are subject to the provider's general contractual and ethical obligations:

- To not to make false or misleading statements.
- To maintain the confidentiality of specific reimbursement rates paid by Aspirus Health Plan to the provider.
- To not disparage Aspirus Health Plan or to encourage enrollees to disenroll from Aspirus Health Plan.

Confidentiality

Aspirus Health Plan and provider shall safeguard an enrollee's privacy and confidentiality of all information regarding enrollee in accordance with all applicable federal and state statutes and regulations, including the requirements established by Aspirus Health Plan. In addition, the provider agrees to ensure the accuracy of an enrollee's medical, health, and enrollment information and records, as applicable.

Demographic Data Updates

Provider agrees to submit changes at least 30 calendar days prior to effective date of any site opening, closing, change of location or material reduction in services. Provider further agrees to review and confirm demographic information on file with Aspirus Health Plan at least quarterly. Provider shall submit updates to demographic information via Aspirus Health Plan's Provider Forms webpage.

Notification of Medicare Deactivation

Providers contracted with Aspirus Health Plan are required to provide a 10-day written notification of changes in participation status with Medicare. This includes, but is not limited to, informing Aspirus Health Plan when CMS has deactivated Medicare billing.

Notifications related to CMS deactivation should be sent to Aspirus Health Plan at demographicupdatesMA@aspirushealthplan.com and should include the provider name, tax ID, NPI

and the deactivation date. Providers should also indicate whether deactivation is effective at the entity or practitioner level. A copy of the notification from CMS should be included.

Note: It is necessary to notify Aspirus Health Plan when CMS billing privileges have been reinstated.

Medical Review and Evaluation

Provider agrees to cooperate fully with, participate in and abide by Aspirus Health Plan's decisions concerning any reasonable programs, such as quality assurance review, utilization management and peer review, that may be established from time to time by, at the direction of, or in cooperation with, Aspirus Health Plan to promote the provision of high quality covered services to enrollees and to monitor and control the quality utilization and cost of covered services rendered to enrollees by provider.

Provider further agrees to cooperate, as may be reasonably requested by Aspirus Health Plan, with any independent organization or entity contracted by Aspirus Health Plan to provide quality review, utilization review or quality improvement (QI) activities related to covered services rendered under the provider's agreement with Aspirus Health Plan.

Provider agrees to cooperate with Aspirus Health Plan's QI activities to improve the quality of care, quality of services and member experience. Cooperation includes collection, evaluation and participation in the organization's QI programs. Provider shall make available to Aspirus Health Plan any information pertaining to enrollees reasonably requested in connection with said review or program.

Performance Data

Provider agrees to allow Aspirus Health Plan to use data regarding performance by the provider, including its practitioners, for purposes permitted by law, including, but not limited to, WCHQ and WHIO for analysis and peer comparison, QI activities, public reporting to consumers and designation as a preferred or tiered network.

Member Enrollment and Eligibility

Individuals who are eligible and wish to join Aspirus Health Plan's Essential Rx or Elite Medicare Advantage plans must submit a completed enrollment application form to Aspirus Health Plan. Applications are available on the Aspirus Health Plan website. Prospective members can also call the Sales Department to enroll at 715.631.7437 or 855.931.4855 toll-free.

In addition, there are online enrollment options through the Centers for Medicare & Medicaid Services (CMS). An application must be complete (including signature) to be processed. Applications are processed in the date order received.

There are some limits to when and how often a Medicare beneficiary can change health plans. These timeframes are called Election Periods.

Note: If an individual is already a member of another health plan with a Medicare contract, membership in that health plan will automatically end on the effective date of enrollment in Aspirus Health Plan.

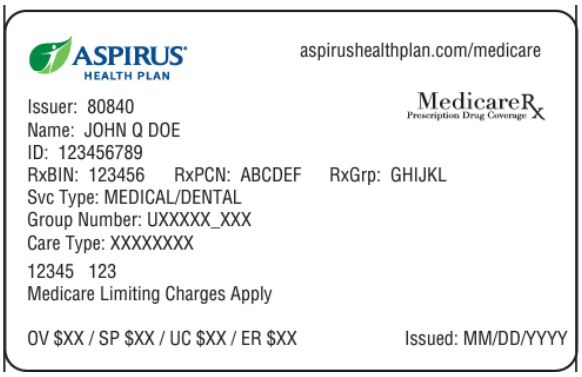
Verification of Eligibility

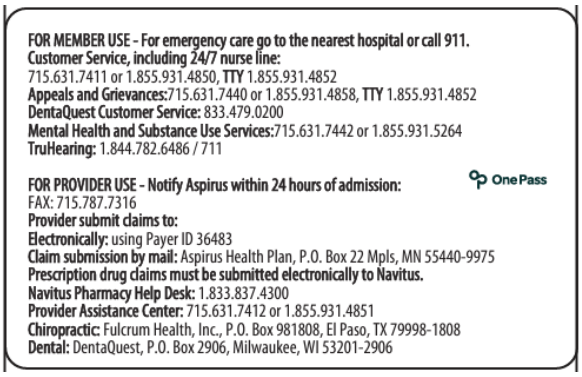
To verify that an individual is an active member, the following options are available 24 hours a day, seven days a week:

- Use the Search Members function in the Provider Portal.
- Use the Interactive Voice Response (IVR) system by calling the Provider Assistance Center at 715.631.7412 or 855.931.4851 toll-free.
    - Have the individual's member ID number and date of birth ready.
    - For claim status inquiries, have your NPI number, member ID, member's date of birth and the claim date of service ready.
- Access the 270/271 transaction via Availity. If your clearinghouse has not already done so, they can enroll with Availity Essentials to begin transmitting these transactions to your organization. Have your clearinghouse contact Availity at 800.282.4548 to begin the enrollment and provisioning process.

Aspirus Health Plan encourages all providers to verify patient eligibility and coverage prior to rendering services to avoid claim denials/rejections.

Sample Member ID Card





Provider Credentialing

Practitioners That Require Credentialing

- LAc Acupuncturist
- APNP Advanced Practice Nurse Prescriber (WI only)
- CICSW Certified Independent Clinical Social Worker (WI only)
- CNM Certified Nurse Midwife
- DDS-Dental Dentist (Delegated to Delta Dental)
- DDS-Medical Dentist
- DC Doctor of Chiropractic (Delegated to Fulcrum Health, Inc.)
- DO Doctor of Osteopathy
- DPM Doctor of Podiatric Medicine
- LCSW Licensed Clinical Social Worker (WI only)
- LMFT Licensed Marriage Family Therapist (Medicare certified only)
- LMSW Licensed Master Social Worker (MI only)
- LP Licensed Psychologist
- LPC Licensed Professional Counselor (Medicare certified only)
- NP Nurse Practitioner (MI only)
- OD Optometrist
- MD Physician
- PA Physician Assistant

Notes:

- Telehealth Practitioners see the Telehealth Requirements section.
- Locum tenens practitioners (all types) require credentialing.

Practitioners That Do Not Require Credentialing

- AuD Audiologist
- AAAE Association for Anesthesiologist Assistant Education
- CMHRP Certified Mental Health Rehabilitation Professional
- CRNA Certified Registered Nurse Anesthetist
- MD Doctor of Anesthesiology (pain management practicing in a clinic)
- HB Hospital-based Practitioners
- HP Hospitalist
- OT Occupational Therapist
- Path Pathologists
- PCA Personal Care Assistant
- PT Physical Therapist

- Rad Radiologists (radiation oncology practicing in a clinic setting require credentialing)
- RD Registered Dietician
- SLP Speech Language Pathologists

Non-billable Practitioners

- CADC Certified Alcohol and Drug Counselor
- CSFA Certified Surgical First Assistants
- CGC Certified Genetic Counselor
- COTA Certified Occupational Therapy Assistant
- CDP Chemical Dependency Professional
- LAMFT Licensed Associate Marriage and Family Therapist
- LGSW Licensed Graduate Social Worker
- OPA-C Orthopedic Physician Assistants
- PTA Physical Therapy Assistant
- RN Registered Nurse
- RNFA Registered Nurse First Assistants
- SA/SAC Surgical Assistant

Facilities That Require Credentialing

Medical

- Ambulatory Surgery Center – Free standing only
- Birth Center – Free standing only
- Hospital – All types including Psychiatric
- Medicare Certified Home Health Care Agency that provides skilled nursing services (not a PCA-only agency)
- Skilled Nursing Facility/Nursing Home

Mental Health and Substance Use Disorder

- Ambulatory setting
- Inpatient
- Residential facilities

Provider Credentialing | Purpose & Standards

Credentialing is the process used to determine if a practitioner or organizational provider is qualified and competent to render acceptable medical care to Aspirus Health Plan members. All actions related to acceptance, denial, discipline and termination of participation status for a practitioner or

organizational provider are governed by the Aspirus Health Plan Credentialing Plan which can be found on Our Network webpage under the Credentialing and Recredentialing section. This Provider Manual section is not intended to supersede the Aspirus Health Plan Credentialing Plan.

Providers should not provide services to Aspirus Health Plan members until their credentialing process has been completed. Aspirus Health Plan has no obligation to reimburse claims submitted for a practitioner's services until the practitioner has successfully completed the credentialing process. Aspirus Health Plan will collect and verify all credentialing criteria in accordance with the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) and the required state standards. Applicants need to cooperate fully in providing all documents requested by Aspirus Health Plan.

Credentialing and Recredentialing Application Submission Process

Practitioners

For credentialed-type practitioners, Aspirus Health Plan Credentialing accepts applications from the Council for Affordable Quality Healthcare (CAQH) or the Uniform Credentialing Application located on Aspirus Health Plan's Provider Forms webpage. This application must be submitted to credentialingMA@aspirushealthplan.com.

Initial

Applications should be submitted at least three months prior to an individual practitioner's start date at a clinic. Aspirus Health Plan strives for a 30-day turnaround time for initial Credentialing. Aspirus Health Plan does not retrospectively apply effective dates. If an application is incomplete, the Credentialing Specialist will reach out for the additional documentation. The 30-day turnaround will not start until the complete application is received.

Recredentialing

When recredentialing is requested from Aspirus Health Plan, applications must be submitted to the email indicated above.

If an individual practitioner's recredentialing application is not submitted in the time allowed, the practitioner's Aspirus Health Plan participating network status will be administratively terminated. Once terminated, no claims will pay, and the practitioner will need to complete the initial credentialing process to become active once again. This will cause a lapse in status between the termination date and the newly issued initial credentialing approval decision date.

Telehealth Requirements

To practice telehealth, providers must meet all Federal and State requirements. Requirements may include licensing, education exams and background checks.

Many states are revisiting their licensure process for telehealth; therefore, it is imperative that providers follow the requirements.

Health professionals must meet any applicable licensure requirements of the state where they are located and be licensed and or legally permitted to practice in the state where the patient is located. The licensure process is intended to protect the general public and to ensure patient safety. Health care providers are expected to maintain and renew their license(s).

Maintenance may require an annual fee, continuing education and self-reporting disciplinary actions.

Organizations

Organizations that require credentialing must complete the Uniform Facility Credentialing Application located on Aspirus Health Plan's Provider Forms webpage. The application and supporting documents should be submitted to credentialingMA@aspirushealthplan.com.

Credentialing and Recredentialing Process

1. Completed applications are evaluated by Aspirus Health Plan's Credentialing staff to determine eligibility. If it is determined that the provider is eligible to participate or continue participating as an Aspirus Health Plan provider, the primary source verification process is completed by the Credentialing staff.
2. Applications that are determined "clean" credentialing/recredentialing files are approved by the Medical Director on a weekly basis.
3. If a practitioner has variations from established credentialing criteria, a review and decision making for network or continued network participation is completed by the Credentialing Committee. The Credentialing Committee meets monthly to consider these items.
4. Recredentialing is performed every 36 months, or earlier for any recredentialing files with variations from credentialing.
5. Recredentialing is conditional upon the practitioner continuing to meet Aspirus Health Plan's credentialing standards and quality performance standards, including but not limited to:
    - Member complaints
    - Results of quality reviews
    - Utilization management information
    - Member satisfaction surveys, where applicable
    - Medical record reviews, when available

Other Reviews

Periodically, Aspirus Health Plan may obtain information about licensure, State or Federal Office of Inspector General (OIG), Preclusion List and Medicare Opt-Out actions taken with respect to its practitioners or providers. If such licensure actions indicate a disciplinary action or OIG/Preclusion List exclusion, Aspirus Health Plan will take whatever disciplinary or termination actions are appropriate in view of the information obtained.

More Information

Provider Credentialing Contacts

Credentialing questions: Contact Aspirus Health Plan's Credentialing Department via email at credentialingMA@aspirushealthplan.com

Claims questions: Contact the Provider Assistance Center at providerassistancecenterMA@aspirushealthplan.com

Chiropractic

Fulcrum Health, Inc.
www.chirocare.com
877.886.4941 toll-free

Dental

DentaQuest
www.dentaquest.com
833.479.0200 toll-free

Hearing

TruHearing, Inc.
www.truhearing.com
855.286.0550 toll-free

Claims & Payment

Claim Submission

Aspirus Health Plan encourages the submission of medical claims electronically. Please see the Electronic Data Interchange section of this manual for details of the submission process and guidelines.

Paper Claims

For paper claims, Aspirus Health Plan uses an optical character reader (OCR) for the entry of claim information into our claim payment system. Faxed copies of claims will not be accepted due to poor image quality.

The following instructions for completing the CMS-1500 and UB-04 forms are recommended. Failure to follow these guidelines could delay the processing of the claim. If necessary, Aspirus Health Plan will return the claim to the provider with a letter indicating what corrections are needed. Use only the official Drop-Red-Ink forms. We cannot accept black and white or photocopied claim forms.

Providers who make changes to the form should consider the following:

- Ink should be dark and dense (Red ink is not acceptable).
- Use UPPERCASE characters only.
- Use 10 or 12 font size.
- Use a standard font such as Arial.
- Do not hand-write on the claim form.
- Do not use slashes, dashes, decimal points, dollar signs or parentheses.
- Enter all information on the same horizontal line.
- Left align all fields.
- A maximum of six line items are allowed in field 24A.
- Line items must be double-spaced.
- Do not use staples.
- Do not fold claims.

Mail paper claims to:
Attn: Claims
Aspirus Health Plan
P.O. Box 22
Minneapolis, MN 55440-9975
Fax: 715.787.7307

Timely Filing

Initial claims must be received no later than 12 months after the date of covered services in a format approved by Aspirus Health Plan and in compliance with state and federal law.

For claims needing adjustments, please see section on Claim Adjustments and Appeals.

Claims Forms

UB-04 CMS-1450

The UB-04 CMS-1450 form is for the submission of facility claims. The National Uniform Billing Committee (NUBC) publishes an instruction manual that explains how to complete the UB-04 CMS-1450 form. A copy of the instruction manual is available on the NUBC website at www.nubc.org.

CMS-1500

The CMS-1500 form is for the submission of professional claims. The National Uniform Claim Committee (NUCC) has an instruction manual that explains how to complete the CMS-1500 form. A copy of the instruction manual is available on the NUCC website at www.nucc.org.

Clean Claims

A clean claim is defined as a claim that is submitted without defect or impropriety, includes any required substantiating documentation and has no particular circumstance requiring special treatment that prevents timely payment from being made on the claim (42 CFR 422.500).

Remittances

Aspirus Health Plan accompanies all payments with a remittance that outlines billing information and Aspirus Health Plan claim processing information.

Explanation of Payment (EOP)

Review remittances as you receive them. If you have questions regarding the status of submitted claims, first check the Provider Portal, then call the Provider Assistance Center at 715.631.7412 or 855.931.4851 toll-free.

Aspirus Health Plan recommends that you retain remittances or EOPs according to your business record retention policies.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Aspirus Health Plan offers EFT and ERA. To enroll in EFT / ERA, providers should go to the Provider Portal, click Resource Center at the top, then, under Document Center Resources, click on the New

Provider Payment and Remittance Selection Form to complete the form. To change or end enrollment for EFT or ERA, providers should submit a Provider Payment and Remittance Change form.

Submission Guidelines and Tips

Maintaining current insurance information for members helps to ensure successful and timely claims processing. Wrong member information can cause suspected fraudulent claims investigations and HIPAA violations. Providers should ask for a current member insurance card each time a member presents for services and update their electronic records with any changes.

When submitting a claim, providers should verify that the information on the claim submission matches the information of the member receiving the service. Avoid commonly missed or incorrectly completed claim forms by double-checking the items listed below:

- Electronic Payer ID – 36483.
- Member ID and/or group number – include all numeric and alpha characters exactly as they appear on the member ID card with no spaces. All Aspirus Health Plan members have unique, nine-digit member ID numbers. Do not submit claims using the subscriber ID number with a dependent code.
- Patient name – submit exactly the way it appears on the member ID card.
- Date of birth – double-check for accuracy.
- Individual provider NPI number – ensure this is in field 24J.
- Procedure codes – ensure they are billed with the correct units of service.
- Diagnosis fields on CMS-1500 – correct combinations of field 24E and field 21.
- Ensure all surgical procedures for the same date of service are combined on a single claim.
- Bill type – use the correct bill type; see Claim Adjustments section of this chapter.
- Taxonomy Code Requirements: Professional and facility claims received by Aspirus Health Plan are required to submit taxonomy codes for billing and rendering or attending provider. When providers submit NPI(s) anywhere on a claim, the corresponding taxonomy must also be submitted.
- There are certain billing providers that do not require a rendering provider NPI and taxonomy on a claim. “Rendering Provider” information on the claim is for practitioner information only, not the location where the service was rendered. A current list of the most common billing providers that do not require a rendering NPI and taxonomy on the claim is available on Aspirus Health Plan’s Claims & Billing webpage under “Taxonomy Requirements.”
- If an unlisted procedure code is used, a narrative description is required on both the CMS-1500 and UB-04.
- All services should be billed line by line and identified by Revenue, CPT or HCPCS codes, ICD-10-CM codes, modifiers (when appropriate), location codes and units.
- Do not stamp over billing data—claims must be legible, and all data must be readable.

