SecureCare HMO
Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our Plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

In keeping with our mission, we have identified members’ rights, along with their responsibilities, that are clearly indicated in the member's handbook.

It is imperative that you be aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. The following Member Services Department is available to assist with any member issues that may arise at 740.695.7907 or 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the
Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at [http://www.ssa.gov/OP_Home/ssact/title19/1902.htm](http://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

**Appeals Overview**

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an “ORGANIZATION DETERMINATION.” Enrollees have a right within 60 days of a denial to request either a standard pre-service (30-day) or post service claim (60 day) or expedited (72 hours) reconsideration whenever a Medicare Advantage organization has denied an enrollee’s request for services. Where the Medicare Advantage organization affirms its advice “Organization Determination” in whole or in part, the Medicare Advantage organization must automatically forward the case file to CMS independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

**Who may request reconsideration (section 70.1)** Chapter 13 Medicare Managed Care Manual—Any party to an organization determination (including a reopened and revised determination) i.e., an enrollee, an enrollee’s representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered. However, contract providers do not have appeal rights. An enrollee, an enrollee’s representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) are the only parties who may request that a Medicare health plan expedite a reconsideration. For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee’s behalf without submitting a representative form. See additional information in section 70.1.1

**For a pre service reconsideration (section 70.1.1)** Chapter 13 Medicare Managed Care Manual—If the reconsideration request comes from the enrollee’s primary care physician in The Health Plan’s contract network, no enrollee notice verification is required.

If the request comes from either an in-network (contract) physician or a non-contract physician, and the patient’s record indicates he or she visited this physician at least once before, a Medicare health plan may assume the physician has informed the enrollee about the request and no further verification is needed. If this appears to be the first contact between the physician requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the physician has given the enrollee appropriate notice.
Provision of Non-Covered Services

CMS views contracted providers as extensions of the MA plan and CMS no longer recognizes the traditional “ABN” for MA plans (they still recognize it for Traditional Medicare). If a member wants to receive a non-covered service, then either the member needs to call customer service or the provider needs to call the pre-auth department prior to services being rendered and request an Organizational Determination (OD). Through the OD process, both the member and provider will then receive a letter indicating the member can be billed for these non-covered services. The only other option would be for the contracted MA provider to NOT BILL The Health Plan for the non-covered services. Then they could bill the member directly. However, the member may “request” the MA plan be billed prior to the member paying, and in that instance, the claim would be denied as “not covered,”.
### Appointment of Representative Statement

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The Health Plan

I do hereby swear that I am the above mentioned beneficiary or an authorized representative of the above mentioned beneficiary. I do hereby appoint the following individual ______________________________ to act as my representative in requesting a reconsideration from The Health Plan and/or the Healthcare Financing Administration, or its designee regarding the services for which the health plan has denied payment or authorization.

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