- If the member has other insurance, submit a remittance advice from the primary insurance carrier with the claim.
- Submit only one member or provider per claim.
- The original Aspirus Health Plan claim number is required for replacement (frequency code 7) and void (frequency code 8) submissions. Follow the guidelines below:
    - CMS-1500-Form field 22 Medicaid Resubmission Code and Original Ref. No.
    - UB-04-Form field 64 Document Control Number

If a non-contracted provider is on the CMS Preclusion List, Aspirus Health Plan has the right to deny claims (including retroactively). Claims may be denied at any time from the date of service for the claim through the date the provider receives payment for the claim (if at all).

Taxonomy Code Requirements

What is taxonomy?

The Healthcare Provider Taxonomy Code Set (HPTC) is maintained by the National Uniform Claim Committee (NUCC). It is a hierarchical code set consisting of codes, code descriptions and definitions. This code set is designed to categorize the type, classification and specialization of health care providers. The HPTC includes two sections:

1. Individuals and Groups of Individuals (e.g., provider groups, physicians defined by specialty, Behavioral Health and Social Service Providers, Pharmacy Providers, Physician Assistant and Advance Practice Providers)

2. Non-Individuals (e.g., Agencies, Ambulatory Health Care Facilities, Hospitals, Nursing and Custodial Care Facilities)

NUCC makes regular updates to the taxonomy code set. CMS published a MLN Matters (MM9659) in October 2016 regarding updates to HPTC.

Taxonomy on claims

Aspirus Health Plan requires the corresponding taxonomy to be submitted whenever a National Provider Identification (NPI) is reported on a claim submitted directly to Aspirus Health Plan or on claims that will crossover and be coordinated with Aspirus Health Plan coverage. When taxonomy is not reported on a claim that includes an NPI number(s), the claim will be rejected.

The following categories of taxonomy are required when the corresponding NPI is submitted on claims to Aspirus Health Plan:

- For professional claims (submitted via 837P or CMS 1500) – billing and rendering taxonomy.
- For institutional claims (submitted via 837I or UB04) - billing and attending taxonomy.

When NPI(s) are submitted on any claim, the corresponding taxonomy is required.

Taxonomy codes need to be included on claims for coordination of benefits with other insurance. When billing and rendering or attending NPI is included on a claim that may be coordinated with Aspirus Health Plan coverage, the corresponding taxonomy must be included for Aspirus Health Plan to process the claim. Claims coordinated with Aspirus Health Plan coverage that do not have taxonomy reported, when applicable, will be rejected.

Provider types that are not required to submit claims with NPI are not required to submit taxonomy on claims to Aspirus Health Plan.

Reporting Taxonomy on Claims

Please refer to the NUCC for guidance on where taxonomy should be reported on paper and electronic claims. Below is more detail on where taxonomy should be reported on paper and EDI claims.

Taxonomy Type	Paper Claim Box	837P Loop Professional	837I Loop Institutional
Billing Provider	CMS-1500 Box: 33B with ZZ indicator UB-04 Box: 81CC, box a First box - Qualifier B3 Second box over – taxonomy number	**2000A** – Billing Provider Specialty Information PRV01 – BI for billing provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number	**2000A** – Billing Provider Specialty Information PRV01 – BI for billing provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number
Rendering Provider	CMS-1500 Box: 24J with ZZ indicator	**2310B** – Rendering Provider Specialty Information PRV01 – PE for performing provider PRV02 – PXC PRV03 – Taxonomy number	N/A

Attending Provider	N/A – Taxonomy not required on paper claims	N/A	**2310A** – Attending Provider Specialty Information PRV01 – AT for attending provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number

The rendering provider NPI and taxonomy should be reported when it is different than the billing provider NPI/taxonomy information. Providers may submit multiple rendering provider NPI and taxonomy at the line level on the CMS paper 1500 form, but rendering provider NPI and taxonomy can only be submitted at the claim level on the 837. NPI is always required when submitting taxonomy. For more information, see the 1500 Claims Instruction Manual at www.nucc.org.

NPPES Numeration

The taxonomy code(s) submitted to Aspirus Health Plan must be registered with the corresponding NPI in the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) and must closely align with the services being provided. It is important that providers regularly verify and update their enumeration with CMS and NPPES. Please confirm the taxonomies linked to your NPPES and CMS enumeration are current and accurately reflect the provider specialties billed under each NPI.

At this time, Aspirus Health Plan is not currently requiring taxonomy information on provider enrollment forms. The taxonomy will only be required at the claim level when professional and facility claims are submitted to Aspirus Health Plan. The taxonomy codes must match the ones that are registered for their NPI(s) on the CMS NPPES website. Additional information is available in the Taxonomy FAQ on the Claims & Billing webpage.

Duplicate Claim Submission

Prior to resubmitting a claim, please verify that Aspirus Health Plan received the initial claim. You can verify this the following ways:

- Consult 277CA response reports from your clearinghouse.
- Check claim status on the Provider Portal.
- Call the Provider Assistance Center at 715.631.7412 or 855.931.4851 toll-free.

Verifying the receipt of your claim may eliminate the need to resubmit.

It is Aspirus Health Plan's standard practice to process clean claims within 30 days of receipt. Re-submission of duplicate claims prior to 30 days is unnecessary.

For replacement, voided claim submission or payment appeals, see the Claim Adjustments section.

To avoid the most common causes of duplicate claims:

- Eliminate "automatic" re-billing from your claims system.
- Allow 30 calendar days for Aspirus Health Plan to process original claims.
- Do not combine previously submitted claims with new claims, as this practice will delay payment of new claims.
- Notify the Aspirus Health Plan member that you will bill their insurance, so the member does not submit a duplicate claim.

Coding Resources

Providers should use available references and resources to determine which ones best suit the claim they are submitting.

Resources include the following (external links):

- Wisconsin Publication: "Instructions Related to 837 Health Care Claim/Encounter: Professional (837P) Transactions Based on ASC X12 Implementation Guide"
- CMS Internet Only Manuals (IOMs)
- CMS Lab NCDs Index
- CMS ICD-10
- CMS National Correct Coding Initiative Edits (NCCI)
- National Government Services (NGS) - Medicare Administrative Contractor (MAC)
- CGS Administrators, LLC (DME MAC)
- Medicare Physician Fee Schedule

Overview

All professional and institutional claims for medical procedures, services and supplies must be submitted with valid codes and modifiers. Aspirus Health Plan requires providers to use Healthcare Common Procedural Coding System (HCPCS) codes, International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM), Procedure Coding System (ICD-10-PCS) and Current Procedural Terminology (CPT) codes as well as Revenue codes. Code sets must be reported in accordance with the type of claim submitted.

All codes must be valid for the date of service on which the service or supply was rendered.

Providers are expected to submit ICD-10-CM codes to the highest level of specificity. It may be reasonable to submit unspecified diagnosis codes during the initial evaluation of a sign, symptom or

complaint; however, once diagnostic testing and/or physical assessment has been performed and a definitive diagnosis has been determined, providers should submit the diagnosis code(s) that provides the greatest detail and specificity.

Any claim submitted with an ICD-10-CM or ICD-10-PCS code, CPT, HCPCS or Revenue code that is not valid for the date of service will be denied.

In addition, as part of Aspirus Health Plan's Payment Policy, the Professional Modifier Grid provides information that may help with the appropriate use of modifiers and billing and payment questions related to a particular modifier, including frequently submitted modifiers like the:

- -22 Increased Procedural Service
- -59 Distinct Procedural Service and X-EPSU modifiers
- -57 Decision for Surgery
- -62 Two Surgeons, and other surgical modifiers

Delegates

For claim information for dental, hearing aids and hearing aid assessment and pharmacy services, see the Working With Delegated Business Services section.

Notifying Aspirus Health Plan of Contracts with Third-Party Billers

Visit the Provider Responsibilities chapter for information.

Provider Exclusion

Aspirus Health Plan will not reimburse a provider excluded from participation in Federal health care programs under 42 CFR 1001.1901 for services rendered before or after the exclusion date. Providers must not be ineligible, excluded or debarred from participation in Medicare and related state and federal programs or terminated for cause from Medicare or other government health care programs. Aspirus Health Plan will deny payment for a health care item or service furnished or prescribed by an individual or entity on the Centers for Medicare & Medicaid Services (CMS) Preclusion List.

Aspirus Health Plan Claims Edits

Aspirus Health Plan Claims and Prospective Payment System

Aspirus Health Plan uses automated claims pricing and editing software. These tools provide consistent and objective claims review to align claims adjudication and payment with expected regulatory and industry requirements.

Claims edits apply across all Aspirus Health Plan products and apply criteria as outlined in various industry and regulatory manuals such as:

- Centers for Medicare & Medicaid Services (CMS) guide
- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 10th Edition (ICD-10)

Pricing-related edits are applied to only the following Medicare services for Aspirus Health Plan:

- Skilled Nursing Facilities (SNF)
- Inpatient Rehabilitation Facilities (IRF)
- Inpatient Psychiatric Facilities (IPF)
- Federally Qualified Health Clinics (FQHC)
- Professional Claims

Pricing software is also used to apply the following methodologies, when appropriate:

- Ambulatory Payment Classifications (APC)
- Ambulatory Surgical Center (ASC)
- Diagnostic Related Groups (DRGs)
- End-Stage Renal Disease (ESRD)
- Inpatient Psychiatric Facility (IPF)
- Inpatient Rehab Facility (IRF)
- Skilled Nursing Facility (SNF)
- Federally Qualified Health Center (FQHC)
- Home Health Agency (HHA)
- Professional Services

These edits align with CMS guidelines and Aspirus Health Plan's published Payment Policies.

Prospective Payment System (PPS)

Aspirus Health Plan utilizes an automated pricing tool for claims for SNF, IPF and IRF, Acute Inpatient Facilities, Hospital Outpatient Departments (HOPD), ASC, FQHC, HHA, ESRD and Professional. This brings greater efficiency to the claims payment process and consistency to provider payments.

Strategic National Implementation Process (SNIP) Edits

Any 837 submissions that do not pass SNIP validations will be rejected. Below are a few examples of the Aspirus Health Plans' SNIP level requirements:

- SNIP 1-5.
- Invalid character or data element.

- Date of service expected to be in numeric format CCYYMMDD.
- Attending Provider Name is required for any services other than non-scheduled transportation claims.
- Ambulance pick-up/drop off location is required.
- Diagnosis code has been already used.
- Admission dates are required on inpatient claims.
- All industry standard code (CPT, HCPCS, revenue, diagnosis, taxonomy, ZIP code, etc.) are valid and active on the date of service.
- Zero units/minutes will not be accepted.
- EPSDT condition indicator 'NU' to be used when there is not referral given.
- Other subscriber Name ID qualifier must be equal to 'MI.'
- The claim level adjustments CAS cannot be equal to zero.

Claims Editing System (CES) Service Edits

Aspirus Health Plan uses version 6.0 of the CES.

Local Coverage Determination and National Coverage Determinations Updates

Aspirus Health Plan uses an automated claims editing software to ensure consistent and accurate processing of Local Coverage Determinations (LCD) and National Coverage Determinations (NCD). A third-party vendor delivers published LCD/NCD updates to Aspirus Health Plan bi-weekly. Once Aspirus Health Plan receives the updates, we implement them within 15 business days.

The published LCD/NCD updates are retroactive to the latest CMS published effective date. Aspirus Health Plan will not retroactively adjust the claims impacted by the updates related to the LCD/NCD but will reprocess claims per provider request. Providers wishing to reprocess claims will need to complete and submit a Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing webpage.

Aspirus Health Plan Payment Policies

The information outlined in Aspirus Health Plan's Payment Policies is intended to provide general information regarding the payment methodologies used by Aspirus Health Plan and is not intended to be a guarantee of payment or address all of the details associated with a particular service. Additional factors may affect reimbursement including, but not limited to, legislative mandates, medical policies, coverage documents, and the physician or other provider contracts. Payment policies may be modified by Aspirus Health Plan at any time by publishing a new version of the policy on the Aspirus Health Plan website.

Fee Schedule Updates

- The rules for the guidelines include events where the Centers for Medicare & Medicaid Services Physician Fee Schedule Look-up Tool (CMS publishes rate or methodology changes).
- Aspirus Health Plan implements such changes within 40 business days of the date that such changes are finalized and published, unless specified by the appropriate regulatory agency, in accordance with the scheduled frequency below. Rate updates due to CMS coding and billing changes impacting the allowable units of service may occur outside of the frequency listed.
- If implementation takes more than 40 business days after the date of the final rate change notice, upon request, Aspirus Health Plan will retroactively adjust claims processed from the 41st business day until the date rates are updated. If updates are implemented within 40 business days, Aspirus Health Plan will not retroactively adjust claims.
- Government-based adjustments as they apply to Managed Care may be reflected in final payment.
- Rate Letters - Critical Access Hospitals (CAHs), Long Term Care Hospitals (LTCHs) and organizations designated as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs) are responsible for notifying Aspirus Health Plan of future updates to federal rates and/or state cost-based per diem rates. Federal rate update letters and/or state cost-based per diem rate letters should be sent to Aspirus Health Plan at: rateletters MA@aspirushealthplan.com or 715.787.7312 (dedicated fax line for rate letters). Aspirus Health Plan will apply the new rates within 30 calendar days of receiving rate updates. That day becomes the new effective date.

Aspirus Health Plan Fee Schedule Updates							
			Hospital		SNF		
Product	Physicians/ Ancillary/ ASC	Mental Health	In-patient	Out - patient	In-patient	Out-patient	Specialized Providers or Services Paid Outside Published CMS Fee Schedules
Aspirus Health Plan	Quarterly	Quarterly	Annual	Quarterly	Annual	Quarterly	As Notified

Note: All updates are subject to a 40-business day implementation delay.

Coordination of Benefits (COB)

When a member has other insurance primary to Aspirus Health Plan, it is the provider's responsibility to bill all third-party liability payers (including Veterans Benefits, private accident insurance, HMO

coverage and other health care coverage) and receive payment to the fullest extent possible before billing Aspirus Health Plan.

Aspirus Health Plan follows CMS eligibility and billing guidelines respectively to determine service coverage. Providers eligible for Medicare coverage may choose to not enroll in Medicare.

A remittance advice from the primary payer(s) must be submitted and received by Aspirus Health Plan within six months of the remittance date or within 12 months from the date of service, whichever is greater. When Medicare is primary, the remittance advice must be received within 12 months of the remittance date.

For specific loop and segment submission guidelines, please refer to the Wisconsin Publication, "Instructions Related to 837 Health Care Claim/Encounter: Professional (837P) Transactions Based on ASC X12 Implementation Guide."

Other Insurance Information Changes

If other insurance information changes for one of our members and Aspirus Health Plan is determined the primary insurer, Aspirus Health Plan will update its systems and reprocess claims denied for needing the primary payer EOP. There is no need for the provider to submit a reconsideration form.

Unsuccessful Third-Party Liability (TPL) Billing

Providers may bill Aspirus Health Plan in cases when three unsuccessful attempts have been made to collect from a third-party payer within 90 days, except where the third-party payer has already made payment to the recipient.

The following documentation is required for payment to be considered:

- A copy of the first claim sent to the third-party payer.
- Documentation of two further billing attempts to the third-party payer, each up to 30 days after the previous attempt.
- Written communication received from the third-party payer.

Claims must be submitted to Aspirus Health Plan within 12 months of the date of service to qualify for payment determination.

Submit claims and supporting documentation to:

Mail:
Attn: Claim Adjustments
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440-9972

Fax: 715.787.7307
Subject: Unsuccessful TPL Billing

If payment is received from the third-party payer following Aspirus Health Plan's payment, a replacement claim is required with the remittance advice from the primary payer(s).

Member Liability

Providers are not allowed to balance-bill the patient for plan-covered services. Balance billing occurs when a provider requests that a patient pay the difference between the amount the provider billed and the amount paid by Aspirus Health Plan. This does not include cost-sharing that may be paid by enrollees in accordance with their benefit plan.

Providers may collect applicable co-payments from the member at the time of service.

Medicare Advantage Plans

Aspirus Health Plan members' financial liability, including cost-share amounts, is determined by the CMS-approved benefit package for these plans.

In order for a provider to hold a member financially responsible for services that are not clearly excluded in the member's Evidence of Coverage (EOC), a pre-service determination must be obtained from Aspirus Health Plan prior to rendering. A pre-service determination can be requested from Aspirus Health Plan by completing the appropriate Authorization Form on the Prior Authorization & Notification Requirements and Referrals webpage. Aspirus Health Plan providers should not use the Advanced Beneficiary Notice (ABN).

When the member's EOC clearly indicates a service is not covered, a pre-service determination is not needed to bill the member for the services.

Qualified Medicare Beneficiary (QMB) Program

Federal law bars Medicare providers from charging Medicare eligible individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program for Medicare Part A and B deductibles, coinsurance or copays.

For people enrolled in the QMB Program, Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the Medicaid State plan for these charges, QMBs are not liable for them).

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB individual. Medicare providers who violate these billing

prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. Sections 1902(n)(3)I; 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.

Note: Copayments still apply for Medicare Part D benefits. For those eligible for QMB, this will be copayments at the Low-Income Subsidy level.

The QMB program applies to all Medicare providers, both participating and non-participating. Further, providers are obliged to accept assignment on all services to these beneficiaries, even if they would not do so otherwise. Accepting assignment means the provider agrees to accept the Medicare and Medicaid payment as payment in full, regardless of whether Medicaid pays or not.

Providers who are not enrolled as a Medicaid provider are still subject to the QMB program limitations. Because Medicaid won't pay providers who aren't enrolled with Medicaid, Medicare cost-sharing balances must be written off and may not be billed to QMB program enrollees.

There are a number of potential ways to identify QMB individuals:

- If you are a Medicaid provider, you can directly query the ForwardHealth system to verify QMB eligibility.
- You can ask the beneficiary if they are enrolled in the QMB program. Medicare beneficiaries eligible for Medicaid QMB programs may have documentation, e.g., QMB eligibility verification letters they can show providers.
- For Original Medicare (Medicare fee-for-service), see CMS MLN Matters "Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System" (Transmittal R3764CP, MM Article # MM9911). This notes providers are able to identify the QMB status of patients in CMS' HIPAA Eligibility Transaction System (HETS).

Find more information on CMS' QMB plans.

Claim Adjustments and Appeals

Aspirus Health Plan has the right to make, and providers have the right to request, adjustments to any previous payment for, or denial of, a claim for covered services; However, any corrections initiated by Aspirus Health Plan, or requests for corrective adjustments made by the provider, must occur within twelve (12) months from the date the claim was paid or denied by Aspirus Health Plan. Requests received from providers outside of this established timeline will result in a timely filing denial.

Void and Replacement Claims

Void claims are claims that should not have been billed or where key claim information such as the billing provider or patient name was submitted incorrectly. Examples include, but are not limited to:

- Claims billed in error
- Changes or updates to:

    - Billing provider information
    - Bill type/submission code
    - Patient information
    - Payer information
    - Service dates
    - Subscriber information

Replacement claims are sent when data elements submitted on the original claim were incorrect or incomplete. Examples include, but are not limited to:

- Procedure code missing
- Line being added
- Changes or updates to:
    - Diagnosis code
    - Procedure code
    - Revenue code
    - Place of service
    - Injury date

For specific loop and segment submission guidelines, please refer to the Wisconsin Publication, "Instructions Related to 837 Health Care Claim/Encounter: Professional (837P) Transactions Based on ASC X12 Implementation Guide."

Refunds

When an overpayment is identified within 12 months of the claim's initial payment date, a replacement or void claim is the accepted method for returning these funds. See the Void and Replacement Claims section above.

Aspirus Health Plan expects refund checks within 12 months of the claim's initial payment date only when claims were subject to coordination of benefits or third-party liability rules. Mail refund checks to Aspirus Health Plan Accounting (see below).

If a refund needs to be applied to a claim that was initially paid more than 12 months ago, providers may do the following:

- Complete and submit the Provider Claim Reconsideration Request Form (found under Forms & Links on the Claims & Billing webpage). On the form, select "Refund" and note the overpaid claim or service(s), including the amount of over payment by line. Claim adjustments will be made per the information submitted on the form.
- Mail refund check with a copy of the remittance advice indicating the overpaid claim or service(s), the amount to be refunded per line of the claim, the member ID, dates of service and reason for refund request.

Note: Refund checks will be returned when a replacement/void claim is more appropriate to correct payment.

Mail refund checks to:
ATTN: Accounting
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440-9972

Provider Adjustment Requests

Providers may submit a request for claim adjustment if they believe a claim was processed and paid incorrectly on initial review. Providers should use the Provider Claim Reconsideration Request Form, under "Forms & Links" on the Claims & Billing webpage when requesting an adjustment in situations where the original claim processed incorrectly even though correct information was provided.

Provider Appeals

Providers can submit a request to Aspirus Health Plan for an appeal to resolve issues relating to administrative and contractual determinations. An appeal will be accepted after the above adjustment request process has been completed. If, after the review of an adjustment request, a provider still believes a claim is processed incorrectly, an appeal request must be submitted to Aspirus Health Plan. Providers must submit a completed Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing webpage with supporting documentation. Aspirus Health Plan will review and, if appropriate, the claims will be reprocessed. If no change is made in the processing of the claim, a written response will be sent to the provider within 60 days of receipt.

In the event an Aspirus Health Plan member may have a grievance, the appeal should follow the member appeal process outlined in the Member Appeals & Grievances section of this manual.

Providers have the option to request a voluntary second level review. Second level appeals must be submitted with additional information over and above what was submitted with the initial appeal. These requests must also be submitted on the Aspirus Health Plan Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing webpage and check Second Request on the form. Aspirus Health Plan will review if the claim's adjudication is upheld, a written response will be sent to the provider within 60 days of receipt.

Post-Service Authorization Appeals

A provider may appeal a claim that is denied related to services needing an authorization within 30 days from the date of the original remittance advice notification. Aspirus Health Plan's post-service review is based on medical necessity. Payment for these services is subject to benefits outlined in the member's Explanation of Coverage. Services may be denied because of exclusions, limitations on pre-existing conditions and/or medical necessity requirements. During the appeal process, all available

information is provided to a physician reviewer who is board certified and was not involved in the original determination.

Coding Appeals

Aspirus Health Plan uses claims editing software that aligns with the CMS's National Correct Coding Initiative (NCCI) and other regulatory guidance such as Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). The software is updated on a regular basis to incorporate changes (additions, deletions or text revisions) to CPT and HCPCS codes as well as changes made to other regulatory guidance (NCDs and LCDs). Claims will be adjudicated against any rules or regulatory guidance in place on the date of service. When appealing a denial, providers should be sure to use the regulatory guidance or references that were in place on the date of service and are from the Medicare Administrative Contractor (MAC) or state agency that has jurisdiction.

We will consider the appeal with additional documentation; however, the denial may still be upheld. Appeals submitted without additional information will not be reviewed.

Non-Contracted Provider Appeals

If you disagree with a denial of payment (zero payment), you may request an appeal. You must make your request within 60 calendar days of the remittance advice notice to have second level appeal rights.

Fax or mail your request to:
Attn: Claims
Aspirus Health Plan
P.O. Box 23
Minneapolis, MN 55440-9983
Fax: 715.787.7306

Include the following: Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing webpage and documentation that supports your request for reimbursement (e.g., the original claim, remittance notification showing the denial and any clinical records). Also include the program-specific Waiver of Liability Statement that can be found on the Claims & Billing webpage.

Your paper claim along with the Provider Claim Reconsideration Request Form can be faxed to 715.787.7306. A Claim Attachment Cover Sheet should not be sent.

Claims Auditing and Recovery

As required by law, and consistent with sound business practice, Aspirus Health Plan has a procedure to ensure that we pay only for eligible services that have been provided and appropriately billed. We expect that any overpayment received by a contracted network service provider is refunded to Aspirus Health Plan within 60 calendar days after the date on which the overpayment was identified, and that

Aspirus Health Plan be notified of the reason for the overpayment, pursuant to section 1128J(d) of the Social Security Act. See the Refunds section for returning overpayments to Aspirus Health Plan.

Overpayments are Aspirus Health Plan payments a provider or beneficiary has received in excess of amounts due and payable under relevant statutes and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the provider to Aspirus Health Plan.

In addition to standard claims processing practices and system edits, Aspirus Health Plan conducts regular post-payment claim audits to identify overpayments. These efforts, in addition to any fraud, waste and abuse investigations, may result in recovery of payments.

When Aspirus Health Plan identifies an overpayment made to a non-contracted provider, a recovery letter is sent to the servicing provider requesting return of the overpaid amount. The provider has 30 days to return the amount owed. If no response is received within 30 days, Aspirus Health Plan will recoup the amount due. No recovery letter is sent to contracted network providers if Aspirus Health Plan identifies an overpayment.

If you have questions regarding a claim overpayment letter you receive, please call the Claims Recovery line at 715.631.7449.

More Information

See the following sections of this Provider Manual for additional information on Claims and Payments.

- Working with Aspirus Health Plan's Delegated Business Services
- Electronic Data Interchange
- Mental Health and Substance Use Disorder Services

Electronic Data Interchange (EDI)

Using electronic transactions for core health care business processes reduces the administrative burden for both Aspirus Health Plan and health care providers.

Electronic Claims Submission (837)

The Payer ID: 36483 should be used for all electronic claims.

Providers or their clearinghouse must contact the trading partner directly to enroll in available electronic transactions. Contact information for Aspirus Health Plan's direct trading partner is listed below:

Availity

- To register, visit Availity's website
- Phone: 800.282.4548 (Monday – Friday, 8 am – 8 pm EST)
- For current Availity customers, login to Availity Essentials to submit a support ticket

Reporting Taxonomy on Claims

Please refer to the NUCC for guidance on where taxonomy should be reported on paper and electronic claims. Below is more detail on where taxonomy should be reported on paper and EDI claims.

Taxonomy Type	Paper Claim Box	837P Loop Professional	837I Loop Institutional
Billing Provider	CMS-1500 Box: 33B with ZZ indicator UB-04 Box: 81CC, box a First box - Qualifier B3 Second box over – taxonomy number	**2000A** – Billing Provider Specialty Information PRV01 – BI for billing provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number	**2000A** – Billing Provider Specialty Information PRV01 – BI for billing provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number
Rendering Provider	*CMS-1500 Box: 24J with ZZ indicator	**2310B** – Rendering Provider Specialty Information PRV01 – PE for performing provider PRV02 – PXC	N/A

		PRV03 – Taxonomy number	
Attending Provider	N/A – Taxonomy not required on paper claims	N/A	**2310A** – Attending Provider Specialty Information PRV01 – AT for attending provider PRV02 – PXC (Health Care Provider Taxonomy) PRV03 – Taxonomy number

Electronic Claim Attachments

A claim attachment may be required to be submitted when either an 837I or an 837P is sent to Aspirus Health Plan for adjudication. When an attachment to a claim is necessary, providers will need to populate the paperwork (PWK) segment in Loop 2300 of the electronic claim. The Cover Sheet must accompany each attachment to ensure a proper match to the electronically submitted claim. To submit a claim attachment after completing the Cover Sheet, fax the documents to Aspirus Health Plan at 715.787.7308. Aspirus Health Plan follows the submission guidelines as outlined in the NUCC. The Healthcare Provider Taxonomy Code Set (HPTC) is maintained by the National Uniform Claim Committee (NUCC).

See the Claims & Billing webpage for specifics on adjustment attachments.

EDI Transactions/Reports

Transaction/Report	Definition
Eligibility and Benefits (270/271)	Providers can access Aspirus Health Plan's eligibility and benefit information through Availity. • If your clearinghouse has not already done so, it can enroll with Availity to begin transmitting these transactions to your organization. • Clearinghouses working directly with the provider can contact Availity to begin the enrollment and provisioning process.
Health Care Claim Status (276/277)	At this time, providers may check individual claims status through the provider portal. We are working to make the 276/277 transaction available through Availity in 2025.
Electronic Claims/Claims Response* (837s/277CA)	When claims reject for missing information, the rejected claims will be reported to providers by their clearinghouses on acknowledgement or 277CA

	reports. These reports indicate if a claim was accepted into or rejected from the claim payment system. The report also indicates why a claim was rejected. A 277CA report validates the claims at the pre-processing stage. The report will show the following for each claim line: • Claim is accepted, will receive a claim number and be processed, or • Claim is rejected along with the reason why.
Implementation Acknowledgement (999)	A 999 acknowledges that the EDI batch submitted to Aspirus Health Plan is "packaged" appropriately. • Batch is readable and will move on, or • Batch is unreadable and is being returned.
Electronic Remittance Advice (835)/Remit	An 835 Remittance Advice assigns an Aspirus Health Plan claim number and provides itemized reasons for payments, adjustments and denials. Remittance Advice will show the following for each claim line: • Denied, or • Paid (payment information will be listed).

Additional information and companion guides can be found on the Claims & Billing webpage under 835 Electronic Remittance Advice.

*Taxonomy Rejections: When a claim is rejected due to taxonomy not being properly reported, a provider may see the rejection or error category of A6 (The claim/encounter is missing the information specified in the status details and has been rejected) and error code 145 (Entity's specialty/taxonomy code). To avoid payment delays on these claims, add taxonomy to the claim and resubmit it to Aspirus Health Plan.

Other Resources

Important definitions and acronyms, available on the Claims & Billing webpage, define the most commonly used terms for electronic transactions.

X12, chartered by the American National Standards Institute, develops and maintains EDI standards and XML schemas, which drive business processes globally. X12 provides documentation adopted

under the Health Insurance Portability and Accountability Act (HIPAA) and other related, value-added documents, such as the Health Care Code lists (ANSI X12 CARC & RARC).

Authorization & Notification Standards

This chapter provides information regarding authorization and notification requirements for Aspirus Health Plan and what is needed when a service is denied.

All services must be medically necessary, and coverage criteria may differ between the plans offered by Aspirus Health Plan.

Definitions

Approval Authority: Aspirus Health Plan or an organization delegated by Aspirus Health Plan to approve or deny prior authorization requests.

Notification: The process of informing Aspirus Health Plan, or delegates of Aspirus Health Plan, of a specific treatment or service within the designated time frame.

Pre-determination (PD): An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-determination if there is a question as to whether the plan will cover an item or service.

Prior Authorization: An approval by an approval authority prior to delivering a specific service or treatment. Prior authorization requests require a clinical review by qualified appropriate professionals to determine if the service or treatment is medically necessary, if it is an appropriate eligible expense and if other alternatives have been considered.

General Guidelines

Services that require authorization or notification are listed on the Prior Authorization & Notification Requirements and Referrals webpage.

If a member needs a service or procedure listed in the authorization and notification requirement grids, the provider must obtain authorization or submit a notification to Aspirus Health Plan within the timeframe indicated on the authorization grids. For services indicated as notifications, the provider must notify Aspirus within the timeframe stated. Failure to obtain authorization in advance or follow notification requirements will result in claim payment delays and potential provider liability denials.

Aspirus Health Plan does not require a referral for members to see specialists within its network and members may directly access medically necessary care through its plan benefits.

Services That Require Authorization or Notification

Aspirus Health Plan strives to minimize the administrative requirements placed on providers. General authorization and notification oversight is used for:

- Services for which lower-cost tests or treatments with comparable safety and effectiveness exist.
- Services or procedures that have accepted indications for limited usage.
- Services that are often overused or inappropriately used.

Aspirus Health Plan uses requirement documents to detail which services require authorizations or notifications. The authorization and notification requirement document lists the approving authority that determines each type of service. If a medically necessary service or procedure is not listed in the Authorization and Notifications Requirements and is a covered benefit, then, in most cases, an authorization or notification is not required.

Authorization and Notification Requirements documents are available on the Prior Authorization & Notification Requirements and Referrals webpage.

How To Submit Authorization or Notification Documentation

Authorization requests should be submitted via fax to the appropriate Approval Authority. Aspirus Health Plan's authorization request forms are available on the Prior Authorization & Notification Requirements and Referrals webpage. The forms will assist you with determining the information needed for an authorization to be considered for a specific service or procedure. Aspirus Health Plan's medical necessity criteria and resources are available in the Medical Necessity Criteria section of this manual. Additional information regarding documentation required for authorization and notification review is outlined there.

At a minimum, the following information must be included in authorization requests:

- Member's name and Aspirus Health Plan ID number.
- Member's date of birth and address.
- Ordering and servicing provider clinic information, including name, address and NPI numbers for both ordering and servicing provider (if they differ).
- Detail and rationale for requested services.
- Past medical history and treatment pertinent to the request.
- X-rays where appropriate.
- Pertinent primary care and/or specialist notes.
- Proposed date of service, provider and location.
- Requestor name, title and contact information (phone, fax and email).
- Procedure code (CPT or HCPCS) and description of service.
- ICD-10 diagnosis code and description.
- **Note:** Aspirus Health Plan does not require photographs.

Reminders When Submitting Authorization Requests

All fields on the authorization request forms should be filled out completely. Completing these forms correctly will reduce the need for additional information and prevent delays in Aspirus Health Plan's response. Authorization forms can be found on the Prior Authorization & Notification Requirements and Referrals webpage.

Note: To comply with the Health Insurance Portability and Accountability Act (HIPAA) and internal compliance requirements, providers should fax one prior authorization form and supporting medical necessity documentation at a time. When authorization requests are faxed in bulk, it increases the risk of information being lost or inappropriately filed.

Services That Require Pre-Determination

A pre-determination (PD) is needed to hold an Aspirus Health Plan member financially liable for non-covered services that are not clearly excluded in the member's Evidence of Coverage (EOC). Providers must obtain a PD BEFORE rendering a service, item or procedure that may not be covered. The non-covered service should not be rendered until Aspirus Health Plan issues a determination. Aspirus Health Plan providers should not use the Advanced Beneficiary Notice (ABN).

Timelines for Decision and Notification for Medical Authorization Requests

The **standard review** timeframe for an authorization decision for a medical item or service is within 14 calendar days from the date the request was received. The standard decision timeframe for medical injectable drug requests is 72 hours from when the request is received.

Notification to the requesting, attending or ordering provider is made via fax, telephone or secure email, followed by a written decision when applicable within one business day of the decision, but not to exceed a total of 14 calendar days from the date the request was received for a medical item or service and 72 hours from the date the request was received for a medical injectable drug.

Written notification of the decision is sent to the member via U.S. mail or a confirmed secure email within one business day of the decision, but not to exceed a total of 14 calendar days from the date the request was received for a medical item or service and 72 hours from the date the request was received for a medical injectable drug.

The **expedited review** timeframe for urgent/emergent medical items or service requests is 72 hours from when the request was received. The expedited review timeframe for a medical injectable drug is 24 hours from when the request was received. Only request an expedited review if waiting for the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function.

Notification to requesting, attending or ordering provider is made via fax or telephone. This is followed by a written decision when applicable within one business day of the decision, but not to exceed a total of 72 hours from the date/time the request was received for a medical item or service and 24 hours from the date the request was received for a medical injectable drug.

Verbal notification attempts are made, and written notification of the decision is sent to the member via U.S. mail, FedEx, courier or a confirmed secure email within one business day of the decision.

Do not submit expedited requests for authorization for post-service or retrospective authorizations.

Fax Mental Health and Substance Use Disorder requests to: 715.787.7314

Mail Mental Health and Substance Use Disorder requests to:
Aspirus Health Plan
Attn: UM Mental Health and Substance Use Disorder Services
P.O. Box 51
Minneapolis, MN 55440-0052

Questions may be directed to 715.631.7442 or 855.931.5264 toll-free.

Fax medical requests to: 715.787.7316

Mail medical requests to:
Aspirus Health Plan
Attn: UM Medical Services
P.O. Box 51
Minneapolis, MN 55440-9972

Medical Injectable Drugs: See the Working with Delegated Business Services section, Care Continuum.

Hospital Notifications: See the Hospital Services section.

Nursing Home Admissions: See the Skilled Nursing Facility Services section.

Transplant Notification: Call Aspirus Health Plan upon inpatient admission at 715.631.7443 or 855.931.5265 toll-free.

Decision-Making on Authorization Requests

Aspirus Health Plan or delegated approval authorities use written medical necessity review criteria based on clinical evidence to make authorization decisions. The criteria used to evaluate an individual case are referenced in the Medical Necessity Criteria section of this manual and are available upon request. Specific criteria for medical necessity may be obtained by submitting the Medical Necessity

Criteria Request Form found on the Provider Forms webpage. Additionally, you may speak to a Medical Director at Aspirus Health Plan or to the delegated Approval Authority who reviewed your request.

Authorization decisions are based on the appropriate level of care and the member's coverage.

Authorization decisions do not constitute the practice of medicine, and Aspirus Health Plan does not reward providers or other individuals for issuing denials of coverage or services. Additionally, Aspirus Health Plan does not encourage decisions through financial or other means that result in the underutilization of services.

Approval of an authorization request does not guarantee payment. Reimbursement is subject to the member's eligibility status and benefits at the time of service.

Medical Necessity Criteria for Services Requiring Authorization

For services to be eligible for payment by Aspirus Health Plan, the services must meet Aspirus Health Plan's standards for coverage, including medical necessity criteria. Coverage and benefits may vary among different plans offered by Aspirus Health Plan. Refer to the Evidence of Coverage (EOC), specific to the member's Aspirus Health plan.

See the Aspirus Health Plan website and the following sections of this Provider Manual for additional details:

Mental Health & Substance Use Disorder Services
Home Care Services
Physician Administered Drugs
Skilled Nursing Facility Services

The request form for Medical Necessity Coverage Criteria can be found on the Prior Authorization & Notification Requirements and Referrals webpage.

Medical Necessity Criteria for each plan is outlined in the applicable Aspirus Health Plan Authorization and Notification Requirements Grid. For services requiring Authorization and Notification, please refer to the grid on the Prior Authorization & Notification Requirements and Referrals webpage. A column for Medical Necessity Criteria is included, outlining the relevant criteria and reference sources for medical procedures or services:

- Acute Inpatient Rehabilitation
- Back (Spine) Surgery
- Bariatric Surgery (Gastric Bypass)
- Cosmetic or Reconstructive Procedures
- Cranial Nerve Stimulation, including Vagus Nerve and Hypoglossal Nerve
- Durable Medical Equipment (Purchase and Rental)
- Genetic/Molecular Diagnostic Tests
- Inpatient Hospital, Acute
- Inpatient Mental Health Admission
- Inpatient Substance Use Disorder Admission
- Long-Term Acute Care (LTAC)
- Proton Beam Therapy
- Skilled Nursing Facility (SNF) or Swing Bed Admission
- Spinal Cord Stimulation
- Transcranial Magnetic Stimulation

- Transplant
- Vein Procedures
- Wheelchairs Accessories
- Wheelchair – Rental
- Wheelchair - Purchase

Overview of Medical Necessity for Medical, Mental Health and Substance Use Disorder Services

To determine if a level of care is medically necessary or meets the community standard of care, Aspirus Health Plan uses a hierarchy of medical necessity clinical decision support tools and published criteria when evaluating medical necessity. Aspirus Health Plan uses the following for its Medicare Advantage plans:

1. Change Healthcare InterQual, a nationally recognized evidence-based medical necessity criteria guideline.
2. Written criteria developed and published by the Centers for Medicare & Medicaid Services (CMS), including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
3. American Society of Addiction Medicine (ASAM) Criteria powered by Change Healthcare InterQual as appropriate for Substance Use Disorder (SUD).
4. Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance.
5. When medical necessity criteria are not available from Change Healthcare InterQual, CMS or ASAM, medical necessity determinations are based on credible scientific evidence, which includes:
    a. published peer-reviewed literature
    b. consensus statements or guidelines from national medical alliances or specialty societies
    c. HAYES Technology Assessment

General References

- Medicare clinic criteria resource: CMS Medicare Coverage Database at National Coverage Determinations (NCD), Local Coverage Determinations (LCD) CMS Gov Medicare-coverage-database
- Medicare Benefits Policy Manual & Medicare National Coverage Determinations Manual: CMS Gov Regulations and Guidance Internet-Only Manuals (IOMs)

Coverage Policies

Coverage Policies are developed to clarify coverage for benefits under Aspirus Health Plan Medicare Advantage plans. Coverage policies are an accompaniment to the coverage and benefit information in Aspirus Health Plan member contracts.

Coverage policies are intended to serve as a general reference regarding Aspirus Health Plan's administration of health benefits. They are not intended to address all issues related to coverage for health services provided to Aspirus Health Plan members.

Providers can access Aspirus Health Plan Coverage Policy information by going to the Coverage Policies webpage. Here, providers can learn more about the Coverage Policy Team and specific coverage policies.

Member Appeals & Grievances

Member Rights and Responsibilities

Aspirus Health Plan takes member rights and responsibilities seriously. Members can access these rights and responsibilities in their Evidence of Coverage (EOC) found on the Plan Documents and Information webpage. Aspirus Health Plan expects that providers be familiar with the Member Rights and Responsibilities and has included them here for your reference.

Member Rights and Responsibilities

As an Aspirus Health Plan member of this plan, you have the right to:

- Available and accessible services including emergency services, as defined in your Evidence of Coverage, 24 hours a day and seven days a week;
- Be informed of health problems, and to receive information regarding medically necessary treatment options and risks that is sufficient to assure informed choice, regardless of cost or benefit coverage;
- Refuse treatment, and the right to privacy of medical and financial records maintained by Aspirus Health Plan and its health care providers, in accordance with existing law;
- Make a grievance or appeal a coverage decision, and the right to initiate a legal proceeding when experiencing a problem with Aspirus Health Plan or its health care providers.
- Receive information about Aspirus Health Plan, its services, its practitioners and providers, and your rights and responsibilities;
- Be treated with respect and recognition of your dignity and your right to privacy;
- Participate with your providers in making health care decisions; and
- Make recommendations regarding the organization's member rights and responsibilities policy.

As an Aspirus Health Plan member of this plan, you have the responsibility to:

- Supply information (to the extent possible) that the organization and its providers need in order to provide care;
- Follow plans and instructions for care that you have agreed to with your providers to sustain and manage your health;
- Understand your health needs and problems, and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Pay copayments at the time of service and to promptly pay deductibles, coinsurance and, if applicable, additional charges for non-covered services.

Member Appeal and Grievance Process

See also: member's Evidence of Coverage (EOC) and Medicare Managed Care Manual, Chapter 13: Enrollee Grievances, Organizational Determinations, and Appeals Guidance.

Definitions & Overview

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Aspirus Health Plan provides health care services, regardless of whether any remedial action can be taken.

Grievances do not involve problems related to coverage or payment for medical care, problems about being discharged from the hospital too soon, and problems about coverage for skilled nursing facility, home health agency or comprehensive outpatient rehabilitation services ending too soon.

Examples of grievances:

- Problems with the quality of the medical care, including quality of care during a hospital stay.
- Problems with Customer Services.
- Problems with wait time on the phone, in the waiting room, in a clinic/hospital or in the exam room.
- Problems with getting appointments or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists or other staff.
- Cleanliness or condition of doctor's offices, clinics, nursing facilities or hospitals.
- Difficult-to-understand notices and other written materials.
- Failure to provide required notices.
- Discrimination.

Who Can File:

A member or their representative.

Timeline for Filing:

Within 65 days of the date of the incident that precipitated the grievance. The filing timeline may be extended if there is good cause for the delay.

How to File:

By calling Aspirus Health Plan Customer Services or submitting a written grievance to Member Appeals and Grievances.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Oral Grievances

- Oral grievances are investigated, and the findings or outcome are verbally communicated to the member within 30 calendar days from receipt of the grievance. A member can request a written response.
- The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.
- If the member does not agree or is dissatisfied with the response, the member can file a written grievance.

Written Grievances

- Written grievances are investigated, and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within 10 calendar days after receipt of the written grievance.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

An expedited grievance is a member's complaint that Aspirus Health Plan or one of its delegated entities refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration timeframe. Aspirus Health Plan must resolve these grievances within 24 hours of receipt.

Quality of Care Grievances

A Quality of Care (QOC) complaint may be filed through Aspirus Health Plan's grievance process (See Quality of Care Review Process section in this chapter) and/or a Quality Improvement Organization (QIO).

If Aspirus Health Plan receives a grievance about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process. The letter also includes information on how to file a QOC grievance with the QIO.

Quality Improvement Organization (QIO): An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans and ambulatory surgical

centers. A QIO determines whether the quality of services meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The member or their representative has the right to file a Quality of Care (QOC) grievance with the QIO in the state where they reside.

QOC grievances filed with the QIO must be made in writing.

A member who files a QOC grievance with the QIO is not required to file the grievance within a specific time period.

Below is the QIO where Aspirus Health Plan members can file a QOC grievance or seek additional information about the QIO's review process:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 888.524.9900
Fax: 833.868.4059

Member Appeals | Definitions & Overview

Organization determination: Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care or urgently needed services.
- Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Medicare health plan.
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the Medicare health plan.
- Discontinuation of a service if the member believes that continuation of the services is medically necessary.
- Failure of the Medicare health plan to approve, furnish, arrange for or provide payment for health care services in a timely manner or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes they are entitled to receive, including delay in providing, arranging for or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR

422.566(b). These procedures include reconsideration by Aspirus Health Plan and if necessary, an independent review entity – MAXIMUS Federal Services, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC) and judicial review.

Reconsideration: This is a member's first step in the appeal process after an adverse organization determination. Aspirus Health Plan re-evaluates an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Standard Reconsideration: A written request asking Aspirus Health Plan to reconsider the denial, reduction or termination of coverage for a service or the denial of payment for services already received.

Expedited Reconsideration: A verbal or written request asking Aspirus Health Plan to reconsider the denial, reduction or termination of coverage for a service. This does not include requests for payment of services already furnished. An expedited request is granted to the member if applying the standard 30 calendar day timeframe could seriously jeopardize the member's life, health or ability to regain maximum function.

Who Can File an Appeal?

- A member or their authorized representative. A valid appointment of representative form must be received before a request for reconsideration is accepted and the review process timeline begins. This could include Power of Attorney document, Health Care Proxy document, a signed CMS Appointment of Representative form (CMS 1696) or an Aspirus Health Plan Statement of Representative form found on the Plan Documents and Information webpage.
- The legal representative of a deceased member's estate.
- An assignee of the member: A non-contracted physician or other non-contracted provider who has furnished a service to the member and signs a Waiver of Liability form agreeing to waive any right to payment from the member for that service.
- For appeal of a pre-determination, a physician may request reconsideration on behalf of the member.
- For post-service (claims) a physician may request a reconsideration but must be an authorized representative for the member. See Provider Appeals section of this Provider Manual.

Expedited Reconsideration: A physician can request an expedited reconsideration. A physician may also provide oral or written support for a member's request for an expedited reconsideration.

Timeline for Filing: Members or their representative(s) must file an appeal request within 65 days of the date of the notice of denial. The filing timeline can be extended if the party shows good cause for the delay in filing a request.

How to File:

- Standard reconsideration must be filed in writing.

- Expedited reconsideration may be filed verbally or in writing.

Decision:

- Aspirus Health Plan Appeals and Grievances staff review all information and facts related to the case before making the reconsideration decision. A Provider Relations and Contracting Coordinator may also contact the provider involved in the case to obtain information, provide guidance on contract or CMS requirements, etc.
- Requests for reconsideration involving a decision based on medical necessity will be reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue and who was not the individual who made the initial determination.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Aspirus Health Plan notifies the member in writing of the decision.

Timelines for resolution include:

- *Standard reconsiderations:* For service requests, as expeditiously as the member's health requires but within 30 calendar days from receipt of the request. For Part B drug service requests, as expeditiously as the member's health requires but within seven calendar days from receipt of the request. Part B service requests cannot be extended beyond seven calendar days. The timeframe for resolving standard service reconsideration can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member and/or the appealing party is immediately notified in writing of the reason(s) for the delay.
    - For payment requests, within 60 calendar days from receipt of the request. Payment requests cannot be extended.
- *Expedited reconsiderations:* As expeditiously as the member's health requires but within 72 hours of receipt of the request. The timeframe for resolving an expedited reconsideration that is not Part B drug appeal can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member and/or appealing party is immediately notified verbally and in writing of the reason(s) for the delay.

Automatic 2nd Level Appeals

If Aspirus Health Plan does not make a fully favorable decision, that is, does not agree to fully cover or pay for a service, the reconsideration request is automatically forwarded to an independent review entity under contract with CMS, MAXIMUS Federal Services for an external review.

Appeal Levels 3-5

If the decision by the independent review entity is fully or partially adverse to the member, the member may, based on certain requirements, request an Administrative Law Judge hearing (ALJ), review by the Medicare Appeals Council (MAC), and judicial review. See member's Evidence of Coverage (EOC) for further information on these appeal levels.

Note: "Fast Track" Appeals with the QIO

- Members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with Aspirus Health Plan's decision that Medicare coverage of their services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) should end.
- When Aspirus Health Plan has approved coverage of a member's admission to a SNF, or coverage of HHA or CORF services, the member must receive a Notice of Medicare Non-Coverage (NOMNC) at least two days in advance of the termination of coverage for these services (See the Skilled Nursing Facility Services, Home Care Services or Comprehensive Outpatient Rehabilitation Facility Services sections).
- A timely request for an expedited review by the QIO is one in which a member requests an appeal from the QIO either by noon of the day following receipt of the NOMNC; or, where a member receives the NOMNC more than two days prior to the date coverage is expected to end, a member requests an appeal with the QIO no later than noon of the day before coverage ends (that is, the "effective date" of the notice).
- A member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with Aspirus Health Plan under the provisions explained above for an expedited reconsideration.
- A member who disagreed with the decision to be discharged from the hospital can appeal the discharge decision that inpatient care is no longer necessary and must request an immediate QIO review. (See Hospital Services section). A member who fails to request an immediate QIO review of the discharge decision in accordance with the filing timeline requirements may request an expedited reconsideration with Aspirus Health Plan.

Medicare Part D Prescription Drug Program | Member Appeal and Grievance Process

See also: member's Evidence of Coverage (EOC) and Medicare Prescription Drug Benefit Manual, Chapter 18: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Grievance | Definitions and Overview

Grievance: Any complaint or dispute, other than one involving a coverage determination or a Low Income Subsidy (LIS) or Late Enrollment Penalty (LEP) determination, expressing dissatisfaction with any aspect of Aspirus Health Plan operations, activities or network pharmacies, regardless of whether remedial action is requested.

Examples include:

- Problems with wait times at the pharmacy when filling a prescription.
- Delays in reaching someone by phone or getting information needed when filling a prescription or requesting prescription drug benefit information.
- Problems with the quality of the prescription dispensing (e.g., errors in drug or dose).
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of network pharmacy.
- Notices and other written materials are difficult to understand.
- Failure to provide required notices.
- Discrimination.

Who Can File?

A member or their representative.

Timeline for Filing:

Within 65 days of the date of the incident that precipitated the grievance for Aspirus Health Plan members. The filing timeline may be extended if there is good cause for the delay.

How to File:

By calling Aspirus Health Plan Customer Services or submitting a written grievance to Member Appeals and Grievances.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Oral Grievances

- Oral grievances are investigated, and the findings or outcome are communicated verbally and/or in writing to the member within 30 calendar days from receipt of the grievance. A member can request a written response.
- The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

- If the member does not agree or is dissatisfied with the response, the member can file a written grievance.

Written Grievances

- Written grievances are investigated, and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within 10 calendar days after receipt of the written grievance.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if Aspirus Health Plan justifies a need for additional information and the delay is in the member's best interest. If Aspirus Health Plan extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

An expedited grievance is a member's complaint that Aspirus Health Plan or its Pharmacy Benefits Manager (PBM) refused to expedite a coverage determination or redetermination request. Aspirus Health Plan must resolve these grievances within 24 hours of receipt.

Quality of Care Grievances

- A Quality of Care (QOC) complaint may be filed through Aspirus Health Plan's grievance process (See Quality of Care Review Process section in this chapter) and/or a Quality Improvement Organization (QIO).
- If Aspirus Health Plan receives a grievance about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process. The letter also includes information on how to file a QOC grievance with the QIO.

Quality Improvement Organization (QIO): Comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, Medicare Part D prescription drug plans and ambulatory surgical centers. A QIO must determine whether the quality of services provided by a Medicare Part D prescription drug plans providers meets professionally recognized standards of health care.

The member or their representative has the right to file a Quality of Care (QOC) grievance with the QIO in the state where they reside.

QOC grievances filed with the QIO must be made in writing.

A member who files a QOC grievance with the QIO is not required to file the grievance within a specific time period.

Below is the QIO where Aspirus Health Plan members can file a QOC grievance or seek additional information about the QIO's review process:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 888.524.9900
Fax: 833.868.4059

Appeal | Definitions & Overview

Coverage determination: Any determination (i.e., an approval or denial) made by Aspirus Health Plan or its Pharmacy Benefits Manager (PBM) with respect to the following:

- A decision about whether to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the plan's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the Part D plan sponsor determines that the drug is otherwise excluded under section 1862(a) of the Act if applied to Medicare Part D) that the member believes may be covered by the plan.
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the member.
- A decision concerning a tiering exceptions request under 42 CFR 423.578(a).
- A decision concerning a formulary exception request under 42 CFR 423.578(b).
- A decision on the amount of cost sharing for a drug.
- A decision whether a member has, or has not, satisfied a prior authorization or other utilization management requirement.

Appeal: Any of the procedures that deal with the review of adverse coverage determinations made by Aspirus Health Plan or its PBM on the benefits under a Part D plan the member believes they are entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amounts the member must pay for the drug coverage, as defined in §423.566(b). These procedures include redeterminations by Aspirus Health Plan, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC) and judicial reviews.

Redetermination: The first level of the appeal process, which involves Aspirus Health Plan re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Standard Redetermination: A verbal or written request asking Aspirus Health Plan to reconsider the denial of coverage for a medication (prior authorization, non-formulary exception, tier exception, quantity limit exception).

Expedited Redetermination: A verbal or written request asking Aspirus Health Plan to reconsider the denial of coverage for a medication (prior authorization, non-formulary exception, tier exception, quantity limit exception). This does not include requests for payment of medication already furnished. An expedited request is granted to the member if applying the standard seven calendar day timeframe could seriously jeopardize the member's life, health or ability to regain maximum function.

Who Can File?

- A member or the member's authorized representative. A valid appointment of representative form must be received before a request for reconsideration is accepted. This could include, Power of Attorney document, Health Care Proxy document, a signed CMS Appointment of Representative form (CMS 1696) or an Aspirus Health Plan Statement of Representative form.
- The legal representative of a deceased member's estate.
- A physician may also request a redetermination.
    - Standard Redetermination: A physician may request a redetermination.
    - Expedited Redetermination: A physician can request an expedited redetermination.
- A physician may also provide oral or written support for a member's request for an expedited reconsideration.

Timeline for Filing:

Within 65 days of the date of the notice of denial. The filing timeline can be extended if the party shows good cause for the delay in filing a request.

How to File:

- Standard redetermination may be filed orally or in writing.
- Expedited redetermination may be filed orally or in writing.

Decision:

- Aspirus Health Plan Appeals and Grievances staff obtain all information used to make the initial coverage determination, contact the prescribing provider for any new or additional information, and gather the coverage criteria for the prescription medication in question. For payment requests, review of coverage requirements and current status of True Out-of-Pocket (TrOOP), etc. are reviewed. All information and facts related to the case are gathered before making the redetermination decision.
- Requests for redetermination involving a decision based on medical necessity will be reviewed by a pharmacist and physician with expertise in the field of medicine that is appropriate for the services at issue and who is not the individual who made the initial determination.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

- The member is notified in writing of Aspirus Health Plan's decision.
- Timelines for resolution include:
    - Standard Redeterminations: As expeditiously as the member's health requires but within seven calendar days from receipt of the request.
    - Standard Payment Redeterminations: As expeditiously as the member's health requires but within 14 calendar days from receipt of the request.
    - Expedited Redeterminations: As expeditiously as the member's health requires but within 72 hours of receipt of the request.

2nd Level Appeals

If Aspirus Health Plan does not make a fully favorable decision, that is, does not agree to fully cover or pay for a prescription medication, the member is informed of the reconsideration process. The member must request a 2nd level appeal by the independent review entity under contract with CMS, C2C Innovative Solutions.

Appeal Levels 3-5

If the decision by the independent review entity is fully or partially adverse to the member, the member may, based on certain requirements, request an Administrative Law Judge hearing (ALJ), review by the Medicare Appeals Council (MAC) and judicial review. See member's Evidence of Coverage (EOC) for further information on these appeal levels.

Quality of Care Review Process

- Quality of Care (QOC) grievances/concerns involve situations where the reporter indicates that the quality of clinical care or quality of service did, or potentially could have, adversely affected a member's health or well-being.
- Potential clinical QOC situations may be identified and reported internally by any Aspirus Health Plan staff person, including Customer Service, Quality Management, Clinical Services, or externally by members or their representatives, delegated entities, regulatory agencies or providers.
- The QOC grievance/concern is reviewed to ensure that it is appropriate for a QOC review and to determine if the case warrants priority evaluation.
- All cases are reviewed using a confidential peer review process.
- A nurse reviewer is responsible for coordinating the QOC review process. The nurse reviewer collaborates with the Medical Director to discuss the approach and information needed for the review.
- Medical Director reviews the QOC referral to decide whether or not it is appropriate for a QOC review.

- When a QOC review is opened, the Medical Director decides to request medical records or send a letter to the facility's leadership regarding the issues.
    - Medical Records
        - The nurse reviewer will review Medical Records and report the findings to the Medical Director. The Medical Director may request additional information from the facility's leadership if needed.
    - Letter to the facility's leadership
        - The facility may be asked to conduct the investigation and report the findings to Aspirus Health Plan.
- If the facility's response is not satisfactory, Aspirus Health Plan may perform an independent review to ensure that appropriate investigation and action is taken.
- If the QOC review indicates a potential serious outcome for other Aspirus Health Plan members, it may include temporary suspension of member access to the service(s) provided by the provider and transition of current members to the care of another provider, pending the completion of the QOC review.
- The Medical Director makes the final determination if a QOC issue exists, its severity level and the action to be taken regarding the case.
- If the QOC issue is substantiated, the Medical Director decides if notification to the facility is appropriate. If it is, Aspirus Health Plan notifies the appropriate person responsible for supervising the involved provider or staff (e.g., clinic or hospital Medical Director, nursing facility Director of Nursing, etc.) regarding the QOC review outcome.

If a QOC issue is substantiated and notification is appropriate, the Medical Director makes recommendations in the letter about areas of potential process or service improvement. The provider is responsible for ensuring that appropriate measures are implemented to prevent recurrent issues. The provider is then monitored through the threshold monitoring process.

Clinical Practice Guidelines - Medical & Mental Health and Substance Use Disorder

Aspirus Health Plan adopts and disseminates clinical practice guidelines to support good decision-making by patients and clinicians, improve health care outcomes and meet state and federal regulatory requirements. Guidelines are designed to assist clinicians by providing a framework for the evaluation and treatment of members.

Aspirus Health Plan, through the Quality Improvement and Medical Management Committee (QIMM), adopts guidelines to assist health care professionals and providers in recommended courses of intervention but not as a substitute for the advice of a physician or other knowledgeable health care professional or provider. Guidelines can serve as a tool to identify areas of clinical improvement.

Medical

Aspirus Health Plan has five medical clinical practice guidelines:

Asthma, Diagnosis and Management
Primary Source: Global Initiative for Asthma

Diabetes, Type 2; Diagnosis and Management
Primary Source: American Diabetes Association

Management of Heart Failure in Adults
Primary Source: Journal of the American College of Cardiology (JACC)

Obesity in Adults; Prevention and Management
Primary Source: American Academy of Family Physicians

Preventive Services for Adults
Primary Source: American Academy of Family Physicians

Mental Health & Substance Use Disorder

Aspirus Health Plan has five mental health and substance use disorder clinical practice guidelines:

Treatment of Patients with Major Depressive Disorder
Primary Source: American Psychiatric Association

Treatment of Patients with Schizophrenia
Primary Source: American Psychiatric Association

Treatment of Patients with Substance Use Disorders (SUD)
Primary Source: American Psychiatric Association

Treatment of Opioid Use Disorder
Primary Source: American Society of Addiction Medicine

Management of Posttraumatic Stress Disorder and Acute Stress Disorder
Primary Source: U.S. Department of Veterans Affairs

Quality Program

Aspirus Health Plan exists to deliver direct access to high-value, personalized health care that aims to improve the health and well-being of its membership and to address all health care needs. Aspirus Health Plan is committed to:

- Making our high-quality health care services cost-effective.
- Integrating health care so that members' personal needs and preferences are considered.
- Improving the communities we serve.

The Aspirus Health Plan Quality Improvement Program (QIP) drives organizational improvement for excellence through efficiencies, increasing competitive advantage, building trust and recognition in the community to improve the health status, safety and satisfaction of our members.

The QIP is the framework by which we assess and track our performance through a systematic approach of monitoring, evaluating and improving the quality and effectiveness of care for our members. This approach enables Aspirus Health Plan to focus on issues of appropriateness, efficiency, safety and health outcomes and satisfaction of our members and their providers. This is achieved by continuous monitoring of our performance according to, or in comparison with, objective measurable performance standards. The QIP promotes accountability and assures identification and evaluation of issues that impact our ability to better our performance and improve health care and administrative services provided to our members.

Our guiding principle is to provide services with the following characteristics of evidence-based, data-driven decisions for the safety and welfare of our members. The following goals are the areas of focus and priority:

- Ensure an objective and systematic approach to monitoring, evaluating, improving and communicating the quality, safety, effectiveness and value of care and services provided to Aspirus Health Plan members and other customers.
- Maintain compliance with regulatory requirements.
- Protect confidential personal health information.
- Provide an adequate and accessible network of qualified practitioners and providers through credentialing, peer review and contracting process.
- Exceed member experience expectations.
- Monitor the quality of care provided for our members and address their concerns.
- Implement a population health management strategy to address the needs of members across the continuum of care and address social risk factors and health care disparities.
- Focus on maintaining and improving member health through Medicare Star Ratings by maintaining a 4 Star Rating for Star Year 2026.

Aspirus Health Plan's QIP is designed to meet or exceed the quality-related requirements of the Centers for Medicare & Medicaid Services (CMS), Wisconsin Department of Health Services (DHS) and Wisconsin Office of the Commissioner of Insurance and the National Committee for Quality Assurance (NCQA).

The QIP's scope encompasses all aspects of care delivered by participating and contracted providers. This includes medical, mental health, substance use disorder, dental, chiropractic and pharmacy services, which are provided in ambulatory, hospital, emergency department, skilled nursing facility and other settings. The QIP is responsive to the changing needs of the health care environment and the standards established by our local medical community and national regulatory and accrediting bodies.

Aspirus Health Plan routinely elicits members' perceptions of the health care services they receive and their interactions with the plan itself. Aspirus Health Plan assesses service aspects of quality such as access, availability and other administrative issues that affect the delivery of care. Aspirus Health Plan also works with providers to share information, disseminate practice guidelines, and implement ways to improve care and service to our members.

Aspirus Health Plan's Quality Improvement Advisory Committee (QIAC) provides structure for promoting and achieving excellence in all areas and at all levels of the organization. The QIAC has oversight for the structure and resources that are reviewed throughout the calendar year.

Medical Record Documentation and Audits

Aspirus Health Plan conducts an annual Medical Record Standards Audit. We review whether medical records are current, accurate, legible, detailed, accessible and permit effective and confidential member care and quality review of all patient interactions. We share results of these audits with providers as necessary.

At a minimum, providers should have policies and procedures in place to ensure medical record documentation meets the following criteria:

No.	Medical Record Standard
1	Medical Record is legible to someone other than the author.
2	For every entry, the visit note includes the practitioner's signature and credentials with the date and time documented.
3	Record contains a current problem list or problems are documented in the progress notes with dates.
4	The medication list, including OTC drugs, is updated at the last visit and is documented in the progress notes. Prescribed medications should include dosages and dates of initial and refill prescriptions.

5	The presence/absence of allergies/adverse reactions is documented in a consistent, prominent location. If the member has no known allergies or adverse reactions, this is noted in the record.
6	If the member has been referred to a specialist, the summary of care and/or operative treatment reports and other reports are present in the medical record.
7	If the member received care at a hospital or an outpatient care facility, the report for that care is in the medical record.
8	Immunizations are updated and documented on an immunization record.
9	Documentation exists related to the inquiry/counseling of smoking habits and/or exposure.
10	Documentation exists related to the inquiry/counseling of alcohol/other substances habits and/or exposure.
11	Abnormal lab/diagnostics are noted and there is documented follow-up*.
12	Documentation addresses the availability of preventive screening services.
13	Documentation exists on the social determinants of health and any follow-up or treatment provided to address any identified needs.

***Note**: Forms or notes have notation of follow-up communication or visits to resolve or address any subsequent treatment or actions on the part of the patient or primary care provider. Consultation from a specialist (if needed) is formally requested, and there is a plan for after the consultation with the primary care provider. Medical records should clearly document these steps, and specialty consultation summaries should be included in the patient's primary care record.

Continuity and Coordination of Medical Records

Maintaining a location for consulting and/or external facility patient medical records such as visit summaries, lab results and letters or progress notes is critical to ensure consistent care. Communications between providers should be in chronological order and accessible through the patient's primary medical record. Pre- and post-hospitalization documentation should show the following coordination within the primary care record:

- Notification of inpatient admission on day of admission or within two days after; or evidence of a pre-admission exam completed in relation to a planned admission.
- Receipt of discharge information on day of discharge or within two days after. Discharging information must include:
  - The practitioner responsible for the member's care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnoses at discharge.
  - Current medication list (including medication allergies).

- Testing results or documentation of pending test results.
- Instructions to the PCP or ongoing care provider for continued patient care.

Medication Reconciliation Post Discharge

A critical component of ensuring proper coordination of care post inpatient episode is to confirm members receive a complete medication reconciliation within 30 days of discharge. Medication reconciliations help reduce the likelihood of a readmission and can be part of a follow-up visit or can be prepared by a primary care provider without a patient encounter. Whenever possible, medication reconciliations post discharge should be billed by a provider's office with the following CPT codes or CPT Category 2 codes:

- 99483: Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all the following required elements:
    1. Cognition-focused evaluation including a pertinent history and examination.
    2. Use of standardized instruments for staging of dementia.
    3. Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity.
    4. Medication reconciliation and review for high-risk medications, if applicable.
    5. Evaluation for neuropsychiatric and behavioral symptoms, including depression, including the use of standardized screening instrument(s).
    6. Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks.
    7. Evaluation of safety (e.g., home safety), including motor vehicle operation, if applicable.
    8. Address palliative care needs, if applicable and consistent with beneficiary preference.
- 99495: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge. Medical decision-making of at least moderate complexity during the service period and a face-to-face visit within 14 calendar days of discharge.
- 99496: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge. Medical decision-making of high complexity during the service period and a face-to-face visit within seven calendar days of discharge.
- 1111F: Discharge medications reconciled with the current medication list in outpatient medical record.

Transitional Care Management (TCM) service codes may be used for new and established patients to the provider. For reimbursement, TCM codes require:

- Non-face-to-face communication within two business days of discharge.
- A face-to-face encounter within 7 to 14 days of discharge.

- Medication reconciliation and management no later than the face-to-face encounter.

Note: Inpatient status includes acute hospital, rehabilitation hospital and long-term acute care hospital.

Advanced Directives Audits and Resources

Aspirus Health Plan conducts an annual audit of advanced directive documentation and evidence of advanced care planning found in members' medical records (for adults aged 18 and older). We share results of these audits with providers as needed. Resources for advanced care planning are made available to providers, members and care teams in the following way:

Advanced Directives

Compliance and Fraud, Waste and Abuse

Preventing Health Care Fraud, Waste and Abuse

Health care fraud is a significant concern for Aspirus Health Plan and the entire health insurance industry. According to National Health Care Anti-Fraud Association estimates, 3 to 10 percent of what Americans spend annually on health care is lost to fraud — that's between $114 billion and $380 billion a year. Health care fraud can also put members' safety at risk.

What is Aspirus Health Plan doing about it?

We take a proactive approach to detecting and investigating potential health care fraud, waste and abuse. Aspirus Health Plan has a Special Investigations Unit (SIU) to detect and investigate allegations of fraud, waste and abuse. The SIU detects potential fraud, waste and abuse through ongoing audits and analysis of billing patterns. The SIU also receives reports or complaints of suspected fraud, waste and abuse. Regardless of how the issue is detected, the SIU investigates each instance of potential fraud, waste or abuse, including collection of necessary documents, data and information.

The mission of the Aspirus Health Plan SIU is to prevent, detect, investigate, report and, when appropriate, recover money lost to health care fraud, waste and abuse.

Aspirus Health Plan strives to protect all health care dollars that otherwise might be lost or wasted. Our SIU works with members; providers; state, federal and other law enforcement agencies; and other health care providers to address fraud, waste and abuse. The SIU is authorized to conduct pre-payment and post-payment reviews to ensure compliance with regulations and contract provisions.

What Is Fraud, Waste and Abuse?

Federal and state laws have specific provisions describing fraud, waste and abuse, which providers must follow and Aspirus Health Plan helps enforce. In addition, Aspirus Health Plan provider contracts have important terms addressing fraud, waste and abuse.

One example of a federal anti-fraud law is the Anti-Kickback Statute (42 U.S.C. § 1320a-7b), which imposes criminal sanctions for the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of business paid by Medicare funds. Another example is the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), which imposes substantial financial penalties against a provider for certain activities including knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way, or offering or giving something of value to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services.

The following are more examples of fraud, waste and abuse.

Fraud: This occurs when someone makes a false statement, false claim or false representation to Aspirus Health Plan where the person knows or should reasonably know the statement, claim or representation is false and where the false statement, claim or representation could result in an unauthorized benefit to the person or some other person.

Fraud includes, but is not limited to, intentionally committing the following acts:

- Billing for services or supplies that were not rendered.
- Altering claims to receive a higher payment.
- Offering bribes or kickbacks in exchange for referrals.
- Allowing someone who is not eligible for Aspirus Health Plan coverage to use a member's ID card.
- Altering or creating documents to show delivery of items not received or services not rendered.

Waste: This is any over-utilization of services and misuse of resources that is not caused by fraud or abuse.

Examples of waste include:

- Ordering excessive laboratory tests.
- Submitting excessive duplicate claims.

Abuse: This is any of the following:

1. A pattern of practice that is inconsistent with sound fiscal, business or medical practices and either directly or indirectly results in unnecessary costs to Aspirus Health Plan, or that fails to meet professionally recognized standards for health care, including:
    - Practices that result in unnecessary costs to the federal program funds that Aspirus Health Plan administers.
    - Practices that result in reimbursement for services that are not medically necessary.
    - Practices that fail to meet professionally recognized standards for health service.
    - Abusive practices are not one-time errors. They include misusing codes on a claim, such as upcoding or unbundling codes as well as balance billing or imposing unauthorized charges on members.
2. Enrollee practices that result in unnecessary cost to Aspirus Health Plan.
3. Substantial failure to provide medically necessary items and services that are required to be provided to an enrollee if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the enrollee.

Documentation

Providers must develop and maintain health service records in order to seek a claim for payment from Aspirus Health Plan. Each occurrence of a health service must be documented and retained in the member's health record in accordance with Aspirus Health Plan, state and federal requirements.

Claims paid for health care, services, supplies or equipment not documented in the health service record are subject to recovery by Aspirus Health Plan, and may be considered fraud, waste or abuse.

The record must be legible at a minimum to the individual providing the care or service and contain the following elements, when applicable:

- The date on which the entry is made.
- The date or dates on which the health service is provided.
- The length of time spent with the member, if the amount paid for the service depends on time spent.
- The signature and title of the person from whom the member received the service.
- Report of the member's progress or response to treatment, and changes in the treatment or diagnosis.
- The countersignature of the supervisor and documentation of supervision (if applicable).
- A copy of authorization for the service or item (if applicable).
- All other state and/or federal requirements.

In addition, the record must state, as applicable:

- The member's case history and health condition as determined by the provider’s examination or assessment.
- The results of all diagnostic tests and examinations.
- The diagnosis resulting from the examination.
- Reports of consultations that are ordered for the member.
- The member’s plan of care, individual treatment plan or individual program plan.
- The record of a laboratory or radiology service must document the provider's order for service.
- For other service-specific record requirements, refer to the appropriate chapter in this manual.

Investigative Process

Aspirus Health Plan, in conducting fraud, waste and abuse investigations, may:

- Interview providers, members or other witnesses.
- Visit a provider’s facility to collect records and/or inspect the equipment and premises.
- Request records via mail, fax or verbal request.
- Inspect business records, payroll, inventory and/or other items.

Providers are required to cooperate with Aspirus Health Plan’s audit or investigation, consistent with your Aspirus Health Plan contract provisions, Aspirus Health Plan policy and applicable laws. Failure to cooperate may result in claim payments being denied or recovered by Aspirus Health Plan.

If an investigation finds there is evidence of fraud, waste or abuse, Aspirus Health Plan may recover identified overpayments, place the provider on a corrective action plan, bar the provider from billing

certain codes, require pre-payment review of claims or submission of records, and if necessary, suspend or terminate the provider's participation. If a credible allegation of fraud is uncovered, Aspirus Health Plan may suspend payment to the provider in accordance with applicable law. As required by law, Aspirus Health Plan makes referrals to appropriate law enforcement agencies.

How can you avoid and prevent health care fraud?

Avoid and prevent fraud by following applicable laws and regulations along with Aspirus Health Plan contract requirements for claims submission and payment. Here are some other tips:

- Always remain current with billing and coding requirements for your area of service.
- Monitor your patient base for potential card sharing and other acts of misrepresentation.
- Only bill for services or equipment actually rendered and only that which has been properly documented.
- Implement internal audit or self-audit protocol to identify mistakes and errors in billing.
- Proactively void, replace or request adjustment to any claims you identify as erroneous (see Claims & Payment section).
- Most importantly, report any suspected fraud, waste or abuse to Aspirus Health Plan (See "Contacting Aspirus Health Plan" below).

Obligations for Providers of Services to Medicare Enrollees

Providers of administrative or health care services to Medicare eligible individuals, including Aspirus Health Plan Medicare Advantage plans, are considered first-tier entities as defined by the Centers for Medicare and Medicaid Services (CMS) (See CMS Medicare Managed Care Manuals Chapters 9 and 21). To meet the CMS requirements related to Aspirus Health Plan oversight of first-tier entities, we require providers to attest to the following:

1. Provider confirms that its owners, controlling interest parties, managing employees, employees and applicable downstream entities are not excluded from participation in state and/or federal health care programs prior to hire or contract, and annually thereafter.
2. Provider's Code of Conduct is comparable to Aspirus Health Plan Code of Conduct in that it meets the requirements of the CMS Medicare Managed Care Manuals Chapters 9 and 21.
3. Employees and applicable downstream entities have completed compliance and fraud, waste and abuse training that meets required standards. CMS requires completion of compliance and fraud, waste and abuse training by employees of organizations that provide health care or administrative services for Medicare eligible individuals under the Medicare Advantage or Medicare Part D programs. This training must be completed within 90 days of hire and annually thereafter. The annual training must be completed no later than December 31 each year.
4. Provider will report suspected Medicare program violations and/or fraud, waste and abuse concerns to Aspirus Health Plan and provider's employees are trained on reporting processes including to the appropriate health plan. Aspirus Health Plan has a strict no retaliation policy

for good faith reporting. Failure to report suspected Medicare program violations and/or fraud, waste and abuse concerns may result in disciplinary action, including termination of provider's contract with Aspirus Health Plan.

- Monitoring your downstream entities: Providers, who are first-tier entities, as defined in the CMS Medicare Managed Care Manuals Chapters 9 and 21, must ensure they have a system in place to monitor any of their downstream entities' compliance with Medicare program requirements.
- Prohibited affiliations per 42 CFR 438.610 must be reported immediately in writing to Aspirus Health Plan upon discovery.

5. To accomplish oversight of these Medicare requirements, Aspirus Health Plan may:
    - Audit the provider;
    - Require self-monitoring reporting, such as training completion evidence, of the provider; and
    - Require the provider complete a survey or submit an attestation.

Aspirus Health Plan Code of Conduct

As a provider serving Aspirus Health Plan members, you are a critical component of Aspirus Health Plan's corporate culture of integrity and openness. The Aspirus Health Plan Code of Conduct reflects the ethical and legal expectations for our employees, volunteers, Board of Directors and business partners—such as you. Aspirus Health Plan's mission and values, and this Code of Conduct, express a consistent message of doing the right thing for Aspirus Health Plan members, Aspirus Health Plan employees and company, our business partners and government agencies.

Aspirus Health Plan Code of Conduct

Contacting Aspirus Health Plan

If you suspect any of the above situations, or if you have any questions, please contact our toll-free Compliance hotline. You may remain anonymous, and this line is available 24 hours a day, every day.

You may contact Aspirus Health Plan regarding concerns the following ways:

- Call the Aspirus Health Plan Compliance hotline: 800.450.2339 toll-free
- Email your concern to: complianceMA@aspirushealthplan.com
- Mail your concern to:
  Attn: Special Investigations Unit
  Aspirus Health Plan
  P.O. Box 51
  Minneapolis, MN 55440

Risk Adjustment Data

Risk adjustment is a process that predicts the insurer's enrollees' health care expenditures based on demographics (age/gender) and health status (diagnostic data). Based on these predictions, a health plan receives capitated payments each month to cover the beneficiaries' health care expenses. This differs from standard fee-for-service payments where payment is received for each service provided.

Risk adjustment is based on risk scores that are determined by the reported diagnoses (ICD-10-CM codes) via encounter data. Aspirus Health Plan must provide valid and accurate encounter data to government agencies for calculating risk adjustment payments. The primary source of encounter data submitted for this calculation is extracted from claims with additional health conditions being identified during chart review and health assessments. Aspirus Health Plan requires providers to submit complete, accurate and truthful claims data. Risk adjusted payments occur for Medicare Advantage.

The provider's role in risk adjustment includes the following actions:

- Code identified conditions in accordance with the current ICD-10-CM Official Guidelines for Coding and Reporting to the highest level of specificity.
- Ensure documentation is complete, clear, concise, consistent and legible.
- Reported diagnosis codes are supported by the medical record documentation from a face-to-face encounter between the patient and the provider.
- Document all conditions being assessed during the encounter including those conditions that coexist and affect patient treatment or management.
- Document all active conditions including health status conditions at least annually to capture the complete health profile.
- Document "history of" to indicate only those conditions that are no longer present. Do not use "history of" to report a condition that is present and actively being treated or monitored.
- Document an evaluation/assessment and plan for all active conditions. Diagnoses listed solely in a problem list are not acceptable for risk adjustment.
    - Examples of assessment language: stable, improved, tolerating treatment, unstable, etc.
    - Example of plans: monitor, d/c meds, continue current med, refer to, change med, etc.
- Ensure records are signed with credentials from the rendering provider.
- Use standard abbreviations.
- Ensure each progress note can stand alone. Do not refer to previous progress notes or problem lists.

The requirements for risk adjustment data imposed by CMS for Medicare Advantage plans are stated in 42 C.F.R. § 422.310 as well as other CMS guidance documents. Aspirus Health Plan provider contracts require providers to follow CMS requirements in submitting accurate risk adjustment data

and maintaining the supporting medical documentation and impose financial penalties for a provider's non-compliance.

It is expected that providers have quality assurance processes in place to validate the diagnosis codes submitted on claims (encounter data), and to report to Aspirus Health Plan immediately any corrections or issues with respect to previously submitted codes. Aspirus Health Plan's expectation is that providers cooperate and support our risk adjustment chart and quality review in accordance with CMS guidelines, by providing Aspirus Health Plan with access to specific member medical records.

CMS will validate encounter data by performing annual risk adjustment data validation (RADV) audits on a selection of Medicare Advantage plans. During an audit, it is imperative that providers cooperate with Aspirus Health Plan in providing relevant medical records to support the sampled encounter data. CMS will intervene and take action against providers that do not cooperate with these audits.

Culturally Congruent Care

What is Culturally Congruent Care? Why is it Important?

Culturally congruent care is defined as the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families and communities.

Cultural congruency is important because health care professionals and providers are able to provide better services and quality of care for all members. Following are resources to assist providers to be more culturally congruent.

Cultural Competency & Language Access: Wisconsin Department of Health Services information and resources.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: Issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

Culture Care Connection - Stratis Health: Culture Care Connection is an online learning and resource center that supports clinical and non-clinical health care professionals to reduce health disparities and promote health equity.

Disease Management Programs

Aspirus Health Plan offers disease management programs to our members living with diabetes and heart failure. These programs reinforce and complement the provider-patient relationship, increase the patient's level of self-care and improve health outcomes. The member's primary care provider is notified of member enrollment into the disease management program. Please review our disease management programs on the Prior Authorization & Notification Requirements and Referrals webpage and complete the referral form for members that would benefit from diabetes or heart failure disease management.

Candidates for our programs include members who:

- Are not checking their blood sugars as directed or weighing themselves daily.
- Are experiencing challenges with management of their chronic condition.
- Are not adhering to their chronic condition medication.
- Do not understand their diagnosis and could benefit from education/coaching on their condition.
- Are looking to improve their health through learning how to manage their chronic condition.

Diabetes

Interactive Voice Response (IVR)/Texting Program: Adult members in our IVR/texting program receive regularly scheduled education phone calls providing chronic condition education and condition-related questions to respond to. Answers are triaged for follow-up support provided by an Aspirus Health Plan health coach where the call is triaged for further education, referral to PCP or enrollment in the health coaching program.

Health Coaching: Adult members in our diabetes program receive regularly scheduled health coaching calls with an Aspirus Health Plan health coach. Our team of coaches partner with members to discover their barriers and vision for the future, establish short- and long-term behavior change goals and empower members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Diabetes management tools such as a diabetic bracelet and wrist blood pressure cuff are provided to participating members.

Heart Failure

Healthy Hearts: Adult members in our Healthy Hearts heart failure program receive regularly scheduled health coaching calls with an Aspirus Health Plan health coach. Our team of coaches partner with members to discover their barriers and vision for the future, establish short- and long-term behavior change goals and empower members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Heart failure management tools, such as a bathroom scale and wrist blood pressure cuff are provided to participating members.

Health Promotion Programs

Aspirus Health Plan is committed to helping keep our members healthy and safe. The following Health Promotion programs and resources are available to eligible Aspirus Health Plan members. Visit the Health and Wellness webpage to learn more.

Fitness Programs

One Pass

One Pass is a complete fitness solution for the body and mind, available to members at no additional cost. Members have access to more than 24,000 participating fitness locations nationwide, plus:

- Thousands of on-demand and livestreaming fitness classes.
- Workout builders to help members create their own workouts and walk them through each exercise.
- Home fitness kits available to members who are physically unable to visit or who reside at least 15 miles outside a participating fitness location.
- Personalized, online brain training program to help improve memory, attention and focus.
- Social activities, community classes and events available for online or in-person participation.

For additional information, go to medicare.aspirushealthplan.com/ahp_onepass or call 877.504.6830 toll-free (TTY 711), 8 am – 9 pm, Monday – Friday.

Quit Smoking and Vaping Program

Aspirus Health Plan members can get help to stop smoking, vaping or chewing tobacco through the Tobacco and Nicotine Quit Line at no charge. Nicotine patches, gum or lozenges are also available to eligible Aspirus Health Plan members.

- Members can receive help through the following methods:
  Call the tobacco and nicotine quit line 855.260.9713 (TTY 711) toll-free, available 24 hours a day, seven days a week.
- Visit myquitforlife.com/aspirus.
- Download the Rally Coach Quit For Life mobile app.

Aspirus Health Plan Healthy Benefits+ Visa® Card

The Aspirus Health Plan Healthy Benefits+ Visa® card offers the flexibility and convenience of one card for:

- Over the counter (OTC) allowance.
- Prescription eyewear allowance.

- Grocery discounts.
- Rewards and incentives.

The Healthy Benefits+ Visa card is reloadable each year and is valid until the expiration date or until a member is no longer covered by Aspirus Health Plan. Members should be sure to keep their card, as they won't be sent a new one each year. The card won't work for non-members. Allowance amounts and expiration dates vary by plan and program.
To register the card, learn more or check a card balance, members can visit healthybenefitsplus.com/aspirus or call 833.862.8276 toll-free (TTY 711). This phone number is also on the back of the Healthy Benefits+ Visa card.

Prescription eyewear allowance

Aspirus Health Plans includes an annual prescription eyewear allowance. These allowances range from $175 to $250, depending on the plan. The annual allowance amount is loaded on the member's Aspirus Health Plan Healthy Benefits+ Visa® card. Members then pay for eligible eyewear using the card. The allowance expires at the end of the year or upon plan termination. The card won't work if you're no longer a member.

To register the card, learn more or check a card balance, members can visit healthybenefitsplus.com/aspirus or call 833.862.8276 toll-free (TTY 711). This phone number is also on the back of the Healthy Benefits+ Visa card.

Grocery discounts

Members can save on healthy foods like milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more at participating grocery stores. Weekly discounts are pre-loaded onto the Aspirus Health Plan Healthy Benefits+ Visa® card. Members can simply scan the Healthy Benefits+ card when paying to access the discount.

To register the card, learn more or check a card balance, members can visit healthybenefitsplus.com/aspirus or call 833.862.8276 (TTY 711). This phone number is also on the back of the Healthy Benefits+ Visa card.

Over-the-Counter (OTC) allowance

Members get an over-the-counter (OTC) allowance loaded to the Healthy Benefits+ Visa® card to purchase eligible health items at participating retailers. Eligible items include cough drops, first aid supplies, pain relief, sinus medications, toothpaste and much more! Allowance amounts and expiration dates vary by plan and program. The card won't work if you're no longer an Aspirus Health Plan member. To register the card, learn more or check a card balance, members can visit healthybenefitsplus.com/aspirus or call 833.862.8276 toll-free (TTY 711). This phone number is also on the back of the Healthy Benefits+ Visa card.

Garmin discount

Aspirus Health Plan is partnering with Garmin to offer members a 20% discount on select Garmin wearable products, like fitness trackers and running watches.

Members should access the member portal to browse or purchase Garmin wearable products. The discount is only available online.

The discount is available on up to two Garmin wearable and two Garmin accessories (like a watch or strap) per calendar year.

Strong and Stable Kit

The Strong and Stable Kit provides tools to help members stay strong and prevent falls.

The Strong and Stable Kit has:

- Resistance band strength kit.
- Tip sheets with helpful falls prevention advice.
- Tub grips to install on slippery areas.
- A nightlight that stays lit when the power goes off and can be used as a flashlight.
- A medication box.

Members may order a kit* through their account at https://medicare.aspirushealthplan.com/member-login or by calling Customer Service at the number on the back of their member ID card.

Note: Must be an eligible Aspirus Health Plan member at the time of the order. Limit one kit per year per member. Kit contents and availability may be subject to change. Members should allow 4 – 6 weeks for delivery.

Activity tracker plus Personal Emergency Response System (PERS) device

Available for Aspirus Health Plan Essentials Rx members only.

Aspirus Health Plan Essentials Rx members can get an easy-to-use activity tracker plus Personal Emergency Response System (PERS) device. This device features:

- 24/7 emergency call-for-help to a support agent directly through the watch.
- Step and heart rate tracking to help reach health goals.
- Built-in GPS to support members both inside and outside the home.

The device is ready-to-use right out of the box and does not need to be set up or paired to a cell phone or Wi-Fi.

Members who use the device are eligible for a blood pressure monitor. For more information and to request the device call 612.294.0023.

Rewards and incentives

Aspirus Health Plan offers member incentives for a variety of preventive health services. Members should log in to or create an online member account at https://medicare.aspirushealthplan.com/member-login or call Customer Service at the number on the back of their member ID card to see if they are eligible.

Additional information about services and vouchers are available on Aspirus Health Plans' Rewards and Incentives webpage.

Aspirus Health Plan Member Perks

Aspirus Health Plan offers additional perks to its members. Visit the Health and Wellness webpage for a current listing.

Mental Health and Substance Use Disorder Services

This chapter provides information regarding mental health and substance use disorder services provided to Aspirus Health Plan members.

Manage Your Provider File

You can access information on updating your provider profile on the Our Network webpage. Mental health and substance use disorder providers currently not in the Aspirus Health Plan network can also submit a request to join the network. Please visit the Our Network webpage for information on credentialing, updating your organization's information and requesting to join the Aspirus Health Plan Medicare Advantage network.

Mental health and substance use disorder providers must be set up in the Aspirus Health Plan system for electronic claim submission. Please contact the Provider Assistance Center for guidance on being set up in our system at 715.631.7412 or 855.931.4851 toll-free.

Mental Health & Substance Use Disorder Services

The services listed below are not a comprehensive list of all mental health and substance use disorder services available to Aspirus Health Plan members. The list is intended to serve as a resource for providers; coverage and benefits vary among different Aspirus Health Plans. Please refer to the Member Enrollment and Eligibility section of this Provider Manual, or the Evidence of Coverage (EOC) specific to the member's plan for more details.

See the Authorization & Notification Standards section of this Provider Manual to review authorization requirements for mental health and substance use disorder services.

Mental Health

The list below is a partial summary of mental health services available to Aspirus Health Plan members.

Diagnostic Assessment, Psychotherapy, Psychological & Neurological Testing

- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

Partial Hospitalization Program

- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

Substance Use Disorder

The list below is a partial summary of substance use disorder services available to Aspirus Health Plan members.

Opioid Treatment Programs (OTP)

- A Medicare accepted assessment is required to evaluate substance use and individual risk, create an appropriate treatment plan and/or access OTP services.
- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

Outpatient Substance Use Disorder Treatment

- Medicare practitioner and place of service rules must be followed for use of Medicare benefits. A Medicare accepted assessment must be used.

Substance Use Disorder Assessments

- Aspirus Health Plan must receive a copy of the Medicare accepted assessment.

Inpatient Hospital Mental Health and Substance Use Disorder (admissions)

See the Hospital Services section of this Provider Manual and the Prior Authorization & Notification Requirements and Referrals webpage for additional information relating to mental health and substance use disorder inpatient hospital (acute settings). For detox information, see the Hospital Services section of this Provider Manual.

Level of Care Determination (Medical Necessity)

To determine if a level of care is medically necessary or meets the community standard of care, Aspirus Health Plan adopted criteria created by Medicare, Change Healthcare InterQual Behavioral Health Level of Care and Aspirus Health Plan Medical Polices. The type of benefits/coverage the member has determines which level of care criteria is utilized. Providers, members and consumers may request a copy of the criteria used to make level of care decisions.

It is important to remember that the member must have a benefit for the service for it to be covered by Aspirus Health Plan.

Below are links to the criteria used and how to request a copy of level of care criteria:

- Medicare Products (Medicare Coverage Database – Centers for Medicare & Medicaid Services)
- Medicare Products (National Government Services)
- Medical Policies
- Change Healthcare InterQual Behavioral Health Level of Care - request a copy (Aspirus Health Plan Medical Necessity Criteria Request form on the Provider Forms webpage)

Mental Health & Substance Use Disorder Services Claim Denials

Providers must complete the claim reconsideration form as an adjustment request and attach medical records. Directions for submitting an electronic claim attachment can be found in the Electronic Data Interchange section of this Provider Manual. If your claim has denied for medical records, use the Provider Claim Reconsideration Request Form found on the Claims & Billing webpage under Forms & Links. The reason for the request is "other." It is important to complete this form correctly.

Peer-to-Peer Review

In the event coverage guidelines or medical necessity has not been established for the level of care or service requested, Aspirus Health Plan Utilization Management Specialists will consult with the Mental Health and Substance Use Disorder (MH & SUD) Medical Director. The Aspirus Health Plan MH & SUD Medical Director will review the case and render a determination. If the MH & SUD Medical Director's decision results in an adverse determination, the ordering or treating provider has the opportunity to discuss the plan of care and clinical basis for the level of care or service requested in a peer-to-peer review with the Medical Director. If an adverse determination has already been given, the member or member's representative maintains their right to file an appeal. Please contact Aspirus Health Plan at 715.631.7442 or 855.931.5264 toll-free if you would like to request a peer-to-peer review.

Mental Health & Substance Use Disorder Clinical Practice Guidelines

Aspirus Health Plan adopted mental health and substance use disorder clinical practice guidelines to support good decision-making by patients and clinicians. These guidelines are adopted from various nationally or locally recognized sources. See the Clinical Practice Guidelines for Medical and Mental Health and Substance Use Disorders section of this Provider Manual for more information.

Aspirus Health Plan Mental Health and Substance Use (MHSUD) Case Management

The goal of MHSUD case management is to provide member-centric advocacy and access to appropriate care for mental health, substance use and/or social risk factors across the life span.

MHSUD case managers work with members that are transitioning from an inpatient or residential setting and ensuring the member has the appropriate follow up, medication, transportation to appointments, understanding of discharge needs and more.

Comprehensive Outpatient Rehabilitation Facility Services

Notifying Aspirus Health Plan Members of Medicare Coverage Termination

The Centers for Medicare and Medicaid Services (CMS) requires that Comprehensive Outpatient Rehabilitation Facilities (CORFs) provide an advance notice of Medicare coverage termination to Aspirus Health Plan enrollees no later than two days before coverage of their services will end.

Denial & Discharge Notices

The following forms and instructions described below are located on the Denials webpage.

NOMNC – Notice of Medicare Non-Coverage

- Issued by CORF staff when ongoing services will be terminated.
- Must be given two days prior to discharge or service termination.

NOMNC Valid Delivery Documentation Form

- Worksheet for CORF staff when issuing a NOMNC via phone.
- This is not to be sent to a member or member representative.

NDMCP – Notice of Denial of Medical Coverage/Payment

- Issued by Aspirus Health Plan or delegates when CORF services **are denied at or prior to the start of services**.

DENC – Detailed Explanation of Non-Coverage

- Issued by CORF staff when the member does not agree with service termination and wants a fast appeal using the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO). The BFCC-QIO for Wisconsin members is Livanta – Helpline 888.524.9900 toll-free and TTY 888.985.8775.

Discharge Notification Guidelines

The Notice of Medicare Non-Coverage form (NOMNC) is used when ongoing CORF services are being denied. The NOMNC is also known as the “Advance Notice” and informs the member of the date that coverage of services will end. The NOMNC describes what should be done if the member wishes to appeal the decision or needs more information.

1. The service provider is responsible for delivering the NOMNC to the member no later than two days before the end of coverage. Even if a provider does not agree with the decision that covered services should end, the provider must deliver the notice.
    - If the total span of services is expected to be fewer than two days, the NOMNC should be delivered to the member upon admission or start of services.
    - If there is more than a two-day span between services, the NOMNC should be issued on the next to last time services are furnished. This notice should be delivered as soon as the service termination date is known.
2. The provider must carry out valid delivery of the NOMNC, meaning that all patient-specific information required in the notice is included and the member (or authorized representative) must sign and date the Medicare Office of Management Budget (OMB)-approved notice to acknowledge receipt.
3. If a member has an appointed authorized representative, the representative must receive all required notifications. The notice must be mailed to the representative on the same day as the telephone notification.
4. Authorized representatives may be notified by telephone if personal delivery is not available immediately. The authorized representative must be informed of the contents of the notice, and the date, time and phone number of the call must be documented.
5. The provider may document the valid delivery of the NOMNC on Aspirus Health Plan's NOMNC Valid Delivery Documentation Form, available on the Denials webpage or in the member's medical record.
6. If the member decides to appeal the end of coverage, they must contact the BFCC-QIO no later than noon the day before services are to end (as indicated in the NOMNC) to request a review. The BFCC-QIO will inform Aspirus Health Plan and the provider of the request for review.
    - The provider is responsible for providing the BFCC-QIO and member with a Detailed Explanation of Non-Coverage (DENC) Form (also known as the "Detailed Notice"), which explains why services are no longer necessary.
    - The BFCC-QIO must make a decision by the close of business of the day coverage is to end. The provider and Aspirus Health Plan must cooperate with the QIO to provide information for the review. The provider must obtain appropriate signatures from the member and/or the member's representative. The BFCC- QIO for Wisconsin members is Livanta – Helpline 888.524.9900 toll-free and TTY 888.985.8775.
    - Protected Health Information provided to the QIO must be handled in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
7. Providers must issue advanced or detailed notices to Aspirus Health Plan members when directed to do so by Aspirus Health Plan or by an Aspirus Health Plan delegated entity. The provider must follow the direction of Aspirus Health Plan or Aspirus Health Plan's delegated entity and must not delay the delivery of the notice.

8. The provider must use the most current version of the denial notice from Aspirus Health Plan's website each time rather than saving and reusing a previous version. Notices cannot be altered in any way and a CORF cannot create its own notice.

Home Care Services

Home care providers are not allowed to subcontract to another entity to provide covered services for Aspirus Health Plan members unless they obtain prior written approval from Aspirus Health Plan. The approval is at Aspirus Health Plan's sole discretion. If requested by Asprius Health Plan, the provider must provide copies of the subcontracts.

Home Care Services Criteria

Aspirus Health Plan follows Medicare criteria for coverage of home care services. Services must be delivered by a Medicare-certified home health agency. Members must meet Medicare criteria.

Medicare home health services DO NOT include coverage for custodial care, general household services such as laundry, meal preparation, shopping or other home care services furnished mainly to assist in meeting personal, family or domestic needs.

Billing Home Health Services

Providers billing Medicare Certified Home Health Care services to Aspirus Health Plan must submit claims in accordance with Centers for Medicare & Medicaid Services (CMS) billing guidelines, including all required claim elements. Please refer to the CMS Medicare Claims Processing Manual for detail on required elements.

Regulations

Home health agencies must provide a Notice of Medicare Non-Coverage (NOMNC) to Aspirus Health Plan members no later than two days before coverage of their services will end. If the member does not agree that covered services should end, the member may request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in that state. The provider must furnish a detailed notice explaining why services are no longer necessary or covered. The review process will be completed within 48 hours of the member's request for a review.

Download the customized denial forms for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities from the Denials webpage each time the form is needed to ensure use of the most current version.

The member (or authorized representative) must acknowledge receipt of the NOMNC and contact the BFCC-QIO (within specified timelines) if they wish to obtain an expedited review.

The BFCC-QIO contacts Aspirus Health Plan and the provider if a member requests an expedited review. The BFCC-QIO makes a determination no later than the day Medicare coverage is projected to end.

When to Deliver the NOMNC

Based on the determination by Aspirus Health Plan or our delegated approval authority regarding when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to last less than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (such as in the home health setting), the NOMNC should be issued on the next-to-last time services are furnished. Providers should deliver the NOMNC as soon as the service termination date is known. Providers need not agree with the decision that covered services should end but are responsible under the Medicare provider agreement to issue the notice.

How to Deliver the NOMNC

The provider must deliver the NOMNC. The member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative the same day.

Expedited Appeal Process

If an Aspirus Health Plan member decides to appeal the end of coverage, he or she must contact the BFCC-QIO no later than noon on the day before services are to end (as indicated in the NOMNC) to request a review. The BFCC-QIO will inform Aspirus Health Plan and the provider of the request for a review. The provider is then responsible for providing the BFCC-QIO and member with a second notice, the Detailed Explanation of Non-Coverage (DENC) found on the Denials webpage. The provider may need to present additional information needed for the BFCC-QIO to make a decision. Providers must cooperate with the BFCC-QIO's requests for assistance in gathering required information. The BFCC-QIO decision should take place by close of business on the day coverage is to end.

Timely Notification

Providers should structure their notice delivery and discharge patterns to ensure arrangements for follow-up care are in place; scheduling equipment to be delivered (if needed) and writing orders or instructions in advance.

More Information

Further information on this process, including frequently asked questions and the required notices and related instructions, can be found on the Centers for Medicare & Medicaid Services (CMS) website. The regulations are at 42 CFR 422.624, 422.626, and 489.27, and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance includes information on the process.

Hospital Services

This section provides information regarding the hospital admission notification process for all Medicare Advantage plans offered by Aspirus Health Plan. For information regarding Swing Beds admission notification processes, see the Skilled Nursing Facility Services section in this Provider Manual. For information regarding fiscal and intermediary letters (rate sheet) for Critical Access Hospitals, Federally Qualified Health and Rural Health Clinics, see the Medicare Professional Fee Schedules in the Claims & Payment section.

This section also includes information regarding Medicare's Important Message and the Detailed Notice of Discharge (DND) for Aspirus Health Plan members.

Hospital Admission Notification | Aspirus Health Plan Members

Hospital Responsibility

Hospitals should verify member eligibility prior to providing service.

Mental Health and Substance Use Disorder inpatient admissions: Notification of admission can be faxed to Aspirus Health Plan at 715.787.7314 or emailed (secured) to mhsudservicesMA@aspirushealthplan.com. Refer to the authorization requirements grid on the Prior Authorization & Notification Requirements and Referrals webpage or call 715.631.7442 or 855.931.5264 toll-free within one business day from the date of admission. Please include the member's name, Aspirus Health Plan ID number, date of birth, ICD-10 diagnosis and admission date.

Detoxification in a hospital: This is not a mental health or substance use disorder admission. Detoxification for members needing medical stabilization is a medical service; providers should follow the inpatient admission process listed below. When the member is ready for substance use disorder treatment, contact Aspirus Health Plan.

Medical inpatient admissions: Fax daily inpatient admissions report to the Utilization Management Intake line at 715.787.7316 or email (secured) to clsintakeMA@aspirushealthplan.com. Refer to the authorization requirements grid on the Prior Authorization & Notification Requirements and Referrals webpage or call 715.631.7443 or 855.931.5265 toll-free within one business day from the date of admission. Please include the member's name, Aspirus Health Plan ID number, date of birth, ICD-10 diagnosis and admission date.

Aspirus Health Plan reserves the right to require a concurrent review for any inpatient hospital stay.

Acute Inpatient Rehabilitation and Long-Term Acute Care (LTAC) admissions: Aspirus Health Plan requires authorization for Acute Inpatient Rehab and LTAC hospital admissions. Notification is required within 24 hours of admission, and Aspirus Health Plan reserves the right to complete concurrent review.

Aspirus Health Plan uses utilization triggers for utilization management and case management. Hospitals are expected to:

- Promptly provide adequate clinical information for any stay upon request.
- Provide reasonable access to hospital utilization review staff.
- Notify Aspirus Health Plan when case management or discharge planning support needs are identified.

Note: All Acute-In-Patient Rehab or LTAC admissions are processed by Aspirus Health Plan Medical Utilization Management Intake Line at 715.631.7443 or 855.931.5265 toll-free or by fax at 715.787.7316.

Notice of Discharge and Medicare Appeal Rights

When an Aspirus Health Plan member is admitted to a hospital, the facility must provide the member with inpatient hospital discharge appeal rights. "An Important Message from Medicare About Your Rights (IM)," a statutorily required notice, explains members' rights as hospital inpatients, including discharge appeal rights.

Use of Standardized Notice: Hospitals must use the standardized IM form (CMS-10065) (Expiring Dec. 31, 2025). Hospitals may not deviate from the form's content except where indicated. The Office of Management and Budget (OMB) control number must be displayed on the notice.

Delivery Timeframe: If the IM is not given prior to admission, hospitals must deliver the IM to the enrollee at or near admission but no later than two calendar days following the date of the enrollee's admission to the hospital. The hospital may deliver the IM within seven days of admission but only in cases where an enrollee has a scheduled inpatient visit, such as elective surgery. Hospitals may not deliver the IM to an enrollee who is in an outpatient or observation setting on the chance that the patient may end up receiving inpatient care.

Follow-up Important Message from Medicare: A follow-up copy of the signed IM must be delivered to the member using the following guidelines: *If the member is being discharged more than two calendar days after receiving the IM at admission, hospitals must deliver the follow-up copy as far in advance of discharge as possible, but no more than two calendar days before the anticipated/planned date of discharge. Thus, when discharge seems likely within one to two calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice so that the member has a meaningful opportunity to file an appeal if the member disagrees with the discharge plan.*

When Aspirus Health Plan or the attending physician determines that a member no longer meets inpatient hospital criteria and is being discharged to a non-covered, custodial level of care, the follow-

up copy of the IM should be given. However, for members who are to be moved to the covered, skilled level of care (swing bed or a skilled nursing facility), the IM should only be delivered once a bed is available.

Detailed Notice of Discharge (DND): A member of a Medicare inpatient hospital stay has a right to request an immediate review by the Quality Improvement Organization (QIO). If Aspirus Health Plan or the hospital determines that inpatient care is no longer medically necessary and the member files an appeal, the QIO will contact Aspirus Health Plan and request the DND to be delivered to the member. The DND provides the member with a detailed explanation of why the Aspirus Health Plan or the hospital decided inpatient care should end. If Aspirus Health Plan makes the decision that inpatient care should end, the DND will be completed by Aspirus Health Plan staff and faxed to hospital staff for delivery to the member. The DND must be delivered to the member as soon as possible but no later than noon of the day after the QIO notification. Hospital staff must keep documentation of the delivery time of the DND.

Use of Standardized Notice: Hospitals must use the Detailed Notice of Discharge (CMS-10066) (Exp. Dec. 31, 2025). The Centers for Medicare & Medicaid Services will accept this form until a new one has been introduced.

In-Person Delivery: The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee's representative.

Notice Delivery to Representatives: CMS requires that notification of the enrollee's Medicare appeal rights be made to the enrollee's representative when the enrollee is not competent or able to receive or comprehend the information. A representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the enrollee's legal guardian or someone appointed in accordance with a properly executed "durable medical power of attorney").

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for them but who has not been named in any legally binding document may be a representative for the purpose of receiving the notices described in this section. Such representatives should have the enrollee's best interests at heart and must act in a manner that is protective of the enrollee and the enrollee's rights. Therefore, a representative should have no relevant conflict of interest.

Regardless of an enrollee's competency, if the hospital is unable to personally deliver a notice to a representative, the hospital should telephone the representative to advise them of the enrollee's rights as a hospital inpatient, including the right to appeal a discharge decision.

When direct phone contact cannot be made, the hospital should send the notice to the representative by certified mail, return receipt requested or any method in which delivery may be tracked and verified (e.g., UPS, FedEx, etc.). The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. The hospital should place a copy of the notice in the enrollee's medical file and document the attempted telephone contact with the member's

representative. The documentation should include the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call and the telephone number called.

If both the hospital and the representative agree, hospitals may send the notice by fax or email. However, hospitals must meet the Privacy and Security requirements of the Health Insurance Portability and Accountability Act (HIPAA) when transmitting IMs by email or fax.

Ensuring Enrollee Comprehension: Notices should not be delivered during an emergency. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee's signature. This includes explaining the notice to the enrollee if necessary and allowing them to ask questions. The hospital should answer all the enrollee's questions orally to the best of its ability. The enrollee should be able to understand that they can appeal a discharge decision without financial risk but may have to pay for any services received after the discharge date if they stay in the hospital and do not appeal.

These instructions do not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice but is either physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance.

Enrollee Signature and Date: The IM must be signed and dated by the enrollee or representative to demonstrate that the enrollee or representative received the notice and understands its contents.

Refusal to Sign and Annotation: If an enrollee refuses to sign the notice, hospitals may annotate the notice to indicate the refusal and the date of refusal. The date of refusal is considered the date of receipt of the notice. The annotation may be placed on the unused patient signature line in the "Additional Information" section on page two of the notice, or another sheet of paper may be attached to the notice. Any insertions on the notice must be easy for the enrollee to read (i.e., in at least 10-point font) in order for the notice to be considered valid.

Notice Delivery and Retention: Hospitals must give the patient a copy of the signed or annotated notice and retain a copy for their records. The hospital may determine whether to retain the original notice or give it to the enrollee. Providers may also determine the method of storage that works best within their existing processes, for example, storing a copy in the medical record or electronically.

For more information regarding CMS requirements for member notification, please see Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. Aspirus Health Plan requires providers and facilities to work collaboratively with the member and their family to ensure care is coordinated as members transition from one setting to another, such as when they are discharged from an acute setting to a community setting.

- For both planned and unplanned transitions, the sending facility should share the member's plan of care with the receiving facility within one business day of the transition. This can be done in several ways, such as by sending a complete facility transfer form or a copy of the discharge instructions or communicating verbally with the receiving facility.
- For planned and unplanned transitions from one setting to another, the facility/provider should communicate with the member or members' responsible party about the transition process and any changes to the member's health status and plan of care.

Aspirus Health Plan requires that facilities such as hospitals, skilled nursing facilities, rehabilitation facilities or customized living centers communicate with the member's primary care provider regarding planned and unplanned transitions.

The Aspirus Health Plan case manager facilitates safe transitions for members who are open to case management when discharged from the hospital or Skilled Nursing Facility (SNF) to their home. Based on a recent discharge home, members who are not currently open to case management may be identified for outreach.

Skilled Nursing Facility Services

This chapter describes Aspirus Health Plan's authorization requirements, coverage details and denial notification requirements for skilled-level care provided in a skilled nursing facility.

Definitions

Skilled Care (also known as Medicare Part A extended hospital coverage): A level of inpatient nursing home care available for qualifying Aspirus Health Plan members who require skilled nursing or rehabilitative care following an injury, illness or exacerbation of a chronic condition. These services must meet each of the following criteria:

- Provided under physician orders.
- Require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists and/or audiologists.
- Provided directly by, or under the general supervision of, the skilled nursing or skilled rehabilitation personnel to assure the member's safety and achieve the medically desired result.

Skilled Nursing Facility (SNF): A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation or other related health services. Such services can only be performed by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility Coverage | Medical Necessity Criteria

The following basic services are covered during a skilled nursing facility stay:

- Room and board when skilled care is required.
- Daily skilled nursing services.
- Restorative rehabilitation services.
- Drugs and blood transfusions administered in the facility.
- Medical supplies and durable medical equipment required during the admission to the skilled nursing facility stay.

Services that are not covered as skilled care:

- Respite, hospice and non-rehabilitative or custodial care.
- A private room beyond the standard amount for routine accommodation services.

Coverage for skilled nursing facility care is subject to the following limitations:

- The member must have available skilled nursing facility benefits.
- The nursing facility must participate in Medicare.
- The member must meet medical necessity requirements for admission to a skilled nursing facility as defined by Medicare, except for a preceding three-day inpatient hospital stay (Aspirus Health Plan does not require a three-day inpatient hospital stay but does review each skilled nursing facility authorization request for medical necessity).
- Daily skilled care must be furnished pursuant to a physician's order, be reasonable and necessary for the treatment of the member's illness or injury both in duration, quantity and require the skills of professional health personnel such as registered nurses, physical therapists, occupational therapists and speech-language pathologists.
- The skilled care must be provided directly by or under the supervision of the skilled nursing and/or rehabilitation personnel.

Skilled care coverage may be considered medically necessary when all the following criteria are met:

- Services require a skilled nursing facility level of care and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech-language pathologists or audiologists.
- Services are provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the member and to achieve the medically desired result.
- Services are provided under a plan of care established and periodically reviewed by a physician.
- Skilled services are necessary for treating an illness or injury with the expectation of improvement within a reasonable and generally predictable period of time. Alternatively, such services must be required to establish a safe and effective maintenance program. At least one of the following types of skilled services is needed:
    - Skilled nursing services: Services necessary when the member's condition continues to require skilled assessment, treatment and management/modifications on a daily basis or is potentially or acutely unstable and requires frequent and ongoing monitoring and assessment. The skilled nursing services must be provided daily (seven days per week).
    - Rehabilitative services: Therapies performed to increase or enhance the member's functional mobility or status. These may include physical therapy, occupational therapy and speech therapy. Rehabilitative services must be provided at least five days per week.

Nursing facility care is not considered skilled-level care and/or not medically necessary for the following situations, including but not limited to:

- Services that do not meet medical necessity criteria as defined by Medicare and/or as previously described.
- Services are solely provided to allow respite for the member's caregivers or family.
- Care of a custodial nature.
- Care for the sole purpose of subcutaneous daily injections of maintenance medications, such as insulin.
- Administration of oral medications, including oral antibiotics for urinary tract or upper respiratory infections.
- Care of stable or chronic wounds.
- Care of stable medical conditions or conditions with an established plan of care.
- Administration of medical gases (oxygen).

Authorization Requirements for Skilled Nursing Facility Stays

Find authorization requirements for medical services on the Prior Authorization & Notification Requirements and Referrals webpage.

Skilled nursing facility stays require notification within 24 hours of admission. Medicare medical necessity criteria must be met for approval.

All skilled nursing facility admissions are subject to concurrent review. They must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay/concurrent review:

- Documentation of progress toward long- and short-term goals.
- Expected length of treatment.
- Examples of documentation that may be requested:
    - Nursing assessments and progress notes.
    - Rehabilitation therapy assessments and progress notes.
    - Physician orders and progress notes.

Qualifying Events

Aspirus Health Plan waives the three-day hospital stay requirement for skilled nursing facility coverage for Aspirus Health Plan members. Aspirus Health Plan does not follow the Medicare presumption of coverage upon discharge from a hospital stay, regardless of the length of hospitalization. Aspirus Health Plan looks directly at medical necessity and the qualifying event leading to the need for a skilled level of care, whether or not there was a hospital stay immediately prior.

To be eligible for skilled nursing facility coverage, the member must have Medicare Part A days available, the stay must meet Medicare skilled-level coverage criteria, and the Aspirus Health Plan must authorize the stay. One of the following conditions must be met:

- The member resides in the community or long-term care, is discharged from an inpatient hospital stay, and presents to a clinic, emergency room or urgent care setting. Or the member has been evaluated by a physician, physician assistant or nurse practitioner at their residence or via telehealth visit.
- **All** of the following must be true:
    - The member has an injury, illness or acute exacerbation of a chronic condition and
    - The member requires ongoing skilled care, observation, monitoring or rehabilitation therapy that cannot be appropriately provided in the home setting and
    - The member meets skilled nursing facility coverage/eligibility criteria.
- Alternatively, a resident of a long-term care facility or nursing facility who experiences an acute illness, injury or exacerbation of a chronic condition that would meet the criteria for an inpatient hospital admission may be authorized for skilled nursing facility care if the skilled care can be provided safely in a skilled nursing facility. When a member moves from custodial to skilled nursing facility level of care, the physician or nurse practitioner must evaluate the member in person within 24 hours of exacerbation. The physician, physician assistant or nurse practitioner must communicate with nursing personnel either by telephone or in person at least every 24 hours thereafter.

Aspirus Health Plan Coverage Details

Benefit Periods

- Aspirus Health Plan covers up to 100 days of skilled nursing facility level of care per benefit period, including days used under fee-for-service Medicare or Medicare Advantage contracts.
- A “benefit period” is a period of consecutive days that begins with the first day of admission to a hospital, skilled nursing facility or intermediate care facility.
- A new benefit period begins following a period of 60 consecutive days during which the member has not been an inpatient at any hospital or received skilled care in a skilled nursing facility.

Separation Periods

- A separation period is 60 or more consecutive days when the member has not been inpatient at any hospital or received skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility but not receiving a skilled level of care, the non-skilled days count toward the 60-day separation period.
- If the member is hospitalized for any reason, regardless of the type of care received in the hospital, upon discharge, the 60-day separation period starts over. A member may have more than one benefit period if the separation criteria are met.

Swing Bed Authorization Requirements

Notification is required for swing bed stays prior to admission or within 24 hours of admission. Medicare medical necessity criteria must be met for approval.

All swing bed admissions are subject to concurrent review and must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay concurrent review:

- Documentation of progress toward long- and short-term goals.
- Expected length of treatment.

Examples of documentation Aspirus Health Plan may request:

- Nursing assessments and progress notes.
- Rehabilitation therapy assessments and progress notes.
- Physician orders and progress notes.

Medical necessity for swing bed admission follows Medicare skilled level of care criteria. Hospital providers of extended care services are expected to identify skilled nursing facilities within their geographic region and determine the availability of skilled nursing facility beds prior to requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities. Hospital providers must transfer the member to a skilled nursing facility as soon as a bed becomes available. The typical duration of a swing bed authorization is three to five days. The admission will be concurrently reviewed for continued coverage.

Denial and Discharge Notices

Denial and discharge notices for skilled nursing facility services are issued by nursing facilities for Aspirus Health Plan members. A copy of the completed denial notice is required to be sent to the Aspirus Health Plan Utilization Management Intake Line:

- Phone: 715.631.7443
- Fax: 715.787.7316

Aspirus Health Plan Denial Forms

Find the customized forms on the Denials webpage.

NOMNC – Notice of Medicare Non-Coverage

- Issued by skilled nursing facility staff when ongoing services will be terminated.
- Must be delivered two days prior to discharge or service termination.

NOMNC Valid Delivery Documentation Form

- Worksheet for Comprehensive Outpatient Rehabilitation Facilities (CORF) staff when issuing a NOMNC via phone.
- This is not to be sent to a member or member representative.

DENC – Detailed Explanation of Non-Coverage

- Issued by skilled nursing facility staff when the member does not agree with service termination and wants to appeal via fast track, using the Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO).

NDMCP – Notice of Denial of Medical Coverage or Payment Issued by Skilled Nursing Facility staff when:

- Admission to a skilled nursing facility is denied prior to or at admission.
- A member exhausts the 100-day skilled benefit in a facility.
- There is a denial, reduction or termination of a Medicare service that does not include a skilled Medicare stay.

Skilled Nursing Facility Responsibilities Regarding Denial Notices

Use the Notice of Medicare Non-Coverage (NOMNC) when ongoing services in a skilled nursing facility are denied. The NOMNC, also known as the advance notice, informs the member of the date coverage of services will end. The form describes what to do if the member wishes to appeal the decision or needs more information.

The facility is responsible for delivering the NOMNC to the member no later than two days before the end of coverage. The facility does not need to agree with the decision that covered services should end, but it must deliver the notice.

If the total span of services is expected to be fewer than two days, the NOMNC should be delivered to the member upon admission or start of services.

If there is more than a two-day span between services, the NOMNC should be issued on the next to the last time services are furnished. This notice should be delivered as soon as the service termination date is known.

The facility must carry out valid delivery of the NOMNC, meaning that all patient-specific information required by the notice is included, and the member (or authorized representative) must sign and date the NOMNC Valid Delivery Documentation Form found on the Denials webpage. If a member representative has been appointed, the representative must receive all required notifications. Authorized representatives may be notified by telephone if personal delivery is unavailable immediately.

- The authorized representative must be informed of the contents of the notice.
- The call's date, time and phone number must be documented.

- The notice must be mailed to the representative on the same day as the telephone notification.
- The provider may document the valid delivery of the NOMNC notice using the Aspirus Health Plan NOMNC Valid Delivery Documentation Form.

If a member decides to appeal the end of coverage, they must contact the Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO) no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review.

The BFCC-QIO will inform Aspirus Health Plan and the provider of the request for a review.

- The BFCC-QIO for Wisconsin is Livanta (This information is on the Aspirus Health Plan-specific denial forms for Aspirus Health Plan).
- The provider is responsible for providing the BFCC-QIO and member with a Detailed Explanation of Non-Coverage (DENC), also known as the detailed notice, which explains why services are no longer necessary.
- The BFCC-QIO must make a decision by close of business on the day coverage is to end.
- The provider and Aspirus Health Plan must cooperate with the BFCC-QIO to provide information for the review.
- The provider must obtain appropriate signatures from the member and/or the member's representative.
- Information provided to the BFCC-QIO must be in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines.

Facilities must issue all notices to Aspirus Health Plan members when directed to do so by Aspirus Health Plan or by the delegated approval authority. The facility must follow the direction of Aspirus Health Plan or the delegated approval authority and must not delay the delivery of the notice.

The facility must use the most current Aspirus Health Plan version of the denial notice for Aspirus Health Plan Health Plan whenever a notice is delivered to a member. (Find the customized forms on the Denials webpage.)

The facility must ensure that the notice and delivery are valid. Notices cannot be altered in any way.

Appendix A: Provider Manual Updates

April 30, 2025 Update

Page	Chapter	Topic Changes	Type of Change			
			Update	New	Deletions	Other
19	Provider Responsibilities	Demographic data changes submission requirement time updated.	X			
24	Provider Credentialing	Locum tenens practitioners added to practitioners that require credentialing.		X		
28	Claims & Payment	Structure and order of chapter changed. Sections updated/moved/removed.	X	X	X	
46	Electronic Data Interchange (EDI)	Structure and order of chapter changed. Sections updated/moved/removed.	X	X	X	
86	Disease Management Programs	List of diabetes management tools provided to members updated.	X			